#07-25-07

Bulletin

December 4, 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
- Tribal Health Directors
- Long -Term Care Consultation Contacts
- Housing with Services Providers
- Managed Care Organizations

ACTION/DUE DATE

Please implement criteria for authorization of 24 hour customized living service. Document criteria in MMIS. Apply policy clarification to services planning and rate negotiation.

EXPIRATION DATE

December 4, 2009

Update on Elderly Waiver Program Integrity Initiative: Criteria for Authorization of 24 Hour Customized Living

TOPIC

Outline criteria for authorization of 24 hour customized living service under the Elderly Waiver program. Review MMIS edits related to these criteria. Clarify related policy issues raised in preliminary implementation phases.

PURPOSE

Outline "other" criteria for authorization of 24 hour customized living service as allowed in the 2007 legislative changes to Minnesota Statutes, section 256B.0915 governing the Elderly Waiver program. Inform lead agencies and providers about edits in MMIS that will become effective January 1st, 2008. Provide policy clarification around related issues.

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SIGNED

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I. Background

The 2007 Legislature approved amendments to Minnesota Statutes, section 256B.0915 governing the Elderly Waiver (EW) program. These amendments included changes to existing language and the addition of a new subdivision. Section II below provides a brief summary of the legislative changes.

This bulletin summarizes implementation of legislative requirements related to customized living and 24 hour customized living service provided under the EW program. This Bulletin outlines criteria, including the "other" criteria, for authorization of 24 hour customized living service, reiterates the MMIS changes that will become effective January 1, 2008, and includes an Attachment that summarizes questions and answers related to legislative implementation, policy, assessment, services planning, and rate negotiations posed by providers and lead agencies since Bulletin 07-25-01 was issued in June 2007.

II. Summary of Legislative Changes to Minnesota Statutes, Section 256B.0915

Changes to existing language renamed the service formerly known as "assisted living" and "assisted living plus" to "customized living" and "24 hour customized living" services, respectively. This change was needed to differentiate the service available to EW recipients, and the provider requirements for this service under the EW program, from those outlined in 2006 legislative language that amended Minnesota Law, Chapter 144 by adding a new Chapter, 144G outlining requirements for any registered Housing with Services provider that utilized the term "assisted living" for any purpose. These requirements were not consistent with the language in the federally-approved EW plan related to "assisted living" and "assisted living plus".

Language was also added to Minnesota Statutes, section 256B.0915 to memorialize in statute policy previously communicated in bulletins, and reflects requirements related to all waiver service authorizations. This language also explicitly requires lead agencies authorizing EW services to follow guidelines now established in statute when negotiating and setting rates for customized living and 24 hour customized living service.

A new subdivision was also added to Minnesota Statutes, section 256B.0915. Subdivision 3h addresses service rate limits and criteria for the authorization of 24 hour customized living service, and states:

> 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.[1]

Bulletin 07-25-01, issued June 26th, 2007, contained waiver policy clarifications, the 2007 legislative changes to the statute governing the Elderly Waiver program, and an explanation of planned changes to MMIS to support the implementation of these legislative changes to be effective October 1st, 2007[2]. A memo was forwarded to lead agency administrative staff on August 15th, 2007 announcing a delay in proposed implementation of MMIS edits. The decision to delay was made to allow the implementation of cost of living increases approved in 2007 legislative session, to allow Aging and Adult Services (AAS) staff to further analyze information forwarded from lead agencies about 24 hour customized living service consumers, and to complete additional analysis needed to determine "other" criteria for authorization of 24 hour customized living service.

III. "Other" Criteria for Authorization of 24 Hour Customized Living Service

A lead agency worksheet designed to provide AAS staff with feedback about people who were authorized for 24 hour customized living (assisted living plus) service who did not meet any of the three specific criteria in statute was attached to bulletin 07-25-01. AAS staff compiled a sample of EW consumers authorized for 24 hour customized living service in May 2007 and forwarded this sample to lead agencies. This sample was used by lead agencies to complete the worksheet, which asked for information about consumer needs, as well as allowed lead agencies to check for errors in assessment or service authorizations. AAS staff also reviewed a sample of EW consumers authorized in October 2007 for either customized living or 24 hour customized living service to assess patterns of need as documented in the Long Term Care Screening Document subsystem in MMIS that collects assessment information for all consumers participating in the EW program.

The information provided by lead agencies via the worksheets and the data analyzed from the October 2007 sample was used to determine the "other" criteria that can be met in order to authorize 24 hour customized living service.

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1 Language taken from the Minnesota Legislature web site, Office of the Revisor of Statutes at http://ros.leg.mn/bin/getpub.php?pubtype=STAT_CHAP_SEC&year=current&section=256B.0915&image.x=16&image.y=8

2 Bulletin 07-25-01C was issued July 27, 2007 to clarify an error and correct references included in the first publication.

The 2007 legislation specifies that 24 hour customized living service can be authorized for people who have an assessed need for intermittent, unscheduled assistance with toileting or transferring, a need for staff intervention to address cognitive or behavioral needs, or who need clinical monitoring of a medical condition over 24 hours.

In addition to these specific needs, 24 hour customized living service can be authorized for a person who needs assistance with medications AND at least an average of 50 hours of direct staff time per month to be provided by the 24 hour customized living service provider. This will require that the person has been assessed by the lead agency to have a dependency in medication management, based on information collected during the Long Term Care Consultation assessment, and as reflected in the Long Term Care Screening Document subsystem in MMIS. This establishes the "other" criteria for authorization of 24 hour customized living service. This combined criterion was selected to meet the definition of "other" criteria for several reasons:

- There is a high need for this type of assistance indicated in the EW population: 59% of the October 2007 sample analyzed met these criteria, and lead agencies frequently indicated high needs for medication management, particularly with "as needed" or PRN medications, as the basis for authorizing 24 hour customized living service in the lead agency worksheet responses.

- Data about medication assistance needs is captured in the Long Term Care Screening Document subsystem in MMIS, allowing the department to implement these criteria without administrative review or approval on a case-by-case basis.

- Despite the high *prevalence* of need for medication management, the level or *intensity*, *frequency* and the *types of assistance needed* related to medications can *vary widely*, depending on the number and types of medications a person has been prescribed, the schedule of medication, and the kinds of medication management or medication administration that might be needed. For example, a person may need a lot of help or constant supervision, but only once a week to take one particular medication. This kind of variance in need is not captured in the single item in DHS Form 3428 or 3428A related to the need for medication assistance, and thus the need for 24 hour customized living service is not as clearly indicated using medication assistance as a sole criteria to define "other" allowable criteria for authorizing 24 hour customized living service.

- Based on the component services provided in customized living and 24 hour customized living service settings, and the fee-for-service rates for comparable services that must be used in negotiating rates for customized living and 24 hour customized living service, it is reasonable to require that a minimum amount of direct service be needed before authorizing and purchasing 24 hour customized living service.

The next Section outlines documentation that needs to be present in the Long Term Care Screening Document to satisfy each of these criteria, including the "other" criteria described above, for authorizations of 24 hour customized living service for Elderly Waiver participants effective January 1st, 2008 and beyond.

IV. Documentation Required for Authorization of 24 Hour Customized Living Service

All individuals receiving services and supports under the EW program participate in a face-to-face assessment to determine service eligibility for the program, and at least annually thereafter. The purpose of the assessment, completed by the lead agency[3] using DHS Form 3428 or 3428A, the Long Term Care Consultation Assessment form, is to develop a community support plan or service plan that addresses identified needs, and that reflects the consumer's preferences and goals.

The community support plan, captured on either DHS Form 4166 or 2925, identifies services that will be provided by various EW providers, as well as services or supports that will be provided by informal caregivers or quasi-formal agencies (volunteer services, e.g.). In addition, a person may refuse services to address any particular need, and choose to manage personal risk as documented in the approved community support plan.

DHS Form 3427 (Long Term Care Screening Document) captures core assessment information about the EW consumer's needs that will be entered into the Long Term Care Screening Document subsystem of MMIS by lead agency staff. In order to document that assessed needs meet one of the criteria for authorization of 24 hour customized living service, the Long Term Care Screening Document information entered in MMIS must match one of the criteria outlined below.

1. **Authorization based on intermittent and unscheduled need for assistance with toileting or transferring.** In the Section "Functional Assessment: Activities of Daily Living" in the Long Term Care Consultation Assessment form, DHS Form 3428 or 3428A, the need for assistance with **transferring** must be scored at least 02 or higher (needs another person to help), **OR** the need for assistance with **toileting** is scored at least 01 or higher (needs some help). This criterion for authorization of 24 hour customized living service will be captured in the Service Plan Summary Section of the Long Term Care Screening Document as described in *Attachment A.*

2. **Authorization based on the need for staff intervention needed to address cognitive, orientation, mental health, or behavioral needs.** In the same section of DHS Form 3428 or 3428A, the need for staff intervention to address **cognitive or behavioral** needs must be scored 02 or higher (the person needs and receives regular staff intervention in the form of redirection. A score higher than 02 indicates even more intensive staff intervention is needed and is received.) **OR** in the same section related to functional assessment, the item related to **orientation** (the awareness of a person to his or her present environment) must be scored at least 02 or higher (the person has partial or intermittent periods of disorientation). This criterion for authorization of 24 hour customized living service will be captured in the Service Plan Summary Section of the Long Term Care Screening Document as described in *Attachment A.*

3. **Authorization based on the need for clinical monitoring and treatment.** Clinical monitoring must be required at least once every eight hours to meet this criterion. Clinical monitoring must be paired with a medical treatment, and a formal plan for clinical

3 "Lead agency" refers to a county, or a managed care organization or tribe under contract with the department, to manage the Elderly Waiver program.

monitoring must be in place. The requirements for the clinical monitoring plan can be found in DHS Form 3428B, the Case Mix Classification Worksheet. The item capturing the need for **clinical monitoring** on DHS Form 3428 or 3428A must be scored as 02 (all shifts, interpreted here to mean at least once every eight hours). The person may or may not require a medical treatment of the type that is specified on DHS Form 3428B that results in a case mix classification of "Special Nursing". This criterion for authorization of 24 hour customized living service will be captured in the Service Plan Summary Section of the Long Term Care Screening Document as described in *Attachment A.*

4. **Authorization based on "Other Criteria": Medication needs combined with a minimum number of hours of direct service to be provided by the 24 hour customized living service provider.** The "other" criterion combines the need for medication management with at least 50 hours of direct service to be provided to an individual consumer on average per month.

    a. **Documenting medication management needs.** In the section of DHS Form 3428 or 3428A "Independent Living: Instrumental Activities of Daily Living," the item addressing the person's ability to take their own medications must be scored 03 or 04 higher (the person needs a lot of help or constant supervision, or they can't manage their medications at all). While this is the item that will be captured in the Long Term Care Screening Document, several other items in DHS Form 3428 or 3428A provide additional information about medication management or medication administration needs. The lead agency case manager or care coordinator must take all of the information available about medication and the need for assistance with medications into account in order to determine the level of need for medication assistance.

    b. **Documenting the number of hours of direct service.** The lead agency case manager or care coordinator will determine, as part of finalizing the 24 hour customized living component service plan, that at least 50 hours of direct service time is needed and will be provided, on average, per month, by the 24 hour customized living service provider. Documentation of the number of hours of direct service to be provided by the 24 hour customized living service provider will exist in the consumer's EW community support plan using (DHS Form 4166 or 2925), as well as in the provider's service delivery plan, and will not be captured in nor edited by MMIS.

    Under all waiver programs, the community support plan must always indicate the type, amount, and units of all home and community-based services that are being authorized. Under both customized living and 24 hour customized living service plans, the plan must include the types, amount, and units of component services to be provided. Case managers and care coordinators should be able to easily ascertain whether any given 24 hour customized living service plan includes at least 50 hours of direct service, on average, per month.

"Medication management": Medication management, as defined in Minnesota Statutes, section 144A.45, *Regulation of Home Care Services*, subdivision 1, item (d) includes the central storage, handling, distribution, and administration of medications.

"Direct service": Direct service means staff time spent with the individual consumer, or on the behalf of the individual consumer, in delivering any component service included in the 24 hour customized living service plan approved by the lead agency case manager or care coordinator, as reflected in the community support plan using DHS Form 2925 or 4166, and in the provider's service delivery plan for the consumer. Bulletin 07-25-01 (or 07-25-01C) outlines the component services and service definitions for customized and 24 hour customized living service. Staff time spent in providing any of these component services, as outlined in the approved community support plan using DHS Form 2925 or 4166, and in the provider's service delivery plan for the consumer, is direct service time.

If the service or support will be provided by one staff to, or on the behalf of, more than one consumer at a time, the amount of staff time to be attributed to any single individual must be reasonable and allocated among **all** consumers served or supported by the staff during the period of time under consideration. Examples of this type of "shared" service could include meal preparation, provision of transportation, shopping, laundry, or supervision. If socialization service meets the definition of this component service under the EW program, it might also be delivered as a shared service.

Negotiated rates for customized living and 24 hour customized living service plans must be based on the component services to be provided by the customized living or 24 hour customized living service provider, under an approved plan, as determined by the lead agency case manager or care coordinator, and as agreed to by the EW consumer.

V. Changes to MMIS related to program integrity goals

MMIS edits have been developed and will be implemented effective January 1, 2008. These edits are currently set as either informational or force-able within MMIS. These changes will enhance several aspects of program integrity:

- **Provide better descriptions and documentation of the component service planned and approved within a customized living service package.** Since customized living and 24 hour customized living are 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 or 24 hour customized living service package. More descriptive information about the types of services that are included in the service plans for people receiving customized or 24 hour customized living service will be available to the department.

- **Limit 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.

- **Document assessed need to authorize 24 hour customized living service.** Edits have been created that compare assessment information on the Long Term Care Screening Document and the services planned in Section G of the same Document (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 service will only be allowed to be authorized on a Service Agreement when at least one of the criteria is indicated as met on the Long Term Care Screening Document.

Attachment A provides more detailed information about the MMIS editing.

VI. Related policy questions and answers

Over the course of implementing the 2007 legislative changes, policy questions have been raised by providers and lead agencies related to assessment, support planning, service delivery, clinical monitoring, and rate negotiation and purchase of services. AAS prepared a question and answer document that was forwarded as part of training materials in the September 2007 videoconference. *Attachment B* includes an abridged version of that material, and incorporates some additional questions submitted in the interim and not previously addressed. It is hoped this document provides further clarification of policy and requirements related to this service and to the Elderly Waiver program.

VII. Additional Resources

Bulletin 07-25-01C can be located at
http://www.dhs.state.mn.us/dhs16_137006

The manual *"Entering the LTC Screening Document and Service Agreement into MMIS"* is located at
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4625-ENG

The legislation referenced in this bulletin can be located at
http://ros.leg.mn/bin/getpub.php?pubtype=STAT_CHAP_SEC&year=current&section=256B.0915&image.x=21&image.y=11

VIII. Special Needs

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

Attachment A

Summary of the MMIS Changes for EW Customized Living Services

Effective January 1st, 2008, these edits will be applied to Long Term Care Screening Documents entered or revised on or after January 1st, 2008, and to Elderly Waiver Service Agreements entered or revised on or after January 1st, 2008, for customized living or 24 hour customized living service line items with dates of service on or after January 1st, 2008.

LTC Screening Document – Service Plan Summary Section: New codes here allow the component services authorized as part of customized living and 24 hour customized living services to be recorded in the service plan summary.

- New valid values
  - 52 – personal emergency response
  - 53 – delegated medication administration
  - 54 – delegated health related
  - 55 – arranging transportation
  - 56 – individualized socialization support
  - 57 – personal assistance, not PCA
  - 58 – 24 hour intermittent and unscheduled support
  - 59 – clinical monitoring over 24 hours
  - 60 – 24 hour supervision for dementia/orientation/mental health/behavior
  - 61 – supervision less than 24 hours per day
  - 62 – laundry
  - 64 – 50 hour direct staff/medication management assistance

- New Source Code "C" allows the case manager to indicate which services will be provided by a customized living or 24 hour customized living service provider
  - "C" stands for customized living or 24 hour customized living service provider
  - Is used in combination with services codes to identify component services
  - Source code "C" may only be used if program type is 03 or 04 (Elderly Waiver)

- 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. These have been replaced with customized living and 24 hour customized living service for EW consumers.

- New Edits

1. Edit 517 (Funding Code C Invalid) allows funding code C for **only** these service values, and reflects the component services available as part of customized living or 24 hour customized living service:
   - 01 – Shopping
   - 04 – Home delivered meals

- 05 – Congregate meal service
- 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 intermittent and unscheduled support
- 59 – clinical monitoring over 24 hours
- 60 – 24 hour supervision for dementia/orientation/mental health/behavior
- 61 – Less than 24 hour supervision
- 62 – Laundry
- 64 – 50 hour direct staff/medication management assistance

Edit 517 also works to supports the policy that personal emergency response cannot be authorized in combination with 24 hour customized living service. This edit will not allow service value 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), 60 (24 hour supervision for dementia/orientation/mental health/behavior), or 64 (50 hour direct staff/med management assistance) are also valued with source code C.

2. Edit 520 (24-hour Supervision Not Valid) will post if no criteria for authorizing 24 hour customized living service is reflected in information in the Long Term Care Screening document about the person's needs for assistance. This edit will post if:

- Value 58 (24 hour intermittent and unscheduled support) is chosen and there is no dependency in toileting or transferring coded. Toileting field must be valued 01 or greater, *or* the Transfer field must be valued 02 or greater to choose 24 hour intermittent and unscheduled support as the basis for authorizing 24 hour customized living service.

- Value 59 (clinical monitoring over 24 hours) is chosen and the clinical monitoring field does not indicate the need for clinical monitoring over 24 hours, coded as 02.

- Value 60 (24 hour supervision for dementia/orientation/mental health/behavior) is chosen and the Behavior item does not indicate a need for staff intervention (the Behavior item is not valued 02 or greater) ***or*** Orientation is not valued 02 or greater.

- Value 64 (50 hours direct staff/medication management assistance) is chosen and the medication management field is not coded as 3 or 4.

Lead agency staff may code more than one reason for the need for 24 hour supervision in this section, as long as each reason coded meets its own criteria as outlined above.

3. Edit 529 (Invalid Service Codes) will post if:

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

   - Values 53 – 61 and 64 are used with any program type other than 03 or 04 (EW).

Elderly Waiver Service Agreement Edits

- ✓ New edit to insure there is a documented need for 24 hour customized living service on the LTC screening document, and identification of the component services to be provided.

1. Edit 523 (Customized Living Services Invalid)

   - This edit will post if there is a line item with a begin date of 01/01/08 or greater for 24 hour customized living service (T2030 with modifier TG) and the last approved screening document with an assessment result date within the service agreement header period does not have 58 (24 hour intermittent and unscheduled support), 59 (clinical monitoring over 24 hours), 60 (24 hour supervision for dementia/orientation/mental health/behavior), or 64 (50 hour direct staff/medication management assistance) valued with source code C in the Service Plan Summary section.

   - This edit will post if there is a line item for customized living service (T2030) with a begin date of 01/01/08 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 58 (24 hour intermittent and unscheduled support), 59 (clinical monitoring over 24 hours), 60 (24 hour supervision for dementia/orientation/mental health/behavior), or 64 (50 hour direct staff/medication management assistance) is valued with source code C. **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, and this edits posts, 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, and are found 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 B

The table here is an abridged version of and summarizes the "Questions and Answers" document that Aging and Adult Services staff included in the handouts forwarded to people, who registered for videoconference training on September, 27, 2007.

Questions Related to Nurse Delegation	**Response**
I assume that your reference to the "home health aide" is the unlicensed staff that have been trained per the Class F License. Are there any tasks that nurses are prohibited from delegating under the Class F License? Who would I get similar clarification from regarding the Class A License? (An email address would be helpful)	Your description of home health aides who provide "home health aide-like tasks" under a Class F license is correct. If a provider is operating under a Class A license, of course, staff must meet those training requirements. The statute and rule with regards to the Class F license only states that injections other than insulin *cannot* be delegated. It is silent on what *can* be delegated. If you have questions regarding a Class A (licensed only - non-Medicare) or Class F Home Care license, please call the Minnesota Department of Health at 651-201-4302. Department of Health staff refer providers to the Board of Nursing for more direction on the Nurse Practice Act, and for guidance on delegation of nursing tasks.
It has been problematic for Class F providers to refer people who need intermittent "skilled" services to a Class A/Medicare certified agency. I would like to facilitate a list of concerns resulting from the Class F restrictions for billing MA home care and wonder if you have suggestions on how to proceed.	DHS would welcome your listing of concerns and suggestions or proposals to address them. Please forward your information to Lisa.Rotegard@state.mn.us.
Questions Related to Clinical Monitoring	**Response**
Just wondering if you could clarify the definition of "clinical monitoring" in regards to the LTCC tool. Is it a checking of 02 stats and vital signs each shift? Or more of an awareness of how the client is doing? Or something else entirely?	Before an intervention can be "counted" as clinical monitoring, certain criteria have to be met. The reason the condition is being monitored is to adjust care or treatment. The criteria from DHS Form 3428B (Case Mix Classification) related to clinical monitoring plans are: 1) there has to be a physician identification of the need for monitoring a condition, and treatment for that condition (monitoring is not the same as supervision, i.e.) 2) There is a formal written plan for this monitoring 3) The monitoring is documented (whatever is being monitored and measured

	is systematically recorded 4) The plan includes what steps need to be taken based on these measurements 5) There is periodic reassessment by the physician that documents the continuing need for monitoring. If the clinical monitoring plan includes these elements, and the monitoring occurs on “all shifts” (in the community, "all shifts" can be interpreted as” At least once every 8 hours"), 24 hour customized living service can be authorized. The treatment involved may or may not meet the criteria for case mix classification of “special nursing”. The service plan, and the negotiated rate, will reflect what type of monitoring, provided by which type of staff, how often, for how long, etc. All of these elements should be reflected in the clinical monitoring plan. In the community, some staff and even family members can receive training to monitor a variety of conditions and deliver care based on that monitoring. What kind of treatment or care is needed will determine in part who can do it. This ends up being pretty individualized. Provider license will also provide direction about the scope of work and allowable service or activity for staff under different licenses.
I am still stuck on Special Nursing. I have read and reread the case mix directions and form from the training last week. I am still unsure about clinical monitoring. Can an HHA, PCA or CNA do the monitoring if it is delegated by an RN and they have access to an RN if there is a problem? The direction sheet refers to" licensed or unlicensed nursing personnel".	Yes. The case mix tool does not change how care can be delivered or by whom according to profession, setting, service requirements, license, delegation, etc. The case mix decision tree outlines what type of care (treatment) and the extent of monitoring (and the purpose, etc) that has to be in place in order to count for case mix purposes. Nursing service to be included in a customized living and 24 hour customized living service plan cannot include services beyond those listed in Bulletin 07-25-01C.
Questions Related to Supervision and/or Emergency Response	**Response**
Our 24 hr. assisted living uses a seven digit telephone number as their system to call for help. None of my clients have been able to remember this number when I have asked them how they would call for help from the facility if they	Emergency response is not 24 hour supervision, no matter how it is being provided. If you have quality concerns, you can insist on some additional emergency response system from your provider through the contract.

needed it. Is this an appropriate way to call for help? My clients don't carry their telephones with them, and when they have fallen are no where near their telephone.	Providers are responsible to implement the service plan designed by you and the consumer, including how any supervision needs will be met and/or what effective emergency response service is needed. Bulletin 07-25-01C, page 13, requires that a provider "provide each consumer with a means to effectively summon assistance." When purchased in combination with customized living, and authorized as part of the person's support plan, the authorized amount for a personal emergency response device is not included under the service rate limit for customized living. If you are purchasing 24 hour customized living service from this provider, based on documented need for 24 hour supervision and an approved provider plan to meet those needs, the provider is responsible for ensuring emergency response. You cannot authorize personal emergency response devices in combination with 24 hour customized living service. If the provider chooses a system that fails to meet consumer needs, you can insist on some additional or different emergency response capacity from your provider through the contract.
Is it that we can't authorize customized living for **anyone** unless they meet the state criteria, or that we can't pay for the 24 hour supervision piece of customized living service if they don't meet the criteria set forth in the law?	If a person does not meet the criteria, the lead agency cannot authorize 24 hour customized living service. A service plan can certainly include supervision provided as part of a customized living service plan. This supervision would have to be purchased under the customized living service rate limit if the person does not meet the criteria that allow authorization of 24 hour customized living service, and the 24 hour customized living service rate limit.
Are staff required to physically check on the resident day and night in order to be considered 24 hr Customized Living and how often are they required to check on the resident?	The mode of contact and frequency of contact of staff providing supervision to a resident as part of an approved plan for either customized or 24 hour customized living service needs to address the documented needs of the individual. The mode and frequency of supervision should be delineated in the customized living or 24 hour customized living service plan. Please see Section VI of DHS Bulletin #07-25-01C for provider qualifications related to the provision of supervision under both customized living and 24 hour customized living service.
Not sure if you are familiar with The Quiet Care systems - but is this sufficient to be considered 24 hr emergency response system? Quiet care systems usually just track an individual's routine movements in the apt and if anything deviates from this the system alerts staff to this unusual amount or decreased amount of activity.	The system described could be an effective emergency response system for some people, and not appropriate for other people. This service, like all other component services, needs to be individualized for a person. *Emergency response systems* are not the same as, and do not meet the criteria for 24 hour *supervision.*

	The use of technology to identify the individual's need for and to summon assistance is acceptable, again, as long as it is tailored to meet the supervision needs of an individual.
Our lead agency indicated that we as providers must have someone in the building 24 hours a day. Our building is connected by a link to our skilled nursing facility. How is this viewed? Since we usually have only 4-5 residents receiving services at one time, it is not financially possible to have a person in that specific building 24 hours a day. We are connected with a link with staff able to respond within minutes 24 hours a day.	24 hour customized living service (formerly called assisted living plus) requires 24 hour supervision by staff working within the customized living program. This has always been the policy for this service. In the situation you describe, staff are working in the nursing home. This does not meet the provider requirement for supervision in 24 hour customized living service. The service you are providing appears to be customized living, not 24 hour customized living service. Please note that other services can be authorized in addition to customized living in order to meet client needs. These additional services are not included under the service rate limit for customized living. Work with lead agency case managers or care coordinators to identify alternative services, if needed.
Client meets the 24 hour supervision criteria as defined by DHS either by meeting toileting, transferring, case mix or behavior criteria. Care Coordinator determines that the needs can be met by the provider that provides 24 hour supervision with up to 8 hours by means of a call system with sleep staff OR staff responding from another contiguous campus building as assistance is required. Care coordinator determines that this is appropriate level of service based on this individual client. Provider meets the 24 hour exemption as outlined by MDH for Assisted living. Will the reimbursement for customized living be based on the rate for 24 hour supervision OR NON 24 hour supervision (which would be the lesser of the rate tool or the service rate limit)? This determination will affect whether clients may have to relocate because of the clarification of the customized living reimbursement of 24 hour supervision versus non 24 hour supervision.	The Minnesota Department of Health (MDH) exemption referred to here is related to a provision that allows asleep staff in settings with 12 or fewer residents. Asleep staff is not an issue in determining the need for, and receipt of, 24 hour supervision as it has been defined under the EW program, nor is asleep staff prohibited under the supervision service component definitions that are part of customized or 24 hour customized living services. Please review Section VI of DHS Bulletin 07-25-01C for complete information about supervision requirements for providers. While the residents may meet the service need criteria in this example, the provider will not meet requirements with staff responding from a contiguous campus. If this is the service delivery model chosen, the service must be customized living. Two other related notes: There is not a “rate” per se for 24 hour customized living. Like customized living, there is a service rate limit. Neither lead agencies nor providers should view the case mix budget caps as rates. With respect to consumers being asked to “relocate”, consumers have rights as both tenants with respect to eviction, and as public program participants. There are protections against discrimination based on disability that may apply to some of these kinds of actions. And we believe providers should carefully

	consider adopting a policy that results in ongoing "relocation" of residents after they have exhausted their private resources.
In looking at X County's Assisted Living Programs, or rather the Customized and 24 hour Customized Living Services, we have run into a controversy regarding payment for "supervision" for the non-24 hour service. Can "supervision" be billed for Assisted Living/Customized Living Services clients?	Supervision is a distinct component service available under both customized living and 24 hour customized living service. In either case, if supervision is not needed by an individual, it cannot be authorized, should not be part of the person's service plan, and is not billed. Supervision specifically needed and delivered is billable under both services. Under 2007 legislation, if a person does not meet established criteria, 24 hour customized living service cannot be authorized for that person. Any supervision service provided as a component service to people who do not meet the 24 hour customized living service criteria must be provided under the customized living service rate limit.
I was a little concerned that the discussion about clients approved for 24-hour customized living services who are away from the building could have been interpreted to imply that the provider may have some obligation for responding even when the client is away from the building without staff escort. While VA would impose some obligations on providers to consider the safety of a client leaving a building alone or with a family member or friend, I would hope that future conversations would make it clear that providers can't monitor clients who are on leave without staff escorts.	When contracting for supervision of an individual as a component of either customized living or 24 hour customized living service plan, the case manager or care coordinator should delineate the elements specified on Page 11 of DHS Bulletin #07-25-01C, including the "locations in which supervision will be provided and changes in supervision depending on activities/location of the client". There may be some service plans when a provider is in fact responsible to provide staff escort, etc. The case manager is responsible to ensure that the overall community support plan reasonably ensures health and safety, including health and safety issues that may arise during community integration activity.
What does DHS expect with regard to replacing lost personal emergency response devices, both for clients who are just on customized living (where it's authorized outside the package) and for clients on the 24-hour package where the provider is responsible for providing the device. Can EW pay for the installation of Lifeline and then for a replacement button if needed?	Additional devices can be authorized if needed. If the client is approved for 24 hour customized living, the provider would cover the cost of any emergency response devices or systems. If there is an issue with a resident losing their device, this could be reflected in the negotiated payment for that person. EW can pay for the installation of Lifeline and a replacement button, assuming this person is not receiving 24 hour customized living service. Personal emergency response (Lifeline is one example) and 24 hour customized living service cannot be authorized for the same person.
As we are moving forwarding with implementing the customized living changes, we have one provider in an apartment building setting where we have paid for the personal emergency response devices which has them as the first responder. With the legislative changes, we can't authorize the 24 hour customized living service and the provider does not want to take the cost on for this. If the person moves to the customized living and retains the PAL unit the	The personal emergency response device can be authorized separately for recipients receiving customized living.

provider does not want to take the cut in reimbursement.	
Questions Related to Rate-Setting	**Response**
What is the base rate for assisted living? What is included in that base rate?	Please refer to DHS Bulletin #07-25-01C, section XI, for information about rate negotiation parameters, including a description of what can and cannot be in a "base rate", and other criteria.
Time is getting short to make changes to our Lead County Contracts and Service Agreements, if Counties are going to be required to make changes in how they purchase this service. It was unclear in our memo if the rate setting change addressed in legislation was going to be implemented by October 1, 2007 or was delayed to December. I would appreciate a brief update to keep my Commissioners informed on when contracts can be completed.	Editing (other than posting Informational edits) of Long Term Care Screening Documents and Service Agreements will be effective January 1, 2008. It is hoped that lead agencies have enough information about authorization, pricing, and rate-setting to proceed with contract renegotiations. Negotiating contracts to include both customized living and 24 hour customized living service is needed in most communities. Comparison to costs for similar services in other settings can be done in order to negotiate and establish component service charges as required under statute.
If a facility does not have kitchen facilities, and brings in meals on wheels, can they bill for food prep? We have two cases where this is being done.	EW pays for one home delivered meal per day. The payment includes food preparation. If a provider is contracting for delivered meals, the charge per meal should include food preparation cost. Food or meal preparation should not be billed twice. The charge per meal should not exceed the cost of a home delivered meal. Under the parameters for rate-setting outlined in statute, for EW consumers, the price of these delivered meals should not exceed the maximum allowable price for a home delivered meal.
I was under the impression that clients who have been authorized for 24-hour customized living services were not supposed to have a reduction in services or their rates until the "other" conditions that qualify for the 24-hour supervision are identified by DHS.	DHS will not enforce edits until January 1, 2008. That said, this bulletin outlines the "other" criteria for authorization of 24 hour customized living, and DHS expects lead agencies to implement the criteria, as well as additional criteria outlined in Subdivision 3.h copied on page 2 of this bulletin.
Do we still use the nursing home geographic group rate limit for customized living? The new bulletin lists "up to case mix budget cap" for both customized living services and 24 hour customized living service. Which rate limit do we use in that instance for the customized living services?	Customized living service rate limits are used for this service only. The client still has access to their full case mix budget cap. The lead agency has the option of using the statewide average rather than Group 1 or Group 2 service rate limits. The statewide average customized living service rate is that used in MMIS for editing Service Agreements. 24 hour customized living service rate limits (which are equal to the case mix budget caps) are used for clients who need 24 hours of supervision. 24 hour customized living should only be authorized, and coded as such on the authorization, for a person who meets the criteria for 24 hour customized living.

At the UCIG meeting on Wednesday, several participants (providers and MDH staff) indicated that counties are setting rental rates in their contracts with assisted living providers.	The only rental rates that can be negotiated are the number of GRH beds with a set rate as specified in provider GRH contracts. Providers are limited to those rates for the number of beds specified in contract. Lead agencies can require that providers indicate what their rental rates are in the lead agency contract. This is not to be interpreted that lead agencies can set those rental rates. It is, however, important information for case managers and care coordinators to have to help consumers choose between available customized living or 24 hour customized living services providers.
My lead agency refuses to explain how my rates are being set. Shouldn't this be clear to me as a provider?	Rate negotiation should be individualized, and based on units of component services to be provided, purchased at a unit cost comparable to similar home and community-based service, reflect economies of scale and "shared" staff. The lead agency method of establishing negotiated rates should be clear and available to their contracted vendors, just as component costs and units and amounts of component services that will be included in a plan need to be clear and available.
Questions Related to Implementation of Program Integrity Plan	**Response**
What happens 12-1-07 (now January 1st, 2008) to those individuals who are in the system? Is there something that will "kick" them out of the system if they have been authorized to continue to receive services in the current system and may (or may not) meet "other" circumstances identified?	The MMIS system edits will not be "automatically" applied to screening documents or service authorizations for persons authorized for 24 hour customized living on January 1st, 2008. For existing EW participants, the non-forcible edits will be applied *the next time* the screening document or service agreement is opened on or after January 1st, 2008. These edits will appear if a reassessment is entered, or a service agreement is opened to change a provider, a date, or a rate. Both screening document and service agreement edits will be applied to all new EW participants who open to the program on or after January 1st, 2008. Please see Attachment A for complete editing information, noting the effective date to now be January 1st, 2008.
Are we going to need to enter a reassessment screening document after January 1st, 2008 in order for these individuals to continue to receive (24 hour) customized living services?	No. Finalized edits will post for people who do not meet any of the finalized criteria *the next time* a Screening Document or Service Agreement is updated or re-entered for that person. This could be the result of a scheduled reassessment, or be the result of the need to change dates on a Service Agreement, or rates, or services included in the Agreement.
According to Bulletin #07-25-01C, we are suppose to identify and correct any errors in either Long Term Care Screening Document assessment information or correct Service Agreement errors for clients who are currently receiving customized living services and are coded as 24 hour customized living, or who	If the ADL or other fields need to be changed because of a change in condition or a change in need, these changes should be based on a completed face-to-face reassessment visit. The Screening Document should indicate the actual level of care needs of the person as determined by a face-to-face visit with the

are authorized for 24 hour customized living but do not meet the criteria as it is currently known. Our case managers would like to update the toileting or transferring information on the screening document for some of their clients. Can you please tell me how this should be entered?	person. This would be done using Activity Type 06 (reassessment) and Assessment Result 13 (continuing on same program). If the data was simply entered in error and you are trying to fix the error, the Screening Document should be deleted and a replacement document with correct information should be entered.
Have a situation in which this lady has been in Assisted Living Plus for several years. She belongs there. But the system doesn't think she needs supervision with what I have entered. Not even intermittently. She is oriented but forgetful. Her main problem is that she is ANXIOUS. This is why she could not live in her own apartment. If someone is not around all of the time she has problems. An apartment doesn't do it. She was calling her family or the ambulance in the middle of the night. Her pain gets worse and then if she lived alone she would start using pain pills inappropriately. She has reduced her hospitalizations and her anxiety level remains at bay with intermittent supervision.	After talking with lead agency staff, it was clear that, while this person's need for supervision itself was intermittent, staff intervention of various kinds was occurring regularly that have resulted in decreases in behaviors associated with anxiety. It's important to capture staff intervention needed to maintain improvements in behavior as well as to intervene when behaviors occur. Coding the level of staff intervention needed as described under the Behavior item in the LTCC Assessment tool resulted in a new case mix classification that allowed customized living to be authorized, at the customized living service rate limit under the higher case mix classification. While a significant amount of supervision is being provided, there was no need to access 24 hour customized living service rates, or 24 hours of supervision which was not needed or being provided, in this case.
We have documented all the "other" reasons for people to be authorized for 24 hour customized living and submitted them to you and the health plans. We are now concerned that some of the people that we feel need 24 hours of supervision, and the higher rate limit will be ok'd by you or the health plans AND SOME WILL NOT!! Those people that you decide are NOT 24 hour will need to be notified, given a notice of action and appeal rights, in a timely fashion. Will there be a "grace period" for persons in this situation? How will we be notified that our assessment hasn't justified the service? And then – what if one of our providers decides not to provide customized living, only 24 hour. Is the person going to have a time frame to move out? Inquiring minds want to know!!!	It is erroneous to assume that a person who needs more services than are available under the rate limit for customized living, but who do not meet the criteria for 24 hour supervision, cannot receive additional services. Throughout this document, we have promoted the option to combine customized living services and other services, which can, in combination, be purchased up to the person's case mix budget cap. This may be an excellent option for providers who do not meet the provider requirements for 24 hour customized living service, and for residents who do not meet criteria for 24 hours of supervision, but who have need for additional services that can be provided in combination with customized living. If a person's services are denied, terminated, or reduced by a lead agency, the lead agency must send appropriate notice within 10 days of the decision, along with appeals rights information. If a provider is terminating or reducing services, the provider must follow their service contract and provider notice requirements under the Housing with Services Act and as required under the Home Care Bill of Rights. A person or provider has no appealable interest in the rates a provider is approved for.

	It's important to remember this person also has a Housing with Services contract that has to be honored, and that they have tenants' rights as renters in these settings, and process rights related to evictions, etc. Ensuring that people understand and can receive help in exercising these rights is an important part of this initiative. Your local Ombudsman for Long Term Care can assist consumers who receive notices to move, or with other issues that may arise with a customized living or 24 hour customized living service provider or lead agency action.
I have a client that I screened for EW who wants to go into an assisted living facility. Currently this client is living independently in the community and is receiving lifeline and case management through the waiver. Her name has now been chosen at an assisted living facility. After screening her, her only ADL is that she walks with a walker. There are concerns about her balance and she is at risk of falling. I do not feel she needs the 24 hour supervision but I'm having a hard time with this situation and the family is very upset. Do you have any helpful thoughts for me?	The provider must offer component services individually if they want to participate in EW as an MA-enrolled provider, with negotiated payments for each component, including the amount of each component an individual will receive based on your needs assessment. The family, provider, and consumer must understand that you can only authorize and purchase services that the person needs. If they are requesting 24 hour customized living service, and you are in effect denying that service, you should send a DTR notice with appeal rights information. Include the legislation that limits you as a lead agency to authorization of that service for people who meet criteria.
Given that the current focus on many ends has been on managing the AL associated costs, we will most likely be seeing more vs. less of this targeted shortage of AL facilities willing to work with either form of public pay/MSHO clients.	The customized living service provider industry is very diverse, and has responded to the implementation of legislation in diverse ways. Based on the information we have received back from lead agencies on the consumer sample, there were very few providers unwilling to negotiate customized living (and perhaps additional services were added to the person's support plan) when neither reassessment nor checking for error resulted in adequate documentation of the need for 24 hour supervision according to the 3 specific criteria used. Given the availability of "other" criteria, a better understanding of service options, clarification of supervision and delegation requirements and options, targeted training about certain assessment issues, and changes in the ways lead agencies negotiate rates, DHS is confident that we will continue to be able to offer customized living and 24 hour customized living service as a home and community-based service option.
Miscellaneous	**Response**
County has a lot of settings (mostly B & L's, but some AFC's) that opted for Assisted Living (Plus) in the beginning, and continue to serve CADI (and probably a few TBI) residents. Chapter 26A of the MHCP Manual indicates that Customized Living and 24 Hour Customized Living service apply only to the EW waiver. Assisted Living & Assisted Living Plus are no longer listed services in this manual.	Due to legislation in 2006 that specifically defined Assisted Living for purposes of marketing, the waiver policy staff (EW, TBI, and CADI) decided to rename the Assisted Living waiver service to Customized Living. This name change requires a federal waiver plan amendment for each of the waivers affected. The Elderly Waiver was amended and approved by CMS effective 01-01-07.

The DSPM waiver covering CADI & TBI does not list the Customized Living services, but it does list Assisted Living & Assisted Living Plus. My question is this: What is the correct service for CADI and TBI residents living in a setting that provides Customized Living and/or 24 Hour Customized Living for EW? Are the Customized Living services available to them? Are the Assisted Living services available to them? Or have they been left in limbo with this transition?	There is a waiver plan amendment in draft form for TBI and CADI that will change the name of Assisted Living to Customized Living. A waiver plan amendment that includes this name change as well as other amendments related to new provider standards requirements from 2007 legislation will be submitted to CMS. Assisted Living service remains available to CADI and TBI waiver participants. Until the waiver plan amendment is submitted and approved by CMS, the service will continue to be called Assisted Living under CADI and TBI. DHS will provide notification when the TBI and CADI waiver plan amendments have been approved.
Is a Class F (only) provider able to bill **AC** for services rendered in a HWS facility? To clarify, the Class F provider has not chosen to use "Assisted Living" in their nomenclature or advertising. Services are provided under the Class F provision. A Class A/Medicare certified agency provides the "skilled" services. I understand that AC eligible people can no longer access assisted living but this is not "assisted living." I am under the impression this would be acceptable. Am I right?	Yes, "like" services can be paid for under the AC program as long as they are not being billed as assisted living or customized living. This may be an alternative for people who might otherwise be displaced. The person would need to meet all AC eligibility requirements, of course, and a service plan that included the services a person needed as the alternatives to the assisted living services would have to be developed, be able to be delivered by the provider, and be approved by the case manager.
What is the proper coding on the screening document for living arrangement and housing type for people in assisted or customized living service? We don't consider an assisted living facility a "congregate setting" so……	The living arrangement codes capture information about who I live with: alone, with my spouse or parent, with friends or family, or a lot of people I don't know (congregate). Housing type reflects any physical plant licenses held by the housing manager. These are coded the same regardless of the type of SERVICE I might receive. For example, I may live in a Housing with Services establishment that is individual apartments at a senior high rise. In this case, I live alone or maybe with a spouse, and I live in my own home. I may or may not receive customized living services there. Any other housing with service setting will be a congregate living arrangement, and will have either a board and lodge or non-certified boarding care physical plant license. These licenses should be visibly posted at the site.
I have an assisted living facility that has charged the family of an EW client, who is moving in, a $400 "assessment" fee, for their nurse to assess the client in that facility. I have been checking the information I have on assisted living, and I don't believe that under EW, other charges can be leveled at clients and their families. I'm not sure where to look for this as a written policy.	The assessment used to establish eligibility, develop the care plan and authorize services for customized living and 24 hour customized living under EW must be done by the lead agency Long Term Care Consultants (LTCC) or case managers. Various providers such as foster care, adult day care, and home care providers, must perform assessments as part of their licensing requirements. These assessments are not paid for as a separate service under Medicaid, but are considered part of the indirect costs associated with the charges for services delivered under a subsequent provider services delivery plan. An Elderly Waiver consumer cannot be charged for this assessment, and families cannot be required to pay for charges that the Elderly Waiver program will not cover.

I'm working on a client who is in a customized living setting. She has Long Term Care insurance that is paying $900 a month. The facility is telling the family (who I have cc'd this email to) that the insurance will be above and beyond what EW will pay. Is this correct or is the $900 subtracted from the EW payment?	Elderly Waiver is the payer of last resort. The long term care insurance is to be used as the first payer and Elderly Waiver services are the secondary payer. If the policy states what services it will pay for, then EW should only be used if more of those or different services are needed. If the policy is not specific in what services are to be paid, then the $900 for services needed should be used first and then EW would pay for other needed services as specified in the care plan. There are many kinds of benefits under different long term care insurance policies. For example, lodging and food costs may be covered by some LTC insurance. The county/lead agency staff should evaluate what a particular client's insurance benefit explicitly covers. Counties/lead agencies should not assume that the entire LTC insurance benefit should go toward the client's home care service costs. Please make sure that the financial worker understands that this policy needs to be entered in the TPL system like any other third party Liability insurance. The financial worker can assist the case manager in determining what services or other benefits a given insurance policy may include.
What actually concerns us MORE is the number of ALs that keep people far past their ability to care for them. They have turned themselves into 'mini nursing homes'. They want to keep beds full so they keep people that are very fragile and very high risk. When we try to express that concern, I have been told they have the right to choose. When I asked about the right to choose on the other end, I was told we can't pay for services that they don't need. We are caught very much in the middle. We have reported many cases to MDH but they are overwhelmed with the number of assisted livings.	Community service arrangements successfully support many people who are considered fragile and/or "at risk". Risk management plans have been the tools for case managers to outline risks and plan services to minimize those risks, including personal risk management plans. Of course, a provider must be able to demonstrate they can meet an individual's need for the services you want to authorize. For a Class F provider, this may mean that a contract with a Class A certified home care provider is needed to order to meet needs that require *nursing* services. This doesn't mean the person needs *nursing facility* services. In any case, a lead agency cannot categorically deny a sub-group of the EW population from receiving a service for which they have a documented need, for which there is a community alternative, and while the person continues to choose community versus institutional services. Lead agency staff can authorize and pay for services in these settings in multiple ways.