Comprehensive Policy on Elderly Waiver (EW) Residential Services

TOPIC
Elderly Waiver residential services

PURPOSE
Replace Bulletin #14-25-06

Clarify Elderly Waiver residential services policy and use of rate-setting tools

CONTACT
PolicyQuest
Lead agency EW residential services policy questions

EWRSHelp@state.mn.us
All other EW residential services questions

SIGNED
LOREN COLMAN
Assistant Commissioner
Continuing Care Administration

TERMINOLOGY NOTICE
The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.
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I. Background

Minnesota offers an array of home and community-based services (HCBS) through the Elderly Waiver, including services provided in a participant’s own home, and services provided in residential settings. Services provided in residential settings include customized living (CL) services, family and corporate adult foster care (AFC), and residential care (RC).

The Elderly Waiver is authorized under Minnesota Statute, section 256B.0915, and subject to all state and federal requirements governing the provision of HCBS services under a waiver plan approved by the Center for Medicare/Medicaid Services (CMS). A copy of the federally-approved EW waiver plan can be found at CMS’ Demonstrations & Waivers webpage.

This bulletin replaces Bulletin 14-25-06 and includes new information related to:

- Adult foster care (family and corporate), and residential care policy
- Updated service rate limits
- Changes in and clarification of provider billing and payment for residential services
- Person-centered planning requirements
- Home and community-based setting requirements

II. CMS Final Rule for HCBS

In January 2014, the CMS issued a final rule that governs HCBS for all states. The intent of the rule is to ensure individuals receiving MA-funded HCBS have the opportunities to receive services in a manner that protects choice and promotes community integration. The rule outlines specific requirements related to person-centered planning, conflict-free case management, and the nature and qualities of HCBS and HCBS settings. The information below provides a brief overview of two of these requirements.

A. Person-Centered Planning

The HCBS rule includes criteria for person-centered planning processes and individual person-centered plans. The rule applies to people who receive services through all HCBS waivers and other HCBS state-plan services funded through Medical Assistance. The HCBS rule includes specific person-centered requirements for the planning process, creating service plans and reviewing plans. They require that:

- The person who receives supports must direct the planning process, which can include people who the person chooses to participate in the process.
- The plan must identify the goals and preferences the person chooses.
- The planning process and the plan help the person achieve the outcomes he or she chooses in the most integrated community setting. This ensures that the delivery of services reflects the person’s choices and preferences, and positively contributes to the health and welfare of the person.
For additional information about person-centered planning, go to the CMS website for rule language, fact sheets and additional resources. Please also see DHS Bulletins 16-56-01, 16-56-02, and 16-56-03 related to person-centered planning.

B. HCBS Settings - Qualities and Characteristics

The HCBS rule requires that all HCBS settings, both non-residential and residential, have certain qualities, and that any provider-controlled or provider-owned residential services settings meet additional requirements. Any residential or non-residential setting where individuals live and/or receive HCBS must demonstrate the following five qualities:

- The setting is integrated in and supports full access of individuals to the greater community (including opportunity to seek employment, work in competitive, integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS).
- The setting is selected by the individual from among setting options including non-disability-specific settings and options for a private unit in a residential setting. The person-centered service plan documents the options based on the individual’s needs, preferences, and for residential settings, resources available for room and board and/or rent.
- The setting ensures an individual’s rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services, supports, and who provides them.

A residential setting that is provider-owned or controlled is subject to additional requirements. A setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS, which include housing with services establishments that provide customized living services and family and corporate foster care. These requirements include:

- The specific unit/dwelling is owned, rented or occupied under a lease or other legally enforceable agreement that provides the same responsibilities/protections from eviction as all tenants under landlord tenant law.
- Each participant has privacy in their sleeping or living unit.
- Units have lockable entrance doors.
- Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Participants have freedom and support to control their schedules and activities and have access to food at any time.
- Participants may have visitors at any time.
- The setting is physically accessible to the individual.
Modification of these requirements must be supported by a specific assessed need and justified, and documented in the person-centered services plan.

DHS is working with stakeholders to implement the requirements of the HCBS Final Rule to ensure Minnesota is in compliance by March 2019. Each state is required to submit a statewide transition plan to the CMS that details how the state will be compliant with the rule by March 2019, including those related to HCBS settings. For more information about the HCBS rule go to DHS’ HCBS transition plan webpage or CMS’ HCBS rule page. Lead agencies and providers will receive more information from DHS about requirements and expectations related to the rule.

### III. EW Monthly Budgets – 2015 Legislative Change

The monthly cost of all waiver services for an individual may not exceed the monthly budget related to the participant’s case-mix classification as required under Minnesota Statutes, section 256B.0915, except when a conversion limit is approved. DHS publishes the case-mix classification budget limits each year on its website.

Case-mix classification is completed by the participant’s assessor at the initial assessment, at the required annual reassessment, and when significant changes in the participant’s needs occur. This classification is completed using criteria established by DHS and specified in DHS Form 3428B.

In 2015, the Minnesota Legislature reestablished a link between nursing facility rate change and monthly budget limits under EW and AC (See Minnesota Statutes, section 256B.0915, subdivision 3a), as well as the service rate limits for CL and 24-Hr. CL. This statute requires the limits to increase annually by the greater of the nursing facility rate increase or any increase to home and community-based services (HCBS) rates during a state fiscal year.

As a result of this legislative change, the case-mix budget caps for the Elderly Waiver (EW) and the service rate limits for customized living and 24-hour customized living increased by 21.3% effective July 1, 2016. See Bulletin #16-25-01 for information on implementing this increase for 2016.

### IV. Residential Services Under the Elderly Waiver

Customized living (CL), adult foster care (AFC), and residential care (RC) services are planned and purchased as a “bundled” service. That is, each service is comprised of allowable component services approved for a participant when there is a documented need for the component service(s) and when the participant chooses to have identified needs met through their residential service plan.

Of these residential services, the most frequently-used service on EW is CL. DHS has submitted an amendment to CMS indicating that residential care will be phased out as a service under EW as of 6/30/18, and no new authorizations after 7/1/17. Lead agencies will receive further instruction about working with individuals who receive this service, helping them transition.
Residential services are individualized and made up of covered component services designed to meet the assessed needs and goals of an EW participant. The component services, their definitions, and guiding service planning principles are defined in Customized Living Component Service Definitions: A Reference Guide for Computing Time for Rate-Setting Tools, eDoc DHS-6790H-ENG.

CL, AFC, and RC providers are required to enroll with DHS Provider Enrollment in order to deliver reimbursable services. All enrolled providers enter into an MHCP Provider Agreement, submit required documents, and provide signed assurances as part of enrollment and/or license review. Providers of all direct contact services must comply with owner and staff background study requirements. Newly enrolling providers must complete state waiver program and waiver billing training (See Minnesota Statutes, section 256B.4912, subdivision. 7).

HCBS waiver providers enrolling with DHS must meet general and service-specific Minnesota Health Care Program (MHCP) requirements. See Attachment A for residential service provider qualifications or visit the following website for updated information: MHCP Enrolled Providers Webpage

V. Planning and Authorization of Residential Services

Following well-established requirements for authorization of all HCBS services, lead agencies shall adhere to these policies and practices when planning for and authorizing payment for residential services.

**Participant Choice:** As required under federal waiver requirements and state policy, HCBS service plans must be based on the participant’s choice among all available services, providers, and sources of support. Services to be provided by the residential service provider must be based on the participant's informed choice. The participant may choose which of their needs will be addressed by the residential service provider, by other Medicaid state plan or EW service providers, or by quasi-formal supports or informal supports, with the following exceptions:

- Services eligible for Medicare payment must be provided by a Medicare-certified provider in order to maximize the participant’s Medicare benefit before accessing either Medicaid state plan or EW services; and, Medicaid state plan must be utilized to pay for covered services, when applicable, not EW.

**Service Flexibility:** As part of person-centered planning required under all HCBS waiver programs, EW case managers and care coordinators will facilitate informed choice by outlining different combinations of supports that are available through EW, Medicaid state plan, long-term care insurance and/or quasi and informal supports that would meet the participant’s needs.

**Personalized Component Services:** Case managers and care coordinators will authorize residential services that include the amount of component services requested by the participant to meet assessed needs and that enable the achievement of participant goals.
whenever possible, e.g., transportation to weekly events or to visit friends to maintain community and family involvement.

**Personal Risk Management:** One dimension of choice and self-direction is the right to assume and manage personal risk. When a person chooses to manage their own risk, i.e., they choose to *not* have a service to meet an identified need, the assessor, case manager, or care coordinator will provide education to the person. This will include how any resulting health and safety issues might be managed, and what the acceptable threshold of risk can be while still meeting waiver care plan requirements related to reasonable health and safety.

**Full Access to the Community:** The assessor, case manager, or care coordinator shall ensure through the planning process that the participant has full access to the greater community. This should be documented in the CSP/CSSP and service delivery plan. Access to the greater community can be supported through either informal supports such as family and friends, or through formal residential component services including socialization, arranging transportation, non-medical transportation services, and/or mileage.

Socialization is designed to support the participant in attaining person-centered goals and outcomes. Socialization may include support that assists the participant in maintaining or developing relationships, communicating with family and friends, supporting the participant in realizing socially valued roles of their choice, e.g., volunteering or serving on a committee, or support that allows the participant to engage in meaningful leisure activities.

Activity programs that do not facilitate the participant’s stated outcomes and goals are not considered socialization and are not covered.

**Long Term Care Assessment and Provider Input:** In order to be eligible for the EW, participants must be assessed face-to-face through the Long Term Care Consultation or MnCHOICES assessment at least once yearly, i.e., 365 days. Providers may not attend the assessment, but with the person’s permission, providers may submit written recommendations related to the participant’s care needs. This input should be provided to the assessor prior to the assessment (Minnesota Statutes, section 256B.0911, subdivision 3 (a)).

**CL, AFC, or RC service plan must be completed prior to authorization of service:** Assessors shall complete the CL, AFC, or RC service plan for all participants new to EW if the planned service will start before the case manager is able to complete the tool. This ensures prospective rate and service planning as well as a person-centered workflow. Case managers are responsible for completing the service plan after annual reassessment is completed, or as necessary, to ensure that the service plan adequately addresses changes in participant’s needs and goals.

**The service plan shall:**

- Be person-centered
- Describe assistance that will be provided in each component service authorized
- Avoid duplication of time allocated
- Include the following information when time is authorized to address behavioral or
orientation needs:
  o personalized goals
  o specific staff interventions, including frequency and other service details
  o required staff training
  o baseline and ongoing daily and other documentation needs
  o re-evaluation timeline and criteria

As with any HCBS service, the type and amount of each component service included in the
personalized plan must be based on and linked to the documented needs and goals of the
EW participant. The EW Residential Services Tool (RS Tool) is designed to support
services planning related to both assessed needs and the person’s choices in services.

**Supervision:** Supervision is ongoing awareness of a participant’s needs and activities, and
includes the recognition of the need for assistance and provision of the assistance required
or the summoning of appropriate assistance. Customized living may include supervision,
whereas if the determination is made that the participant needs 24-hour supervision, the
customized living plan must include a plan to provide 24 hours of supervision which is
provided in a way that meets that person’s documented assessed needs and preferences.

Supervision is incorporated into the customized living plan when:

- The need for supervision has been assessed and documented by the LTCC or
  MnCHOICES assessor.
- The level and type of supervision that will be provided to meet the assessed need is
documented in the participant’s service plan. As with all services to be provided to
the participant, the scope and duration of supervision must be specified, and the
information must be readily available to the participant and to the lead agency
(counties, health plans or tribes).

When assessing the supervisory needs of participants, assessors, case managers, or care
coordinators should consider the person’s:

  - health status, including physical, sensory, and cognitive impairments;
  - need for assistance that is intermittent and cannot be scheduled, such as
    assistance with toileting;
  - ability to identify their own needs and seek assistance when needed;
  - ability to identify danger and harmful situations, and to seek help;
  - ability to make decisions regarding health and safety;
  - prior lifestyle in addressing one’s health and safety needs; and
  - other information about the participant’s needs that could contribute to the need for
    supervision as defined here.

The lead agency will determine whether the participant meets the criteria for 24-hour
supervision. As required for any HCBS service, the lead agency will not authorize services
unless the participant has a documented need for the service, including the need for 24
hours of supervision and the need is to be met by the provider within the customized living
plan. Customized living providers that provide 24-hour supervision must have the ability to
provide 24 hours of supervision as defined in Attachment B.
If supervision is assessed as needed and is to be included in the service plan, the following elements should be included:

- frequency of contact that needs to be initiated and maintained by the staff;
- type of needs and activities for which staff are observing and providing oversight;
- different modes of contact between the participant and the staff;
- locations in which supervision will be provided, and changes in supervision depending on activities/location of the participant;
- identification of supervision that may be provided by people other than paid staff, and
- delineation of when supervision is required, e.g. all the time or less than 24 hours a day.

Assessors, case managers, and care coordinators should address whether a participant requires supervision outside of their home as well as within the housing with services establishment. The service plan should clearly indicate providers or others responsible for provision of supervision when leaving the housing with services establishment.

Supervision outside of the housing with services establishment should be included in the section of the plan related to the participant’s need for supervision as a discrete service, and as part of the delivery of other component services. For example, if the participant has orientation challenges, it should be included in the active behavioral or cognitive support section. If the participant needs assistance with wheeling, it should be addressed in that section of the service plan. The plan should facilitate meaningful participation in community life.

**VI. Establishing Residential Service Payment Rates**

The rate established for each residential service is based on and varies depending on the participant’s assessed needs and the service delivery plan developed between the case manager or care coordinator and the EW participant. The residential service rate limits for an individual are established based on the person’s case mix classification. The residential service rate limit is not the same as the person’s monthly EW case-mix budget limit described in Section III.

While each service plan and resulting rate must be individualized, Minnesota’s EW Plan approved by CMS requires all counties and tribes to use uniform statewide service rate-setting tools for CL, AFC, and RC.

The Minnesota Department of Human Services (DHS) requires the use of the *EW Residential Services Tool (RS Tool)*, an Excel workbook, to ensure that the rates paid for all residential services are individualized and based on documented needs, participant choice, and the type and amount of component services authorized. Effective July 1, 2015, the RS Tool is required to be used to plan and set rates for AFC and RC in addition to CL. Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h govern customized living rates; subdivision 3i addresses capitation rates for managed care organizations (MCOs).
A. Service Rate Limits

The rate limits for residential services are included in the LTSS Rate Limits publication, and may not be exceeded, with the exception of pre-approved conversion rates for individuals returning to the community from a qualifying nursing facility stay. See Bulletin #14-25-08 for more information about conversion rates.

B. Residential Services Payment Rate Parameters

The following rate-setting policies apply to CL, AFC, and RC:

- CL, AFC, and RC service rate limits represent “up to” amounts and should not be considered rates or funding amounts that the provider can expect or charge for a service plan.
- Service authorizations must be individualized and based on the participant’s need for each component service, the amount of each component service to be delivered, and the provider’s qualification, ability, and willingness to deliver the needed component service at the authorized rate. In addition, participants have choice in how needs will be met in the service plan and within their support plan as a whole.
- The authorized rate must be based on the services authorized, not on a base rate established by the provider.
- The authorized rate is the rate established using the EW Residential Services Tool (RS Tool), up to the service rate limit for the person.
- Effective for services provided and billed on or after July 1, 2016, for CL and AFC, the authorized rate is a daily rate, which is based on the amount of services to be delivered in an average month and as reflected in the EW Residential Services Tool (RS Tool). For RC, the authorized rate is a monthly rate as reflected in the EW Residential Services Tool (RS Tool).
- The rates authorized for a unit of a component service shall not exceed the fee-for-service EW or Medicaid state plan rate limit for a similar service and units of service delivered outside of a residential services setting. The RS Tool includes the component rates that must be used.
- The authorized rate cannot exceed the EW service rate limit for the particular service being authorized.
- Managed care organizations cannot exceed the maximum component rates or the service rate limits for customized living services as required under Minnesota Statutes, section 256B.0915, subdivision 10.
- Service payments must account for economies of scale in areas including staffing and administrative overhead.

C. 24-Hour Customized Living Services Rate Limits

Minnesota Statutes, section 256B.0915, subdivision 3h, paragraphs (a) and (b) include requirements for lead agency authorization of services using the 24-hour CL rate limits. In order to be eligible for the higher 24-hour CL rate limit, the participant must have the following needs as determined by an assessor, case manager, or care coordinator completing the Long Term Care Consultation (LTCC) or MnCHOICES assessment:
• Cognitive or behavioral intervention; or
• Clinical monitoring with special treatment; or
• Staff assistance in toileting, positioning, or transferring (single dependency); or
• Medication management and at least 50 hours of service per month and a dependency in at least three of the following activities of daily living (ADL’s): bathing; dressing; grooming; walking; or eating (when eating is scored as 3 or greater)

“Fifty hours of service” means 50 hours of direct component services per month approved to be part of the 24-hour customized living plan as determined by the assessor, case manager, or care coordinator and the waiver participant.

Under these criteria for 24-hour CL rate limits, EW participants who receive a case-mix “L” classification are not eligible for the 24-hour CL rate limit but can still receive customized living within their approved rate limit as well as all other EW services within the approved case-mix budget cap.

A participant’s eligibility for a 24-hour customized living rate is based on their needs and whether their needs meet criteria for 24-hour supervision, not amounts available under the monthly case-mix budget.

D. Additional Considerations

Lead agencies should also consider the following policies when determining the customized living rate for EW participants:

• Temporary increases or decreases of time needed to provide component services should be factored into the development of the participant’s service plan and monthly rate as part of the average estimated time needed to meet the participant’s identified needs.
• All EW program service costs, such as case management services or specialized supplies and equipment, plus the participant’s CL, AFC, RC, service payment rate, other EW services, and state plan home care services, may not exceed the participant’s monthly case-mix budget cap.
• Room and board or rental rates are not defined or controlled directly by the EW program. However, the Medicaid income standard limits the EW participant’s income available to pay room and board or rent. Settings with GRH agreements must be able to accommodate participants whose income limits them to the GRH rate.
• Room and board costs are not included in component service unit costs or authorized service rates. Board is defined as a full daily nutritional regimen. If meals are provided, the service payment may include the cost of meal preparation and service as a component service but may not include the cost of raw food.

Case managers and care coordinators shall not authorize uncompensated care.

Services included in a participant’s service plan must be authorized within the service’s rate limit. There are several strategies assessors, case managers and care coordinators can use in service plan development that can be supported using these limits and the EW case-mix budget cap:
- Maximize other payors for short term and intermittent needs. Medicare, Medicaid State Plan and other third party payors such as long-term care insurance should be used when appropriate. Needs that can be addressed by other payors cannot be included in the customized living plan.
- Evaluate if reductions in component service time can still meet participant needs to bring the customized living plan under the customized living service rate limit.
- Purchase needed services from other more cost-effective providers in combination with CL, AFC, or RC. Consider transportation options, use of technologies and equipment to replace human assistance, and companions or personal care assistance (PCA) services when appropriate.
  - Personal care assistance (PCA) and extended PCA services authorized and purchased outside of the customized living plan must be purchased from a qualified PCA provider who is not the housing provider as per Minnesota Statutes, section 256B.0659, subdivision 3. All other Medicaid state plan home care services must be purchased from a Medicare certified home care agency.
- Authorize a plan that represents an average estimate that takes into account short term changes in need and component services that may occur.
- Ensure the assessment reflects all participant needs and that the appropriate case-mix classification has been assigned.

VII. Limitations on Services in Combination with Residential Services

In carrying out their quality management role, case managers must assure that there is no duplication of services authorized. For example, a person may choose transportation from another vendor in addition to or in place of the residential services provider. In this case, while the residential services provider may offer transportation service, the assessor, case manager, or care coordinator cannot duplicate and must differentiate this service in the service plan, and must only authorize those services that will actually be provided to the participant by the residential service provider within the service plan.

**Homemaking services** cannot be authorized in addition to residential services, but they must be included, if needed, in the CL, AFC, or RC service plan.

**Chore services** cannot be authorized in addition to residential services, nor can they be authorized as part of the CL, AFC, or RC service plan.

**Personal emergency response devices or systems** cannot be authorized in addition to 24-hour customized living. A rate is negotiated with a provider who is authorized to provide 24 hours of supervision to a person who has been identified as meeting the criteria for need of this level and type of service as part of supervision. The provider may choose to use a personal emergency response device to meet the requirement of providing participants with a system for requesting assistance, or as part of the plan for 24 hours of supervision. Additional payment for personal emergency response cannot be authorized in addition to the 24-hour customized living rate for summoning devices designed for use within the housing with services establishment.
A personal emergency response device or system can be authorized and purchased through EW under specialized supplies and equipment through a qualified supplies and equipment provider if the person receives customized living services containing no or less than 24 hours of supervision.

**Respite services** cannot be authorized for the benefit of paid service providers as these services are intended to support informal and unpaid caregivers. Respite service cannot be authorized in combination with any 24-hour residential-based service such as adult foster care, residential care, or customized living services.

**Consumer-directed community supports (CDCS)** cannot be authorized for participants receiving residential services.

**VIII. Provider Billing and Payment**

**A. Change from Monthly to Daily Billing**

Effective for services provided and billed on or after July 1, 2016, for CL and AFC, the authorized rate is a daily rate, which is based on the amount of services to be delivered in an average month and as reflected in the EW Residential Services Tool (RS Tool). For RC, the authorized rate is a monthly rate as reflected in the EW Residential Services Tool (RS Tool).

**B. Days Absent**

Providers may not bill for full days on which participants are absent from the residential services setting. An overnight absence of more than 23 hours is a non-covered day. An absence of less than 23 hours on the first day is covered. After the first 23 hours, each time the clock passes midnight counts as another non-covered day. Providers must pro-rate billing to reflect non-covered days during the month.

Example:

<table>
<thead>
<tr>
<th>Leave</th>
<th>Return</th>
<th>Non-covered Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30 P.M. Friday</td>
<td>11:30 A.M. Saturday</td>
<td>0 (Less than 23 hours)</td>
</tr>
<tr>
<td>4:30 P.M. Friday</td>
<td>5:00 P.M. Saturday</td>
<td>1 (More than 23 hours)</td>
</tr>
<tr>
<td>4:30 P.M. Friday</td>
<td>8:00 P.M. Sunday</td>
<td>2 (More than 23 hours; past midnight once)</td>
</tr>
<tr>
<td>4:30 P.M. Friday</td>
<td>7:30 A.M. Monday</td>
<td>3 (More than 23 hours; past midnight twice)</td>
</tr>
</tbody>
</table>

DHS authorized payment rates take into account identified, approved fixed costs incurred by the provider as computed by the EW RS Tool for anticipated absences from the setting by a participant.

Regardless of calculating absence, a residential service provider may not bill for dates of service that overlap with a long-term care facility admission date and can bill for the day the person was discharged from the LTC facility if service was provided that day. The [MHCP](https://www.mn.gov/health/long-term-care-medicare.html)
Billing for Waiver and Alternative Care (AC) Program web page provides more detailed waiver claiming instructions.

C. Supplemental Payments for Covered Services Not Allowed

Providers may not request supplemental payment for covered services or the component services approved for in the RS Plan. For example, if the person has light housekeeping planned for in the RS Plan, the provider may not charge the person a fee above and beyond the RS Tool component service rate and may not charge for extra units of light housekeeping beyond what’s approved in the plan (Minnesota Statutes, section 256B.0915, subdivision 3e (g).

IX. Use and Submission of EW Residential Services Tool (RS Tool)

The purpose of DHS’ issued RS Tool is to:

- Provide a tool for the development of the Coordinated Service and Support Plan (CSSP) that describe the type and amount of component services in the individualized CL, AFC, or RC service plan.
- Meet requirements CMS set forth as a condition of the EW Plan renewal.
- Implement Minnesota statutory requirements related to authorization and purchase of these services.
- Provide a consistent statewide approach to the authorization of rates for CL, AFC, and RC services.
- Implement statewide component rates and service rate limits.
- Support program integrity goals.
- Establish a rate reflective of the participant’s approved CL, AFC, or RC service plan.

Lead agencies shall complete the EW RS Tool to develop the individualized service plan and establish a rate prior to authorization of EW CL, AFC, or RC services. All counties, tribes, and managed care organizations using the EW RS Tool must submit completed tools to DHS within 15 days of the service authorization line item begin date.

The rate authorized and paid for individual participants receiving EW CL, AFC, or RC must be equal to, or less than, the rate on the RS Tool submitted to DHS. A new EW RS Tool must be submitted for any subsequent rate change within 15 days of the start date of the new rate.

The EW RS Tool, an Excel workbook, contains worksheets that are used to develop a participant’s CL, AFC, or RC service plan and to calculate their individualized rate. Instructions for completing the workbook, Instructions for up-loading completed EW RS Tools, and other helpful documents are available for download from DHS’ EW Customized Living, Foster Care and Residential Care website.

The RS Tool is designed to:
• Use documented needs (assessment data in the Screening Document Input worksheet) as the basis of the service plan and CSSP development.
• Determine the component services and the amount of each to be provided to a specific EW participant.
• Describe participant preferences and needs to be met through the RS service plan.
• Generate a personalized rate within each participant’s allowable service rate limit (based on their case-mix classification) that is based on the component services and units of service included in the participant’s service plan. This rate is to be entered into MMIS or other payment system for the participant’s service agreement.
• A copy of the RS Plan and Rate Guide are printed and provided to the participant and the provider (be sure MA and the waiver are open before these are given to the provider).

In order to use the EW RS Tool as the CSSP: The Community Support plan (CSP) is provided to everyone who gets an assessment, and the CSSP is created for people receiving public programs. In addition, for EW participants receiving a residential service, the RS Tool must be completed. When the RS Tool is completed, it may be done in lieu of a separate CSSP when:

• The lead agency staff also completes the EW Services Authorized worksheet which provides a computation of all services included in the participant’s CSSP in addition to CL, AFC, and RC services.
• The Print CSSP worksheet is printed in combination with the Print RS Plan and Print Rate Guide. All other informal and/or quasi-formal supports must be included on the ‘Individual RS Plan’ worksheet and signatures must be obtained. The participant receives a copy of the three worksheets.

Additional documents found on DHS’ EW Customized Living, Foster Care and Residential Care website include:

• Instructions for Completion and Use of the Residential Services Tool, a PDF document, describe how to complete the EW Residential Services Tool.
• The Customized Living Component Service Definitions: A Reference Guide for Computing Time for Rate-Setting Tools, eDoc DHS-6790H-ENG, provides a list of each component service, the definition, and guidance to case managers when completing the RS Tool.
• Uploading your EW Residential services Tools instructions (PDF) provides instruction for submitting the EW RS Tool through MN-ITS.
• EW Residential Services Tools Release Notes is a PDF document providing up to date information regarding the latest changes to the EW RS Tool.
• EW Residential Services Tips, Alerts and Guidance (PDF) provides other useful links, assistance on requesting previous RS Tools, opening secure DHS emails, handling errors, interpreting management reports, and further clarification of RS Tool functionality.

X. Group Residential Housing Funds (GRH)

Group Residential Housing (GRH) funds are available to pay for room and board in group settings or a person’s own home. The setting must have a license or registration
from the state or tribal government. Examples of GRH settings include: housing with services establishments, adult foster care, boarding care homes, supervised living facility, or tribally-certified housing. To receive GRH payments, a setting must have a GRH agreement with the county or tribal service area where it is located.

If the participant is on EW and GRH, meal preparation and laundry of personal linens shall be authorized through EW as part of a service plan if either or both are assessed as needed, and there is adequate room in the service rate limit and the EW case-mix budget. If the participant’s service rate limit or community budget cap is inadequate to cover meal preparation and laundry of personal linens in addition to other needed component services, the GRH rate shall cover the portions of these services which do not fit within the participant’s service rate limit or community budget cap.

**Family supplementation of the GRH room and board rate** is allowable if it is for payment for something not covered in the contract room and board rate. For example, if the contract room and board rate pays for a bed in a double room, the family may pay extra for a private room.

**Families may supplement rent and raw food costs for EW participants who are not on GRH** as these are not covered by HCBS waivers. Payments must be made directly to the landlord or they will be counted as income to the participant.

**GRH does allow payment, within limits, for room and board costs if a person is temporarily absent** from the establishment and is expected to return. GRH can pay up to 18 days per episode of absence, not to exceed 60 days in a calendar year, for a GRH participant who is temporarily absent. For non-emergency absences, county approval is required.

**Lead agencies should direct GRH policy questions** to Policy Quest. All other GRH related inquiries can be sent to dhs.dhs.grh@state.mn.us.

**XI. Web Links to Resource Information**

All DHS forms can be found at edocs

DHS Bulletins can be found at DHS Bulletins

For Person-Centered Planning Bulletins, see Bulletins 16-56-01, 16-56-02 and 16-56-03

Minnesota Statutes, section 256B.0915, Medicaid Waiver for Elderly Services

Directory of Licensed Home Care Providers and Registered Housing with Services Establishments

Housing with Services Establishment Registration Information

Licensure Application Forms for Home Health Care Providers

Minnesota Statutes, Chapter 144D Housing with Services Establishment
Minnesota Statutes, Chapter 144G, Assisted Living Services

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-2500 (voice) or toll free at (800) 882-6262 or by using your preferred relay service. For other information on disability rights and protections, contact the agency’s ADA coordinator.
Attachment A - Residential Services Provider
Requirements
Licensure and Dwelling for CL

Customized Living service providers must:

- Maintain a comprehensive home care license issued by the Minnesota Department of Health (MDH).
- Register with MDH each housing with services establishment at which they deliver or plan to deliver services.
- There must be a contract between the housing with services establishment and the home care provider, if they are not the same legal entity.
- Provide services in one of the following qualified settings:
  - A setting of 1-5 unrelated people living together in a residential unit, or
  - A setting of 5 or more unrelated people which is licensed by the Minnesota Department of Health as a board and lodge,\(^1\) or
  - A residential center which is a building or complex of contiguous or adjacent buildings of 3 or more separate and distinct living units (apartments) which participants rent or own.
- Provide each participant with means to effectively summon assistance.
- Providers preparing meals must assure that federal FDA standards are met.

“Assisted Living” requirements are delineated in Minnesota Statutes, Chapter 144G. The EW does not require providers to meet the standards of Minnesota Statutes, Chapter 144G to provide customized living services. However, if the provider chooses to use the term “assisted living” as part of its marketing materials or business name, these requirements must be met. See Attachment B for additional CL provider requirements related to staffing and supervision.

Adult Foster Care

Adult Foster Care (AFC) provided under the EW program is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 or Community Residential Settings (CRS) under Minnesota Statutes, Chapter 245D.

Corporate AFC providers that are assisted living pursuant to Minnesota Statutes, Chapter 144G must enroll as customized living providers and may not enroll as adult foster care. Providers required to register as housing with services establishments and that provide

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\(^1\) If there are five people living together, the setting must be licensed as a board and lodge by the Minnesota Department of Health OR be licensed by DHS as adult foster care under Minnesota Rules, parts 9555.5105-9555.6265. A foster care license may be issued for a capacity of 5, if all persons in care are age 55 or older and do not have a serious and persistent mental illness or a developmental disability.
services that exceed the scope of services and supports allowed within an adult foster care licensure must enroll to provide customized living, not foster care waiver services, and meet all provider standards for customized living services, including holding a comprehensive home care license.

Residential Care

Residential care providers must be licensed as a board and lodging establishment and meet the standards in Minnesota Statutes, sections 157.15-157.17.
Attachment B – Staffing and Supervision Requirements for CL

Employ staff who meet the following requirements:

- Recognize the need for and provide assistance required or summon appropriate assistance.
- Have the physical ability to provide the services identified in the participants’ service plans.
- Drivers must have a valid driver’s license and adequate insurance coverage as required by Minnesota Statutes, Chapter 65B.
- Be able to:
  - work under intermittent supervision
  - communicate effectively with other staff and participants
  - read, write, and follow written and verbal instructions
  - follow participant’s personalized service plans
  - identify and address emergencies including calling for assistance
  - understand, respect, and maintain confidentiality

Supervision for CL

In addition to the staff requirements listed above, staff providing supervision to participants must also:

- Work on-site within the customized living program.
- Have as their primary work responsibility the supervision of participants in the housing with services setting (generally this means the same building).
- Have ongoing awareness of the participants’ needs and activities.
- Be capable of communicating with participants, recognizing the need for assistance, and providing or arranging for appropriate assistance.
- Be an employee of the customized living provider who is not a participant of services.
- Be able to respond in-person to a participant within a time frame that meets the participant’s needs and in no event exceeds ten minutes.