#07-25-01

Bulletin

June 26, 2007

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Health Plans
- EW Administrative Contacts
- Customized living providers
- Housing with Services Establishments
- EW Case Managers
- EW Care Coordinators
- EW Tribal Administrators

ACTION

- Implement 2007 legislation
- Implement MMIS changes by Oct 1 2007
- Complete and submit Lead Agency Worksheet by July 31 2007
- Review and implement policy

EXPIRATION DATE

June 26, 2009

Comprehensive Policy on Elderly Waiver (EW) Customized (Formerly Assisted) Living

TOPIC

EW customized living and 24 hour customized living service (formerly assisted living and assisted living plus).

PURPOSE

- Outline 2007 legislative changes establishing criteria for the authorization of 24 hour supervision as a component of customized living service.
- Integrate and replace all former bulletins pertaining to EW customized living and 24-hour customized living services (formerly called assisted living and assisted living plus).
- Clarify EW customized living service policy.
- Announce changes to MMIS to support program integrity.

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SIGNED

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I. Background

The 2006 Legislature enacted Minnesota Statute, section 144G, *Assisted Living Services*, which restricts the use of the words "assisted living" to providers who meet the criteria outlined in that section. The requirements of Minnesota Statutes, chapter 144G are not the same as existing provider requirements for assisted living and assisted living plus (AL and AL+) in the federally approved Elderly Waiver (EW) plan. In order to differentiate the services covered under EW from "assisted living" as defined in Minnesota Statutes, chapter 144G, a waiver amendment was submitted to the Center for Medicare and Medicaid Services (CMS) to maintain the provider standards and requirements for this service under the Elderly Waiver, and to change the names of assisted living and assisted living plus services to customized living and 24-hour customized living services, respectively. The waiver amendment approved by CMS also clarifies the supervision component that is and continues to be an optional component service under AL and a specifically included service component of AL+.

In addition, the 2007 Legislature approved amendments to Minnesota Statutes, section 256B.0915 governing the Elderly Waiver program. This amendment outlines criteria that must be met to authorize 24 hour supervision as a component of customized living services. In addition, the amendments establish the commissioner's authority to require rate negotiation for these services. These parameters have been previously published in bulletins referenced in Section XIV of this bulletin.

This bulletin describes the 2007 legislative amendment in more detail, reiterates policy related to the former EW assisted living and assisted living plus service that continues to be applicable to customized living and 24-hour customized living services, and :

- Outlines the change in the name of the EW assisted living and assisted living plus services to EW customized living and 24-hour customized living services, respectively

- Reiterates federal requirements related to consumer needs assessments and individualized service planning as prerequisite to authorization and purchase of any waiver service, including EW customized living packages

- Clarifies the previously established policy regarding supervision, an optional component service in customized living and a specifically included component of 24-hour customized living services

- Outlines criteria established in the 2007 Legislature that must be met to authorize 24 hour supervision as a component of 24 hour customized living services

- Reviews existing AL/AL+ provider requirements and their continued use as provider requirements for the provision of customized living and 24-hour

customized living services, with minor changes resulting from the enactment of legislative changes to Minnesota Statutes, section 144A in 2006

- Reiteration of previously published state policy regarding negotiation of individualized rates for assisted living and assisted living plus services that continues to be applicable to customized living and 24-hour customized living services.

With the exception of the criteria for the authorization of 24 hour supervision as a component of customized living service, these policies previously have been published in AL and AL+ bulletins issued by the department and listed in Section XIV of this bulletin. This bulletin summarizes the information that continues to be applicable to customized living and 24-hour customized living, incorporates the changes resulting from enactment of Minnesota Statutes, section 144A in 2006, and replaces previous bulletins.

Changes to MMIS related to program integrity goals and customized living and 24-hour customized living services are also outlined here that help accomplish three goals related to program integrity in the Elderly Waiver program:

- More descriptive information about the types of services that are included in the service plans for people receiving customized or 24-hour customized service packages will be available to the department

- Documentation that assessed need for hours of supervision, in particular 24 hours of supervision, meet legislative criteria, and required documentation is provided prior to authorization of 24 hours of supervision as a component of customized living service

- Combinations of services not allowable in addition to customized living or 24-hour customized living services will not be authorized for payment under the EW program.

Section XIII describes the plan for implementation of the 24 hours of supervision criteria and the MMIS changes related to this implementation.

II. Elderly Waiver Services Planning

Minnesota's Elderly Waiver (EW) Program, governed by Minnesota Statutes, section 256B.0915 and a waiver plan approved by the Center for Medicare and Medicaid services, offer a broad menu of home and community based services to eligible seniors including services such as chore, caregiver support, homemaker, extended home health care and extended personal care assistant (PCA) services, and customized living services. This array of services may be used to provide seniors with supports needed to remain in their own homes, to live in less restrictive settings, to remain as self-sufficient as

possible, to have greater autonomy and choice over the services they receive, and to continue to maintain their lifestyle preferences. For complete information about all EW services, go to http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056766

Elderly Waiver Eligibility Determination

Long Term Care Consultation (LTCC) staff perform in-person assessments and community support or services planning as required under Minnesota Statutes, section 256B.0911. LTCC staff, through this assessment, determine the need for nursing facility level of care, identify the need for an Elderly Waiver service, develop a community support or care plan that will reasonably assure the consumer's health and safety, and establish that the person meets the service eligibility requirements for the EW program.[1]

Elderly Waiver Services Planning

Once a person has been determined to be eligible for EW, a case manager or care coordinator performs both administrative and consumer support tasks. Both LTCC staff and EW case managers or care coordinators play a critical role in helping seniors understand the expanding array of service options available to them, including services available in housing with services settings. Under federal requirements related to care planning for all Home and Community Based Services (HCBS) waiver programs, and as described in Minnesota Statutes, sections 256B.0911 and 256B.0915, community support plans:

- Integrate services or supports provided by informal caregivers with those funded under the EW program
- Address all identified consumer needs
- Reflect the person's preferences regarding sources and types of supports they want and need
- Include identification of risks and how risks will be addressed
- Include the type, source, duration and cost of each service to be included in the plan.

EW case managers or care coordinators also link people to needed services, including customized living service. The consumer's selection among types of services such as customized living, home health care, or caregiver supports is made after they have been

1 In addition, before EW eligibility can start, a county financial worker makes the financial eligibility determination for Medical Assistance, the funding source for the Elderly and all other waiver programs administered by the department.

informed of all the service options, and after they have had the opportunity to consider the pros and cons of specific services available to meet their needs. When selecting customized living service as their service option, the consumer and their care coordinator or case manager further determine which of their needs will be met within the housing with services setting, by

- informal caregivers
- quasi-formal supports such as volunteer organizations, or
- other services available under the medical assistance state plan or
- EW program.

In some cases, the individual may prefer to receive no service to meet an identified need.

Regardless of the source or type of service, EW funding can be used only to meet **assessed needs**, and to purchase services **specifically identified** in the community support or service plan.

The goods and services purchased under all HCBS programs must meet all of the basic waiver requirements for authorized services. Proposed goods or services must:

- Meet the individual's needs identified in the Community Support Plan AND
- Support assurance of health, safety, and welfare AND
- Collectively provide an alternative to institutional placement AND
- Be the most cost efficient (least costly alternative that reasonably meets health and safety needs) AND
- Be for the sole benefit of the person AND
- Be needed in addition to state plan medical assistance services available to all Medicaid participants regardless of eligibility for home and community-based services.

In addition to the program requirements outlined above, goods and services are appropriate purchases under HCBS programs when they are reasonably necessary to support any or all of these outcomes desired by the individual and reflected in the community support plan developed by the consumer with assistance from their EW case manager or EW care coordinator:

- Maintain community living
- Enhance or maintain family or community involvement
- Develop or maintain social, physical or work-related skills
- Decrease dependence on formal support services
- Increase independence of the person

- Increase ability of unpaid family and friends to provide support by receiving training and education needed to provide that support.

Customized living and 24-hour customized living services, like all HCBS services, are intended to meet chronic or long term care needs. Services needed to meet acute care needs should not be included in the customized living service plan. Consumers may choose among all available, appropriate providers to meet their acute care needs, and these services must be billed to the appropriate payer, including fee-for-service Medical Assistance (MA), pre-paid Medical Assistance health plans (Minnesota Senior Health Options, or MSHO, for example), Medicare or private insurance.

III. EW Consumer Service Budgets

For fee-for-service Elderly Waiver clients, the monthly service authorization limit or budget for the cost of *all* of their waiver services and Medicaid state plan home care services may not exceed the monthly service rate limit for that client's case mix classification, as required under Minnesota Statutes, section 256B.0915.

Case mix classification is completed by the consumer's case manager or LTCC staff at the initial assessment, at the required annual reassessment, and when significant changes in the person's needs occur. This classification is completed using criteria established by the department, and specified in DHS Form 3428B. This form can be accessed at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3428B-ENG This classification establishes the fee-for-service budget limit under which the community support plan for all EW and state plan home care services must be developed.

Case mix classification is based on the:

- Need for assistance in activities of daily living
- Need for staff intervention to implement a response to address behavioral needs that have been assessed by qualified professionals, and for whom a formal program has been developed, including staff training and implementation of the program, monitoring progress of the intervention, and adjusting the intervention
- Need for special nursing services that include a specific, identified set of medical treatments combined with clinical monitoring of the condition for which the treatment has been ordered by a physician
- High levels of need for assistance with eating, or high levels of need for assistance as a result of certain neurological diagnoses such as paraplegia.

The department publishes the case mix classification budget limits each year in a bulletin. The budgets for State Fiscal Year 2007 were published in Bulletin #06-25-04, which can be downloaded at

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054468.

These budget limits represent "up to" amounts that can used to purchase EW and state plan home care services, including case management. However, an individual's actual authorization for services may be less than the budget limit, since the service authorization will reflect assessed need, as well as various sources of needed support such as informal caregivers, in any given consumer's community support plan.

EW consumers also participate in Medical Assistance under prepaid managed care models that include HCBS services in their managed care benefit set. See Section 6.1.10 D of the 2007 Model Contract located at http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_054908.pdf for information about the use of these case mix budget limits for EW and state plan home care services under the managed care purchase and delivery model.

IV. Customized Living Service Definition and Components

The following definitions and components of customized living service and 24-hour customized living service are the same as those of the former assisted living and assisted living plus service definitions.

Customized living service is a package of component services individually designed to meet the assessed needs of an EW participant living in a qualified setting. The component services that can be included in a customized living service package include:

- Home management tasks
  - Snack and/or meal preparation
  - Personal laundry
  - Housekeeping/cleaning
  - Shopping

- Supportive services
  - Assisting consumers in setting up meetings and appointments
  - Assisting consumers with managing funds
  - Assisting consumers in setting up medical and social services
  - Arranging for or providing transportation
  - Socialization is an allowable component when
    - it is individualized
    - it is not primarily diversional or recreational in nature
    - the plan is designed to support the consumer in maintaining or developing relationships or to support the individual in socially valued roles of their choice, e.g. volunteering, being a grandmother, or serving on a committee
    - it is specifically included in customized living plan of care

- that plan has established goals and outcomes for socialization

- Home care aide-like tasks
  - Preparing modified diets such as diabetic or low sodium diets
  - Reminding consumers to take regularly scheduled medications or perform exercises
  - Performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease
  - Performing household chores when the consumer's care requires the prevention of exposure to infectious disease or containment of infectious disease
  - Assisting with dressing, oral hygiene, hair care, grooming and bathing, if the person is ambulatory, and has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

- Home health aide-like tasks
  - Administration of medications, per Minnesota Rules, chapter 4668 (Home Care License)
  - Performing routine delegated medical or nursing or assigned therapy procedures, per Minnesota Rules, chapter 4668 [2]
  - Assisting with body positioning or transfers of consumers who are not ambulatory
  - Feeding of individuals who, because of their condition, are at risk of choking
  - Assisting with bowel and bladder control, devices, and training programs
  - Assisting with therapeutic or passive range of motion exercises
  - Providing skin care, including full or partial bathing and foot soaks
  - During episodes of serious disease or acute illness, providing services performed for a person or to assist a person to maintain the hygiene of the their body and immediate environment, to satisfy nutritional needs, and to assist with the person's mobility, including movement, change of location and positioning, bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

- Central storage of medications

- Incidental nursing services[3]

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2 For clarification on nurse delegation under Class A or Class F Home Care Licenses, contact the Minnesota Department of Health at FPC-CMR@health.state.mn.us or call 651 201 4302.

3 **A Note About Medical Assistance Home Care Services Under the State Plan**: All Medicaid participants have access to a package of services or benefits, regardless of their eligibility for home and community-based waiver programs. Nursing services other than those listed under "incidental nursing" above needed by an individual cannot be provided within a customized living service package of services. These, and other state plan home care services, must be authorized and purchased according to Medicaid state plan home care requirements, including the requirement that these services are to be provided by a Medicare-certified home care agency, and that Medicare is to be billed as applicable. State plan home care services will be authorized and purchased fee-for-service or authorized and paid for by the person's health plan if they are enrolled in Medicaid managed care. These services are included in the community support plan, and must be purchased under the consumer's EW budget limit as described in Section III of

  - Medication setups
  - Insulin draws

- Supervision as a component service must meet the criteria in Section V of this bulletin.

24-Hour Customized Living Service

24-hour customized living is an individualized package of component services that, for a person living in a qualified setting, and in addition to other component services as outlined above, includes 24 hours of supervision of the person, provided in a way which is designed to meet that person's documented, assessed needs. Supervision as a component service must meet the criteria in Section V of this bulletin. In addition to the requirements related to 24 hour supervision as a *service*, the 2007 legislative amendment establishes criteria for the authorization of this component of customized living service for Elderly Waiver participants. This criteria is outlined in the next Section of this bulletin.

V. Supervision as a Component of Customized Living Service

The following description of supervision as a component service follows previously established criteria for assisted living and assisted living plus, communicated via bulletins listed in Section XIV.

Supervision is defined as a service which includes an ongoing awareness of a person'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 service *can* include supervision, whereas 24-hour customized living service *must* include 24 hours of supervision for an individual assessed as needing this service.

Supervision is allowed as a component service in an EW package of customized living services when:

- The need for supervision has been assessed and documented. The Long Term Care Consultant (LTCC) or EW case manager or EW care coordinator must assess the supervisory needs of the person and document these in the Long Term Care assessment tool.

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this bulletin. Please go to
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000822
for complete information about policy, benefits, authorization, and provider qualifications for home care services including home health aide, skilled nursing, private duty nursing and home care therapies.

- The level and type of supervision that will be provided to meet the assessed need is documented in the person's individualized EW community support plan. As with all services to be provided to the person, the scope and duration of supervision must be specified, and the information must be readily available to the consumer and to the lead agency (counties, health plans, and, in some communities, tribes) contracting for purchase of the service.

When assessing the supervisory needs of consumers, LTCC staff and EW 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
- Any other information about the person's needs that could contribute to the need for supervision as defined here.

If supervision is assessed as needed, and is to be included in the customized living package of services, the following elements should be included in the customized living service plan developed by the case manager or care coordinator, consumer, and provider:

- The frequency of contact that needs to be initiated and maintained by the staff
- The type of needs and activities for which staff are observing and providing oversight
- Different modes of contact between the client and the staff
- Locations in which supervision will be provided, and changes in supervision depending on activities/location of the client
- Identification of supervision that may be provided by people other than paid staff
- Whether formal supervision (ongoing awareness and ability to respond) is required all the time or less than 24-hours a day.

Criteria for Authorization of 24 Hour Supervision

Minnesota Statutes, section 256B.0915 was amended in the 2007 legislative session. A new subdivision 3h. was added, and includes this language:

> "The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision. For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:
> (1) intermittent assistance with toileting or transferring;

(2) cognitive or behavioral issues;
(3) a medical condition which requires clinical monitoring; or
(4) other conditions or needs as defined by the commissioner of human services."

See Attachment A for the complete Subdivision 3h. amendment, which also includes provisions related to rate negotiations.

Section XIII describes the department's plan for implementation of the 24 hours supervision criteria and the MMIS changes related to this implementation.

VI. Customized Living Provider Requirements

Provider requirements for customized living services and 24-hour customized living services are the same as requirements for AL and AL+ as approved in previous EW waiver plans, as allowable under Class A or Class F Home Care licenses, and as published in previous bulletins cited in Section XIV of this bulletin, with minor changes needed as a result of the amendment of Minnesota Statute, chapter 144A in 2006. Providers enrolled in Minnesota Health Care Programs to provide customized living or 24-hour customized living services to Elderly Waiver participants must:

- Register as a "Housing with Services Establishment" under Minnesota Statutes, chapter 144D or be a provider under contract with the Housing with Services Establishment or a Class A home care provider under contract with the lead agency
- Have a Class A or Class F (formerly the ALHCP) Home Care License
- 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 Department of Health as a board and lodge[4] 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 clients rent or own.
- Provide each consumer with means to effectively summon assistance
- Employ staff who meet the requirements listed below.

Staff Requirements: As communicated in previous bulletins and approved in the federal EW waiver plan, staff employed by the customized living service provider must:

- Be able to respond in-person to a consumer within a time frame that meets the person's needs and in no event exceeds ten minutes

4 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 under Minnesota Rules 9555.5105-9555.6265. A Minnesota Rule 9555.5015-9555.6265 license for 5 people is available only if all residents are 60 years old or older and none have a serious and persistent mental illness or a developmental disability.

- Recognize the need for and provide assistance required or summon appropriate assistance
- Have the physical ability to provide the services identified in the consumers' service plans
- Have a valid Minnesota driver's license and required insurance if they provide transportation
- Be able to
    - Work under intermittent supervision
    - Communicate effectively with other staff and consumers
    - Read, write, and follow written and verbal instructions
    - Follow consumers' individualized service plans
    - Identify and address emergencies including calling for assistance
    - Understand, respect, and maintain confidentiality

- In addition to the staff requirements listed above, staff providing **supervision** to consumers must also:
    - Work on-site within the customized living program
    - Have as their primary work responsibility the supervision of consumers in the housing with services setting (generally this means the same building)
    - Have on-going awareness of the consumers' needs and activities
    - Be capable of communicating with consumers, recognizing the need for assistance, and providing or arranging for appropriate assistance
    - Be an employee of the customized living provider who is not a recipient of services

24-Hour Customized Living Provider Requirements

24-hour customized living provider requirements include all requirements stipulated for Customized Living providers plus the ability to provide 24 hours of supervision as defined in this bulletin.

"Assisted Living"

The Elderly Waiver *does not* require providers to meet the standards of Minnesota Statutes, chapter 144G to provide customized living or 24-hour 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. Please go to http://ros.leg.mn/bin/getpub.php?pubtype=STAT_CHAP&year=2006&section=144G for these requirements.

VII. Lead Agency Authorization of Customized Living Services

Following well-established requirements for authorization of all HCBS services, lead agencies must adhere to the following policies and practices when authorizing customized living or 24 hour customized living.

- **Type and Amount of Services**: Customized living and 24-hour customized living are individualized packages of component services from the prescribed list in this bulletin which are designed to meet the documented, assessed needs of the client living in a qualified setting. As with any HCBS service, the type and amount of each service included in the individualized package must be based on and linked to the documented needs of the EW consumer.

- **24-hour or less than 24-hours of supervision:** The lead agency will specify whether customized living or 24-hour customized living is being authorized. As required for any HCBS services, the lead agency will not authorize services unless the individual has a documented need for the service, including the need for 24 hours of supervision as delineated in this bulletin.

  The 2007 amendment to Minnesota Statute, section 256B.0915 included need-based criteria that must be met in order to authorize 24-hour customized living service for an individual; the criteria is specified in Section V in this bulletin. This criteria is also specified in the approved federal waiver plan amendment. Programming changes to the Long Term Care Screening Document and Service Agreement subsystems in MMIS will require documentation that the need for 24 hour supervision meets these criteria before 24-hour customized living service can be authorized. Section XIII of this bulletin provides more detail about implementation of these changes, and the assessment information needed to document this need.

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

  - Services eligible for Medicare payment must be provided by a Medicare-certified provider in order to maximize the consumer's Medicare benefit before accessing either Medicaid state plan or EW services

- **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 the Elderly Waiver, Medicaid state plan, and/or quasi and informal supports that would meet the individual's needs.

- **Individualized component services:** Case managers will authorize customized and 24-hour customized living services that include the amount of component services requested by the consumer to meet assessed needs and that contribute to the achievement of consumer goals as outlined in Section II of this bulletin 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 case manager will provide education to the person about how any resulting health and safety issues might be managed, and what the acceptable threshold of risk can be and still meet waiver care plan requirements related to health and safety.

- **Duplication of service:** 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, as well as or in place of the customized living provider. In this case, while the customized living provider may offer transportation service, the case manager cannot duplicate and must differentiate this service in the component package, and must only authorize those services that will actually be provided to the consumer by the customized living services provider within the package.

VIII. Limitations on Services That Can Be Authorized in Combination with Customized Living Services

- Homemaking services cannot be authorized in addition to customized living service, but must be included, if needed, in the customized living or 24-hour customized living service package.

- Personal Emergency Response devices or services cannot be authorized in addition to 24-hour customized living service. 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 of supervision. The provider may choose to use a personal emergency response device to meet the requirement of providing consumers with a system for requesting assistance, or as part of the plan for 24 hours of supervision, but additional payment for personal emergency response cannot be authorized in addition to 24 hours of supervision.

- A Personal Emergency Response device or service can be authorized and purchased through EW under extended 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 are services intended to support informal and unpaid caregivers, and cannot be authorized for the benefit of paid service providers. Respite service cannot be authorized in combination with any 24 hour residential-based service such as adult foster care or residential care, or in combination with either customized or 24 hour customized living service.

IX. Lead Agency Contracting for Customized Living Services

Lead agencies (counties, health plans and tribes) are responsible for negotiating contracts with all HCBS providers as required under the Elderly Waiver plan approved by CMS. Lead agencies should enter into contracts for customized living and 24-hour customized living services with vendors with whom there is reasonable expectation that needed services will be provided within the public program payment rate limits.

Contracts must minimally include the following information as elements of the parameters allowed to be established under Minnesota Statute, section 256B.0915:

- Lead agencies should utilize the new service names when amending or renegotiating contracts with providers.

- Whether the provider will offer customized living, 24 hour customized living or both services

- The component services the provider makes available, and any limitations on the component services that will be made available

- Units of each component service and the rates per unit of each component service

- Required license(s) and/or registration(s). The lead agency is responsible to take all necessary steps to ensure that such license(s) and/or registration(s) are current, and that providers meet applicable provider standards as stated in state or federal statute or rule. Please see Section XV for links to web sites that include licensing and registration information.

- Socialization included as a component service covered by the contract provided that it is delivered and is purchased as part of the consumer's plan of care, related to established goals and outcomes and not solely diversional or recreational in nature.

- Specification of how rates will be set for each EW consumer. The rates must be based on the amount of each component service that will be provided to the

individual, including for component services that are included as a "base package" of services.

- Requirement that the unit charges and package service rates for an EW consumer shall not exceed the unit charges and package service rates for a non-EW consumer.

- Prohibition of room and board costs included in component service unit costs or negotiated package 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 not the cost of raw food.

- Providers will not bill for full days on which clients are absent from the customized living or 24-hour customized living setting. However, the negotiated payment rates may take into account identified, approved fixed costs incurred by the provider.

As for all HCBS services contracts, lead agencies may add contract requirements such as:

- The continuing stay criteria of the Housing with Services setting

- A copy of the Housing with Services Agreement between the establishment and each EW consumer

Provider Enrollment

Lead agency contracts are required for provider enrollment, and must be completed and signed before services can be authorized for an EW consumer. In order to receive authorization to provide customized or 24-hour customized living serviced to an Elderly Waiver participant, providers must be enrolled as a Medical Assistance provider. Verification of a signed contract with a lead agency is required to enroll.

DHS Provider Enrollment provides technical assistance to providers as well in information on the enrollment process. Please go to http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000221 for forms and technical assistance related to provider enrollment into Minnesota Health Care Programs.

X. Customized Living and 24-Hour Customized Living Service Rate Limits

The customized service rate limit is defined as the non-federal share of the greater of either the statewide or any of the geographic groups' weighted average monthly Medical

Assistance nursing facility payment rate (for persons 65 and older) of the client's case mix classification.

The 24-hour customized service rate limit may not exceed the consumer's case mix budget cap, less all other state plan home care or waiver services costs, including individually authorized case management, other waiver services authorized, and state plan home care services that are included in the calculation of the consumer's waiver support plan costs.

The service rate limits for both customized and 24-hour customized living services for State Fiscal Year 2007 were published in Bulletin #06-25-04, which can be downloaded at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054468.

As with the case mix classification budget limits, these service rate limits represent "up to" amounts, and should not be considered rates or funding amounts the provider can expect or charge for packages of service. Authorizations for payment for customized and 24-hour customized living services must be individualized, and must be based on an EW consumer's need for each service component offered by the provider, how frequently each service is delivered, the amount of each service to be delivered, and the provider's qualification, ability and willingness to deliver the needed service.

XI. Customized Living Rate Negotiation Parameters

Individualized Rates for Individualized Services

"Individualized" means services are chosen and designed specifically for each consumer's needs, rather than services provided or offered regardless of illness, disability or physical condition.

In the 2007 Minnesota Legislative session, Minnesota Statute, section 256B.0915 was amended to require that rate negotiations for customized living and 24 hour customized living services must be conducted within the parameters established by the commissioner. See Appendix A for the complete Subdivision 3h. amendment to Minnesota Statutes, section 256B.0915.

The following rate negotiation parameters have previously been published in the bulletins referenced in Section XIV, or are specifically included in the 2007 amendment to Minnesota Statutes, section 256B.0915, subdivision 3e.

- The negotiated rate must be based on the services to be delivered, not on the individual's assessed needs or a base rate established by the provider.

- The negotiated rate is a monthly rate.

- Individualized rates negotiated for a unit of a component services shall not exceed the fee-for-service rate limits for similar services and units of services delivered outside of a customized living or 24-hour customized living services setting.

- The total negotiated rate for customized living cannot exceed the service rate limit as describe above.

- Service payments defined in the contract should account for economies of scale in areas including staffing and administrative overhead.

- The rate methodology must allow for different amounts of component services to be authorized within the customized living service plan or the base package, i.e. substitution of services.

- Assure that if "base packages" and/or "base rates" are utilized that they meet the following criteria:
    - Base rates must specify the amount of each service included in the base package that will be provided to the individual

    - Base packages and/or rates ***may*** include:
        - Supervision as defined in this bulletin that is *needed by and provided to all residents* of the program
        - Home management tasks
            - Congregate snack and/or meal preparation
            - Limited personal laundry
            - Limited housekeeping/cleaning
            - Limited shopping
        - The following supportive services
            - Assisting clients in setting up meetings and appointments
            - Assisting clients with managing funds
            - Assisting clients in setting up medical and social services
            - Arranging for or providing transportation

    - Base rates ***cannot*** include:
        - Home care aide-like tasks
        - Home health care aide-like tasks
        - Socialization
        - Incidental nursing
        - Central storage of medications
        - Nursing oversight, or management (also not an allowable component service)
        - Administrative costs related to the provision of services (also not an allowable component service).

Lead agencies should also consider these policies when determining an individualized customized living or 24-hour customized living service payment rate for EW clients:

- All assistance with personal care purchased from a non-Medicare certified Class A Home Care Agency or Class F provider must be purchased as part of the customized living or 24-hour customized living package of services. Fee-for-service personal care assistance (PCA) services may be purchased from a qualified PCA provider; all other state plan home care services can be purchased from a Medicare certified Class A Home Care Agency only.

- Customized living and 24-hour customized living services, like all HCBS services, are intended to meet chronic or long term care needs. Services needed to meet acute care needs should not be included in the customized living service plan. Consumers may choose among all available, appropriate providers to meet their acute care needs, and these services must be billed to the appropriate payer, including fee-for-service Medical Assistance (MA), pre-paid Medical Assistance health plans (Minnesota Senior Health Options, or MSHO, for example), Medicare, long term care insurance or private insurance.

- All EW program service costs, such as case management services or supplies and equipment, plus the consumer's customized living or 24-hour customized living service payment rate may not exceed the client's monthly case mix budget cap. The case mix budget cap amount does not change whether the person will receive customized or 24-hour customized living service.

- Room and board or rental rates are not defined or controlled directly by the EW program. However, the Medicaid income standard limits the EW consumer's income available to pay room and board or rent. Consumers may choose to pay housing costs in excess of Group Residential Housing (GRH) negotiated rates for additional amenities, but settings with GRH agreements must be able to accommodate consumers whose income limits them to the GRH rate.

XII. Group Residential Housing Funds (GRH)

Group Residential Housing funds are to be available to pay for room and board in Housing with Services (HWS) establishments, in settings licensed by DHS as a Minnesota Rules, parts 9555.5105-9555.6265 foster care provider, or a licensed board and lodge which are not registered as HWS. The county in which the establishment is located is responsible to establish the group residential housing contract with the provider. GRH funding cannot be accessed without a GRH contract with the host county.

Family Supplement of the Room and Board Rate
If a GRH payment is being made for a person, the person or person's family may only

supplement the GRH room and board rate if they are paying for something not covered in the base room and board rate. For example, if the base room and board rate pays for a bed in a double room, the family may pay extra for a private room.

Temporary Absence
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.

Elderly Waiver Allocation
A recipient of EW services who resides in a GRH setting and who is allocating a portion of their income to a community spouse under the provisions of the EW Program may deduct an amount equal to the allocation from their income when calculating the amount of a GRH payment.

For more information on the Group Residential Housing Program, contact
Duane Elg, duane.elg@state.mn.us

XIII. Individual Housing with Services Contracts

All providers of customized living or 24-hour customized living must be registered as a Housing with Services Establishment or have a contract with a registered Housing with Services Establishment to provide services. The Housing with Services Establishment must meet all requirements in Minnesota Statutes, chapter 144D. Minnesota Statutes, section 144D.04 requires a HWS establishment execute a contract with each individual resident that includes, at minimum, the 17 elements that are listed in this section of the statute. All of the elements are important in identifying what services will be provided, the cost and payment of the services, and any conditions related to the delivery of services.

XIV. Plan for Implementation of the 2007 Legislated Criteria for Authorization of 24 Hour Supervision

Changes to MMIS are being implemented to enhance program integrity. These changes can be summarized around three particular goals:

- **Gathering information about component services on the Long Term Care Screening Document.** Since customized living is authorized in MMIS as a "bundled" service, the Service Plan Summary section of the Long Term Care Screening Document will be used to allow for better descriptions and documentation of the component services planned and approved within a customized living service package. This Service Plan Summary section includes services to be provided to the individual as well as codes used to indicate the type

or source of support. Previously, these codes indicated "formal", "informal" or "quasi-formal" sources of support. To allow for better descriptions and documentation of the component services planned and approved within a customized living service package, a new source code of "C" has been added, as well as new values to reflect customized living component services. And edits have been created to ensure the use of these codes and values in ways that made the data valid and reliable.

- **Limiting the combination of services that can be authorized in addition to customized living.** Service Agreement edits have been created to ensure allowable combinations of services with customized living or 24-hour customized living services.

- **Requiring documentation of the assessed need for 24-hours of supervision before 24 hour customized living can be authorized.** Edits have been created that compare assessment information on the Long Term Care Screening Document and the services planned in Section G, Service Plan Summary. Information must meet criteria before 24 hour supervision can be included in the Service Plan Summary. In addition, 24 hour customized living will only be allowed to be authorized on a Service Agreement when these criteria are met.

ALL OF THE EDITS REFERENCED ABOVE ARE SET TO INFORMATIONAL STATUS at present. It is the department's goal to have all of the edits active by October 1, 2007. The department set these edits to informational status to:

- **Allow lead agency staff time to identify and correct any errors** in either Long Term Care Screening Document assessment information or Service Agreement errors, or to update this information if the current information is outdated for EW consumers currently receiving assisted living plus who do not appear to meet one of these criteria required for authorization of 24 hour supervision
  - Cognitive or behavioral needs
  - Need for assistance with toileting or transferring
  - Special nursing (treatment and clinical monitoring)

  The department has compiled a list of Elderly Waiver consumers who are currently authorized for 24-customized living (assisted living plus) who do not meet the criteria established in the 2007 legislative session for need for assistance due to any one of the three needs listed above as documented in the Long Term Care Screening Document subsystem. Lead agency staff will use this list to perform the review described above using the worksheet and instructions describing the review tasks in Attachment C.

- **Receive information from lead agencies about the basis of the authorization of 24 hour supervision for people who do not meet one of the three criteria**

listed above in order to inform how the department defines "Other conditions or needs as defined by the commissioner" as allowed in the 2007 amendment language.

For people who remain on the list of consumers forwarded to lead agencies after corrections to either assessment information or service authorizations, lead agency staff will forward the department information about the need for supervision. This feedback will allow department staff to determine what types of needs the "Other" criteria for authorization of 24 hour supervision may need to reflect. In addition, the department must establish how requests for approval of 24 hour supervision will be submitted, and any required documentation prior to setting edits to deny Long Term Care Screening Document approval or Service Agreement approval by October 1, 2007.

Attachment B contains detailed information about these edits, new valid values for component services, and assessment information currently identified as needed as documentation for 24 hour supervision.

XV. Obsolete Bulletins Related to Assisted Living

This bulletin replaces:

- Bulletin #99-25-19, "New MDH rule changes home care licensing options for housing with services establishments," November 19, 1999
- Bulletin #00-25-04, "Assisted Living Plus" service available for qualified Housing with Services Establishments and "Assisted Living" service name
- Bulletin #00-25-04c, "Counties may contract directly with Class A Home Care Agency for "Assisted Living Plus" service delivered in registered Housing with Services Establishments"
- Bulletin #02-25-03, "DHS Answers Frequently Asked Questions About Assisted Living Services for Persons 65+on the Alternative Care Program (AC) and Elderly Waiver (EW)," March 11, 2002

XVI. Web Links to Resource Information

Minnesota Statutes, chapter 144D Housing with Services Establishment Definitions and Requirements
http://www.revisor.leg.state.mn.us/bin/getpub.php?pubtype=STAT_CHAP&year=current&chapter=144D

Housing with Services Establishment Registration Information
http://www.health.state.mn.us/divs/fpc/profinfo/lic/lichws.htm

Minnesota Statutes, chapter 144G Assisted Living Services Definitions and Requirements
http://www.revisor.leg.state.mn.us/bin/getpub.php?pubtype=STAT_CHAP&year=current&chapter=144G

Directory of Licensed Home Care Providers:
http://www.health.state.mn.us/divs/fpc/directory/providerselect.cfm

Class A – Licensed Only (Non-Medicare Provider) Survey Results
http://www.health.state.mn.us/divs/fpc/profinfo/cms/hcacla/hcaclasurveyresults.html

Quality Measures for Medicare Certified – Class A Home Care Providers
www.medicare.gov/HHCompare/home.asp

Class F Home Care Provider Survey Results
http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurveyresults.htm

Licensure Application Forms for Health Care Providers
http://www.health.state.mn.us/divs/fpc/profinfo/licensure.html

XVII. Special Needs

Special Needs: This information is available in other forms to persons with disabilities by calling (651 431 2500 or 1 800 882-6262), or contact us through the Minnesota Relay Service at 1 (800) 627-3529 (TTY), 7-1-1, or 1 (877) 627-3848 (speech-to-speech relay service).

ATTACHMENT A

2007 Amendments to Minnesota Statutes, Section 256B.0915 Governing the Elderly Waiver Program

Changes to existing language:

Subd. 3e. ~~Assisted Living~~ Customized living service rate. (a) payment for ~~assisted living service~~ customized living services shall be a monthly rate negotiated and authorized by the ~~county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.~~ lead agency within the parameters established by the commissioner. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. Customized living services must not include rent or raw food costs. The negotiated payment rate must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

The addition of a new subdivision:

Subd. 3h. Service rate limits; 24-hour customized living services. The payment rates for 24-hour customized living services is a monthly rate negotiated and authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision. For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting or transferring;
(2) cognitive or behavioral issues;
(3) a medical condition that requires clinical monitoring; or
(4) other conditions or needs as defined by the commissioner of human services. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient. Customized living services must not include rent or raw food costs. The negotiated payment rate for 24-hour customized living services must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. The individually negotiated 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a.

ATTACHMENT B

MMIS Changes Related to Customized Living Services

Attachment B includes detailed information regarding the new valid values for component service, edits, and actions case managers or care coordinators must take for existing and new consumers receiving customized or 24-hour customized living services.

These edits are set to "Informational" status at present, and will be activated October 1, 2007 to deny service authorizations or Long Term Care Screening Document approval unless the criteria described below are met.

The Service Plan Summary Section of the Long Term Care Screening Document

This section should be kept updated by entering a new screening document using activity type 05 and assessment result 98 at any time services are stopped or started.

- ✓ *New, additional* valid values that reflect the component services available as part of customized living services. Other values will continue to be used as well, such as homemaker or meals that might be part of a customized living service plan for an individual.
  - 52 – personal emergency response system
  - 53 – delegated medication administration
  - 54 – delegated health related
  - 55 – arranging transportation
  - 56 – individualized socialization support
  - 57 – personal assistance, not PCA
  - 58 – 24 hour supervision for intermittent and unscheduled support
  - 59 – 24 hour supervision for clinical monitoring over 24 hours
  - 60 – 24 hour supervision for dementia/orientation/mental health/behavior/sensory
  - 61 – less than 24 hour supervision
  - 62 – laundry

- ✓ *New Source Code "C"* to indicate those services that will be provided by a customized living provider
  - Customized Living Service (CLS)
  - Identifies the bundle of services provided under CLS for the Elderly Waiver consumer (previous assisted living and assisted living plus services)
  - "C" code may only be used if program type is 03 or 04 (EW program type codes)

- ✓ *Edits that won't allow the use of Values* 31 (assisted living) and 39 (24-hour supervision)
  - Cannot be used with the EW program types or source code C. Continue to use these values for the CADI and TBI program. Assisted Living is no

longer available under the EW program, and the old 24-hour supervision code has been replaced with codes that have more information attached about the reason for supervision.

✓ *New Edits check for the allowable combination of service codes* and source codes in the Service Plan Summary section of the LTC Screening Document.

o **Edit 517 (Source Code C Invalid)** allows source code C only for component services that can be provided as part of a customized living package of service. Use C as a source code only with these service descriptions and their codes or values:

- 01 – Shopping
- 04 – Home delivered meals
- 05 – Congregate dining
- 06 – Homemaker/housekeeper
- 07 – Money management
- 08 – Arranging medical appointments
- 52 – Personal emergency response system
- 53 – Delegated medication administration
- 54 – Delegated health related
- 55 – Arranging transportation
- 56 – Individualized socialization support
- 57 – Personal assistance, not PCA
- 58 – 24 hour supervision for intermittent and unscheduled support
- 59 – 24 hour supervision for clinical monitoring over 24 hours
- 60 – 24 hour supervision for dementia/orientation/mental health/behavior
- 61 – Less than 24 hour supervision
- 62 – Laundry

o **Edit 517 *will not* allow 52 (personal emergency response system) with funding code C or F if 58 (24 hour supervision** for intermittent and unscheduled support), 59 (24 hour supervision for clinical monitoring over 24 hours), or 60 (24 hour supervision for dementia/orientation/mental health/behavior) is valued with source code C. This does not mean that personal emergency response cannot be coded as part of the plan; it cannot be coded *with* 24-hour supervision if 24 hour supervision will be provided by the customized living provider.

o **Edit 520 (24-hour Supervision Not Valid)** will post if the information about the person contained in the Long Term Care Screening Document taken from the Long Term Care Consultation assessment does not indicate a need for 24 hours of supervision based on the following criteria:

- **Value 58 (24 hour supervision for intermittent and unscheduled support)** is chosen and the Toileting field is not valued 01 or greater, *or* the Transfer field is not valued 02 or greater.
- **Value 59 (24 hour supervision for clinical monitoring** over 24 hours) is chosen and the Case Mix field is not valued C, F, or K.

- **Value 60 (24 hour supervision for dementia/orientation**/mental health/behavior) is chosen and the Behavior field is not valued 02 or greater *or* Orientation is not valued 02 or greater.

Edit 529 (Invalid Service Codes) will post if:

- Values 31 (assisted living) or 39 (24-hour supervision) are used with program types 03 or 04

- Values 53 – 61 are used with any program type other than 03 or 04. The new component services are to be used only for summarizing the service plan for EW consumers.

Elderly Waiver Service Agreement

✓ New edit to insure there is a documented need on the LTC screening document of 24 hours of supervision when 24-hour customized living is authorized

- **Edit 523 (Customized Living Services Invalid):** This edit will post if there is a service agreement line item with a begin date of 7/1/07 or greater for 24-hour Customized Living (formerly Assisted Living Plus) for authorization using T2030 with modifier TG without matching information about the need for supervision on the last approved screening document. MMIS will look for the screening document with an assessment result date within the service agreement header period. If the service plan summary does not have 58 (24 hour supervision for intermittent and unscheduled support), 59 (24 hour supervision for clinical monitoring over 24 hours), or 60 (24 hour supervision for dementia/orientation/mental health/behavior) valued with source code C in the Service Plan Summary section, 24-customized living will not be able to be authorized.

✓ New edit to ensure that component services to be provided in the customized living "bundle" are identified on the Service Plan Summary of the Screening Document before customized living service can be authorized.

- **Edit 523** will also post if there is a line item for Customized Living/Assisted Living (T2030) or 24-Hour Customized Living (T2030 and modifier TG) with a begin date of 7/1/07 or greater and there are no services on the service plan summary valued with source code C for the last approved screening document in which the assessment result date falls within the header period. It will also post if Customized Living is the proposed authorized service (using T2030) and the service plan summary indicates 24 hours of supervision will be provided by a customized services provider. If any of the codes for 24 hours of supervision (58-24 hour supervision for intermittent and unscheduled support, 59-24 hour supervision for clinical monitoring over 24 hours, or 60-24

hour supervision for dementia/orientation/mental health/behavior) is valued with source code C, this edit will post for authorizations for customized living only.

Action needed:

When you enter a service agreement to make changes or add a new service agreement and one of the line items is T2030 or T2030 TG, this edit will post. You will need to enter a new screening document using activity type 05 and assessment result 98 and change or correct the values in the Service Plan Summary in Section G.

Form Changes

The following forms were changed to include these new valid values in the Service Plan Summary section. The forms are on the DHS website at www.state.mn.us under Forms (eDocs).

- LTC Screening Document (DHS-3427)
- Minnesota Long-Term Care Consultation Services Assessment Form DHS-3428
- Minnesota Long-Term Care Consultation Services Assessment Form (two person) DHS-3428A

ATTACHMENT C

Directions for Completion of Lead Agency Customized Living Review Worksheet

1. Complete and submit **electronically** to DHS by July 31, 2007.
   a. DHS will send each EW Administrative contact person an electronic form to be completed either as a Word or Excel document.
   b. Completed worksheets must be sent to Darlene.Schroeder@state.mn.us by July 31, 2007.

2. Reviewing EW recipients identified by DHS in desk audit.
   a. DHS conducted a desk audit of MMIS data to identify EW recipients
      i. Currently authorized to receive assisted living plus
      ii. Who do not meet any of the following criterion of need for 24 hour supervision:
         1. Dependency in toileting or transferring
         2. Cognitive or behavioral dependency
         3. Special Nursing
   b. Lead agencies will be provided with a list of EW recipients via email as delineated in 2.a. on a Lead Agency Worksheet.

3. Completion of Worksheet
   a. Verify the PMI number (Col A)
   b. Enter the current authorized assisted living plus rate. (Col B)
   c. Indicate if the current authorized assisted living plus rate is less than the what the assisted living service (not plus) cap limit is given the client's case mix geographic location. (Col B – Appropriate service cap from http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_136437.pdf)
   d. If 3c is "yes," correct service authorization to customized living (assisted living) and indicate "yes" in Col D. No further information is required to be forwarded to DHS. However, please see g. below to ensure that your provider contracts include both customized living as well as 24 hour customized living.
      If 3c is "no," proceed to next step.
   e. Check to see if there is a coding error on the assessment. Review the data sent on the electronic spreadsheet for accuracy, particularly, dependencies in toileting, transferring, cognition or behavior or the need for special nursing as calculated under the Case Mix Classification tool (DHS 3428B). For further information on assessment, contact Jolene Kohn at 651 431 2579, or Jolene.Kohn@state.mn.us
      i. If there was a coding error, enter "yes" in Col E, and describe error and change in Col F, and indicate that the correction has been made on the screening document.
      ii. If there was no assessment coding error, go to next step.

f. If the person has a need for 24 hours of supervision other than those indicated above, indicate “yes’ in Col G and briefly describe the need. This information will be used to establish criteria used to determine DHS approval of 24 hours of supervision and 24-hour customized living service for “Other” reasons as allowed under the legislative criteria in addition to those described in 2. above.

4. Send completed worksheets to darlene.schroeder@state.mn.us by July 31, 2007. Worksheets must be submitted electronically, with all columns in order.

5. DHS will develop additional implementation directions, if needed, based on the information provided by lead agencies.

Sample Lead Agency Worksheet

Directions:

Lead agencies will complete this on an *electronic document that will be sent to EW Administrators via email.*

	Check for and Correct Error in Service Authorization			Check for and Correct Error In Coding Assessment		Different Need for 24 Hr Supervision
PMI #	Enter Current AL Plus Service Rate	Is AL Plus Rate Less than AL Rate Cap? Yes/No	If yes, Is Service Authorization Corrected? Yes	Was There an Error in Coding Assessment? Yes/No	Document Assessment Error and Change and Enter on Screening Document	Does the individual have a different need requiring 24 hour supervision Yes/No Describe assessed need that requires 24 hour supervision.
Col A	Col B	Col C	Col D	Col E	Col F	Col G

Return ***electronic document*** to darlene.schroeder@state.mn.us *by* ***July 31, 2007***.