



Bulletin

NUMBER

#14-25-06

DATE

July 9, 2014

OF INTEREST TO

County Directors

Social Services Supervisors
and Staff

Health Plans

EW Administrative Contacts

Customized Living
Providers

Housing with Services
Establishments

EW Case Managers

EW Care Coordinators

EW Tribal Administrators

ACTION/DUE DATE

Please read information
and prepare for
implementation

EXPIRATION DATE

July 9, 2016

Comprehensive Policy on Elderly Waiver (EW) Customized Living

TOPIC

EW customized living service

PURPOSE

Replace bulletin #12-25-03

Clarify EW customized living services policy and use of rate-setting tools

CONTACT

[PolicyQuest](#)

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TERMINOLOGY NOTICE

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

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I. Background

Scope of Elderly Waiver (EW) customized living services: Minnesota offers an array of home and community-based services (HCBS) through the EW, including customized living services, which have differentiated rate limits based on the participant's needs.

Customized living services are planned and purchased as a bundled service. That is, there is a monthly rate established to purchase the type and amount of allowable component services approved for a participant when there is a documented need for the component service(s) and when the participant elects to have identified needs addressed through their customized living service plan. This stands in contrast to services that are planned and authorized by participant service type and which are typically billed in smaller amounts or units, such as ¼ hours, ½ hours, days or miles.

The Minnesota Department of Human Services (DHS) requires the use of the *EW Customized Living Tools* to ensure that the rates paid for customized living services are based on documented needs and reflect the type and amount of component services authorized to meet particular participant needs.

Legislative authority: Minnesota Statutes, section 256B.0915 authorizes EW HCBS. Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h govern customized living rates. Minnesota Statutes, section 256B.0915, subdivision 3i addresses capitation rates for managed care organizations (MCOs).

Minnesota's Olmstead Plan: The United States Supreme Court's Olmstead Decision came out of the 1999 civil right case, *Olmstead v. L.C. U.S. 581*. The Court held that it is unlawful for governments to keep people with disabilities in segregated settings when they can be supported in the community. Minnesota has made progress in increasing community-based supports and integrated options, but Minnesota recently completed writing an Olmstead Plan to direct the State's comprehensive work towards full inclusion of people with disabilities. Minnesota's development and implementation of the Plan is required as part of a settlement agreement in a federal court case.

Minnesota's vision for the outcome of the Olmstead Plan is that Minnesotans with disabilities will have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life. This includes:

- The opportunity and freedom to have meaningful choice, self-determination and increased quality of life;
- Systemic change through government policies and practices to support self-determination;
- Readily available consumer information about rights, options, risks and benefits.

Use of statewide tools required by Centers for Medicare and Medicaid (CMS) for EW renewal: Minnesota's Elderly Waiver Plan, approved by CMS for a five year period, requires all counties and tribes to use customized living rate-setting tools for customized living services.

Changes and clarification from the last issued bulletin #12-25-03 include:

- Qualities of person-centered planning issued in new CMS rules
- HCBS setting requirements issued in new CMS rules
- New provider enrollment system requiring providers to enroll directly with DHS as a Tier 1 provider. As of January 1, 2014 lead agencies (counties, managed care organizations and tribes) will no longer enter into contracts for customized living services
- Transition from a Class A or F to a Comprehensive home care license
- Provider input in the development of participant's customized living plan

II. EW Community Support Plan (CSP) Budgets

The monthly cost of all waiver services, including customized living services, may not exceed the monthly service budget related to the participant's case mix classification as required under Minnesota Statutes, section 256B.0915. DHS publishes the case mix classification budget limits each year in a bulletin. The case mix budgets for State Fiscal Year 2015 were published in [bulletin #14-69-03](#).

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

III. Rate Limits

The monthly customized living or 24-hour customized living rates may not exceed the service rate limits as noted in [bulletin #14-69-03](#), with the exception of pre-approved conversion rates which are addressed in [bulletin #13-25-07](#).

Customized living service rate limits represent "up to" amounts and should not be considered rates or funding amounts the provider can expect or charge for a customized living plan. Payment authorizations for customized living services must be individualized; based on the participant's need for each component service; the amount of each component service to be delivered; and the provider's qualification, ability, and willingness to deliver the needed component service at the authorized rate. In addition, participants have choice in how needs will be met in the customized living plan and within the CSP as a whole.

Managed care organizations shall not exceed the maximum component rates or the service rate limits for customized living services as required under Minnesota Statutes, section 256B.0915, subdivision 10.

Case managers and care coordinators shall not authorize uncompensated care.

Services included in a participant's customized living plan must be authorized within the customized living services rate limit. There are several strategies assessors, case managers and care coordinators can employ in developing the customized living service plan that can be supported under the service rate limits in customized living using the rate tools and in developing the broader CSP under the participant's EW community budget cap:

- Maximize other payors for short term and intermittent needs, e.g., Medicare, Medicaid State Plan and other third party payors such as long term care insurance should be used when appropriate. Needs that can be addressed by other payors cannot be included in the customized living plan.
- Evaluate if reductions in component service time can still meet participant needs to bring the customized living plan under the customized living service rate limit.
- Purchase needed services from other providers in combination with customized living and/or 24 customized living, e.g., transportation options, use of technologies and equipment to replace human assistance, and companions or personal care assistance (PCA) services when appropriate.
- Authorize a plan that represents an *average* estimate that takes into account short term changes in need and component services that may occur. This is an important step because many years of experience show that estimated units of services authorized typically exceed the units actually provided and claimed in unbundled services. It may also be important to examine the provider's actual staff availability to ensure the estimated time can be delivered when all participants' plans are considered.
- Consider more cost effective ways to buy similar services in combination with the customized living services plan. For example, companion services may be a more cost effective way to meet a participant's need for assistance while out in the community.
- Consider other housing settings including family foster care.
- Ensure the assessment reflects all participant needs and that the appropriate case mix classification has been assigned.

IV. Customized Living Payment Rate Parameters

The following rate-setting policies apply to customized living:

- The authorized rate must be based on the services authorized to be delivered, not on the participant's assessed needs or a base rate established by the provider.
- The authorized rate is a monthly rate.
- The participant rates authorized for a unit of a component service shall not exceed the fee-for-service EW or Medicaid state plan rate limit for a similar

- service and units of service delivered outside of a customized living services setting.
- The authorized rate cannot exceed the EW customized living service rate limit.
- Service payments must account for economies of scale in areas including staffing and administrative overhead.
- Authorized rates cannot be developed or approved using a provider's base rate or base packages of service.

Customized living services rate limits are differentiated. Minnesota Statutes, section 256B.0915, subdivision 3h (a) and (b) includes requirements for lead agency authorization of 24-hour CL rate limits. In order to be eligible for the higher 24-hour CL rate limit, the participant must have the following needs as determined by an assessor, case manager, or care coordinator completing the Long Term Care Consultation (LTCC) or MnCHOICES assessment:

- Cognitive or behavioral intervention; or
- Clinical monitoring with special treatment; or
- Staff assistance in toileting, positioning, or transferring (single dependency); or
- Medication management and at least 50 hours of service per month and a dependency in at least three of the following activities of daily living (ADL's): bathing; dressing; grooming; walking; or eating (when eating is scored as 3 or greater)

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

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

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

- All assistance with personal care purchased from a non-Medicare certified Class A, Class F, or Comprehensive home care provider must be purchased as part of the customized living package of services. Personal care assistance (PCA) services authorized and purchased outside of the customized living plan must be purchased from a qualified PCA provider who is not the housing provider as per Minnesota Statutes, section 256B.0659, subdivision 3. All other Medicaid state plan home care services must be purchased from a Medicare certified home care agency.
- Customized living services, like all HCBS, are intended to meet chronic or long term care needs. Services needed to meet acute care needs should not be included in the customized living service plan. Participants may choose among all available, appropriate providers to meet their acute care needs, and these

services must be billed to the appropriate payer, including Medicaid state plan, pre-paid Medical Assistance health plans (Minnesota Senior Health Options, or MSHO, for example), Medicare, long term care insurance or private insurance.

- Temporary increases or decreases of time needed to provide component services should be factored into the development of the participant customized living plan and monthly rate as part of the average estimated time needed to meet the participant’s identified needs.
- All EW program service costs, such as case management services or specialized supplies and equipment, plus the participant’s customized living service payment rate, other EW services, and state plan home care services, may not exceed the participant’s monthly case mix budget cap. The case mix budget cap amount does not determine whether the participant will receive either of the differentiated service limit rates. A participant’s eligibility for a 24-hour customized living rate is based on their needs and whether their needs meet criteria for 24- hour supervision, not amounts available under the monthly case mix budget.
- Room and board or rental rates are not defined or controlled directly by the EW program. However, the Medicaid income standard limits the EW participant’s income available to pay room and board or rent. Participants may choose to pay housing costs in excess of Group Residential Housing (GRH) negotiated rates for additional amenities, but settings with GRH agreements must be able to accommodate participants whose income limits them to the GRH rate.
- Room and board costs are not included in component service unit costs or authorized service rates. Board is defined as a full daily nutritional regimen. If meals are provided, the service payment may include the cost of meal preparation and service as a component service but may not include the cost of raw food.
- Providers may not bill for full days on which participants are absent from the customized living or 24-hour customized living setting. An overnight absence of more than 23 hours is a non-covered day. An absence of less than 23 hours on the first day is covered. After the first 23 hours, each time the clock passes midnight counts as another non-covered day. Providers must pro-rate billing to reflect non-covered days during the month.

Example:

| Leave | Return | Non-covered Day |
|------------------|---------------------|---|
| 4:30 P.M. Friday | 11:30 a.m. Saturday | 0 (Less than 23 hours) |
| 4:30 P.M. Friday | 5:00 p.m. Saturday | 1 (More than 23 hours) |
| 4:30 P.M. Friday | 8:00 p.m. Sunday | 2 (More than 23 hours; past midnight once) |
| 4:30 P.M. Friday | 7:30 a.m. Monday | 3 (More than 23 hours; past midnight twice) |

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

Supplemental Payments for Covered Services Not Allowed: Providers may not request supplemental payment for covered services. Minnesota Statutes, section 256B.0915,

subdivision 3e (g) state “a provider may not bill or otherwise charge an EW participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.”

V. Customized Living Provider Requirements

DHS Provider Enrollment Replaces Lead Agency Contracts: DHS implemented a new federally compliant system to manage and monitor providers January 1, 2014. Lead agencies (counties, managed care organizations and tribes) no longer have contracts for waiver services, including customized living as of January 1, 2014. The new system increases access to services by expanding participant choice among all qualified providers and standardizes service delivery to ensure consistency in compliance with person-centered service quality standards. Customized living providers are required to enroll directly with DHS as a Tier 1 provider in order to deliver reimbursable services. HCBS waiver providers enrolling with DHS must meet general and service-specific Minnesota Health Care Program (MHCP) requirements. All enrolled providers enter into an [MHCP Provider Agreement](#), submit required documents, and provide signed assurances as part of enrollment and/or license review. Providers of all direct contact services must comply with owner and staff background study requirements. Newly enrolling providers must complete state waiver program and waiver billing training (See Minnesota Statutes, section 256B.4912, subdivision. 7). See [bulletin #13-56-02](#) for a full a full explanation of this change.

Corporate Adult Foster Care Providers that are assisted living pursuant to Minnesota Statutes, chapter 144G must enroll as customized living providers and may not enroll as adult foster care. Providers required to register as housing with services establishments and that provide services that exceed the scope of services and supports allowed within an adult foster care licensure must enroll to provide customized living, not foster care waiver services, and meet all provider standards for customized living services, including holding a Class A, Class F, or Comprehensive home care license.

Customized Living Provider Enrollment:

Customized living providers will be required to submit evidence of housing with services registration (providers must register each housing with services establishment at which they deliver or plan to deliver customized living services with the Minnesota Department of Health), home care licensure, and may also be asked to submit evidence of a contract between the housing with services establishment and the home care provider if they are not the same legal entity. Forms, instructions and technical assistance related to enrollment in Minnesota Health Care Programs are located at [DHS Provider Enrollment](#).

Customized living providers must meet the following standards:

- Maintain a Class A, Class F, or Comprehensive home care license.
 - For new licensees, as of January 1, 2014 the provider must be licensed with a Comprehensive home care license.
 - For current Class A or Class F licensees as of December 31, 2013, upon license renewal the provider must become licensed with the Comprehensive home care license.
- Provide services in registered housing with services establishments
- Assure that each building is registered as a housing with services establishment in which they provide customized living services and have a contract with a registered housing with services establishment to provide services. The housing with services establishment must meet all requirements in Minnesota Statutes, chapter 144D. Minnesota Statute, section 144D.04 requires housing with services establishments execute a contract with each resident that includes, at minimum, the 17 elements that are listed in this section of the statute. All of the elements are important in identifying what services will be provided, the cost and payment of the services, and any conditions related to the delivery of services.
- Provide services in one of the following qualified settings:
 - A setting of 1-5 unrelated people living together in a residential unit, or
 - A setting of 5 or more unrelated people which is licensed by the Minnesota Department of Health as a board and lodge,¹ or
 - A residential center which is a building or complex of contiguous or adjacent buildings of 3 or more separate and distinct living units (apartments) which participants rent or own.
- Provide each participant with means to effectively summon assistance
- Employ staff who meet the following requirements:
 - Recognize the need for and provide assistance required or summon appropriate assistance.
 - Have the physical ability to provide the services identified in the participants' service plans
 - Drivers must have a valid driver's license and adequate insurance coverage as required by [Minnesota Statutes, chapter 65B](#)
 - Be able to:
 - work under intermittent supervision;
 - communicate effectively with other staff and participants;
 - read, write, and follow written and verbal instructions;
 - follow participant's personalized service plans;
 - identify and address emergencies including calling for assistance;
 - understand, respect, and maintain confidentiality.

¹ If there are five people living together, the setting must be licensed as a board and lodge by the Minnesota Department of Health OR be licensed by DHS as adult foster care under Minnesota Rules, parts 9555.5105-9555.6265. A foster care license may be issued for a capacity of 5, if all persons in care are age 55 or older and do not have a serious and persistent mental illness or a developmental disability.

- In addition to the staff requirements listed above, staff providing *supervision* to participants must also:
 - work on-site within the customized living program;
 - have as their primary work responsibility the supervision of participants in the housing with services setting (generally this means the same building);
 - have on-going awareness of the participants' needs and activities;
 - be capable of communicating with participants, recognizing the need for assistance, and providing or arranging for appropriate assistance;
 - be an employee of the customized living provider who is not a participant of services;
 - be able to respond in-person to a participant within a time frame that meets the participant's needs and in no event exceeds ten minutes.
- Providers preparing meals must assure that federal FDA standards are met.
- Ensure the setting is in compliance with [42 C.F.R. §441.301](#) which requires that:
 - **All HCBS settings** meet certain qualifications, including:
 - the setting is integrated in and supports full access to the greater community;
 - ensures participant rights of privacy, dignity and respect, and freedom from coercion and restraint;
 - optimizes autonomy and independence in making life choices; and
 - facilitates choice regarding services and who provides them
 - **Provider-owned or controlled residential** settings which include housing with services establishments in which customized living services are offered, requires that the following additional conditions be met:
 - The specific unit/dwelling is owned, rented or occupied under a legally enforceable agreement
 - Participants have the same responsibilities/protections from eviction as all tenants under landlord tenant law
 - Each participant has privacy in their sleeping or living unit
 - Units have lockable entrance doors
 - Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
 - Participants have freedom and support to control their schedules and activities and have access to food at any time
 - Participants may have visitors at any time
 - The setting is physically accessible to the individual
 - Modification of these requirements must be supported by a specific assessed need and justified and documented in the person-centered services plan
 - a. Documentation includes: the specific individualized assessed need; prior intervention and supports including less intrusive methods; ongoing data measuring effectiveness; established time limits for periodic review; informed consent; and assurance that interventions and supports will not cause harm ([42 C.F.R. §441.301](#)).

“**Assisted Living**” requirements are delineated in [Minnesota Statutes, chapter 144G](#). The EW *does not* require providers to meet the standards of Minnesota Statutes, chapter 144G to provide customized living services. However, if the provider chooses to use the term “assisted living” as part of its marketing materials or business name, these requirements must be met.

VI. Lead Agency Planning and Authorization of Customized Living Services

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

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

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

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

Personalized component services: Case managers and care coordinators will authorize customized living services that include the amount of component services requested by the participant to meet assessed needs and that enable the achievement of participant goals as outlined in Section VI of this bulletin whenever possible; e.g. transportation to weekly events or to visit friends to maintain community and family involvement.

Personal risk management: One dimension of choice and self-direction is the right to assume and manage personal “risk.” When a person chooses to manage their own “risk,” i.e., they choose to *not* have a service to meet an identified need, the case manager will provide education to the person about how any resulting health and safety issues might be

managed and what the acceptable threshold of risk can be and still meet waiver care plan requirements related to reasonable health and safety.

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

Socialization should be designed to support the participant in attaining person-centered goals and outcomes. This may include support that assists the participant in maintaining or developing relationships, communicating with family and friends, supporting the participant in realizing socially valued roles of their choice, e.g., volunteering or serving on a committee, or support that allows the participant to engage in meaningful leisure activities. Activity programs that do not facilitate the participant's stated outcomes and goals are not covered.

Long Term-Care Assessment and Provider Input: In order to be eligible for customized living services, participants must be assessed through the Long Term Care Consultation or MnCHOICES process at least once yearly. "The assessment must be conducted in a face-to-face interview with the [participant] being assessed and their legal representative, and other individuals as requested by the participant who can provide information on the needs, strengths, and preferences of the participant necessary to develop a CSP that ensures the participant's health and safety, but who is not a provider of service or has any financial interest in the provision of services... [Providers may], with the permission of the participant being assessed or their designated or legal representative, submit a copy of their nursing assessment or written report outlining its recommendations regarding the participant's care needs. The assessor will notify the provider of the date by which this information is to be submitted. This information shall be provided to the assessor prior to the assessment" ([Minnesota Statutes, section 256B.0911, subdivision 3 \(a\)](#)).

Customized living plan must be completed prior to authorization of service:

Assessors shall complete the customized living plan for all participants new to EW in order to assure timely initiation of service and proper authorization. Case managers will be responsible for completing the customized living plan on annual reassessment, or as necessary, to assure that the customized living plan adequately addresses changes in participant's needs and goals.

Customized living component services: Customized living services are individualized and made up of covered component services designed to meet the assessed needs and goals of an EW participant living in a qualified setting. The component services, their definitions, and guiding service planning principles are defined in [Customized Living](#)

[Component Service Definitions: A Reference Guide for Computing Time for Rate-Setting Tools, eDoc DHS-6790H-ENG](#), which is incorporated by reference as part of this bulletin.

The customized living plan shall:

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

As with any HCBS service, the type and amount of each component service included in the personalized plan must be based on and linked to the documented needs and goals of the EW participant and have the following person-centered qualities.

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

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

Supervision is incorporated into the customized living plan when:

- The need for supervision has been assessed and documented. LTCC or MnCHOICES assessors must assess the supervisory needs of the participant and document these in the assessment.
- The level and type of supervision that will be provided to meet the assessed need is documented in the participant's EW CSP. As with all services to be provided to the participant, the scope and duration of supervision must be specified, and the information must be readily available to the participant and to the lead agency (counties, health plans or tribes).

When assessing the supervisory needs of participants, LTCC or MnCHOICES assessors, or EW case manager/care coordinator should consider the person's:

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

If supervision is assessed as needed and is to be included in the customized living plan, the following elements should be included in the customized living plan developed by the case manager/care coordinator, participant, and provider:

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

Assessors and EW case managers/care coordinators should address whether a participant requires supervision outside of their home as well as within the housing with services establishment. The CSP should clearly indicate providers or others responsible for provision of supervision when leaving the housing with services establishment. Supervision outside of the housing with services establishment should be included in the section of the plan related to the participant's need for supervision as a discrete service, and as part of the delivery of other component services. For example, if the participant has orientation challenges, it should be included in the active behavioral or cognitive support section. If the participant needs assistance with wheeling, it should be addressed in that section of the customized living plan. The plan should facilitate meaningful participation in community life.

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

Duplication of service: In carrying out their quality management role, case managers must assure that there is no duplication of services authorized. For example, a person may choose transportation from another vendor in addition to or in place of the customized living provider. In this case, while the customized living provider may offer transportation service, the case manager/care coordinator cannot duplicate and must differentiate this service in both the CSP and the customized living plan, and must only authorize those services that

will actually be provided to the participant by the customized living services provider within the service plan.

Homemaking services cannot be authorized in addition to customized living, but they must be included, if needed, in the customized living or 24 hour customized living plan. Chore services cannot be authorized in addition to customized living, nor can they be authorized as part of the customized living plan.

Personal emergency response devices or systems cannot be authorized in addition to 24 hour customized living. A rate is negotiated with a provider who is authorized to provide 24 hours of supervision to a person who has been identified as meeting the criteria for need of this level and type of service as part of supervision. The provider may choose to use a personal emergency response device to meet the requirement of providing participants with a system for requesting assistance, or as part of the plan for 24 hours of supervision. Additional payment for personal emergency response cannot be authorized in addition to the 24 hour customized living rate for summoning devices designed for use within the housing with services establishment.

A personal emergency response device or system can be authorized and purchased through EW under specialized supplies and equipment through a qualified supplies and equipment provider if the person receives customized living services containing no or less than 24 hours of supervision.

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

Participant-directed community supports cannot be authorized for participants living in housing with services establishments and therefore may not be authorized in combination with customized living.

VIII. Use and Submission of EW Customized Living Tools

The purpose of DHS issued customized living tools is to:

- Provide tools for the development of CSP and Coordinated Service and Support Plans (CSSP) that describe the type and amount of component services in the individualized customized living plan
- Meet requirements CMS set forth as a condition of the EW Plan renewal
- Implement Minnesota statutory requirements related to authorization and purchase of this service
- Provide a consistent statewide approach to the authorization of rates for

- customized living service
- Support program integrity goals
- Establish a rate reflective of the participant's approved customized living plan
- Implement statewide component rates and service rate limits

Lead agencies shall complete the EW Customized Living Workbook to develop the individualized customized living plan and establish a rate prior to authorization of EW customized living services. All counties, tribes, and managed care organizations using the DHS EW Customized Living Workbook must submit completed workbooks to DHS within 15 days of the service authorization customized living line item begin date.

The rate authorized and paid for individual participants receiving EW customized living must match the rate on the CL Tool submitted to DHS. A new EW Customized Living Workbook must be submitted for any subsequent rate change within 15 days of the start date of the new rate.

The EW Customized Living Workbook, an Excel workbook, **commonly referred to as the CL Tool**, contains worksheets that are used to develop a participant's customized living plan and to calculate their individualized rate. [Instructions for completing the workbook](#), [Instructions for up-loading completed EW Customized Living Workbooks](#), and other EW CL Tools are available for download from [DHS' EW Customized Living Tools website](#).

The CL Tool is designed to:

- Use documented needs (assessment data in the Screening Document Input worksheet) as the basis of CSP and CSSP development.
- In order to use the EW Customized Living Workbook as the CSP, all of the CL Tool must be completed:
 - The case manager/care coordinator also completes the *EW Services Authorized* worksheet which provides a computation of *all* services included in the participant's CSP in addition to customized living services.
 - The CSP worksheet is printed in combination with the CL Plan. All other informal and/or quasi-formal supports must be included on the 'Participant CL Plan' worksheet and signatures must be obtained. The participant receives a copy of the two worksheets.
 - For managed care organizations, the care plan may be substituted for the CSP in the CL Tool, in which case completion of the EW Services Authorization page is optional.
- Delineate the customized living component services and the amount of each to be provided to a specific EW participant.
- Describe participant preferences and needs to be met through the customized living plan.
- Generate a personalized rate within each participant's allowable service rate limit (based on their case mix classification) that is based on the component services and units of service included in the participant's customized living plan. This rate is to be entered into MMIS or other payment system for the participant's service agreement.
- A copy of the Rate Guide is printed and provided to the participant and the

provider. The rate authorized in MMIS or the managed care organization's payment system should match the amount on the Rate Guide.

Additional documents found on [DHS' EW Customized Living Tools website](#) include:

- *Instructions for Use of EW Customized Living Workbook*, a PDF document, describe how to complete the EW Customized Living Workbook.
- *The Customized Living Component Service Definitions: A Reference Guide for Computing Time for Rate-Setting Tools*, [eDoc DHS-6790H-ENG](#), provides a list of each component service, the definition, and guidance to case managers when completing the CL Tools.
- *EW Customized Living Tools instructions (PDF)* provides instruction for submitting the EW Customized Living Workbook through MN-ITS.
- *EW Customized Living Tools Release Notes* is a PDF document providing up to date information regarding the latest changes to the EW Customized Living Workbook.
- *EW Customized Living Tools Workbook (PDF)* provides a screen shot of all the EW Customized Living Workbook sheets and forms.
- *FAQs EW Customized Living Tools FAQs, Tips and Alerts (PDF)* provides other useful links, assistance on requesting previous CL Tools, opening secure DHS emails, handling errors, interpreting management reports, and further clarification of CL Tools functionality.

IX. Group Residential Housing Funds (GRH)

Group Residential Housing (GRH) funds are available to pay for room and board in housing with services establishments, a licensed adult foster care, boarding care home, board and lodge, residential care home, or supervised living facility. To receive GRH payments, an establishment must have a GRH agreement with the county in which it is located.

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

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

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

GRH does allow payment, within limits, for room and board costs if a person is temporarily absent from the establishment and is expected to return. GRH can pay up to 18 days per episode of absence, not to exceed 60 days in a calendar year, for a GRH participant who is temporarily absent. For non-emergency absences, county approval is required (Providers shall not bill EW for services on days that the resident is absent from the establishment and must pro-rate the monthly customized living bill to reflect days absent).

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

Counties should direct GRH policy questions to [PolicyQuest](#). Other GRH-related inquiries from counties or service providers or other community members can go to the group email at dhs.adultincomesupport@state.mn.us.

X. Obsolete Bulletin Related to EW Customized Living

This bulletin replaces bulletin #12-25-03 “Comprehensive Policy on Elderly Waiver (EW) Customized Living.”

XI. Web Links to Resource Information

[Class A – Licensed Only \(Non-Medicare Provider\) Survey Results](#)

[Class F Home Care Provider Survey Results](#)

[Directory of Licensed Home Care Providers and Registered Housing with Services Establishments](#)

[Housing with Services Establishment Registration Information](#)

[Licensure Application Forms for Home Health Care Providers](#)

[Minnesota’s Olmstead Plan](#)

[Minnesota Statutes, chapter 144D Housing with Services Establishment](#)

[Minnesota Statutes, chapter 144G, Assisted Living Services](#)

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[Minnesota Statutes, section 256B.0915, Medicaid Waiver for Elderly Services](#)

[Quality Measures for Medicare Certified – Class A Home Care Providers](#)

Americans with Disabilities Act (ADA) Advisory

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