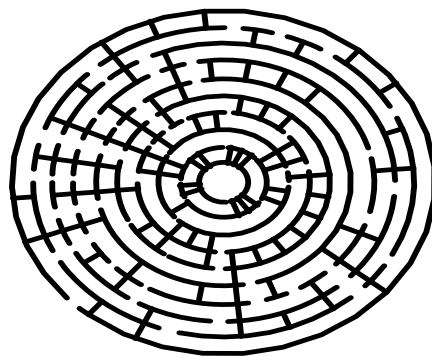


Department of Human Services

To download other “topics” or the entire Who Pays document go to:

<http://www.health.state.mn.us/mcyshn>

Who Pays?



Taking the *MAZE* Out of Funding

Minnesota Children & Youth
with Special Health Needs

The logo for Minnesota Children & Youth features a stylized blue figure with arms raised, a red circle for a head, and a blue vertical bar on the right side.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

651-201-3650 OR 1-800-728-5420
www.health.state.mn.us/mcyshn

Department of Human Services (DHS)

Program Information for Cash, Food & Medical Programs

Minnesota Health Care Programs (MHCP)

MA for Employed Persons with Disabilities (MA-EPD)

Authorization

Home Care Services including Personal Care Assistance

TEFRA

TEFRA Required Documentation

- Physical Disability
- Developmental Disability
- Mental Health Disability

Home & Community Based Services (“Waivers”)

Parental Fees

Family Support Grant

Consumer Support Grant

Program information for cash, food and health care programs

How do you apply for help?

Ask for help from state and county cash, food and health care programs by mail, by phone or in person. You must fill out an application form. You must mail it or bring it in person to your county human services agency. (MinnesotaCare applications must go to either the county agency or the MinnesotaCare office in St. Paul.) The amount of help you can get the first month may depend on the date the county agency gets your application form.

If you are applying for cash assistance or food support benefits, you need an interview with a county worker to go over the forms. You will need to bring proof of:

- Who you are
- Where you live
- What family members live with you
- What your income is
- What you own.

You must contact your county agency for a new appointment if you miss your interview.

Whether or not you can get help and how much you get may depend on:

- How long you have lived in Minnesota
- How many people live with you
- How much income you and these people get each month
- How much money you have.

Each program has different rules.

What are cash benefit programs?

Cash benefit programs provide Minnesotans with low income help with their monthly expenses. It helps you when your income does not cover your expenses. Cash programs include:

- Diversionary Work Program (DWP)
- Minnesota Family Investment Program (MFIP)
- General Assistance (GA)
- Minnesota Supplemental Aid (MSA)
- Group Residential Housing (GRH)
- Refugee Cash Assistance (RCA)
- Work Benefit Program (WB)

DWP is a *short-term* work program that provides job counseling services and basic living costs to eligible families. DWP is for families who are working or looking for work, but need help with basic living expenses.

MFIP is a *monthly* cash assistance program for low-income families and pregnant women. MFIP is for:

- Families who have one or more children under age 19
- Women who are pregnant.

WB is a *monthly* benefit of \$50 for families who are going off DWP or MFIP. WB is for families whose:

- Caregiver is working the required number of hours
- Gross family income is less than 200% of FPG.

GA is a *monthly* cash payment. It helps with interim money for housing and other basic needs. GA is for adults who are unable to work who:

- Have little or no income and
- Will soon return to work, or
- Are waiting to get help from other state or federal programs.

MSA is a small extra *monthly* cash payment. It helps adults who are eligible for federal Supplemental Security Income (SSI).

GRH is a *monthly* payment. It pays room and board for some people who cannot live in their own home. GRH is for people who are:

- Age 65 or older
- Disabled and age 18 or older
- Blind
- Unable to work.

RCA is a *monthly* cash payment for refugees and asylees. RCA is for people who:

- Have been in the United States eight months or less and
- Have refugee or asylee status.

What are health care programs?

Minnesota has several health care programs for low income Minnesotans. These programs may pay for all or part of your medical bills. They can help pay for health care your family and you need. Health care programs include:

- Medical Assistance (MA)
- MinnesotaCare
- General Assistance Medical Care (GAMC)
- Refugee Medical Assistance (RMA)
- Minnesota Family Planning Program

Most people who get cash assistance can also get health care coverage from one of the Minnesota health care programs.

MA is for people who are:

- Under age 21
- Age 65 or older
- Parents or caretakers of a child under age 18. In some cases, parents or caretakers of a child under age 19.
- Pregnant

- Blind
- Disabled

MinnesotaCare helps people who do not have other health insurance. You must pay a premium to get coverage. MinnesotaCare is for people who do not:

- Get MA or GAMC
- Have other health insurance. Some children can still get MinnesotaCare even if they have other health insurance.

GAMC is for adults who:

- Cannot get MA, and
- Are age 21 or older
- Are under 65.

RMA is for people who:

- Cannot get MA, and
- Have been in the United States eight months or less.

Minnesota Family Planning Program is a health care program that covers only family planning services and related supplies.

What is child care assistance?

Minnesota's Child Care Assistance Program makes quality child care affordable for families with low incomes. Help is available from the following programs:

- **MFIP Child Care** is for families who receive assistance from DWP or MFIP.
- **Transition Year Child Care** may be available to families for up to 12 consecutive months after their DWP or MFIP case closes.
- **Basic Sliding Fee Child Care** is for other families with low incomes.

What is Food Support?

Food Support is a federal program that helps Minnesotans with low income buy food. Food support benefits are available through electronic benefits transfer (EBT) cards that can be used like money. Food support benefits are for:

- Single people
- Families with or without children.

Your income and the size of your household determines how much you get.

Your right to file a complaint

If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

Minnesota Department of Human Rights
190 East 5th Street, Suite 700
St. Paul, MN 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TTY)

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice)
(312) 353-5693 (TTY)

U.S. Department of Agriculture
Director, Office of Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(800) 795-3272 (Voice)
(202) 720-6382 (TTY)

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.

(agency)



Minnesota Health Care Programs

This information is effective June 1, 2010 through June 30, 2011.

Minnesota offers several health care programs to people who qualify. You can apply for any of these programs with the same application—the Minnesota Health Care Programs Application.

Contact any of the agencies listed below for more information or to get an application:

- Your county human or social services office.
- MinnesotaCare at (651) 297-3862 or (800) 657-3739 (this toll-free number is only available to people that need to call long distance to reach MinnesotaCare).
- Department of Human Services at (651) 431-2670 or (800) 657-3739.
- The website at www.dhs.state.mn.us/healthcare.

To get health care program coverage, you must meet the program guidelines and be within the income and asset limits. If your income is more than the limit, you may still qualify and you should apply.

Assets that are counted include cash, bank accounts, stocks, bonds, certain vehicles and property where you do not live. Assets that are not counted include the home where you live, personal property and household goods.

Minnesota's health care programs may cover the following medical services:

- Doctor visits
- Dental visits
- Hospital care

- Prescriptions and immunizations
- Eye exams and eye glasses
- Chiropractic care
- Family planning
- Hearing aids
- Mental health services
- Medical equipment and supplies

You may have to pay a small copayment toward some medical costs.

Medical Assistance (MA)

MA may pay for medical bills going back three months from the month you turn in your application. MA also pays for current and future medical bills.

To get MA, you must:

- Live in Minnesota
- Meet income and asset limits
- Be one of the following:
 - Under age 21
 - A parent of a minor child
 - Pregnant
 - Age 65 or older
 - Blind or disabled.

Over →

MA Monthly Income Limits

Family size	1	2	3
Infants under age 2	\$2,527	\$3,400	\$4,273
Children ages 2 through 18	1,354	1,822	2,290
Children ages 19 and 20	903	1,215	1,527
Pregnant woman	--	3,340	4,198
Adults with children	903	1,215	1,527
People who are blind or have a disability	903	1,215	1,527
Adults age 65 and over	903	1,215	1,527

MA Asset Limits

There is no asset limit for pregnant women and for children under age 21. Asset limits apply to the following people.

Family size	1	2 or more
Adults with children	\$10,000	\$20,000
People who are blind or have a disability	3,000	6,000*
Adults age 65 and over	3,000	6,000*

*For each dependent add \$200.

For people who are self-employed, net capital and operating assets are excluded up to \$200,000 for MA for families.

What if I am disabled and working?

If you are disabled and have a job, you may qualify for Medical Assistance for Employed Persons with Disabilities (MA-EPD). You will have to pay a monthly premium. The amount is based on your monthly income.

MA-EPD Asset Limits

The asset limit for MA-EPD is \$20,000 per enrollee. Some items are not counted for MA-EPD, such as your retirement account and your spouse's assets.

MinnesotaCare

MinnesotaCare is available for people who do not have health insurance. Some children may get MinnesotaCare even if they have insurance or access to insurance through an employer.

You will have to pay a monthly premium for MinnesotaCare. The cost depends on your family size and income. When you pay your first MinnesotaCare

premium, coverage will begin on the first of the next month.

To get MinnesotaCare, you must:

- Live in Minnesota. Adults without children must live in Minnesota for 180 days.
- Be a U.S. citizen or a qualifying noncitizen.
- Have had no health insurance and no Medicare for the last four months.
- Meet income and asset limits.

You cannot enroll in MinnesotaCare if:

- Your current employer offers health insurance and pays half or more of the monthly cost of the insurance.
- Your employer offered health insurance, paid half or more of the monthly cost, and stopped insurance within the last 18 months.
- You are a parent, legal guardian, foster parent or relative caretaker, and your gross household income is over the limit for your family size or is \$50,000 or more.

MinnesotaCare Monthly Income Limits

Family size	2	3
Families with children under age 21	\$3,340	\$4,198

MinnesotaCare Asset Limits

There is no asset limit for pregnant women and for children under age 21.

Adults with children have the following asset limits:

Family size	1	2 or more
Adults with children	\$10,000	\$20,000

For people who are self-employed, net capital and operating assets are excluded up to \$200,000.

Should I apply for MinnesotaCare or MA?

The information below will help you decide if MA or MinnesotaCare is right for you.

MinnesotaCare

- You must pay a monthly premium if you and your family members qualify for MinnesotaCare.
- The first premium must be paid before coverage can start.
- Coverage begins in the month after you pay your premium. If you pay the premium in May, your coverage starts on June 1.

- You must pay the premium every month or your coverage will end. If your MinnesotaCare ends, you cannot enroll again for four months if you meet all program rules.
- Coverage cannot go back to previous months, unless your MA or GAMC just ended.
- MinnesotaCare requires that you and your family members be without other insurance coverage for four months before you can qualify. There are some exceptions to this rule for children.
- You and your family members will not qualify for MinnesotaCare if your employer offers health insurance and pays 50% or more of the premium. This rule may not apply to children, depending on the amount of household income.

Medical Assistance (MA)

- You will not have to pay a monthly premium for MA.
- MA coverage may go back three months from when you turn in your application, if you have medical expenses for those prior months.
- You can have other health insurance, even if it is through an employer, and still qualify for MA.
- If you have other health insurance, MA may pay your health insurance premiums.
- If MA ends, you can get coverage again whenever you meet the program rules.

General Assistance Medical Care (GAMC)

GAMC pays for some current and future medical services. GAMC eligibility only goes back to the date you turn in your application or a written request for health care. To get certain services, you will need to enroll in a Coordinated Care Delivery System (CCDS).

To qualify, you must:

- Live in Minnesota for at least 30 days
- Intend to stay in Minnesota. This may not apply if you have a medical emergency
- Be a U.S. citizen or a qualifying non-citizen
- Not be eligible for MA
- Meet income limits
- Meet asset limits.

GAMC Monthly Income Limits

Family Size		
1	2	3
\$677	\$911	\$1,145

Medicare Savings Programs

If you are enrolled or eligible to enroll in Medicare, and your assets are below \$10,000 for one person or \$18,000 for two people, you may qualify for one of the following programs:

- Qualified Medicare Beneficiary (QMB)
- Service Limited Medicare Beneficiary (SLMB)
- Qualified Individuals (QI)

Qualified Medicare Beneficiary (QMB)

QMB pays monthly Medicare premiums, deductibles, copayment and co-insurance.

QMB Monthly Income Limits

Family size		
1	2	3
\$923	\$1,235	\$1,547

Service Limited Medicare Beneficiary (SLMB)

SLMB pays monthly Medicare Part B premiums.

SLMB Monthly Income Limits

Family Size		
1	2	3
\$1,103	\$1,477	\$1,851

Qualified Individual (QI) Program

QI pays monthly Medicare Part B premiums.

QI Monthly Income Limits

Family Size		
1	2	3
\$1,239	\$1,660	\$2,081

Qualified Working Disabled (QWD)

QWD pays for Medicare Part A premiums if you cannot get free Medicare Part A.

The asset limit is \$4,000 for one person and \$6,000 for two people.

QWD Monthly Income Limits

Family Size		
1	2	3
\$1,825	\$2,449	\$3,073

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

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កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

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Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປຼດຊາບ. ຖ້າທ່ານກຳລັງຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທໂທລະສານເລກໂທ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

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Ogow. Haddii aad dooneyso in lagaa kaalmeyyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.



Minnesota Department of Human Services

Medical Assistance For Employed Persons with Disabilities (MA-EPD)

Background

Medical Assistance for Employed Persons with Disabilities (MA-EPD) promotes competitive employment and the economic self-sufficiency of people with disabilities. It does this by assuring continued access to Medical Assistance (MA) for necessary health care services.

MA-EPD allows working people with disabilities to qualify for MA with no upper income limit and higher asset limits than regular MA. The goal of the program is to encourage people with disabilities to work and enjoy the benefits of being employed.

Who qualifies for MA-EPD?

To qualify for MA-EPD, a person must:

- Be certified disabled by either the Social Security Administration (SSA) or the State Medical Review Team (SMRT)
- Be at least 16 but less than 65 years of age
- Be employed and have required taxes withheld or paid from earned income
- Have monthly earnings of more than \$65
- Not be eligible for MA under other, more beneficial categories
- Meet the asset limit*
- Pay a premium**
- Pay an “unearned income obligation,” if required. **

What is the MA-EPD asset limit*?

The asset limit for MA-EPD is \$20,000. Some assets that do not count towards the limit are:

- Spouse’s assets
- Homestead property
- Retirement accounts

- Medical expense accounts set up through an employer
- One motor vehicle, under certain conditions
- Household goods, clothing and personal items
- Burial fund (up to \$1,500).

What is the MA-EPD premium and unearned income obligation**?

Premiums:

Participants in the program must pay a monthly premium to be on MA-EPD. Premiums are based on a sliding fee scale or a minimum of \$35, whichever is greater. Income and household size are used to calculate the premium. There is no maximum income limit or maximum premium amount for MA-EPD.

Unearned Income Obligation:

In addition to the monthly MA-EPD premium, people who have unearned income, such as Social Security Disability, must pay one-half percent of their unearned income. To calculate the monthly unearned income obligation, multiply the total unearned income amount by .005.

The Department of Human Services has developed a Web site that will assist in estimating MA-EPD premium cost. The Web site is located at <http://www.dhs.state.mn.us/maepdpremium>

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2400 or (800) 747-5484. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.

Medical Assistance For Employed Persons with Disabilities (MA-EPD)

What if a person loses their job or can't work because of a medical condition?

Job Loss:

People on MA-EPD who lose their job through no fault of their own (they didn't quit or get fired) may stay on MA-EPD for up to four months while looking for another job. If they do not have a job at the end of four months they cannot remain on MA-EPD.

Medical Leave:

People on MA-EPD who become unable to work because of a medical condition may stay on MA-EPD for up to four months. They must have a written, signed doctor's statement that says they are expected to return to work within four months. If they cannot return to work within four months, they cannot be on MA-EPD.

What services does MA-EPD cover?

MA-EPD pays for the same services as regular Medical Assistance, including:

- Home care services
- Inpatient hospital services
- Mental health services
- Medical equipment and supplies
- Personal assistance services
- Physical, occupational and speech therapy
- Physician and health clinic visits.

There are co-pays for some services such as non-preventive care visits and eyeglasses. In certain circumstances, Medicare or other health insurance premiums, co-pays and deductibles may be covered under MA-EPD.

Can a person be on MA-EPD and have other health insurance?

Yes, people may have private, group or employer subsidized health insurance or Medicare in addition to MA-EPD. Many services that are not covered by commercial insurance policies or Medicare may be paid for by MA-EPD. If a person has other health insurance, that insurance must be used first, following the rules of that primary plan (must use network providers, obtain referral or authorization as required, etc.). Then services not covered may be paid through MA-EPD.

How can someone apply for MA-EPD?

Applications are available at most medical clinics and at any local, county human service agency. Applications must be returned to a local, county human service agency for processing.

Need more information on MA-EPD?

For more information on MA-EPD, contact your county human service agency. You may also contact the Department of Human Services by calling (651) 431-2400 or (800) 747-5484 (TTY/TDD: (651) 632-5110 or MN Relay - 711).

Wondering about how working affects other benefits?

For information on how working may affect other benefits (such as Social Security income, Medicare, private disability insurance, subsidized housing, Food Support, etc.), contact the Minnesota Work Incentives Connection at (651) 632-5113 or (800) 976-6728 (TTY/TDD: (651) 632-5110 or MN Relay-711).

AUTHORIZATION

Some covered health services, items, and medications require prior approval or authorization by the patient's private health plan or by the patient's Minnesota Health Care Program (MHCP). This requirement is used to safeguard against inappropriate and unnecessary use of health care services.

Where do I get more information about prior approval or authorization requirements? If the recipient is covered by a private health plan, the health care provider must follow the specific requirements of the health plan. The provider can contact the health plan's Customer Service Department for their requirements and definition of medical necessity. The family may contact the health plan for their appeal process if the approval/authorization request is denied.

For MHCP recipients in a prepaid health plan, the provider must contact the appropriate health plan (UCare, BlueCross/Blue Shield, County Based Purchasing Plan, etc.) for their authorization requirements. Managed care organizations are under contract with DHS to provide, all medically necessary health services that would be covered under MA, GAMC or MinnesotaCare.

For MHCP recipients on Fee-for-Service (FFS) Medical Assistance (MA), the health care provider must follow DHS' authorization procedure. An authorization is the written approval and includes an authorization number by the medical review agent under contract to DHS. Providers must be enrolled as a MHCP provider and get authorization prior to providing a service or, in some circumstances, after a service has been provided.

Obtaining an authorization alone does not guarantee payment to the provider. Providers must, also, follow MHCP billing guidelines and the MHCP recipient must be eligible at the time the service is rendered.

Details and the list of items/services that need to be authorized are found in the MHCP Provider Manual. Or go to the chapter that specifically discusses the particular service, item, medication or equipment. The manual is on the DHS website: www.dhs.state.mn.us Click Publications, then Manuals and then Minnesota Health Care Programs Provider Manual.

What are some examples of items or services that need authorization? (This is not a total list.)

- Durable Medical Equipment - certain wheelchairs, accessories & repairs, augmentative communication devices, orthotics & other equipment exceeding a certain amount of money (purchased or projected ongoing rental cost).
- Some dental procedures, orthodontia or more frequent dental care than typical,
- Certain mental health assessments/treatment services or services over specific "threshold" amounts.
- Certain diagnostic tests & surgical procedures (EX: PET and CT scans, MRIs, hysterectomy surgery & some surgeries if they are non-emergency: spinal fusion, cesarean section, insertion of PE tubes for ears).
- Audiology, OT, PT, ST assessment/treatment sessions above specific "threshold" amounts,
- Certain noncontract hearing aids & the provision of more than one hearing aid in 5 years,
- Certain medications, vision therapy and most contact lenses,
- Diapers, incontinence pads, formula/nutritional products and other supplies.
- Personal Care Assistance (PCA) services and more than 9 skilled nurse home visits,
- Surgery or behavior modification for weight reduction or procedures considered cosmetic or investigative.

When does DHS require authorization? DHS requires authorization as a condition of payment if the service:

- Could be considered, under some circumstances, to be of questionable medical necessity
- Requires monitoring to control expenditures;
- A less costly, appropriate alternative service is available;
- Is investigative or experimental;
- Is of a continuing nature and monitoring prevents continuation when it ceases to be beneficial;
- Is newly developed or modified;
- Is comparable to a service provided in a skilled nursing facility/hospital but is provided in a recipient's home; or
- May be considered cosmetic.

Who is responsible for requesting an authorization? The appropriate health care provider (doctor, dentist, pharmacist, mental health professional, home care agency, etc.) must request the authorization. The provider must include assessment information and evidence that the service is medically necessary and effective for the person.

Who processes the authorization? DHS contracts with a medical review agent, Care Delivery Management, Inc. (CDMI). If information is missing, the provider should be contacted to provide more information.

Are authorizations necessary for care obtained in another state? Except for emergency services, out-of-state providers must obtain prior authorization before providing MHCP covered services.

- Providers must be an enrolled Minnesota Health Care Program provider and follows program guidelines;

- Services are medically necessary;

The services meet one of the following criteria:

- Services are provided in response to an emergency while the recipient is out of state; or
- The services are not available in Minnesota or its local trade area, and the attending physician has determined medical necessity and obtained prior authorization from CDMI. The county is responsible for travel expenses associated with obtaining the out-of-state services or
- Services are required because recipient's health would be endangered if required to return to MN for treatment.

How will I know if the service/item has been authorized? DHS notifies the provider and the recipient, in writing, of action taken on the request. Providers may need to send more information to determine medical necessity.

What if the authorization is delayed? If the authorization request is delayed beyond 6 weeks, the family should contact the provider to make sure the authorization request was submitted.

- The provider can contact the **Provider Call Center 651-431-2700 (DHS)** to check the status.
- Recipients/families can call the **MN Health Care Programs Help Desk 651-431-2670 or 1-800-657-3739** to check on the status.

What if the request is denied? If MHCP or CDMI deny or reduce an authorization, the recipient may appeal the decision and receive a fair hearing before a referee from DHS. To request a fair hearing, the recipient must contact the county agency or the Appeals Unit at DHS. Providers do not have the right to appeal a denied authorization request under the MHCP fair hearing process. An authorization frequently is denied because the provider made an error or omission when submitting the request. Providers may submit additional documentation and ask CDMI for a reconsideration of a decision. See **Appeals section of this manual** for more information.

What if no authorization was requested & the person received the service, equipment or supplies? If the provider did not request authorization, the family is not responsible for paying the bill.

What if I have private insurance and MA? The individual's private insurance must be billed first. The provider would then bill MA and include the Explanation of Benefits (EOB) from the insurance company.

HOME CARE SERVICES, Including PERSONAL CARE ASSISTANCE (PCA) SERVICES

NOTE: The information in this Maze handout is only intended to be a summary of information related to Home Care Services through Minnesota Health Care Programs—Fee for Service Medical Assistance (MA). For the most current, detailed and specific information about policies, procedures, forms & publications go to the DHS website www.dhs.state.mn.us . Select Publications, then Manuals & scroll down to the following manuals: **Disability Services Program Manual (DSPM) & Minnesota Health Care Programs (MHCP) Provider Manual. Information specifically on personal care assistance (PCA) services is available at: www.dhs.state.mn.us/pca .**

What is home care?

Home care offers a range of medical care & support services provided in a person's home & community. Services range from simple assistance in activities of daily living to a level of care similar to cares provided in a hospital.

NOTE: If you are enrolled in a private health plan, you will need to contact your health plan's Customer Service for specific information on how to get home care services through your private health plan. The phone number for the health plan's Customer Service is on your membership card.

Who is eligible for home care services through Minnesota Health Care Programs (MHCP)?

To be eligible for home care services, recipients must be covered for services under one of the following programs:

- Medical Assistance (MA), including TEFRA.
NOTE: There are a variety of types of MA such as Refugee Medical (RM), Non-citizen Medical (NM), Emergency Medical Assistance (EMA) etc.; it is recommended that the individual/family check on the individual's eligibility for home care services for these types of MA. (See paragraphs below for whom to contact for questions "**How do I get information about home care services if I am covered by one of the MHCP's above?**").
- MinnesotaCare for pregnant women, children and adults with and without children [**Exclusion: Personal Care Assistance (PCA) and Private Duty Nursing (PDN) services are NOT COVERED for non-pregnant adults on MinnesotaCare**]; and

How do I get information about specific home care services if I am covered by one of the MHCP's above?

If you are enrolled in a **county based prepaid health plan, PMAP or MinnesotaCare**, you, will need to contact your health plan's Customer Service for specific information on how to get home care services through your health plan. The phone number for Customer Service is on your membership card.

If you are on **Fee for Service Medical Assistance (MA)**, call your local county human services agency. Their number is in the phone book under County Numbers. Other resources for information are the **MN Health Care Programs Member Help Desk 651-431-2670 or 1-800-657-3739** & the **Disability Linkage Line 1-866-333-2466**.

Medical Assistance covers the following home care services:

- Private duty nursing (PDN);
- Skilled nursing visits (SNV), either face to face or with tele-home-care technology;
- Home health aides (HHA);
- Rehabilitation therapies, (occupational (OT), physical (PT), respiratory (RT) & speech-language (ST));
- Equipment & supplies (such as wheelchairs & diabetic supplies);
- Personal care assistance (PCA).

Qualifying home care services must be:

- Provided to an eligible recipient on MA, MinnesotaCare or HCBS;
- Prior authorized per home care service authorization guidelines (see next page);
- Medically necessary and cost effective;
- Ordered by a physician if nursing or home health aide;
- Provided to recipients in their own residence (not a hospital, nursing facility or intermediate care facility);
- Documented in a written care plan; and
- Reviewed by the recipient's physician, when required.

Department of Human Services (DHS) requires authorizations for the following:

- All home health aide services;
- All private duty nursing services;
- Skilled nurse visits for more than 9 visits per recipient, per calendar year;
- All tele-home-care skilled nurse visits;
- More than 2 face-to-face PCA assessment visits by the county PHN, per recipient, per calendar year;
- All PCA services & supervision of PCA services.

What is a skilled nurse visit?

A skilled nurse visit is an intermittent home visit to provide professional nursing tasks based on a patient's assessed need for services to maintain or restore health. These visits can only be provided in the person's home.

A skilled nurse visit can include the following services:

- "Hands on" nursing care that requires substantial and specialized nursing skill,
- Health care teaching and training to the recipient and/or their family,
- Observation and assessment of the recipient's physical and/or mental health status.

Who can provide a skilled nurse visit?

Only a registered nurse (RN) or licensed practical nurse (LPN) licensed in Minnesota & employed by a Medicare-certified home health agency may provide this service.

What is private duty nursing (PDN)?

Private duty nursing services are more extensive than a skilled nurse visit and can include:

- Professional nursing care based on an assessment of the recipient's medical needs;
- Ongoing professional nursing observations, monitoring, intervention and evaluation;
- Private duty nursing services can be provided in the person's home or outside the home when normal life activities take the person outside the home, including school and work.

Who can provide private duty nursing (PDN)?

- A registered nurse (RN) or licensed practical nurse (LPN) employed by either a home health agency or PDN;
- Class A licensed agency that are enrolled with Minnesota Health Care Programs;
- An independent RN who is enrolled with Minnesota Health Care Programs;
- An independent LPN with a Class A license, who is enrolled with Minnesota Health Care Programs.

Can a parent or family foster parent of a minor child, spouse, or unpaid legal guardian provide PDN & be paid by MA?

Yes, they could provide PDN if the person is a nurse and received approval for a PDN Hardship Waiver from DHS.

What is a PDN Hardship Waiver?

APDN Hardship Waiver allows a parent or family foster parent of a minor child, a spouse or an unpaid legal guardian to be paid by MA for providing private duty nursing services to their family member. There are limits to how many hours can be paid through the PDN Hardship Waiver. A person must meet all of these requirements:

- Be a registered nurse (RN) or licensed practical nurse (LPN) currently licensed in MN;
- Be employed by a Medicare-certified home health agency or PDN class A licensed agency;
- Pass a criminal background check;
- Expect to continue non-reimbursed family responsibilities of primary caregiver & emergency backup.

In addition, relatives of the consumer must, also, meet one of the authorization criteria to be eligible for a Hardship Waiver. For more information on the authorization criteria and possible employment, call a private duty nursing agency provider. A **PDN Hardship Waiver Request Form (DHS-4109)** needs to be completed by the private duty nursing agency, signed and submitted to DHS along with the supporting documentation for review and approval. Go to the Minnesota Health Care Program (MHCP) Provider Manual: Home Care Services at www.dhs.state.mn.us for more information and to access the form.

What services can home health aides (HHA) provide?

HHAs provide medically oriented tasks required to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence. HHAs are able to:

- Assist with personal cares such as bathing, dressing, grooming, feeding, toileting, routine catheter and colostomy care, ambulating, transfers or positioning;
- Perform simple dressing changes that do not require the skills of a licensed nurse;
- Assist with medications that are ordinarily self-administered and do not require the skill of a licensed nurse for safe and effective provision;
- Assist with activities that are directly supportive of skilled therapy services but do not require the skill of a therapist to be safely and effectively performed, such as routine maintenance exercises;
- Do routine care of prosthetic and orthotic devices;
- Perform incidental household services necessary to the provision of one of the above health related services;
- Assure recipients get to medical appointments identified in the care plan.

A HHA follows a care plan developed by the registered nurse of the Medicare Certified Class A Licensed Home Health Agency. The home health aide is supervised by the registered nurse or by the appropriate therapist (physical, occupational, speech).

NOTE: HHA visits for the sole purpose of providing household tasks, transportation, companionship or socialization are not covered. Services must be ordered by the primary medical provider and be medically necessary.

What are home care therapies?

Home care therapies are therapies provided in the home to improve/maintain a person's functioning. Home care therapies include physical, occupational, speech-language pathology and respiratory therapies. If a person is able to obtain the needed therapy services at a rehabilitation center or outpatient clinic, they are not eligible for payment through home care services.

PERSONAL CARE ASSISTANCE SERVICES

The Department of Human Services (DHS) has a new home page location for personal care assistance information in greater detail (sometimes referred to as the PCA Portal) www.dhs.state.mn.us/pca . DHS updates this site regularly with new information, policy and procedures and resource documents. You can, also, sign up to be notified by email of PCA changes and updates.

What are personal care assistance (PCA) services?

Personal care assistance services provide assistance and support to persons with disabilities living independently in the community including the elderly and others with special health care needs. A PCA may be able to help you if you have a physical, emotional or mental disability, a chronic illness or an injury.

There are four different categories of services a PCA can provide:

1. Assistance with doing **Activities of Daily Living (ADL)**. These are things a person does every day such as dressing, grooming, bathing, eating, positioning, transferring, toileting and mobility;
2. If the person's PCA assessment determines a need for assistance with ADLs, the person may also use some of their time allotted for PCA services, to address assistance with **Instrumental Activities of Daily Living (IADL)**. IADL assistance includes meal planning and preparation, assisting with paying bills, shopping for food, clothing, and other items, homemaking tasks, communication by telephone or other means, getting around and participating in community activities including to medical appointments;

(NOTE: IADL's are NOT covered for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services, for the sole benefit of the child, and the need is listed in the service plan by the assessor.)

3. Assistance in **Health Related procedures and tasks**, are services that can be delegated or assigned by a licensed health care professional such as a nurse or a physician. Health-Related **procedures and tasks** must be provided under the direction of a registered nurse, who is the Qualified Professional (QP). (Read on for more information on QPs later in this document.) Examples of Health Related **procedures and tasks** are range of motion exercises and passive exercise to maintain a recipient's strength and muscle functioning; interventions for seizure disorders, including monitoring and observation, assistance with self-administered medication such as: reminders to take medication, bringing medication to the recipient, assistance with opening medication under the direction of the recipient or responsible party, and respiratory assistance such as tracheotomy NON-sterile surface suctioning.
4. **Observation and Redirection for Behaviors.** For Level I Behaviors, this includes observation and redirection of behaviors that cause or could cause harm.

What is Level 1 Behavior?

Level I behavior means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

The PCA Care Plan found in the home must describe what the PCA will need to do to observe, monitor and redirect Level I Behaviors. Specific training for the individual PCA needs to occur based on the specific behaviors exhibited by the recipient. PCA staff are NOT trained or paid to do mental health or behavioral therapy.

Where can PCA services be provided?

PCA services may be provided in the person's own home, or workplace, or in the community in places a person may go in a typical day. Places where the services are to be provided must be included on the PCA Care Plan. A PCA may accompany the person in a common carrier or special transportation. The PCA agency's policy will determine whether a PCA may transport the person.

Who is eligible for the personal care assistance (PCA) services through MHCP Home Care?

To be eligible for PCA services, all of the following criteria must be met:

- The person is covered by Medical Assistance (MA), including TEFRA, MinnesotaCare (only pregnant women & children);
NOTE: There are a variety of types of MA such as Refugee Medical (RM), Non-citizen Medical (NM), Emergency Medical Assistance (EMA) etc.; it is recommended that the individual/family check on the individual's eligibility for PCA services with these types of MA. (See 1st page of this handout, "**How do I get information about home care services if I am covered by one of the MN Health Care Programs' above?" for who to call about PCA services.**)
- The person must have a **stable** medical condition but needs PCA services to live in the community;
- The person lives in their own home or foster care home licensed for 4 or less clients;
- The person is able to make decisions about their care or has a Responsible Party who can make decisions on the person's behalf;
- The PCA services are determined **medically necessary** through the assessment process due to the recipient's illness, injury, physical or mental condition (see next page for more information about assessment for PCA);
- There is a service plan developed at the time of the assessment stating specific PCA needs. A care plan based on the service plan must identify how services will be delivered and supervised by the Qualified Professional (QP);
- The PCA services are prior authorized and approved by DHS with a service agreement in place.

What is a responsible party?

A responsible party is required for a recipient not capable of directing his/her own care or who is under eighteen years of age, whether or not he/she is capable of directing his/her own care. The responsible party is an individual who is over 18 and capable of providing the supportive care necessary to assist the recipient to live in the community.

The responsible party must:

- Attend all PCA assessments and make choices for the person regarding the PCA Program (e.g.; type of PCA provider, hiring and scheduling of the PCA);
- Be accessible to the person and the PCA when services are provided as documented in the PCA care plan and the Responsible Party Agreement;

- Develop the care plan with the qualified professional;
- Monitor the PCA services weekly to ensure the care plan is followed and the care outcomes are met;
- Sign required forms, including the PCAs' time card,
- Determine if the person's health & safety are assured with current PCA services,
- Report suspected abuse/neglect of the person to the local county human service agency,
- Enter into a written agreement with the provider as an assurance of meeting the roles and responsibilities of the responsible party.

All recipients must now have a Qualified Professional (QP) supervise PCA staff and services. A QP means a registered nurse, a mental health professional, a licensed social worker or a qualified developmental disabilities specialist, as defined by Minnesota Law. The QP must work for the PCA provider agency and complete the required DHS provider training. (Read more information about the QP under "What does the Qualified Professional (QP) do?" later in this document.)

How can a person find out if they are eligible for personal care assistance services?

A person on a Minnesota Health Care Program, where PCA services are a covered benefit, is entitled to an assessment to determine if they are eligible for PCA services.

What is an assessment for PCA services?

An assessment is a review & evaluation to determine the person's medical need for personal care assistance services. Persons requesting services must first have a face to face assessment to determine the need before PCA services can begin.

How can a person get an assessment?

Ask for an assessment by calling:

- Your county public health nursing agency and ask for a PCA assessment; or
- Your Health Plan if you are on PMAP, MinnesotaCare or a County Based Prepaid Health Plan;
- A home health agency (HHA) or personal care provider organization (PCPO) and ask about PCA services. They will help you to contact the appropriate person for an assessment.

You/your responsible party will be contacted to schedule an appointment for the assessment in your home.

A new assessment and authorization process for PCA services began, January 1, 2010 as noted below:

- There are new forms called the **Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244, 5-2010)** and the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-2010)**.
- The assessor will be learning about a person's needs for assistance by evaluating Activities of Daily Living (ADLs), some types of Complex Health-Related Needs, and behavior issues.
- The assessor **will not** be asking for the amount of time it takes for tasks and activities.

NOTE: Access to the PCA Program is only if a person has been assessed as having a dependency in one or more ADLs and/or meets the definition of having a Level I Behavior.

NOTE: A person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed, for cuing and constant supervision to complete the task; or hands-on assistance to complete the task.

For children under 18, the assessment identifies the needs of the child with a disability that are over and above what a parent would typically provide for a child the same age **but without a disability**. PCA services are not intended to replace the parent's role and responsibility to meet the basic care, nurturing and supervision needs of minor children. A PCA is not to be performing IADLS that are the responsibility of the parent.

NOTE: After July 1, 2011, the eligibility criteria will be changed to require a dependency in at least 2 Activities of Daily Living (ADLs). Level 1 behaviors will NO LONGER qualify a person for PCA services.

Options in the PCA Program Selected at Time of Assessment

1. Traditional PCA Provider Option or PCA Choice Option & selection of the agency to provide the service.

Traditional PCA Provider Option: Under this option, there are two types of service providers: A Personal Care Provider Organization or a Home Health Agency. The PCA Provider provides traditional PCA service delivery and is responsible for hiring, training, and firing of the PCA staff. They assign a Qualified Professional, if the recipient or responsible party selected this. The Traditional PCA Provider, also, bills the state for PCA services, and schedules and pays the PCAs and Qualified Professional.

PCA Choice Option: This option is consumer directed and allows the recipient or his responsible party more choice, flexibility, control & responsibility to provide for the recipient's own service needs. They are responsible for the hiring, training and firing of their PCA staff rather than the PCA agency. Once the person or responsible party has chosen the PCAs, these persons must then be employed by the PCA Choice agency. The PCA Choice agency role is mostly for managing financial matters & it is the fiscal intermediary. The PCA Choice agency provides the qualified professional supervision.

DHS may deny, revoke or suspend the authorization to use PCA Choice Option if the PHN or qualified professional determines that this option jeopardizes the recipient's health & safety, and/or the recipient/responsible party, PCA Choice provider or qualified professional fails to comply with the written agreements and plan of care, and/or there is abusive or fraudulent billing of PCA services. DHS would then require the recipient to receive PCA home care services through a Personal Care Provider Organization (PCPO) or home care agency with less control & flexibility. A recipient/responsible party may appeal the actions. Providers of PCA services may not appeal revoked/denied option.

2. Shared Care Option allows 2-3 recipients to choose to share services in the same setting, at the same time from the same PCA. There must be a back-up plan for times that services cannot be shared as planned. Participation in Shared Care Option does not reduce or increase the total number of service units authorized for each person.

- The PCA must provide shared care services according to each consumer's plan of care & individual needs.
- The PHN/county case manager determines if shared care is appropriate and safe for the recipient and how many service units can be shared.

Pooling PCA Hours, (pooling the sum total of service units among recipients in the same setting) is not a service delivery option for Minnesota Health Care Programs and should not be confused with Shared Care Option.

Flexible Use of Units

All PCA services hours/units are authorized in two 6 month date spans. No more than 75% of the total authorization may be allowed in any six month date span. Unused PCA hours/units do **NOT** transfer from one 6 month span to another 6 month span.

DHS cannot authorize additional hours/units if a recipient has exhausted their hours/units before the end of the authorized date spans.

If the county denies or DHS revokes or denies flexible use, the recipient may be restricted to a more measured use of PCA services. A recipient/responsible party may appeal the action.

What happens after the PHN has completed the Personal Care Assistance Assessment and Service Plan?

The PHN must communicate the results of the assessment to the child's/youth's primary medical provider using the **Communication to Physician of Personal Care Assistance Services Form (DHS-4690)**. This is for information only and does not require any action by the primary medical provider.

What if the assessor determines the person is not eligible for PCA services?

Assessors must recommend referrals in writing to other payers, programs or services that may meet the person's assessed needs more appropriately than PCA services, such as a home health aide or county mental health services. The person must follow up to see if he/she is eligible for the programs and services recommended. The person is also given agencies to contact if they need help with the referrals such as the Disability Linkage Line 1-(866)-333-2466.

Reassessments

The assessment needs to be done at least annually to evaluate the person's needs for PCA. The annual assessment may be a service update. This assessment is done by telephone & only when there has not been a significant change in the recipient's condition **and** there is not a need for a change in the authorized amount of PCA services. A service update can be used for two consecutive years, and then must be followed by a face to face assessment. A face to face assessment must be done annually if the person is using the PCA Choice Option.

The PCA provider is responsible for sending a written request for a reassessment to the person's county public health nurse or case manager. The request must be sent out at least 60 days before the end of the current service agreement with DHS. The annual assessment/service update must be completed before the agreement expires.

Who can be a person's PCA?

- There are specific criteria for becoming a PCA such as:
- At least 18 years old (under certain circumstances, a person 16-17 years may be able to be a PCA);
- Must pass a criminal background check;
- Must enroll with Minnesota Health Care Programs as an individual PCA and be given an identification number;
- Must successfully complete the standardized DHS online PCA training before completing enrollment. This training will be available in other languages as well as with accommodations for persons with disabilities;
- Able to provide covered PCA services according to the recipients care plan, respond appropriately to the recipient's needs, and report changes in recipient's condition;
- Be able to communicate with the recipient; and
- Must not work more than 275 hours per month as a PCA.

NOTE

- **Parents of adult recipients, adult children or siblings of a recipient and legal guardians (if they are not being paid for the guardian services), may provide PCA services to a family member if they meet the above criteria to work as a PCA.**
- **Spouses, parents and stepparents of minor children (under 18), paid legal guardians, family foster care providers (with rare exceptions) and/or the responsible party cannot serve as the PCA and get paid by Minnesota Health Care Programs.**

What does the Qualified Professional (QP) do?

The QP (a registered nurse, a mental health professional, a licensed social worker or a qualified developmental disabilities specialist, as defined by Minnesota Law) must work for the PCA provider agency and complete the required DHS provider training.

The QP is responsible for training, supervision, and evaluation of the PCA staff and evaluation of the effectiveness of the PCA services. Some examples are:

- Develops, reviews and revises the PCA care plan that corresponds with the county PHN assessment, service plan & update;
- Orients the PCA to the cares/needs of the recipient;
- Trains and retrains the PCA to provide hands on assistance with special **health-related functions**;
- Provides observation, supervision & monitoring of the work-performance of the PCA to provide effective care;
- Evaluates service outcomes with the recipient/responsible party; and
- Communicates as appropriate when the needs of the person change;
- Maintains written documentation of all QP activities including date, time of supervisory visit and amount of time spent during observation of PCA performing direct cares.

When and how does the QP supervise the PCA?

Under traditional PCA service delivery, the qualified professional must orient, train and evaluate regularly scheduled individual PCAs within seven days of working for a recipient and again within the first 14 days. These visits to a recipient's home are not required under the PCA Choice option. Qualified professionals must visit and evaluate all 16 or 17 year old PCAs every 60 days, on an ongoing basis.

Under traditional PCA service delivery, the qualified professional must also conduct in-person visits to evaluate and oversee the delivery of PCA services:

- At least every 90 days thereafter for the first year of the recipient's services; and
- Every 120 days after the first year of a recipient's service; or
- Whenever needed for response to a recipient's request for increased supervision of the PCA staff;
- Every 180 days at the locations of shared service sites.

Under the PCA Choice option, the QP must conduct in-person visits every 180 days.

NOTE: After the first 180 days of the recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless in-person visits are needed according to care plan. Please note that only in-person visits are a covered service and only in-person visits can be reimbursed by DHS.

Who can provide PCA services for Minnesota Health Care Programs?

There are three types of providers for PCA services and they must be enrolled as a Minnesota Health Care Program Provider through the Department of Human Services Provider Enrollment Unit. They are:

- Personal care provider organization (PCPO)—provides the traditional services of recruiting and hiring staff, training and orientation, scheduling, collecting time cards, financial management and termination of staff.
- PCA Choice provider—serves in a fiscal intermediary role with the person and their staff.
- Medicare-certified home health agency (HHA)—private or public organization that provides skilled nurse visits, PCA services, home health aide visits, therapies and medical supplies. They are required to meet all federal and state conditions of participation and sign an agreement with Medicare and Medicaid.

How do I find a PCA provider agency in my area?

Visit www.mnhelp.info or call one of the linkage lines: Disability Linkage Line (866) 333-2466, Senior LinkAge Line (800) 333-2433, or Veterans Linkage Line (888)546-5838 to find PCA provider agencies in your area.

If you are covered by a health plan instead of MA, call the Customer Service number on the back of your health plan card or look up health plan contacts at www.dhs.state.mn.us/main/id_052601.

Can I get PCA Services when I am living in another state?

- Persons who temporarily live outside of Minnesota may use PCA services if they meet all of the following:
- Maintain enrollment in Minnesota MA and meet MN residency requirements;
- Temporarily live outside of Minnesota for education, training, employment or vacation;
- Receive an annual face to face assessment in the person's permanent home in MN & authorization by the county;
- Are age 18 or older;
- Direct their own care or live with the responsible party while outside the state;
- Have a written service plan that documents how PCA needs will be met during the time the person lives outside of Minnesota and describes emergency back up plans; and
- The Personal Care Provider Organization or PCA Choice provider in other states must be enrolled as a Minnesota Health Care Programs Provider and follow all MHCP enrollment requirements, including individual PCA identification numbers and background studies as well as providing Qualified Professional supervision and services according to the specific QP requirements in MN.

TEFRA SUMMARY

What is TEFRA? The **Tax Equity and Fiscal Responsibility Act (TEFRA)** of 1982 is a federal law that allows states to make **Medical Assistance (MA)** available to certain children with disabilities without counting their parent's income.

- No additional services other than the MA benefit set are provided under the TEFRA option, but TEFRA can extend MA eligibility for children who are disabled and would not otherwise have a basis of eligibility.
- If a child needs additional services, they can apply for **Home and Community-Based Services “Waivers”** [NOTE: more information on “Waivers” is included later in this DHS topic packet]

Who is eligible? A child must meet **all** of the following:

1. Child is under age 19 years [NOTE: Beginning at age 18, the person usually doesn't need TEFRA, since parent income is no longer counted if the youth is disabled.]
2. Child lives with at least one biological or adoptive parent
3. Child is certified disabled [by the **State Medical Review Team (SMRT)**]
4. Child requires the level of care provided by:
 - A hospital
 - A nursing home, or
 - An **Intermediate Care Facility for persons with Mental Retardation (ICF/MR)** and related conditions

*The cost for home care must not be more than the cost MA would pay for the child's care in an institution.
5. Child's income is under MA limit of 100% of the Federal Poverty Guideline (FPG) for a household size of one. There are no asset limits. Children with incomes over 100% FPG can “spend down” to 75% FPG.

[NOTE: TEFRA is available to noncitizen children as another way to access NMED and EMA services without counting parent's income. For EMA, the child would also need to have a medical emergency.]

How is eligibility determined? The **State Medical Review Team (SMRT)** determines if the child is disabled, and issues a disability certification for 1-4 years, depending on the severity of the child's condition(s). At the end of the certification period, the child must reapply with SMRT. To be certified disabled for TEFRA, the child must meet both **(1) disability** and **(2) level of care criteria**:

1. Disability review:

- Medical, psychological and school records are reviewed to determine if the child's condition(s) meet the disability criteria from the **Social Security Administration (SSA)**. [NOTE: these disability criteria are contained in the “**Tools**” topic packet in this manual under **SSI Medical Evaluation Guidelines-Part B (for children under age 18 yrs.)**]
- SMRT assigns each case to a SMRT Case Manager, who reviews the case and decides if there is enough evidence to make a disability determination. If SMRT needs more evidence, the SMRT Case Manager can assist the client in obtaining the evidence by:
 - Contacting the client directly,
 - Contacting the client's providers and requesting documents.
 - Arranging an appointment for an evaluation, if necessary.

*If the client has no coverage, SMRT can authorize payment for an evaluation, including transportation.

2. Level of Care review:

- SMRT determines the level of care using evidence from medical providers, school-based providers, and others.
- Parents' input is also required and is provided by completing a "Children's Disability Worksheet" (DHS #6126). This worksheet allows parents to express their view of their child's condition(s); their child's ability to perform activities of daily living; and their child's behavior at home, at school, and in the community

Can a family appeal a decision that their child does not meet disability criteria? Yes. A fair hearing request must be made orally or in writing within 30 days by telling their county worker or writing to the State Appeals Office at the DHS.

- If the family appeals a recertification denial **within ten days** of receiving the denial notice or before the termination date, TEFRA will continue while the appeal is heard and decided.
- If the family appeals more than 30 days after receiving SMRT's decision, a hearing will be scheduled to decide if there is good reason for requesting the hearing late.
- If the family loses the appeal, they may be asked to repay to MA the child's service costs that were paid during the appeals process.

Is there any cost to the family? Parents may have to pay a **parental fee** based on family size and income. [NOTE: Information on **Parental Fees** is included later in this DHS topic packet]

- Children with disabilities whose family income is within "regular" MA income standards do not need TEFRA.
- It may be better for some families to not apply for TEFRA if the child would be eligible for "regular" MA with a spend-down as the spend-down may be less than the parental fee.

What happens when the TEFRA enrollee turns age 18? An application should be made for Supplemental Security Income (SSI). The youth's MA is left open (as a disabled child ages 18-21) while the SSI determination is pending.

- If SSI determines that the youth is not disabled and the youth continues to live with the parents, MA eligibility would be determined using the "children under 21" basis and the parent income would be counted.

What if a child with a mental illness or a Severe Emotional Disturbance (SED) is not TEFRA eligible? If the child doesn't meet the TEFRA level of care criteria, the child may still be eligible for certain mental health services from their county human services agency.

- If the child has an SED, the child can receive county case management services and other family community support services under the Children's Mental Health Act. This may include crisis placement, help with independent living and parenting skills, day treatment, respite care, and a number of other services.
- If the child has an emotional disturbance (ED), some services, including crisis assistance, may still be available from their county. [NOTE: See **Mental Health** topic packet for more information.]

How do you apply for TEFRA? Contact your county human services (social services) agency and ask to speak with a Developmental Disability Social Worker about TEFRA.

- Complete the MHCP application to determine if there is eligibility for "regular" MA (because it does not require parents to pay a parental fee).
- Provide all required documentation to the county for a SMRT disability determination (unless your child has already been determined disabled by SSA)



State Medical Review Team

Medical Assistance – TEFRA Option Required Documentation for Physical Disability

The following information is required to complete your client's **physical disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination signed by the physician (**no more than 3 months old**) which includes:
 - Current diagnosis
 - Clinical findings – results of physical or mental status exams
 - Laboratory findings, for example:
 - blood pressure
 - blood test results
 - X-rays
 - Required treatments (include type of treatment, who performs it, and if supervised, credentials of supervisor)
 - Current medications
 - Growth data from the past year (height and weight)
- **Reports from any consulting medical specialists.** The report should be no more than 3 months old and include the primary diagnosis, a detailed summary within the areas of specialty of examination. Also include results of any tests, X-rays, or scans that confirm the diagnosis, and treatment and response.
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.
- If applicable, an **Individual Education Plan** (IEP) or **Individual Family Service Plan** (IFSP) that is current within 1 year, along with the most recent **Team Assessment Summary** (done every three years). For children under school age, submit an **Early Childhood Assessment Summary**.
- If the client receives **ANY** other special services (e.g. speech, physical, or occupational therapy or rehab), please provide updated evaluations and progress notes regarding these activities.
- Discharge summaries from any recent hospitalizations.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.



State Medical Review Team

Medical Assistance – TEFRA Option Required Documentation for Developmental Disability

The following information is required to complete your client's **developmental disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination (**no more than 3 months old**) performed by a medical doctor which includes:
 - Current diagnosis
 - Clinical findings – results of physical exams
 - Laboratory findings, for example:
 - blood pressure
 - blood test results
 - X-rays
 - Current medications
- **Reports from any consulting medical specialists.**
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.
- An **Individual Education Plan** (IEP) or **Individual Family Service Plan** (IFSP) that is current within 1 year, along with the most recent **Team Assessment Summary**. For children under school age, submit an **Early Childhood Assessment Summary**.
- Most recent achievement and IQ scores
- Adaptive behavior rating by both parent and teacher, for example:
 - The Vineland Adaptive Behavior Rating Scale
 - The Battelle Inventory
 - The Childhood Autism Rating ScaleThese documents are most often found in the Team Assessment Summary that comes from the school, but they may also be performed by psychologists or developmental clinics.
- If the client receives **ANY** other special services (e.g. speech, physical, occupational therapy, rehab), please provide updated evaluations/progress notes regarding activities.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.



State Medical Review Team

Medical Assistance – TEFRA Option Required Documentation for Mental Health Disability

The following information is required to complete your client's **mental health disability** determination. Please **do not** submit the case unless all of these items are included.

- Results of a routine physical examination (**no more than 3 months old**) performed by a medical doctor which includes:
 - Current diagnosis
 - Clinical findings – results of physical or mental status exams
 - Laboratory findings, for example:
 - blood pressure
 - blood test results
 - X-rays
 - Current medications
- **Complete psychiatric/psychological evaluation** (no more than 1 year old) performed by a licensed psychologist or psychiatrist. The evaluation must contain **ALL** of the following:
 - Current life situation and sources of stress, including reasons for referral
 - History of client's current mental health problem, including important developmental incidents, strengths, vulnerabilities (include psychiatric and social history)
 - Current functioning and symptoms related to all diagnoses
 - Indicate if the client has a serious and persistent mental illness
 - Diagnosis on **ALL** 5 axes with GAF scores (no provisional diagnoses)
- **If the evaluation is more than 3 months old or the client's condition has changed, an updated progress report is required, in addition to the complete psychiatric/psychological evaluation. The progress report should include ANY changes in the client's condition (behavior, medication management, change of medication, and/or potential for hospitalization).**
- The most current treatment plan signed by a professional which includes:
 - All medical services being performed (including non-mental health), duration, frequency, and level of professional performing the service
 - Supervision/monitoring – who performs, what times of the day (psychiatric disability requires 24-hour supervision or monitoring)
 - Therapy goals, client progress
- Discharge summaries from any hospitalizations, or day treatment reports
- An **Individual Education Plan (IEP)** that is current within 1 year, along with the most recent **Team Assessment Summary** (performed every 3 years).
- A report from the client's school that that outlines:
 - Grades
 - Behavior in school
 - Most recent achievement scores and intelligence (IQ) test scores
- A **Children's Disability Worksheet** (DHS-6126) to be completed by the parent/guardian.

If you have any questions concerning this information, please call SMRT at (651) 431-2493 or (800) 235-7396.

Home and Community-Based Services (HCBS) [also called “Waivers”] and Consumer Directed Community Support (CDCS)

Purpose Of The HCBS (“Waivers”) HCBS help people meet health needs, get support to stay at home and stay out of medical facilities. Under HCBS, an added list of cost-effective services are covered to help the person live in the community as fully, productively and independently as possible. Persons must have an assessed need for supports and services over and above those available through the regular MA State plan. There are **4 types of HCBS “Waivers”**, based on the level of care needed: **CAC** (Community Alternative Care); **CADI** (Community Alternatives for Disabled Individuals); **DD** (Developmental Disabilities); and **TBI** (Traumatic Brain Injury). **NOTE:** HCBS are NOT an entitlement. That means a person could qualify but the HCBS may not be available in the county due to a waiting list. Persons eligible for HCBS are encouraged to get on the waiting list in their county.

Eligibility For HCBS: Must meet **ALL** 6 criteria:

- 1. Be on MA or eligible for MA.** Only the individual’s income and assets are counted (not the parents or spouses, even if the person lives with their parents or spouse); AND
- 2. Be Certified disabled** by either the federal Social Security Administration (SSA) or by the State Medical Review Team (SMRT); AND
- 3. Under age 65** (at application time) for CAC, CADI, TBI. (Can be **any age** for the DD Waiver). AND
- 4. Have a written support plan assuring health and safety, and outlining services needs.** The county must assure that the health and safety needs of the person will be able to be met by providing the necessary waiver services and supports. AND
- 5. Be provided informed choice** – the individual, after becoming familiar with the alternatives, chooses to live in the community rather than the nursing facility; AND
- 6. Need a specific level of care, depending on the type of Waiver** (CAC, or CADI, or DD, or TBI):
 - **CAC** - for persons chronically ill or medically fragile, requiring a hospital level of care (hospital level of care certified by a primary care physician). A person must meet **all four** of the following:
 - a.** Need skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration; AND
 - b.** Due to their health condition, has both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes; AND
 - c.** Require a 24-hour plan of care that includes back-up plan that reasonably assures health and safety in the community; AND
 - d.** Without the CAC Waiver services, would require frequent or continuous care in a hospital.
 - **CADI** - for persons needing the level of care provided in a nursing facility (NF). CADI serves mainly people with physical disabilities or serious mental health needs. A NF level of care requires the person must demonstrate the need for assistance due to **one or more** of the following:

<ol style="list-style-type: none">a. Restorative and rehabilitative or other special treatment; ORb. Unstable health; ORc. Complex care management; OR	<ol style="list-style-type: none">d. Functional limitation; ORe. Existence of complicating conditions; ORf. Cognitive or behavioral condition; ORg. Frailty or vulnerability
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- **DD** – for persons having a condition meeting the definition of developmental disability or a related condition, who need the level of care provided in an intermediate care facility for persons with developmental disability or related conditions (ICF/DD). This requires meeting **all four** criteria:
 - a. Diagnosis of developmental disability or a related condition; AND
 - b. County screening team determines the person would be placed in an ICF/DD if home and community based services were not provided; or the person lives in an ICF/DD and continues to require an ICF/DD level of care; AND
 - c. Requires daily interventions and service needs specified in a 24-hour plan of care. Persons must need “active treatment” (ex: daily intervention, assistance, supervision and on-going habilitation to learn necessary skills and assure health and well-being); AND
 - d. Has made an informed choice of waiver services instead of ICF/DD services.

- **TBI** – for persons with a primary or secondary diagnosis of traumatic or acquired brain injury or related neurological conditions (e.g. traumatic brain injury, infections, anoxia, tumors, toxic chemical reactions, stroke, aneurysm), that resulted in significant cognitive and significant behavioral impairment. The brain impairment cannot be congenital. The person must be able to function at a level that allows participation in rehabilitation. The person must need a Nursing Facility level of care or neurobehavioral hospital level of care (meet the criteria in **either a or b**):
 - a. Nursing Facility Level of Care (TBI-NF) – see above under CADI Nursing Facility; OR
 - b. Neurobehavioral Hospital Level of Care (TBI-NB) – meet the requirements for the nursing facility level of care, plus meet **all of the following** criteria:
 - Requires specialized brain injury services and/or supports that exceed services available under TBI-NF; and
 - Requires a level of care and behavioral support provided in a neurobehavioral hospital to support persons with significant cognitive and severe behavioral needs (a person does not have to be a resident of a neurobehavioral hospital to require this level of care); and
 - Requires a 24-hour plan of care that includes a formal behavioral support plan and emergency back-up plan to reasonably assure health and safety in the community; and
 - Requires availability of intensive behavioral intervention.

Costs For The Family: Families of children under the age of 18 years are required to pay a “parental fee”, if their family income is above a certain amount. [See separate Parental Fee information]

Extra Services Provided under HCBS depend on which waiver the person is on, and the availability of the services. [NOTE: More information on each of the following services can be found on the DHS Website: www.dhs.state.mn.us; click on “publications” across the top; click on “manuals” on the left navigation menu; scroll down to the “Disability Services Program Manual”; Click on “waivers” on the left navigation menu]. **Depending of the type of waiver, the following may be covered:**

- | | |
|---|--|
| <ul style="list-style-type: none"> ▪ Adult day care ▪ Adult day care bath ▪ Assisted living, or Assistive living plus ▪ Assistive technology ▪ Behavioral programming ▪ Caregiver living expenses ▪ Caregiver training and education ▪ Case management and Case management aide (paraprofessional) ▪ Chore services ▪ Cognitive therapy ▪ Companion services | <ul style="list-style-type: none"> ▪ Crisis respite ▪ Consumer-Directed Community Supports ▪ Consumer training and education ▪ Corporate foster care (monthly) ▪ Day Training and Habilitation ▪ Environmental Accessibility Modifications ▪ Family counseling and training ▪ Family foster care (daily or monthly) ▪ Help in learning daily living skills ▪ Home delivered meals ▪ Homemaker/chore services ▪ Housing access coordination |
|---|--|

- Independent living skills or Independent Living skills therapies
- In-home family support
- Personal support
- Respite care
- Specialist service
- Additional supplies and equipment
- Supported employment
- Supported living
- Non-medical transportation
- Prevocational services (to prepare persons for paid or unpaid employment)
- 24-Hour emergency assistance
- Extended services in amounts that may exceed normal MA limits for: home health nursing; home health aide; personal care attendant; nutritional therapy; occupational, physical, speech and respiratory therapies; supplies and equipment; and transportation

DD – “Related Conditions” Guideline

“**Related Conditions**” are those found to be closely related to developmental disability. They include, but are not limited to: Fetal Alcohol Spectrum Disorder; cerebral palsy; epilepsy; autism; and Prader-Willi syndrome. The condition **must meet ALL of the following criteria (A thru G)**:

- A. Is severe and chronic [“*Severe*” means a serious or grave condition, giving cause for concern and having a significant affect on most, if not all of the person’s life. “*Chronic*” means long drawn out, applied to a disease or condition that is not acute.]; AND
- B. Results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities [Considers intelligence test results and adaptive behavior test results]; AND
- C. Requires treatment or services similar to those required for persons with developmental disability. [A combination and/or sequence of special services, interdisciplinary supports and services of varying intensity are needed. The services are needed over a sustained period to provide training and habilitation across environments. There are deficits in cognitive and adaptive skill development in areas such as self-care, understanding and use of language, community living skills, leisure, recreation skills, behavior management, socialization, community orientation, emotional development, cognitive development, motor development, or work.]; AND
- D. Is manifested before the person reaches 22 years of age; AND
- E. Is likely to continue indefinitely [“*Indefinitely*” means lacking precise time limits, yet expected to go on for an extended period of time.]; AND
- F. Is NOT attributable to mental illness (MI) in adults, or an emotional disturbance (ED) in children. [NOTE: “Mental illness” does NOT include autism or other pervasive developmental disorders.]
- G. Results in substantial functional limitations [“*Substantial functional limitation*” is characterized by considerable difficulty in carrying out essential major activities of daily living which is not an age appropriate skill.] **in 3 or more of the following areas of major life activity**:
 - **Self-care** = needing physical, gestural, or verbal assistance to meet most or all personal care particularly in eating, grooming, caring for personal hygiene and toileting; or
 - **Understanding and use of language** = effectively communicating either expressively or receptively without great difficulty]; or
 - **Learning** = cognition, retention and reasoning so the person is unable, or is extremely limited in ability, even with specialized intervention, to acquire knowledge or transfer knowledge and skills to new situations]; or

- **Mobility** = ability to move from one place to another or such difficulty that an unusual and protracted amount of time is required in a barrier free environment]; or
- **Self-direction** = inability to exercise judgments basic to the protection of the person’s own self interest or rights, without supervision on a regular and continuing basis]; or
- **Capacity for independent living** = performing at age appropriate levels in at least 3 areas of independent living including using a telephone, shopping for food, abilities in social skills, communication, work , leisure, home living, and use of the community.

CONSUMER DIRECTED COMMUNITY SUPPORTS (CDCS)

CDCS gives persons more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. [NOTE: A CDCS Brochure and a CDCS Consumer Handbook (DHS-3417) are available on the DHS Website: www.dhs.state.mn.us [click the “Publication” tab at the top of the page; click “E-docs” on the left navigation menu; enter the Handbook DHS number].

CDCS Budget: CDCS annual budget is based on a state-set budget and information from the person’s most current screening. Once the annual budget is set, the services and supports needed are described in the Community Support Plan (CSP), approved by the county. The individual budget must include the costs of all waiver services and MA state plan home care services. [Ex: If persons receive PCA through regular MA State plan home care services, then go onto a DD waiver, the PCA funding now comes out of their total waiver funding.]

CDCS Allowable Expenditures must fit into **one of 4 service categories:**

1. **Personal assistance** – Support or assistance provided by someone hired to help with ADLs (activities of daily living) and IADLs (independent activities of daily living) through hands on assistance, cuing, prompting and instruction in tasks. Under CDCS, persons hired can include friends, family members, neighbors and others, including traditional professional staff. Spouses or parents of minors can be paid up to 40 hours/week to perform support tasks they wouldn’t perform under other circumstances. [40 hour limit is for both parents combined.] Examples: help during transportation, help with activities of daily living, behavioral aides, companion services, and respite care. [NOTE: Within CDCS, parents of minors can ONLY be paid to provide services under this Personal Assistance service category.]
2. **Environmental modifications and provisions** – Ex: adaptive clothing; assistive technology; home and vehicle modifications; home-delivered meals; special diets; supplies/equipment; transportation; environmental supports (snow removal, lawn care, heavy cleaning, etc); costs associated with an adult fitness/exercise program (when is appropriate to treat, improve, or maintain a physical condition).
3. **Self direction support activities** – Ex: help in finding and maintaining workers; costs for managing the person’s budget; development and implementation of the community support plan; fiscal support entity (FSE) administrative fee(s); flexible case management charges; liability insurance and workers compensation; monitoring the provision of services beyond the required monitoring by the county.
4. **Treatment and Training** – Ex: day services/programs; extended therapy treatment; family counseling; habilitative services; independent living services; supported employment; training and education to paid or unpaid caregivers; training and education to persons to increase their ability to manage CDCS.

[SOURCE: DHS Disability Services Manual (HCBS information downloaded 6-21-10)]

PARENTAL FEES

For children approved for Medical Assistance (MA) under TEFRA, CAC, CADI, TBI, a DD Waiver or an out-of-home placement, Minnesota law says that parents may have to pay a parental fee to reimburse the state for part of their child's MA (Medical Assistance) costs.

Who has to pay a parental fee?

- All parents with an **Adjusted Gross Income (AGI)** over 100% of **Federal Poverty Guidelines (FPG)** will have a fee.
- Parents not living with each other may each have to pay a fee.
- Families with more than one child certified disabled have only one parental fee.

[**NOTE:** The following parents do **not** have a parental fee: (1) Parent Adjusted Gross Income is less than 100% FPG; or (2) Parental rights have been terminated; or (3) Child on MA is emancipated; or (4) Child receives state or Title IV-E adoption assistance.]

What information is used to determine parental fees? Parental fees are set by the State Legislature (Minn. Statute 252.27). Parental fees begin the first month in which MA-TEFRA is effective or HCBS program services are received. Fees are billed through the month the child turns age 18 yrs. Parental fees can change each fiscal year due to annual changes in the FPG or changes in family AGI or family size.

Information used to calculate a parental fee includes:

- AGI (before taxes) from last year's federal tax return. Do not include stepparent income.
- The amount of **MONTHLY** court-ordered support paid for the child receiving services.
- Household size. Household size includes the natural and adoptive parents and their dependents who live in their home. The child receiving MA services is included in the household size. Stepparents and stepchildren are not counted.
- Whether the child receiving MA lives in the parent's home.
- Whether the child receiving MA has private health insurance. (Fees will increase if parents can obtain health insurance for their child through an employer at a cost of less than 5 percent of their AGI and they choose not to obtain it.)

What happens if parents fail to send DHS the information needed to determine a parental fee or if they do not pay the parental fee? The child does not lose MA and will not be refused MA services.

- If the parent doesn't send DHS the information to determine the parental fee, they will be charged for the full cost of services provided to the child.
- Legal action may be taken against the parent for not paying parental fees, including, but not limited to, turning the account over for collections, taking parent's state tax refund, and garnishing wages.

What if parents pay more in parental fees than MA pays for cost of the child's care?

- Total amount the parent owes for a fiscal year (July through June) will never be higher than the cost of the services paid by MA and the county for that same year
- Shortly after the fiscal year ends, parents receive a statement comparing the cost of the services MA paid on behalf of their child against the fees they were charged for that year
- If the family paid more in parental fees, overpayment is credited to the next year's parental fees. If the child has turned age 18yr. or is no longer of an MA eligibility type that requires a parental fee, overpayment is refunded to the parents

Can the parental fee be changed? Yes. Parents who have questions about or want to ask for a change in their parental fee should call the Parental Fee Unit at (651) 431-3806, or (800) 657-3751 or (800) 366-2919. The Parental Fee Unit should be notified (preferably in writing) as soon as possible of any of the following changes that occur:

These changes **must** be reported within 30 days:

- Your family size changes (increase or decrease of household members).
- Parents separate and no longer live in the same household. Separate accounts will be set up for each parent and each parent will be responsible for their own fee calculation based on their individual income.
- The child on MA has a change in living arrangement (a child living at home goes into out-of-home placement, or a child in out-of-home placement returns home).
- Family income changes by more than 10% from one month to another.

Other circumstances that **may** change the parental fee:

- Parent obtains or cancels insurance coverage for the child receiving MA.
- Family's past medical expenses paid for the child (not covered by other health insurance or MA) is at least 60% less than the family parental fee.
- The AGI reported on the federal tax form includes capital gains used to purchase a home.
- The AGI reported on the federal tax form is different than the amount of income actually distributed to you, creating a unique financial situation. (Withdrawal of IRA and/or pension fund is not a unique financial situation)
- Family qualifies for a change under a "Variance for Undue Hardship". This can be granted for certain out-of-pocket expenses which are allowable as federal income tax deductions. These expenses include: (1) medical expenses not paid by MA, insurance, or a pre-tax medical account for any member of the household (2) expenditures for adaptations to the home or parent's vehicle necessary to accommodate the disabled child; or (3) casualty losses [NOTE: College education expenses, most new home purchases and clothing/personal expenses are not allowable as hardship deductions]

Can parents appeal the parental fee? Parents have the right to ask for a review or an appeal of their fee. The request must be made in writing within 30 calendar days of the date of the parental fee Determination Order, or within 90 calendar days if parents have good cause for failing to request a hearing within 30 calendar days. Parental fees can't be changed simply because the parent feels they cannot pay it. Minnesota Law does not give authority to either the Financial Operations Division or the Appeals referee to waive the parental fee.

Can parental fees be counted as a deductible medical expense on IRS taxes? Internal Revenue Service (IRS) Code section 213(a) allows itemized deductions for expenses paid for the medical care of the taxpayer, the taxpayer's spouse, or a dependent (if such expenses exceed 7.5% of adjusted gross income). It doesn't matter that the payments (parental fees) are paid to the state versus directly for the medical services. The expenses paid through TEFRA parental fees are clearly medical expenses considered deductible under IRC 213. Parents should contact their tax preparer for specific questions.

Can parental fees be reimbursed through an employer’s flex spending account? Possibly. However, the employer’s flex spending account plan manager determines what expenses can be reimbursed and some do not allow parental fees to be included. The Department of Human Services has NO control over the employer’s flex spending account rules. The 2009 Minnesota Legislature included a change regarding parental fee refunds. If parents pay their parental fee using their employer medical flex spending account, parents may be responsible for paying taxes on the refunded amount (or the amount credited toward next year’s parental fee), since it may be considered taxable income. Parents should contact their tax preparer for specific questions.

ESTIMATING PARENTAL FEES:

A Parental Fees Estimator that will assist in estimating the monthly parental fee while a child is receiving MA TEFRA or Waivered Services is located at the following website: <http://pfestimator.dhs.mn.gov/> The calculated monthly fee is only an estimate and not a legally binding amount. The actual fee will be determined by DHS after receiving a completed questionnaire (DHS-2981) and a copy of applicable federal income tax return. The monthly fee will be recalculated each year to account for changes in the family’s financial situation. Bills can be paid online after being notified of the actual fee. For questions, or help in estimating fees, please contact the parental fee unit at (651)431-3806 or (800) 657-3751.

Parents will need to enter the following information into the estimator to calculate a fee:

- AGI from the previous years federal tax return
- Number of dependents
- Whether the child on MA lives in the home
- Amount, if any, of child support paid that same year for the child receiving MA.
- Whether the child on MA has other private health insurance
- Number of parents living at child’s home

EXAMPLES OF ESTIMATED FEES:

- | | |
|--|---|
| <ul style="list-style-type: none"> • AIG of \$50,000 • 2 dependents • Child on MA lives in home • No child support paid • No private insurance • 2 parents living in home • Estimated Monthly Fee \$75.63 | <ul style="list-style-type: none"> • AIG of \$80,000 • 3 dependents • Child on MA lives in home • No child support paid • Yes to other private insurance • 2 parents living in home • Estimated Monthly Fee \$227.50 |
| <ul style="list-style-type: none"> • AIG of \$50,000 • 2 dependents • Child on MA lives in home • No child support paid • No private insurance • 1 parents living in home • Estimated Monthly Fee \$112.37 | <ul style="list-style-type: none"> • AIG of \$100,000 • 2 dependents • Child on MA lives in home • No child support paid • Yes to other private insurance • 2 parents living in home • Estimated Monthly Fee \$516.39 |

[SOURCES: [1]DHS-2977 (4-10); [2] DHS MHCP manual, Section 16.20 (downloaded 8/3/10); [3]Position Statement on Parental Fees (Oct 2008). Arc Minnesota (downloaded 8-3-10)

FAMILY SUPPORT GRANT (FSG)

What is the Family Support Grant? - It provides cash grants to families of children with certified disabilities to offset the higher than average expenses directly related to a child's disability. The goal is to prevent or delay the out-of-home placement of children and promote family health and social well being, by helping families with access to disability services and supports. Families with more than one child with a certified disability may apply for a grant for each eligible child.

Who is eligible?

- ❑ Persons under the age of 21 years; and
- ❑ Certified disabled: and
- ❑ Lives, or will live with their biological or adoptive family home; and
- ❑ Family annual adjusted gross income of \$91,458 or less, except in cases where extreme hardship is demonstrated. (NOTE: the family annual adjusted gross income limit changes every January.)
[Hardship exceptions, determined by the county, are based on factors such as family size, or presence of disability in other family members, or substantial existing family debt due to the child's disability.]

Persons on the Home & Community Based Services ("Waiver") programs of **CAC, or CADI, or TBI are also eligible** to receive FSG. Persons on the **DD Waiver are not eligible** to receive a FSG at the same time. [Ex: family with a child on the DD Waiver waiting list can apply for and receive services under the FSG. However, if the DD Waiver becomes available they must choose which program they want.]

How do families get the FSG and much can a family receive? The amount is based on individual needs, with a maximum of \$3,060 per year for each eligible child. Grants may be distributed in either a one-time (lump sum) or in on-going (monthly) payments, depending on the child's needs. FSG funds are issued to families as cash, voucher, or direct payment to vendors.

How can the grant be used? The grant must be spent on services and items directly required by the child's Individual Service Plan (ISP) and unavailable through other funding sources (such as private insurance and Medical Assistance). Examples of allowable expense categories include:

- Computers
- Educational services
- Medical services
- Medications
- Respite care
- Specialized clothing or dietary needs
- Specialized equipment (may include home or vehicle modifications)
- Transportation.
- Daycare (disability related help needed in a daycare setting – not generic daycare expenses)

Where do families apply? Families should contact a county Human Services Disabilities Social Worker to ask about the Family Support Grant. There are often waiting lists. Placement on the waiting list is based on the following criteria: (1) extent and areas of the functional limitations of the child with a disability; (2) degree of need in the home environment for additional support; and (3) potential effectiveness of grant to maintain and support the person in the family environment. **NOTE:** When a person exits the FSG program for any reason, the grant funds stay in the county and may be reused for eligible families on the county's waiting list. **NOTE:** When a family stays on the FSG but moves to another county in Minnesota and the County of Financial responsibility changes, the existing county must transfer the grant funds to the new county of residence.

CONSUMER SUPPORT GRANT (CSG)

What is the Consumer Support Grant (CSG)? It is a state funded alternative to the MA (Medical Assistance) home care services of personal care assistant (PCA), private duty nursing (PDN) and/or home health aide (HHA). Eligible persons may choose to receive CSG so they may direct, manage and plan their own services in partnership with their county. This gives consumers greater flexibility and freedom of choice in service delivery specifics and service providers. Spouses, parents of a minor child, legal guardians, other relatives, trusted neighbors or friends, as well as licensed providers and employees of a home care agency can be paid for service. [NOTE: CSG recipients are advised to maintain sensible employment practices such as getting background checks and verification of references for prospective employees.]

Who is eligible? Persons must meet **all 5 criteria**:

1. Eligible for MA;
2. Able to direct and purchases their own care and supports or have a family member, legal representative or other authorized representative available to purchase, arrange and direct care on their behalf;
3. Eligible to receive home care services from a MA home care agency (person has currently has been assessed for PCA, PDN and/or HHA services)
4. Have a functional limitation that requires ongoing supports to live in the community;
5. Live in a natural home setting, that is not licensed by MDH (Minn. Dept. of Health) or DHS.
6. Not participating in Home and Community Based Service (“Waiver”), the Alternative Care Program, Minnesota managed care programs, or MA home care program services (PCA, HHA and/or PDN).

How much does a person receive? In general, the amount of the CSG is based on the person’s home care assessment rating. (Home care assessment ratings for PCAs are done by the county Public Health Nurse.)

How can the grant be used? Grants are given as cash, vouchers for services, or direct payments to vendors. The CSG can be used for a variety of supports and services, which must be related to the person’s functional limitation and provide supports needed to live in their own home. The services and goods must be over and above the costs of supporting a person without a disability. Eligible persons develop a CSG service plan with their county DHS (Department of Human Services) case manager. CSG recipients arrange, manage and pay for the goods, services, and supports described in their county approved plan. All other available sources of payment should be exhausted before using CSG. Examples of allowable expense categories include, but are not limited to:

- Companion services
- Human assistance (Ex: PCA)
- Home adaptations
- Nutrition services
- Chore services
- Family counseling
- Home delivered meals
- Respite care
- Specialized equipment
- Transportation

How do persons get the CSG? Contact your county DHS and ask for a disability social worker. .

NOTE: CSG is not available in all counties. Persons can ask their county DHS to consider adding the CSG program.