

## Chapter 26

# Home and Community Based Services (HCBS) Elderly Waivers

## Introduction

The purpose of the Home and Community Based Services (HCBS) Waiver Programs is to promote community living and independence based on the individual needs and choices of the member by providing various services or additional services beyond what is otherwise available through the Medicaid benefit.

The Elderly Waiver (EW) program is a Federal Medicaid waiver program that funds HCBS for people ages 65 and over who are eligible for Medical Assistance (MA) and require the level of care provided in a nursing home but choose to reside in the community. These programs provide services and supports for people to live in their homes, a community setting, or can delay or prevent nursing facility (NF) care. The purpose of these programs is to promote community living and independence with services and supports designed to address each person's individual needs and choices. In the case of EW, the additional services go beyond what is otherwise available through Medical Assistance (MA).

EW members can receive waiver services and/or MA services funded through PrimeWest Health. This can be through Minnesota Senior Care Plus (MSC+) or Minnesota Senior Health Options (MSHO)\*.

## Eligible Providers

Providers eligible to provide, bill, and be paid by PrimeWest Health for providing HCBS waiver services must:

1. Be contracted with the county or tribal agency authorizing services for the waived member
2. Provide and maintain licensure/documentation supporting their qualifications to provide waiver services as indicated in their contract with the county/tribal agency
3. Have a PrimeWest Health-approved service agreement to provide services for the member
4. Be an enrolled PrimeWest Health provider and continuously maintain qualifications to provide the waiver service

## County Contracting

PrimeWest Health specifies counties and tribal agencies will contract for waiver services with qualified providers. The county and lead agencies are required to do the following:

1. Contract with waiver providers
2. Ensure providers meet all applicable qualifications and service standards
3. Identify any additional competencies in the member's Individualized Service Plan (ISP)
4. Monitor provider performance on an ongoing basis with the case manager about the member's wellbeing and how it is related provider performance

Local agencies are responsible for systematic provider performance monitoring.

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

\*PrimeWest Health's name for this program is PrimeWest Senior Health Complete (HMO SNP)

## Eligible Members

Any member may request a no-cost HCBS assessment for him/herself or another member by making a referral to the local lead agency (public health, tribal agency, or human services). No person or his/her family can be charged for an initial assessment and support planning visit, whether provided in the community to avoid NF admission or provided as transition assistance to return to the community. The lead agency will determine eligibility for HCBS programs. Each waiver program has different application processes, eligibility requirements, and covered services.

All program applicants must qualify for MA. All applicants must meet the service eligibility criteria for the specific HCBS program in which they anticipate receiving services. Refer to Health Care Programs & Services, [Chapter 2](#), for more information about MA and eligibility.

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

## Long-Term Care Consultation (LTCC) Assessment

The LTCC focuses on Minnesota's long-term care information exchange system **and** individual choice regarding community-based options as an alternative to NF placement. The LTCC incorporates several components. Preadmission Screening (PAS) is one component of the LTCC and assists in identifying supports needed to maintain the member in the community or transition him/her back into the community.

The LTCC team assesses the health and social needs of a member and completes an assessment form. The team **must** conduct a face-to-face assessment for members under age 65 years. The legal representative of the member, if applicable, must be present.

All counties/tribes must complete all face-to-face LTCC screening activities for people under age 65 within 35 calendar days before, and 35 calendar days after, the face-to-face screening date.

### Billing for LTCC Assessments

Counties/tribes must submit electronic claims using the 837P claim format for completed face-to-face LTCC assessment activities for people under age 65.

1. All face-to-face assessment activities eligible for payment must be combined into one claim.
2. The date of service must match the date of an approved face-to-face assessment.
3. The maximum number of units allowed for reimbursement is 96.
4. If more than one LTCC team member is involved in the assessment process, combine the units of time into **one** claim.

Face-to-face assessment activities are eligible for payment, including time spent by LTCC team member(s) for the following:

1. Arranging assessment(s)
2. Preparing screening document(s) before assessment
3. Travel time to and from assessment (not including mileage costs)

4. Time actually spent conducting the assessment
5. Time spent in approval of the screening document

For **each** activity in the member's file, the LTCC team member must document the following:

1. Specify activity completed
2. Date the activity was completed
3. Name and role of the team member completing the activity
4. Amount of time spent on the activity

If more than one LTCC team member is involved in the assessment process, the units of time should be combined into **one** claim.

## Eligibility Criteria by Program

HCBS programs provide HCBS necessary as an alternative to institutionalization that promotes the optimal health, independence, safety, and integration of a member into the community. In addition, the member, and/or his/her legal representative/guardian, has made an informed choice to receive HCBS.

**The following HCBS program is currently available through PrimeWest Health for a member who is over the age of 65 at the time of enrollment and who requires the level of care a nursing home provides:**

- EW (Elderly Waiver)

Service	EW
Adult Day Services	X
Adult Day Services Bath	X
All MA-covered services	X
Customized Living	X
24-Hour Customized Living	
Caregiver Training and Education	X
Case Management	X
Case Management Aide (Paraprofessional)	X
Chore	X
Companion	X
Consumer Directed Community Supports	X
Conversion Case Management	
Corporate Foster Care (Monthly)	X
Family Foster Care (Monthly)	X
Home Care – Extended Services	X
Home Delivered Meals	X
Homemaker (15 minutes)	X
Homemaker (Daily)	X
Modification & Adaptations	X
Non-Medical Transportation	X
Nutrition	
Residential Care	X
Respite Care	X
RN Supervision of PCA	
Specialized Supplies and Equipment	X
Telehomecare	X
Transitional Supports	X

## Roles

### County Financial Worker

County financial workers will always determine financial eligibility for these programs. Financial workers will also conduct asset assessments as needed for determination of EW financial eligibility.

### Lead Agency

Lead agencies can be public health, tribal agencies, county human services agencies, counties, or the health plan responsible for the EW benefit set. Lead agencies are responsible for the following:

#### 1. LTCC

The lead agency provides LTCC services including the following:

- a. A community assessment of the needs of the member
- b. Assistance with the application process
- c. Development of a Community Support Plan

#### 2. Case Management

A member approved for an EW program will receive case management from a public health nurse or social worker who implements and monitors the Community Support Plan and is also responsible for reassessment of the individual's level of care and the review of the community support care plan. The lead agency must ensure that the health and safety needs of all members are reasonably met under their Community Support Plans. Members may refuse case management services at any time after enrollment. Members may inform the county case manager or PrimeWest Health care coordinator of their refusal. The refusal can be a verbal or written notification. The county case manager implements and monitors the comprehensive plan of care and is also responsible for reassessment of the individual's level of care and the review of the comprehensive plan of care. The lead agency must ensure that the health and safety needs of all members are reasonably met under their comprehensive plan of care.

#### 3. Program Access and Administration

- a. Lead agencies are responsible for providing program access and administration that includes:
  - i. Working in partnership with the Minnesota Department of Human Services (DHS) and other organizations to provide information, services, and assistance to people who request and wish to gain HCBS access
  - ii. Providing member case management services, that includes:
    - Assessing program eligibility
    - Developing a service plan
    - Assisting members access, coordinate and evaluate available services
  - iii. Generating additional copies of provider service agreement letters, if needed
  - iv. Inputting recipient enrollment data (e.g., screening document) and Service Authorization, as required, into the DHS Medicaid Management Information System (MMIS)
  - v. Authorizing and monitoring services to reasonably assure health and safety
  - vi. Monitoring the ongoing provision of individual services for efficiency, consumer satisfaction, and continued eligibility and adjusting these provisions as necessary
  - vii. Managing the contract(s) and systematic monitoring of provider performance
    - Assuring that all providers meet State standards for licensing or certification relevant to their area of service and have signed provider agreements
    - Authorizes funds for all HCBS services provided to the eligible member

### Notice of Action

By law, the lead agency/State is required to provide notification to the member any time services are denied, terminated, reduced, or suspended. Notification must be in writing and sent at least 10 days prior to the action being taken.

Lead agencies must use the [Notice of Action](#) form to notify a member of impending changes to the waiver services.

## Informed Choice

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

When a member is likely to require the level of care provided in an institution such as a hospital or nursing home, the case manager must inform the member and his/her legal representative of home and community supports as an alternative. The lead agency will do the following:

1. Provide individuals seeking EW services the necessary information to make informed choices among the services for which they are eligible
2. When a member is likely to require the level of care provided in an institution such as a hospital or nursing home, inform the member and legal representative of home and community supports as an alternative
3. Document that the information was given
4. Take reasonable steps to provide the information in a format the member can understand and with a choice of service providers for all services

## Turning 65

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

## HCBS Program Services Provider Information

### Enrollment/Licensure/Certification

HCBS program providers must enroll with PrimeWest Health and meet specific standards in order to bill and receive payment for waiver services. More information about provider enrollment can be found on the [PrimeWest Health website](#).

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

Some waiver services require one or more of the following:

1. License(s) from DHS or the Minnesota Department of Health (MDH)
2. Medicare certification
3. Certification or registration

For more information, please refer to one or more of the following:

1. Social Services department of the county in which you will be providing services
2. DHS Licensing at **1-651-296-3971** or [www.dhs.state.mn.us/Licensing/default.htm](http://www.dhs.state.mn.us/Licensing/default.htm)
3. MDH at **1-651-215-5800** or [www.health.state.mn.us/index.html](http://www.health.state.mn.us/index.html) for general information

## Authorization of Services (Prior Authorizations)

Waiver services require prior authorization from a case manager in the form of a completed service agreement. The service agreement allows the provider to bill PrimeWest Health and receive payment **after** services are provided. Only services on the service agreement can be paid; however, an approved service agreement is not a guarantee of payment. The case manager is ultimately responsible to make sure that the service agreement is accurate.

Providers should verify program eligibility for each member each month. Refer to [Billing Policy](#), Chapter 4, for eligibility verification information.

The service agreement for EW Waivers may include the following:

1. MA home care services of SNV, HHA, PDN, PCA
2. Waiver services consistent with the county contract

### Service Agreement

The service agreement should include all of the following:

1. The PrimeWest Health-enrolled provider who is authorized to provide the needed services
2. The rate of payment for the service
3. The number of units approved
4. Date or date span of authorization of service
5. Diagnosis code to be used when billing claim
6. The approved procedure code(s)

## County Health and Human Service or Lead Agency Responsibilities

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

Local program administration includes the following:

1. Case management/service coordination for members receiving services, including assessment and service plan development
2. Assistance to help people access, coordinate, and evaluate available services
3. Determining the financial and program eligibility of members for services and programs
4. Input of consumer enrollment data (screening document) and service authorization into MMIS
5. Authorizing and monitoring services to reasonably assure health and safety
6. Monitoring the ongoing provision of services for efficacy, consumer satisfaction, and continued eligibility, adjusting as necessary
7. Contracting management and supervision of services
8. Signing delegation agreements with PrimeWest Health counties to assure that all providers meet State standards for licensing or certification relevant to their area of service
9. Systematic monitoring of provider performance
10. Working in partnership with PrimeWest Health and other organizations to provide information, services, and assistance to people over the age of 65 and/or with disabilities
11. The case manager is responsible for any changes made to a member's service agreement. If the rate, procedure code(s), or begin and end dates on the service agreement are incorrect, contact the case manager. If a service agreement line item is changed and approved, the case manager will send the updated service agreement to the provider. It is the most current service agreement that the provider should be billing from.

## Billing for Services

### Payer Determination

All providers and lead agencies are responsible to bill available payers for services. The order of payers is as follows:

1. Third party payers (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, workers' compensation law or plan, no-fault or liability insurance policy or plan)
2. Medicare and Medicare Advantage Plans (Medicare must always be billed unless the item is a Medicare non-covered service)
3. Minnesota Health Care Programs (PrimeWest Health)
4. Waiver Programs

Waiver services must be billed using the 837P claim format. Refer to [Billing Policy, Chapter 4](#), for more information. Under no circumstances may a provider initiate and bill for service delivery prior to the execution of a contract for waiver services.

It is recommended that providers verify the program eligibility of a member on a monthly basis.

### Diagnosis Codes (ICD9-CM)

Diagnosis codes will be required for the new Health Insurance Portability and Accountability Act (HIPAA) national codes, including EW services. Use the most specific, most current primary diagnosis codes.

Service Authorization letters to the provider will display the diagnosis code of the member. The diagnosis will be pulled from the primary diagnosis field on the last approved screening document. Note: it is not necessary to use the diagnosis code listed on the service request letter if you have a more recent or correct diagnosis code.

### Authorized Services vs. Non-Authorized Services

Services that require a service agreement cannot be billed on the same claim as services that do not require a service agreement. For example, for MA eligible members, home care therapy services (physical, occupational, respiratory, and speech therapy) do not require a Service Authorization and cannot be billed on the same claim form as a waiver services (e.g., Adult Day Care).

PrimeWest Health requires counties to enter service agreements or provide Service Authorization forms to providers for EW services prior to the start of service to ensure provider payment. There are many advantages, for both providers and counties to coordinate their efforts to ensure that a member receives his/her necessary services and providers receive timely payments for services rendered.

### Allocation of Units and Rates

#### Allocation of Units

Each waiver service is assigned a procedure code. Waiver services use procedure codes from the Healthcare Common Procedural Coding System (HCPCS). Each procedure code is programmed with an increment for billing. Each procedure code is programmed as one service unit and is equal to one of the following increments:

1. 15 minutes
2. 30 minutes
3. 60 minutes

4. Hourly
5. Daily
6. Full Days
7. Partial Days
8. Occurrence
9. Semi-monthly
10. Per diem
11. Per meal
12. Per item
13. Mileage
14. One-way trip

## Rates

Lead agencies for HCBS waiver programs negotiate contracts with providers and set service provider payment rates.

Rates are a fixed charge per unit of a commodity or service. Various rate methods are used to assist county workers in calculating processes.

## Waiver Leave Days

PrimeWest Health may only make payment for waiver services actually provided to an eligible person, which does not include leave days.

The overhead expense of days when the person is away from a residence is accepted by the Centers for Medicare & Medicaid Services (CMS) as part of a waiver provider's cost of doing business. Overhead expenses may be factored into a provider's rate.

## Billing for Leave Days

**Providers may not bill for days the member is away from the home. PrimeWest Health providers are required to bill only for days they provide services. The time allocation per unit determines if multiple providers can provide service on the service agreement day. How the provider submits the claim will depend on the situation. The provider who bills overnight services depends on where the member is at midnight.**

**Providers will bill only for days in which the member was present in the establishment at 12 a.m. midnight regardless of whether or not the member received services that day.**

Billing examples if the member is admitted to the hospital:

1. If billing 15-minute increments (1 unit per 15-minute increment) and the member went in to the hospital one day and returned the next, the provider will need to end the line on the admit date and create a new line on the claim for the discharge date.
2. If billing a daily rate (1 unit per day), the above scenario will be followed when determining what to bill for. Again, if the member was admitted on one day and discharged the following, the provider will need to have each on separate lines so that the outpatient claim does not cause duplication.
3. If billing a monthly rate (1 unit per month), the time as noted above will determine who bills for that date of service. The provider needs to bill a date span either before the member was admitted and/or after the member is discharged and ask for the total amount the provider is entitled to bill and be paid for (the total

charge will equal the number of days the member actually was receiving services from the provider, according to the guidelines above).

The provider can bill if the member leaves the home after 12 a.m. midnight. The hospital then uses the next day as the admit date. If the member returns home before midnight on the following night, the hospital bills the claim as an outpatient claim and the provider is able to bill for the day the member is discharged, as long as the discharge is before midnight. The inpatient hospital claim indicates the admit hour and discharge hour so the system can tell if the member was in the home until midnight.

## Elderly Waiver Obligation

There are two income limits for individuals who are eligible for EW:

1. People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without an MA spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the **waiver obligation**.
2. People with incomes greater than the SIS may still be eligible for EW, but they will have an MA spenddown. The lead agency's financial assistance unit is responsible for determining the financial obligation of the EW member. The member is informed if he/she has a waiver obligation or will be responsible for a spenddown.

The waiver obligation is deducted from the cost of services received under the EW, and the full amount of the waiver obligation does not have to be met each month. The member is responsible to pay the amount of the obligation toward the services that were utilized that month. This may be a portion of the waiver obligation or the entire waiver obligation. An MA spenddown may be met with any combination of expenditures from State plan services, pharmacy, or waiver services. MA spenddowns are to be met each month.

The county financial worker will enter the waiver obligation into MMIS. PrimeWest Health will report the amount the provider can bill the member on their remittance advice.

A member can designate a preferred provider to pay his/her obligation and notify PrimeWest Health. The member should notify his/her financial worker if he/she wishes to choose this option.

## Home Care Services: MA-Eligible Members Receiving Waiver Services

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

MA covers the following home care services:

1. Personal Care Assistant (PCA)
2. PCA Supervision
3. Home Health Aide (HHA)
4. Skilled Nursing Services (SNV)
5. Private Duty Nursing (PDN)
6. Physical Therapy (PT)
7. Occupational Therapy (OT)
8. Respiratory Therapy (RT)
9. Speech Therapy (ST)

## Extended Home Care Services

1. A member must first access needed home care services through MA home care or PMAP before “extended home care” benefits may be approved.
2. Home care service needs that exceed the limits those programs impose may be approved and billed to the waiver as “extended MA services.”
3. These extended services include extended PCA, extended Home Health Aide, extended Private Duty Nursing (RN/LPN), extended supplies and equipment, and extended transportation.

## Home Care and EW Waiver

1. The PrimeWest Health products that serve EW members are Minnesota Senior Care Plus (MSC+) and MSHO.
2. For PrimeWest Health members receiving EW services, the designated care coordinator is responsible for approval and provision of all home care and EW services.

## Waiver Services, Billing Codes, and Provider Standards

Each home and community based waiver program requires certain questions be asked about services:

1. Are the services necessary to ensure the health, welfare, and safety of the person?
2. Are the services selected by the person as an alternative to institutionalization?
3. Is the service covered by any other funding source?
4. Is the cost of the service considered reasonable and customary and the least costly to reasonable meet the need(s) of the member?

The following waiver service descriptions include a definition, covered and non-covered services, provider qualifications and standards, and secondary information. In some of the information, you will find a process and procedure that has been developed. These services and requirements are the minimum guidelines. Individual counties and lead agencies may negotiate with providers in their contracts to have higher provider standards under each service category than those noted below. PrimeWest Health currently only covers EW services.

## Covered Services

Service	EW
All MA-covered Services	X
Adult Day Care	X
Adult Day Care Bath	X
Customized Living	X
Customized Living 24 Hour	X
Assistive Technology	
Behavioral Programming	
Caregiver Training and Education	X
Case Management	X
Case Management Aide (Paraprofessional)	X
Conversion Case Management	
Chore Service	X
Cognitive Rehabilitation Therapy	
Companion Services – Adult	X
Crisis Respite	
Consumer Directed Community Supports	X

Consumer Training and Education	
Day Training & Habilitation	
DD Screening	
Environmental Modifications	
Family Counseling and Training Service	
CAC Family Training	
Family Foster Care (Monthly)	X
Corporate Foster Care (Monthly)	X
Foster Care (Daily)	
Home Care – Extended Services	
Home Delivered Meals	X
Homemaker (15 minutes)	X
Homemaker (Daily)	X
Housing Access Coordination	
In-Home Family Support	
Independent Living Skills	
Independent Living Skills Therapies	
Live-in Personal Caregiver Expenses	
Modification & Adaptations	X
Night Supervision	
Nutrition Therapy	
Personal Support	
Prevocational	
Relocation Service Coordination	X
Residential Care	X
Respite Care	X
Specialist Service	
Structured Day Program	
Supplies and Equipment	X
Supported Employment	
Supported Living Services	
Therapies (MA & Extended)	
Transitional Supports	X
Non-Medical Transportation	X
24-Hour Emergency Assistance	

**Adult Day Care and Adult Day Care Bath**

Service/HCPCS	EW
<b>Adult Day Service</b>	
<ul style="list-style-type: none"> <li>• S5100 – Center Based Services – 15 minutes</li> <li>• S5100 with modifier U7 – Family Adult Day Services – 15 minutes</li> </ul>	<b>X</b>
<ul style="list-style-type: none"> <li>• S5102 – Center Based Services – Daily</li> <li>• S5102 with modifier U7 – Family Adult Day Services – Daily</li> </ul>	<b>X</b>

<b>Adult Day Service Bath</b>	
<ul style="list-style-type: none"> <li>• S5100 with modifier TF – 15 minutes</li> <li>• Limited to two units per day</li> </ul>	<b>X</b>

### Adult Day Bath

1. Adult Day Bath is limited to two, 15-minute units of service (30 minutes) per day.
2. The second unit may be provided only if the member requires longer than 15 minutes to complete the bath. This code may only be used if the member has a separate adult day care service approved for the same time period.
3. Adult day care providers may provide a bath to a member attending adult day care if required.
4. The bath must be specified on the member’s individual plan of care.

EW only: Members enrolled in MSC+ may **not** access this service as they receive assistance with a bath as part of their MSC+ benefit.

### Adult Day Care

Adult Day Care services are services furnished on a regularly scheduled basis, for one or more days per week, two or more hours per day in an outpatient setting. Services must be designed to meet the health and social needs of the individual. Meals that are provided as part of these services shall not constitute a “full nutritional regimen” (three meals/day). The ISP identifies the needs of the person and is directed toward the achievement of specific outcomes. The cost of transportation is not included in the rate.

1. A licensed adult foster care provider may provide family adult day care under its foster care license if the members are 55 years and over, none of the members are seriously and persistently mentally ill or developmentally disabled, and the combined number of people receiving adult foster care and adult day care does not exceed the number licensed for adult foster care. The commissioner may grant a variance which would allow up to seven individuals to receive adult day care services if the variance is requested as defined in [MN Stat. sec. 245A.04](#), subd. 9, a second caregiver is present whenever six or more recipients are being served, and the variance is recommended by the **lead** agency in the county where the provider is located.
2. The provider cannot be the same provider of adult or corporate foster care.
3. Adult day care services provided in the license holder’s primary residence when the license holder is the primary provider of care must be licensed under [MN Stat. sec. 245A.143](#) (Family Adult Day Services).
4. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under [MN Rules, parts 9555.5105 – 9555.6265](#).

### Provider Standards and Qualifications

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

**License:** Adult day care centers must be licensed under [MN Rules, parts 9555.9600 – 9555.9730](#) and MN [Stat. secs. 245A.01 – 245A.17](#).

Lead agencies shall negotiate the amount of time equal to a day of service with each authorized provider and may negotiate a 15-minute unit instead of the daily unit with individuals who require a longer day as documented in the individual’s care plan.

## Customized Living Services

Service/HCPC	EW
Customized Assisted Living Services <ul style="list-style-type: none"> <li>• T2030 – monthly</li> <li>• T2031 – daily</li> <li>• Providers must not bill for full days in which the member is absent</li> </ul>	X

### Definition

A package of regularly scheduled individualized health -related and supportive services (Customized Living Services are up to 24 hours of supervision, individualized home care aide tasks, home health aide tasks, and home management tasks) provided to a member residing in a residential center (apartment buildings) or other congregate living setting licensed as a home care provider or a Housing with Services establishment.

### Criteria for 24-hour Customized Living Service Effective January 1, 2011

The 2009 Legislature amended the criteria that must be met to authorize 24-Hour Customized Living Services for an individual effective January 1, 2011. While Customized Living Services *can* include supervision, 24-hour Customized Living Service *must* include 24 hours of supervision for an individual assessed as needing this service.

### Criteria for Authorization of 24-Hour Customized Living

MN Stat. sec. 256B.0915, subd. 3h, paragraphs (a) and (b) include requirements for lead agency authorization of 24-hour Customized Living. These criteria are based upon the need for any of the following:

1. Cognitive or behavioral intervention
2. Clinical monitoring
3. Staff assistance in toileting, positioning, or transferring
4. Assistance in medication management **and** 50 hours of direct Customized Living Services per month as determined by the member’s case manager to be part of the 24-Hour Customized Living Services plan

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

Customized Living Services must be provided by the management of the congregate living setting or by providers under contract with the management or lead agency. Individuals receiving Customized Living Services are not eligible for homemaking in addition to Customized Living Services.

### Covered Services

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

1. Up to 24-hour supervision and oversight

2. Home care aide tasks
3. Home management tasks including laundry and meal preparation
4. Arranging for or providing transportation
5. Assisting the member with setting up meetings or appointments
6. Socialization
7. Assisting the member with personal funds management

The following additional services may be available through providers licensed to provide MA home care services:

1. Home health aide
2. Incidental nursing
3. Central storage of medications

### **Non-covered Services**

1. Room and board
2. Waiver-funded homemaker, chore, and respite are not billable services during the period that the person is receiving Customized Living Services
3. Payment for Customized Living Services when the member is not in the setting (see *Waiver Leave Days*)
4. Socialization when it is diversionary or recreational in nature

### **Additional Information**

Service delivery is directed by the member or the provider with oversight from the case manager.

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

All homemaker and chore services needed by a member are included in the Customized Living Services package that is initially negotiated with the provider and meets all of the homemaker and chore service needs for the member. These services are not separately authorized or billed.

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

Customized Living Services are covered under waiver program costs. Room and board (or raw food [groceries] and rent while a member receives Customized Living Services are paid by the member's income, which may include Supplemental Security Income, RSDI, and other retirement. If the member has inadequate income for room and board or rent charges, he/she may be eligible for a Group Residential Housing (GRH) payment to the provider.

### **Provider Standards and Qualifications**

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

1. Class "A" Professional Home Care license
2. Class "F" Home Care License
3. Customized/Assisted Living Home Care providers licensed by MDH under MN Rules parts [4668.0002 – 4668.0870](#) only available to a setting registered as a Housing with Services establishment
4. Customized/Assisted Living Service providers who are not licensed under MN Rules, parts [9555.5105 – 9555.6265](#) (adult foster care) and who provide services in settings of one to four or five residents must

comply with MN Rules, part [9555.6205](#), subps. 1 – 3, and part [9555.6225](#), subps. 1, 2, 6, and 10.

**Home care licenses are issued under MN Rules Chaps. [4668](#) and [4669](#). Providers must be registered with the State under MN Stat. sec. [144D](#), “Housing with services Registration Act.”**

### Staff Qualifications

1. **Home Care Aide** qualifications are listed in MN Rules part [4668.0100](#), subp. 2.
2. **Qualifications for a person who performs home health aide tasks** are listed in MN Rules part [4688.0100](#), subp 5.
3. **Staff providing supervision, oversight, and supportive services must have the following:**
  - a. The ability to read, write, and follow written or oral instructions
  - b. Experience and/or training in caring for individuals with functional limitations
  - c. Good physical and mental health, and maturity of attitudes toward work assignments
  - d. The ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation
  - e. The ability to understand, respect, and maintain confidentiality
  - f. A valid state driver’s license if they provide transportation to waiver clients

### 24-Hour Customized Living Services

Service/HCPC	EW
<ul style="list-style-type: none"> <li>• <b>24-Hour Customized Living T2030 with modifier TG – monthly</b></li> </ul>	X

### Definition

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

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

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

### Covered Services

24-Hour Customized Living/Assisted Living Plus services include individualized supports that are chosen and designed specifically for each member’s needs and can only be provided in a registered Housing with Services establishment. The services include the following:

1. 24-hour supervision and oversight
2. Home care aide tasks
3. Home management tasks
4. Meal preparation
5. Arranging for or providing transportation

6. Assisting the member with setting up meetings or appointments
7. Socialization
8. Assisting the member with personal fund management

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

**24-hour on-site supervision means all of the following:**

1. Ongoing awareness of a member’s needs and the activities provided by an employee of the assisted living provider
2. A method for the member to summon assistance
3. 24-Hour Customized Living/Assisted Living Plus employee available to respond, in person, to the request within a reasonable amount of time

**Non-Covered Services**

1. Room and board
2. Waiver-funded homemaker, chore, and respite are not billable services during the period that the person is receiving 24-Hour Customized Living Services
3. Payment for 24-Hour Customized Living/Assisted Living Plus Services when the member is not in the setting (see *Waiver Leave Days*)
4. Socialization when it is diversionary or recreational in nature

**Additional Information**

The 24-hour Customized Living employee provides supervision for residents as a primary job and cannot be a member of services.

Service delivery is directed by the member or the provider with oversight from the case manager.

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

PrimeWest Health contracts directly with providers for Customized Living and 24-Hour Customized Living. All homemaking tasks and chore services are a part of the 24-Hour Customized Living Services package initially negotiated with the provider and meets all of the home management task service needs for the member.

**Provider Standards and Qualifications**

Providers must be licensed, certified, and registered as required by State law or rule under one of the following:

1. Class “A” Professional Home Care Agency license
2. Class “F” Home Care license
3. Customized/Assisted Living Home Care providers licensed by DHS under MN Rules, parts [4668.0002 – 4668.0870](#) only available to a setting registered as a Housing with Services establishment
4. 24- Hour Customized Living/Assisted Living Plus Services can only be provided in settings registered as “Housing with Services” establishments under MN Stat., Chap. [144D](#).
5. Customized/Assisted Living Service providers who are not licensed under MN Rules, parts [9555.5105 – 9555.6265](#) (adult foster care) and who provide services in settings of one to four residents must comply with MN Rules, part [9555.6205](#), subp. 1 – 3, and pars [9555.6225](#), subps. 1, 2, 6, and 10.

Home care licenses are issued under MN Rules Chaps. [4668](#) and [4669](#). Providers must be registered with the State under MN Stat. sec. [144D](#), “Housing with Services Registration Act.”

## Staff Qualifications

1. Home care aides qualifications are listed in MN Rules part [4668.0100](#), subp. 2.
2. Home health aide qualifications are listed in MN Rules part [4688.0100](#), subp 5.
3. Staff providing supervision, oversight, and supportive services must have the following:
  - a. The ability to read, write, and follow written or oral instructions
  - b. Experience and/or training in caring for individuals with functional limitations
  - c. The ability to perform essential job functions
  - d. The ability to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crises situation
  - e. The ability to understand, respect, and maintain confidentiality
  - f. A valid state driver’s license if they provide transportation to waiver clients

## Caregiver Training and Education

Service/HCPC	EW
<b>Caregiver Training &amp; Education</b> <ul style="list-style-type: none"> <li>• S5116 – per session</li> </ul>	X

### Definition

A service that provides training and education to a parent or primary caregiver when the primary caregiver is not employed by a corporation to provide supervision and care for the member.

### Covered Services

Costs for training registration fees are covered. Caregiver training and education services must be prior authorized by the case manager and must be the least costly options to reasonably meet the need(s) of the member, prevent institutionalization, and assure health and safety.

### Non-covered Services

Costs related to transportation, travel, meals, and lodging are not covered. If any of these costs are included in registration fees, they must be deducted from the reimbursable amount.

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

### Authorization

Documentation of the need for training and an outline of the training (for example, course syllabus, training objectives, and workshop description) must be submitted to the county agency. Based on this information and the member’s needs, the case manager determines if the training will be authorized.

## Additional Information

### EW

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

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

### Reimbursement

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

1. Requested areas of training and education
2. Potential sources of training
3. Identified methods by which the parent or primary caregiver will receive information about training and educational opportunities

Documentation of the training or education (such as the course syllabus, workshop description, or training objectives) and receipts for any fees and expenses **must** be submitted to the local county social service or lead agency prior to payment.

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

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

### Provider Standards and Qualifications

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

### Case Management/Service Coordination

Service/HCPC	EW
<b>Case Management Conversion</b> <ul style="list-style-type: none"> <li>• T1016 – 15 minutes</li> </ul>	X
<b>EW Case Management</b> <ul style="list-style-type: none"> <li>• Face-to-face T1016-UC – 15minute units</li> </ul>	X

<p><b>Screenings</b></p> <ul style="list-style-type: none"> <li>• LTCC S0250</li> <li>• Health Risk Assessment (HRA) S5190 (face-to-face)</li> <li>• HRA S5190-52 telephonic</li> <li>• SNF assessment S0250</li> <li>• Annual reassessment S0250-TS</li> </ul>	<p>X</p>
<ul style="list-style-type: none"> <li>• Telephonic T1016 U4-UC – 15 minute unit</li> <li>• Indirect CM T1016-54-UC – 15 minute unit</li> <li>• Paraprofessional CM T1016-TF-UC – 15 minute unit</li> </ul>	<p>X</p>
<p><b>Non-EW or SNF CM</b></p> <ul style="list-style-type: none"> <li>• Face-to-face CM T1016 – 15 minute unit</li> <li>• Telephonic CM T1016 U4 – 15 minute unit</li> <li>• Indirect CM T1016 -52 – 15 minute unit</li> <li>• Paraprofessional CM T1016-TF – 15 minute unit</li> </ul>	

**Definition**

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

**Covered Services**

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

1. Development of a service plan
2. Informing the member or the member’s legal guardian or conservator, or parent if the member is a minor, of service options
3. Assisting the member in the identification of potential providers
4. Assisting the member access services
5. Coordination of services
6. Evaluation and monitoring of the services identified in the plan
7. Annual reviews of service plans

**Case Management Administrative Activities**

Case management administrative activities are not billable under any HCBS program. Case management administrative activities include the following:

1. Intake
2. Screening activity
3. Service authorization
4. Review of eligibility for services
5. Responding to requests for conciliation conferences and Appeals
6. Diagnosis
7. Transportation

**Non-covered Services**

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

## Additional Information

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

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

Some members receiving case management may also be determined to be eligible for other forms of case management. In these situations, PrimeWest Health recommends the following:

1. A case manager is designated as the primary contact
2. There is coordination among the case managers
3. Roles and responsibilities of each case manager are clearly defined so efforts are not duplicated

Members eligible for and receiving case management under the elderly waivers are not eligible for the following forms of case management:

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

## Provider Standards and Qualifications

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

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

## Elderly Waiver

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

Case management/service coordination may be provided by the following individuals who are employed by, or contracted with, the local agency:

1. Public health nurse
2. Registered nurse licensed under [MN Stat. secs. 148.171 – 148.285](#)
3. Social worker graduate of an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate of an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency. Social workers

must also pass a written exam through the Minnesota Merit System or a county civil service system in Minnesota. Standards are authorized under [MN Rules parts 9575.0010 – 9575.1580](#). Authority to set personal standards is granted under [MN Stat. sec. 256.012](#).

4. Different credential standards can be applied to services provided by tribal governments under [MN Stat. sec. 256B](#), subd. 7.

## Case Management Aide/Paraprofessional

Service/HCPC	EW
<b>Case Management Aide/Paraprofessional</b> <ul style="list-style-type: none"> <li>• T1016-TF &amp; UC – 15 minutes</li> </ul>	X

### Definition

Assistance to the case manager in carrying out administrative activities of the case management function.

### Covered Services

Case management aides shall perform only those tasks delegated and supervised by the case manager that do not involve professional expertise or judgment.

Examples of duties case aides can perform include the following:

1. Filing
2. Contacts to vendors to schedule services
3. Phone contacts

### Non-Covered Services

A case management aide must not assume responsibilities that require professional judgment. Case management aides must not conduct assessments, reassessments, or develop care plans.

### Additional Information

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

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

### Provider Standards and Qualifications

The case management aide must:

1. Be a high school graduate;
2. Have one year of experience as a case aide or in a closely related field or one year of education beyond high school (for example, business school or college);
3. Be employed by the agency providing case management; and
4. Receive oversight by the case manager of delegated tasks.

## Chore Services

Service/HCPC	EW
<b>Chore Services</b> • S5120 – 15 minutes	X

### Definition

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

### Eligibility

Chore services will be covered only if **both** of the following conditions are met:

1. Neither the member nor anyone else in the household is capable of performing **or** financially providing for the chore services
2. There is no relative, caretaker, landlord, local county agency, community volunteer/agency, or third party payer capable of **or** responsible for the provision of the chore services

### Covered Services

Examples of chore services include the following:

1. Heavy household chores such as washing floors, windows, and walls; basic home maintenance
2. Moving or removal of heavy items to provide safe access inside the home and egress or to prevent falls
3. Shoveling snow and lawn maintenance to provide access and egress to and from the home
4. May include customary service charges made for the delivery of grocery store products when these products represent the majority of the members needs for a minimum of a 7-day period and it is the most cost efficient way of procurement of groceries in the community. The amount and service charge should be reasonable and customary in the community.
5. Extermination and pest control limited to the reasonable number of treatments required to alleviate the pest problem.

### Non-Covered Service

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

**Chore services will be covered only if both of the following conditions are met:**

1. Neither the member nor anyone else in the household is capable of performing or financially providing for the chore services
2. There is no relative, caretaker, landlord, local county or tribal agency, community volunteer/agency, or third party payer capable of or responsible for the provision of the chore services

### Additional Information

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

### Provider Standards and Qualifications

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

1. Provided by individuals who meet the unique needs and preferences of the member who will receive the chore services
2. Delivered in a cost-effective manner
3. Directed at the outcomes desired by the member
4. Designed to meet the health and safety needs and preferences of the individual as specified in the ISP or Community Support Plan

## Companion Services – Adult

Service/HCPC	EW
<b>Adult Companion Service</b> <ul style="list-style-type: none"> <li>• S5135 – 15 minutes</li> </ul>	X

### Definition

Non-medical care, assistance, supervision, and socialization provided for an adult in accordance with a therapeutic goal in the Community Support Plan.

### Covered Services

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

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

1. Meal preparation
2. Laundry
3. Shopping
4. Light housekeeping tasks incidental to the care and supervision

### Non-covered Services

Adult companion services **do not** include the following:

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

### Additional Information

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

### Provider Standards and Qualifications

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

1. Is able to read and write
2. Is able to follow written and oral instruction
3. Has had experience and/or training in homemaking skills and/or in care of members with qualifying conditions

4. Is in good physical and mental health
5. Has the ability to converse effectively on the telephone
6. Has the ability to work under intermittent supervision
7. Has the ability to manage emergency and/or crisis situations and report them to the lead agency
8. Is able to understand, respect, and maintain confidentiality in regard to the details of any circumstances surrounding the member

An individual may be required to pass a job-related physical examination before starting to provide services. This would be at the provider’s/worker’s own expense.

## Consumer-Directed Community Supports (CDCS)

Service/HCPC	EW
<b>CDCS</b>	
• T2028 with modifier U1 for Personal Assistance	X
• T2028 with modifier U2 for Medical Treatment and Training	X
• T2028 with modifier U3 for Environmental Modifications and Provisions	X
• T2028 with modifier U4 for Self-Direction Support Activities	X
• Background Checks; T2040 – each check	X
• Required Case Management; T2041 – 15 minutes	X

### Definition

CDCS is a service option that gives members more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. CDCS may include services, support, and/or items currently available through the EW waivers, as well as additional allowable services that provide needed support to members.

People residing in a Customized Living, 24-hour Customized Living Services, Foster Care, or Residential Care Setting are not eligible to choose this option.

### Service Criteria

There are specific requirements for all services, supports, and/or items that are available through MA waivers including CDCS. In order for services, supports, and/or items to be purchased under CDCS, they must.

1. Be for the sole benefit of the member
2. Be the least costly alternative that reasonably meets the member’s identified needs
3. Collectively provide a feasible alternative to an institution
4. Meet the identified needs and outcomes in the member’s Community Support Plan and assure the health, safety, and welfare of the member

If **all** the above criteria are met, services, supports, and/or items are appropriate purchases when they are reasonably necessary to meet the following outcomes:

1. Decrease dependency on formal support services
2. Develop or maintain personal, social, physical, or work-related skills

3. Enhance community inclusion and family involvement
4. Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

## Eligibility

To be eligible for CDCS, a member must **either** already be receiving services on an MA waiver in Minnesota **or** must meet all eligibility criteria for MA waiver and be authorized to receive waiver services by the county.

The following members are **not** eligible for CDCS:

1. CDCS members who have exited the waiver more than once during their service plan year (ineligible for CDCS for the remainder of that service plan year)
2. Members who have had their eligibility restricted at any time by the Primary Care Utilization Review (PCUR)
3. Members whose authorized representative has their eligibility restricted at any time by PCUR
4. Waiver recipients living in residential settings licensed by DHS or licensed/registered with MDH

County workers should check the RPCR screen in MMIS to determine whether the member has been involved with PCUR before discussing the CDCS option with the member.

## Covered Services

CDCS has a range of allowable services, supports, and/or items that can be tailored to meet a member's needs in addition to those currently available through MA waivers. A member can choose to receive traditional waiver services **and/or** design his/her own services using CDCS.

The flexibility built into CDCS allows members to do the following:

1. Describe services and supports in ways that are meaningful to them
2. Design services and supports that are unique to them and best meet their identified needs

Services, supports, and/or items that augment State plan services or provide alternatives to waiver or State plan services are covered under CDCS and must fit into one of the following four service categories:

1. Environmental modification and provisions
2. Personal assistance
3. Self-direction support activities
4. Treatment and training

## Non-covered Services

Services, supports, and items that **cannot** be purchased within the member's CDCS budget are as follows:

1. All prescription and over-the-counter medication, compounds, solutions, and related fees (including insurance premiums and drug copays)
2. Animals and their related costs
3. Costs related to Internet access
4. Expenses for travel, lodging, or meals related to training the member or his/her representative or paid or unpaid caregivers
5. Experimental treatments ([MN Rules, part 9525.3015](#), subp.16)
6. Fees incurred by the member such as copays, attorney costs, or costs related to advocate agencies, with the exception of services provided as flexible case management
7. Home modifications for a residence other than the primary residence of the member or, in the event of a minor with parents not living together, the primary residences of the parents

8. Home modifications that add any square footage
9. Insurance expenses except for insurance costs related to employee coverage
10. Membership dues or costs unless related to a fitness or exercise program for adults when the service is appropriate to treat a physical condition or to improve or maintain the member's physical condition (condition must be identified in the individual's plan of care and monitored by an MHCP-enrolled physician)
11. Room and board and personal items of member that are not related to the disability
12. Services covered by the State plan, Medicare, or other liable third parties including education, home-based schooling, and vocational services
13. Services provided to or by individuals, representatives, providers, or caregivers that have at any time been assigned to the Primary Care Utilization and Review Program
14. Services provided to members living in settings licensed by DHS or MDH or registered as a Housing with Services establishment
15. Tickets and related costs to attend sporting or other recreational events
16. Vacation expenses other than the cost of direct services
17. Vehicle maintenance does not include maintenance to modifications related to the disability.

### Provider Standards and Qualifications

Each member may want to consider his/her needs and requirements when deciding the qualifications he/she would like the provider/staff to have. For example, a member who has frequent seizures may want to hire somebody that has training in how to react when someone is having a seizure or experiencing working with people who have seizures.

Additional qualifications are to be documented in the Community Support Plan. The provider/staff must meet these in order to provide CDCS. The member and/or his/her authorized representative must maintain documentation indicating how the qualifications are met.

When choosing other formal waiver services, **all** provisions of the waiver service **must** be followed including the services description, provider qualifications, and quality assurance mechanisms of the service.

### Criminal Background Studies

Criminal background studies are **not** required under CDCS. A member can choose to request a criminal background study on any or all of his/her staff. If a criminal background study is completed, the member must abide by the results of the study.

If a criminal background study is requested by the member/authorized representative or when the member has chosen a waiver service that requires background studies (MN Stat. Chap. 245C), Human Services Background Studies guidelines apply to determine if the staff person is disqualified. An individual who is disqualified through this process may **not** be paid under CDCS.

The cost of criminal background studies is **not** deducted from the individual budget amount when the member uses a background study as a staff requirement for an individually designed service. The cost will be covered as a service expense through the counties' waiver budget allocations.

If the member chooses to use an agency with choice as his/her fiscal support entity **and** that agency requires background checks, the cost of the criminal background study is included in the administrative rate for that agency.

If the member selects a waiver services in which a background study is a required provider qualification for that waiver service, the cost is included in the rate for that waiver service.

## Foster Care

Service/HCPCS	EW
<b>Foster Care – Corporate</b> <ul style="list-style-type: none"> <li>S5141-HQ– Monthly, Adult</li> </ul>	X
<b>Foster Care – Family</b> <ul style="list-style-type: none"> <li>S5141 – Monthly, Adult</li> </ul>	X

### Definition

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

When placing an adult into a licensed foster care setting, all Federal, State, county, and/or licensing agency rules and regulations **must** be followed.

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

Those services and supports are identified in the member’s comprehensive plan and in the lead agency contract with the provider. A unit of service is defined by the comprehensive plan of care and contract.

### Covered Services

Adult foster homes provide the following:

1. Food
2. Lodging
3. Protection
4. Household services

They may also provide the following:

1. Assistance with activities of daily living
2. Medication assistance
3. Community integration
4. Assistance safeguarding cash resources
5. Care giving
6. Behavioral aide services
7. Supervision and ensuring individual safety
8. Homemaking
9. Oversight and supervision
10. Transportation

### Non-Covered Services

The payment for the waiver service of foster care does not include the following:

1. Room and board
2. Duplication of services paid by other sources
3. Items of comfort or convenience
4. Costs of facility maintenance, upkeep, and improvement
5. Payment for foster services when the member is not in the foster setting (Leave Day Policy)
6. PCA services
7. Payment for foster care services when a member is a resident of a different foster care setting
8. Homemaker and chore services

### Additional Information

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

### Size and Location

Adult foster care providers may be licensed for up to five adults per home if none of the foster care members age 55 or over have a serious persistent mental illness nor any developmental disability.

#### Exceptions:

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

### Provider Standards and Qualifications

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

- Adult foster care: licensed under [MN Rules part 9555.5105 – 9555.6335](#)

### Home Care – Extended Services

Service/HCPC	EW
<b>Home Health Aide, Extended</b>	
• T1004 – 15 minutes	X
<b>LPN Regular Extended</b>	
• LPN Regular, T1003 with modifier UC – 15 minutes	X
• LPN Shared 1:2 T1003 with modifiers TT and UC – 15 minutes	X
<b>LPN Complex Extended</b>	
• T1003 with modifiers TG & UC – 15 minutes	X
<b>Occupational Therapy, Extended</b>	
• S9129 with modifier UC – visit	X
<b>Occupational Therapy Assistant, Extended</b>	
• S9129 with modifiers UC and TF – visit	X

<p><b>PCA – Extended</b></p> <ul style="list-style-type: none"> <li>• 1:1 – T1019 with modifier UC – 15 minutes</li> <li>• 1:2 – T1019 with modifier UC &amp; TT (a “Y” in the Shared Care field of the SERVICE AGREEMENT) – 15 minutes</li> <li>• 1:3 – T1019 with modifier UC &amp; HQ (a “Y” in the Shared Care field of the SERVICE AGREEMENT) – 15 minutes</li> </ul>	<p>X X X</p>
<p><b>Physical Therapy, Extended</b></p> <ul style="list-style-type: none"> <li>• S9131 with modifiers UC and TF – visit</li> </ul>	<p>X</p>
<p><b>Physical Therapy Assistant, Extended</b></p> <ul style="list-style-type: none"> <li>• S9131 with modifiers UC and TF – visit</li> </ul>	<p>X</p>
<p><b>RN, Regular, Extended</b></p> <ul style="list-style-type: none"> <li>• T1002 with modifier UC – 15 minutes</li> <li>• RN Regular Shared 1:2, T1002 with modifiers TT and UC and a “Y” in the Shared Care field of the SERVICE AGREEMENT – 15 minutes</li> </ul>	<p>X X</p>
<p><b>RN Complex, Extended</b></p> <ul style="list-style-type: none"> <li>• T1002 with modifiers TG and UC – 15 minutes</li> </ul>	<p>X</p>
<p><b>Respiratory Therapy, Extended</b></p> <ul style="list-style-type: none"> <li>• S5181 with modifier UC – visit</li> </ul>	<p>X</p>

**Home Delivered Meals (HDMs)**

Service/HCPC	EW
<p><b>HDM</b></p> <ul style="list-style-type: none"> <li>• S5170 – one meal</li> </ul>	<p>X</p>

**Definition**

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

**Covered Services**

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

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

**Non-covered Services**

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

## Additional Information

### Eligibility

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

1. **EW-specific funding requirements:** Providers of HDMs may have multiple funding sources to support their business. To assure the EW program is not supplanting other funds, understanding the funding source(s) and funding amounts each HDM provider receives is critical in developing provider contracts. In particular, funding distributed to HDM providers through contractual agreements with Area Agencies on Aging (AAAs) should not be supplanted by EW funding.
2. **Title IIIC Funding:** HDM providers who contract with AAAs for funding to support their program may be receiving funds available from Title IIIC of the Older Americans Act, USDA funding, or state grants. These funds are all distributed by AAAs through a contractual agreement with the provider. Specific revenue sources may be defined, including all other grants and anticipated recipient contributions in these contracts. Counties agencies may find these contracts helpful in identifying provider revenue resources in determining the portion of the meal cost met by other revenue sources.
3. **No Receipt of Title IIIC Funding:** Although some HDM providers do not receive any Title IIIC funding, USDA funding, or state grants funding, they may receive funding from other sources such as grants from organizations (such as United Way) and grants from local government or revenue from recipient contributions. Information about providers’ other funding sources is essential to assure waiver and Alternative Care (AC) funds are not supplanting other funds and negotiated rates do not exceed the cost of the HDM.

EW clients may not be required to make a contribution to their meal cost or be asked to pay for a portion of their meal cost unless, under EW, the meal is provided as an EW service and a waiver obligation is charged.

### Provider Standards and Qualifications

The following providers may offer HDMs:

1. Hospitals
2. Schools
3. Restaurants
4. Any agency that provides HDMs

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

Insulated hot and cold containers must be used on delivery routes to assure that food reaches persons at appropriate temperatures.

### Homemaker Services

Service/HCPC	EW
<b>Homemaker Service</b>	
• S5130 – 15 minutes	X
• S5131 – per diem	X

## Definition

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

## Covered Services

Homemaker services are listed in the Community Support Plan of the person and may include the following:

1. Meal preparation
2. Shopping and errands
3. Routine household care
4. Assistance with activities of daily living
5. Transportation arrangement
6. Companionship
7. Emotional support
8. Social stimulation
9. Monitoring the safety and well being of the member

## Non-Covered Services

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

## Provider Standards and Qualifications

Providers of Homemaker Services must meet the requirements of [MN Stat. secs. 144A.43 – 144A.46](#).

Homemakers are to meet the minimum training requirements. Homemakers must meet the standards under [MN Rules part 9565.1200](#), subp. 2.

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

## Modifications and Adaptations

Service/HCPC	EW
<b>Home &amp; vehicle modifications</b>	
• S5165	X
<b>Adaptive equipment</b>	
• S5165	X
<b>Environmental modifications</b>	
• S5165 – per item	X

## Definition

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

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

## Covered Services

Modifications and adaptations which:

1. Are for the health, welfare, and safety of the member
2. Enable the person to function with greater independence
3. Are of direct and specific benefit due to the person's disability; and
4. Are the most cost effective solutions.

Adaptations to present residence or new construction may include, but are not limited to, the following:

1. The installation and maintenance of ramps and grab-bars, widening of doorways
2. Modification of bathrooms and kitchens
3. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment
4. Shatterproof windows
5. Floor coverings (e.g., allergy flooring/accessibility flooring)
6. Modifications to meet egress requirements
7. Alarm systems and other requirements of the applicable life safety and fire codes, if any

Vehicle modifications to the person's primary means of transportation may include, but are not limited to, the following:

1. Door handle replacements
2. Door widening
3. Roof extensions
4. Lifting devices
5. Wheelchair securing devices
6. Adapted seat devices
7. Handrails and grab bars

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

## Limitations

Modifications and adaptations are limited to the following:

1. Member's home and/or vehicle, with the vehicle limited to one operating vehicle

The limit of one vehicle does not prohibit vehicle modifications or adaptations when a vehicle must be replaced.

## Non-Covered Services

Supplies covered by an MA State plan. Excluded are adaptations or improvements when a vehicle must be replaced.

Non-covered services include the following:

1. Adaptations adding to the total square footage of the home
2. Adaptions for comfort or convenience
3. General utility
4. Household appliances
5. Adaptions not of direct medical or remedial benefit to the member

Items that are generally not covered include, but are not limited to, the following:

1. Carpeting

2. Central air conditioning
3. Roof repair
4. Plumbing
5. Kitchen/laundry appliances
6. Swimming pools

## **Environmental Modifications and Adaptations for EW Program**

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

### **EW Only**

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

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

### **Provider Standard**

Must be provided in accordance with applicable State and Federal safety and motor vehicle standards.

### **Additional Information**

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

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

### **Authorization Procedures**

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

1. It is recommended that local agencies consider bids from a minimum of two contractors/vendors.
2. All services must be provided in accordance with applicable State and local building codes.
3. If it is determined by the county agency that all of the criteria are met and the bid for the work is reasonable, the local agency enters a line item and amount on the person's service agreement using procedure code S5165.

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

**County Agency Contract or Purchase Agreement**

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

**Provider Standards and Qualifications**

**Provider Type:** Dependent on type of modification.

Modification and adaptation providers must comply with all of the following:

1. Have a current contract or purchase of services agreement with the county agency
2. Hold a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform the service
3. Meet all professional standards and/or training requirements that may be required by State law or rule for the service(s) they provide

Local county agencies are responsible to ensure the following:

1. Providers are qualified to provide necessary modifications and adaptations
2. Modifications to the home are completed in accordance with all applicable state and city building codes
3. Providers have a contract or a purchase agreement with the local agency for the service

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

**Nutritional Therapy**

Service/HCPCS	EW
<b>Nutritional Therapy, Extended</b>	
• S9470 – visit	<b>X</b>

**Definition**

Nutritional therapy includes nutrition counseling and nutrition education.

**Covered Services**

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

Examples include the following:

1. Planning diabetic meal patterns
2. Therapeutic diet instructions such as low sodium and low cholesterol

3. Suggestions for people who are chronically underweight, have severe weight loss, have difficulty chewing or swallowing, or chronic health issues related to obesity

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

Examples of nutrition educational topics include the following:

1. Wise food choices in shopping, food selection, and preparation
2. Methods for therapeutic diets
3. Menu planning
4. Cooking for one or two
5. Tips for eating well on a limited budget

### Additional Information

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

### Provider Standards and Qualifications

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

A qualified nutritional therapist must have a bachelor's degree in nutrition and foods or a closely related field **and** must be a registered as a dietitian with the [Commission of Dietetic Registration](#).

### Residential Care Services

Service/HCPC	EW
<b>Residential Care Services</b>	
• T2032 – monthly	X

### Definition

Supportive and health supervision services provided in a licensed residential setting as identified in the Community Support Plan.

### Covered Services

Supportive services for the person include the following:

1. Up to 24 hour supervision
2. Meal preparation
3. Individualized home management tasks
4. Socialization
5. Assistance in setting up meetings and appointments
6. Assistance in arranging medical and social services
7. Assistance with management of personal funds
8. Arranging for or providing transportation

Health supervision services are limited to minimal assistance with the following:

1. Dressing, grooming, and bathing
2. Reminding a person to take medications that are self-administered

### 3. Storing medications, if requested

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

## Non-Covered Services

1. PCA
2. Homemaking
3. Chore
4. Services duplicated by other State plan covered services or waiver services
5. Items paid for under room and board cannot be duplicated in residential care costs

## Additional Information

Service delivery is directed by the person or the provider with oversight from the case manager. The unit of service is defined by the ISP/Community Support Plan or contract.

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

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

## Size and Location

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

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

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

## Provider Standards and Qualifications

Residential care services are provided to individuals in residential care homes licensed as board and lodging establishments and are registered with MDH as providing specialized services. See [MN Stat. sec. 157.17](#).

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

Staff providing residential care services must have the following:

1. The ability to read and write and follow written and oral instructions
2. Experience and/or training in caring for people with disabilities
3. Good physical and mental health
4. The ability to converse on the phone
5. The ability to work with only intermittent supervision
6. The ability to deal with emergencies
7. The ability to work under stress in a crisis situation
8. The ability to understand, respect, and maintain confidentiality
9. A valid Minnesota State drivers license if providing transportation for a person receiving waiver services

## Respite Care

Service/HCPC	EW
<b>In-home Respite</b>	
• S5150 – 15 minutes	X
• S5151 – per diem	X
<b>Out-of-home Respite</b>	
• S5150 UB – 30 minutes	
• H0045 – per diem	X

### Definition

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

### Covered Services

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

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

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

### Non-Covered Services

Respite care is not provided for people residing in corporate foster care settings

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

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

### Out-of-home respite care

1. Must be provided in a facility approved by the local lead agency such as a hospital, nursing facility, foster home, camp, or community residential facility.
2. When respite care is provided in a non-MA certified facility, that facility must meet applicable State licensure standards.
3. May be provided in a currently registered Housing with Services establishment when services are delivered by a licensed home care agency or in a private unlicensed home when it is determined by the case manager that the service and setting can safely meet the member's needs. The case manager must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the member's needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services.

### In-home respite care providers

1. Must be individuals who meet the State qualifications of registered or licensed practical nurses, home health aides, or PCAs who have been specifically trained to provide care to the member.
2. Respite care workers must have had first-aid training and cardiopulmonary resuscitation training.

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

<b>Respite Care Services</b> <b>Provider standards and qualifications</b> <b>I indicates an in-home provider/location; O indicates an out-of-home provider/location</b>	<b>EW</b>
1. <b>Certified Hospitals – Hospitals</b> are acute care institutions defined in <a href="#">MN Stat. sec. 144.696</a> , subd. 3, licensed under <a href="#">MN Stat. secs. 144.50 – 144.58</a>	<b>O</b>
2. <b>Registered Nurses</b> providing in-home respite care must be licensed <a href="#">under MN Stat. secs. 148.171 – 148.285</a>	<b>I</b>
3. <b>Licensed Practical Nurses</b> must be licensed under <a href="#">MN Stat. secs. 148.29 – 148.299</a>	<b>I</b>
4. <b>Adult Foster Care</b> is licensed under <a href="#">MN Rules parts 9555.5105 – 9555.6265</a>	<b>O</b>
5. <b>Adult Day Care Programs</b> are established under MN Stat. secs. <a href="#">245A.01 – 245A.16</a> and must be licensed under <a href="#">MN Rules parts 9555.9600 – 9555.9730</a>	<b>O</b>
6. <b>Family Day Care Homes and Group Family Day Care Homes</b> are licensed under <a href="#">MN Stat. secs. 245A.01 – 245A.17</a>	<b>O</b>
7. <b>PCAs</b> must meet the standards under <a href="#">MN Stat. sec. 256B.0627</a> and MN Rule part <a href="#">9505.0335</a> .	<b>I</b>
8. <b>Home Health Aides</b> must meet the standards under <a href="#">MN Rules part 9505.0290, subp. 3, B</a>	<b>I</b>
9. <b>Certified Nursing facilities – Nursing facilities</b> must meet the standards under <a href="#">MN Rules part 9505.0175</a> , subp. 23	<b>O</b>
10. <b>Person's Home or Place of Residence</b>	<b>I</b>
11. <b>Assisted Living Services/Assisted Living Plus</b> – Service providers must be licensed as a home care provider and meet the standards as delineated in Assisted Living and Assisted Living Plus waiver service descriptions	<b>O</b>
12. <b>Residential Care Facilities – Residential Care providers</b> must meet all applicable licensing standards and the standards delineated in Residential Care waiver service description	<b>O</b>
13. <b>The Home of an Unlicensed Caregiver</b> when the county and family agree that the caregiver has met criteria to assure the health and safety of the member. <b>In these situations, room and board payment will not be made as part of the respite rate.</b>	<b>O</b>

## Specialized Equipment and Supplies

Service/HCPC	EW
<b>Extended Supplies and Equipment</b> <ul style="list-style-type: none"> <li>T2029 – per item Negotiated based on the needs of the person and county or lead agency contract</li> </ul>	X

See [Equipment and Supplies, Chapter 23](#), for clarification on covered and non-covered items and regulations. This service is only available as an extended service; MA funding must be accessed first.

### Definition

Devices, controls, or appliances, specified in the plan of care, that enable the person to increase his/her ability to do the following:

1. Perform activities of daily living
2. To perceive, control, or communicate with the environment in which he/she lives

State plan medical equipment and supplies are defined under [MN Rules part 9505.0310](#).

### Covered Services

The service covers the following:

1. Items necessary for life support
2. Ancillary supplies necessary for the proper functioning of such life support items
3. Durable and non-durable medical equipment not available under the Medicaid State plan

The State plan will cover some medical equipment and supplies. If certain medical equipment and supplies exceed the limits set for State plan covered services, they may be reimbursed with waiver funds. To determine which medical equipment and supplies are covered by the State plan and which are covered with waiver funds, see [Equipment and Supplies, Chapter 23](#).

### EW

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

### Non-covered Services

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

### Payer Information for the Cost Differences of an Item

#### Medicare

If Medicare is the only payer, (there is no MA coverage for the item), the waiver is able to pick up the difference between Medicare's allowable and the full cost of the item.

## Medical Assistance (MA) or PrimeWest Health

If PrimeWest Health is the only payer for the item, the waiver is not able to pay for any differences between what PrimeWest Health reimburses and the full cost/charge for the item. PrimeWest Health is considered payment in full, no additional payment is allowed.

## Private Insurance

If private insurance is the only payer (there is no MA coverage for the item), the waiver is able to pick up the difference between the private insurance's allowable amount and the full cost of the item.

## Additional Information

### Authorization Criteria

Case managers must ensure and document, in the person's file/Community Support Plan, prior to the purchase of the medical supply or equipment, that the item meets all of the following criteria:

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

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

- |                                        |                            |
|----------------------------------------|----------------------------|
| 1. Individual evaluation or assessment | 3. Installation            |
| 2. Purchase or rental                  | 4. Maintenance and repairs |

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

### Add-ons vs. Upgrades

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

Example: A person wants an MA non-covered basket added to an MA-covered walker. The supplier can bill PrimeWest Health for the walker and bills the person for the basket; or the case manager may determine that the basket is covered by the waiver program but the supplier still must bill PrimeWest Health for the MA-covered service.

For PrimeWest Health members, the provider may receive payment for the covered service under MA and charge the member or waiver program for the add-on.

An **upgrade** is a non-covered Medicaid service (and often a more desirable service) that substitutes for a covered service.

1. The provider may choose to provide the upgrade and receive payment for the basic service as payment in full for the upgrade;
2. The person may choose an upgraded service instead of a Medicaid-covered service, even though PrimeWest Health will not pay for this item. The person is responsible for the entire cost of the upgraded item as long as the provider informed him/her that he/she is responsible before providing the service. In this case, PrimeWest Health recommends that the provider have the person sign a waiver acknowledging that the item is not covered by PrimeWest Health and agrees to pay the entire cost for the upgraded item before the service is provided; or
3. The case manager may authorize an upgraded item to be covered under a HCBS program, if determined to be medically necessary and cover the entire cost of the item under the HCBS program.

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

A case manager may elect to cover the entire cost of a total electric bed under a waiver services program.

If the supplier will not accept MA semi-electric bed payment and the case manager does not approve the upgrade for payment under a HCBS program, the person may still get the total electric bed, but is responsible for the entire charge for the bed as long as the provider informed him/her that he/she is responsible for payment before providing the service.

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

The case manager may need prior approval from PrimeWest Health for some extended supplies depending on the cost of the item. The item must be entered on the service agreement.

### **County Contract or Purchase Agreement**

Counties or lead agencies must contract with or secure purchase agreements with qualified providers of supplies and equipment.

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

### **Cost of Providing Supplies and Equipment under a Recipient's Waiver Cap**

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

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

When a doctor’s order is needed for MA/Medicare reimbursement, the medical supply and equipment provider is responsible to gather and send whatever documentation is needed to PrimeWest Health before ordering/billing. Generally, doctor’s orders are not required for purchases through waiver funds. The provider is ultimately responsible to bill the appropriate payer (insurance, Medicare, MA, etc.) if the item is reimbursable through those payers, regardless of whether the case manager has authorized waiver reimbursement through a Service Agreement or not. When other sources of payment are exhausted, the provider must submit copies of the denials from those payment sources to the case manager. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.

## **Incidental Maintenance on Adaptive Equipment and Supplies While Providing a Direct Care Service**

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

## **Long-term Care Facility/Providing Supplies and Equipment before Discharge**

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

## **Rental**

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

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

## **Repair and Maintenance**

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

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

## Shipping, Handling, and Installation

Shipping and handling costs may be paid by a HCBS program if the shipping cost is included in the price of the item and the waiver is purchasing the item.

Installation can be covered regardless of who purchased the item, if the item meets HCBS program authorization criteria. If installation involves attaching an item to, or altering the existing physical structure of a home or vehicle, the costs are billed under minor environmental adaptations and modifications.

## Used Equipment

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

## Provider Standards and Qualifications

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

1. Home Health Agencies
2. Pharmacies
3. Medical suppliers (including wheelchair and oxygen vendors)

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

## Transportation

Service/HCPC	EW
<b>Transportation, extended</b>	
• T2003-UC – Per one-way trip	<b>X</b>
• X5601 – Per Trip	
• S0215 with modifier UC – Per mile	<b>X</b>
• X5603 – Extra Attendant	<b>X</b>

The county or lead agency determines the transportation needs and resources and may authorize transportation through one of the following ways:

1. Through SES contract in which transportation is provided by SES as a part of the negotiated contract rate
2. Arranged through the waiver service of transportation

**Note: Medical transportation should never be authorized as a waiver service if covered by the State plan. Costs of State plan medical transportation do not count toward the member’s EW community budget cap and are not added to the service agreement.**

## Definition and Covered Services

Transportation services may be approved by the case manager to enable consumers to gain access to EW services, along with other community services, activities, and resources. The case manager must specify the

goals and needs for the service in the plan of care. Whenever possible, family, neighbors, friends, or community agencies that provide this service without charge must be utilized.

Transportation services may be authorized and billed using the mileage rate when simultaneously provided by an individual/organization providing companion services.

Adult day services and transportation are always separately covered, but are sequentially, not simultaneously, provided.

For EW the adjective “extended” is not applicable as a waiver service because waiver transportation services are not an extension of the State plan access (i.e., medical) transportation service but rather a separate and distinct service.

Use of special transportation services (STS) for transporting a member with physical or mental impairment who is unable to safely use a common carrier and does not require ambulance service may be provided. Physical or mental impairment means a physiological disorder, physical condition, or mental disorder that prohibits access to, or safe use of, common carrier transportation. An example includes a wheelchair accessible van for a person with mobility limitations.

### **EW Non-Covered Services**

1. Transportation reimbursement already included in the contracted rate for other services
2. Non-covered services for a personal vehicle include the following:
  - a. Any payment beyond negotiated mileage or trip reimbursement
  - b. Reimbursement to a person for the purpose of transporting him/herself or the use of his/her own vehicle

Do not separately bill transportation when other EW services are provided by the same person. Companion services are an exception to this rule.

### **Additional EW Non-Covered Services**

Access transportation as defined in [Requirements for Providers](#), Chapter 1.

### **Provider Standards**

EW common carrier transportation standards:

1. Bus, taxicab, or other commercial carriers, private automobile, or a county/tribal owned or leased vehicle
2. Private individuals may be designated to provide transportation when they meet the member’s needs and preferences in a cost-effective manner. Examples may include natural supports such as family, neighbors, friends, community agencies, volunteer driver programs, or companion service providers
3. Drivers must have a valid driver’s license and adequate insurance coverage as required by MN Stat. Chap. [65B](#)

### **EW Special Transportation Standards**

Providers of special transportation services, not excluded in MN Stat. sec. [174.30](#), must be certified by the Minnesota Department of Transportation under MN Stat. secs. [174.29 - 174.30](#). The driver must provide driver-assisted services. Driver-assisted services include passenger pickup at and return to the individual’s residence or place of business, assistance in securing passengers/wheelchairs/stretchers in the vehicle.

With EW special transportation provider standards, providers not excluded in MN Stat. sec. [174.30](#), must be certified by the Minnesota Department of Transportation under MN Stat. sec. [174.29 – 174.30](#).

## Responsibilities of the EW Case Manager/Care Coordinator

The EW case manager or service coordinator is responsible for assessing and planning access to services as follows:

1. Help members understand available transportation services through Medicaid State Plan and the EW Program
2. Help members select transportation services through EW that support their community participation and access to resources and social network
3. Determine if the contracted rate for the other needed and authorized services does/does not include transportation
4. Clearly and accurately describe in the care plan transportation provided by different entities
5. Determine and document in the care plan if member will use a family member, friend, neighbor, common carrier, special transportation, and if a non-driver attendant is required
6. Determine if the need for transportation meets criteria. See [Transportation Services, Chapter 21](#).
7. Confirm member eligibility for special transportation using MNITS or [PrimeWest Health's portal](#)

## Other Resources

It is recommended the case manager review the [Transportation Services](#) section, Chapter 21, of this manual, as well as the MHCP Manual for information regarding the MA State plan transportation services and the certification for use of special transportation.

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

## Level of Need Assessments (LONs)

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

## Authorization

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

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

## Authorization/Billing

The case manager completes the Service Agreement by adding the vendor's name, provider NPI/UMPI, appropriate HCPC code, and number of units and rate authorized.

1. The intent of the transportation service mileage rate is to pay for the vehicle, not the associated staff time
2. The negotiated trip rate may/may not include staff time
3. The mileage rate and the trip rate cannot be authorized/billed for the same trip

The mileage rate cannot be used when payment for transportation is received for more than one rider for any portion of the trip regardless of payer.

The trip rate may be used when transporting and receiving payment for more than one person on any portion of a trip.

The mileage rate cannot be authorized or billed for miles when the member is not in the vehicle.

Factors to consider when negotiating one-way trip rates: distance, time, number of individuals transportation payment is received for, and special vehicle/driver requirements.

Use transportation services funded through the [Older Americans Act](#) only when the service/amount of service needed cannot be authorized within the person's [community](#) budget cap.

The case manager/care coordinator completes the Service Agreement by adding the vendor's name, the provider's NPI/UMPI number, appropriate HCPC code, and number of units and locally negotiated rate authorized.

### Provider Standards and Qualifications

Drivers must have a valid driver's license and required insurance coverage. Additional requirements may apply.

### Transitional Services

Service/HCPC	EW
<ul style="list-style-type: none"> <li>T2038 – per service</li> </ul>	X

### Definition

Community transitional support services include expenses related to establishing community based housing for people transitioning to independent or semi-independent community residence from a certified nursing facility or other setting.

### Covered Services Examples

1. Lease and rental deposits
2. Essential furniture
3. Utility set up fees and deposits
4. Personal supports to assist in locating and transitioning to the community based housing
5. Basic household items
6. Personal items
7. One-time pest and allergen treatment of the setting

Expenses must be reasonable and do not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

If there is an unforeseen reason the person does not open to the waiver (due to death or significant change in condition), the local agency may bill for the service and be reimbursed through Medicaid administrative funds. Managed care organizations may not bill for administrative funds under these circumstances.

## Authorization Criteria

The individual:

1. Must not have another source to fund or attain the items or support
2. Must be moving from a living arrangement where the items were provided to a residence where these items are not normally furnished
3. The service will be considered to be provided and may be billed after the waiver is opened
4. When not presently using EW, the local agency must evaluate and reasonably expect that the person will be eligible to open to the waiver within 180 days
5. Incur the expense within 90 days of the waiver opening date
6. Services must be identified on the individual's plan of care

## Non-Covered Services

1. Recreational or diversional items
2. Expenses related to ongoing expenses such as rent, housing costs, food, or clothing

## Provider Qualifications

Providers of personal supports must, as determined by the lead agency, have the following:

1. General knowledge of disabilities and chronic illnesses and their effect on an individual's ability to live independently in the community
2. The ability to assess the individual's community-based housing needs
3. Functional knowledge of housing options in the community
4. Sufficient understanding of housing procurement procedures and funding mechanisms to advise the person regarding these matters
5. The ability to assist the person in attaining the services and supports that are covered by transitional services
6. A contract with the lead agency or MCO that outlines their service responsibilities including maintaining client confidentiality

The case manager must do the following:

1. Assure that the transitional support items are necessary and reasonable
2. Prior authorize the items and include the items in the individual's care plan
3. Contract or obtain purchase agreements for vendors of personal support
4. Receipts and documentation for all transitional support items must be maintained in the members' file for auditing purposes
5. Make sure providers obtain and maintain other applicable licenses, permits, registration, or other governmental approvals required to provide the transition service
6. Consider reconditioned items if they are safe by reasonable standard and determined appropriate by the case manager