

Minnesota Health Care Programs (MHCP)

2017 Legislative Notice to MHCP Members

The 2017 Minnesota Legislature made changes to Minnesota Health Care Programs (MHCP). These programs are Medical Assistance (MA), MinnesotaCare and other public health care programs. This notice gives a brief overview of those changes.

The changes will not affect everyone who gets this notice. You are getting this notice so you are aware of the changes that may affect you. You do not need to do anything when you get this notice other than read it.

If you have questions about anything in this notice, call one of these:

- Your county, tribal or MinnesotaCare worker
 - The County and Tribal Information Directory is available at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0005-ENG>
 - MinnesotaCare's phone number is 800-657-3672
- The MHCP Member Help Desk at 651-431-2670 or 800-657-3739
- Member services at your managed care organization (MCO). The phone number is on the back of your MCO member card
- The Disability Linkage Line®, soon to be called Disability Hub MN, for people with disabilities, at 866-333-2466
- The Senior LinkAge Line®, for people 60 years old or older, at 800-333-2433

For more information about MHCP services, see the DHS Programs and Services page at <https://mn.gov/dhs/health-care-programs/>

Changes to Medical Assistance (MA)

Change to MA special needs trust requirements, approved May 31, 2017

State law was amended to comply with the federal 21st Century Cures Act, which allows special needs trusts that are set up on or after December 13, 2016, to include trusts set up by the person with a disability on his or her own behalf.

Communicator services for a hospitalized MA member who depends on a ventilator, changed June 30, 2017

If an MA member who depends on a ventilator has had a home care nurse or personal care assistant (PCA) in the community and is admitted to a hospital, communicator services will no longer be provided by the agency's nurse or PCA while the member is in the hospital. As of July 1, 2017, hospitals are responsible for providing these services.

Coverage of stiripentol in certain cases, started July 1, 2017

MA may cover stiripentol for a child with Dravet syndrome or a child with malignant migrating partial epilepsy in infancy caused by an SCN2A genetic mutation. Use of the drug must be determined medically necessary, and all other available covered drugs determined medically necessary must have been tried without success. Also, the U.S. Food and Drug Administration must have approved the treating physician's application to use the drug for the patient.

Changes in home health services, started July 1, 2017

- Home health services are covered not only in the home but also in the community.
- For MA to pay for a home health service or for medical equipment, the MA member must visit face-to-face with a qualifying provider. The visit must be related to the main reason the person needs home health services, and the provider must document the visit. The visit can take place through telemedicine. For a home health service, the visit must occur within the 90 days before services start or within 30 days after. For equipment, the visit must occur no more than six months before the person gets the equipment.

Funding to develop a system for identifying and verifying assets of people whose eligibility is based on blindness, disability or age, approved July 1, 2017

DHS received funding to seek a vendor to provide an electronic source of asset information. This source will be used to identify and verify a person's assets held by banks and other financial institutions. DHS will use this source when determining or renewing MA eligibility for people who are blind, have a disability or are 65 years old or older. These applicants and members must continue to report assets and provide proof of assets when asked to.

More community emergency medical technician (CEMT) services, starting August 1, 2017

MA now covers the following services during a CEMT visit after a person is discharged from a skilled nursing facility: reminders of discharge orders and recording and reporting of vital signs to a primary care provider.

Increased spenddown standard for those with eligibility based on blindness, disability or age, starting June 1, 2019

For a person whose MA eligibility is based on being blind, having a disability, or being 65 years old or older, the excess income (spenddown) standard will increase from 80 percent of the federal poverty guideline (FPG) to 81 percent.

Coordination of community-based services after arrest, starting upon federal approval

For certain qualifying members, MA covers coordination of community-based services after an arrest. "Coordination of community-based services after arrest" means activities meant to reduce the rate of jail use and connect people with available services, including case management and care coordination. To qualify, an MA member must have a mental illness or substance use disorder, must not require the security of a public detention facility or be an inmate of a public institution, and must have agreed to take part in post-arrest community-based service coordination instead of being incarcerated.

Use of interactive video for targeted case management, starting upon federal approval

MA will cover targeted case management provided through interactive video. This includes targeted case management for mental health services. The person whose case is being managed must live in a hospital, nursing facility, or certain residential settings. The person can consent to or refuse use of interactive video. Use of interactive video must be approved as part of the person's personal service or care plan. Also, interactive video can be used for no more than 50 percent of the minimum required face-to-face contact.

Housing support services, starting upon federal approval

Once the program is approved, housing support services will be available through MA to a person who has a disability that limits the person's ability to get or keep stable housing. The services would support a person's transition to housing in the community and increase long-term housing stability to prevent the risk of homelessness or being institutionalized. Services would include things like help with searching and applying for housing; help with planning for a move and identifying resources to pay for it; education on complying with a lease and managing a household; crisis planning; and eviction prevention.

Changes to Home and Community-Based Services (HCBS)

New HCBS disability waiver program services, some already started and some starting upon federal approval

HCBS covers individualized home supports. Upon federal approval, HCBS will cover independent living skills specialist services, employment exploration services, employment development services, and employment support services. The new employment services will replace competitive integrated employment-related services in supported-employment services and day treatment and rehabilitation services.

Rights of people living in certain HCBS settings, started May 31, 2017

- State law for HCBS for people getting waiver services was changed to add more service recipient rights to fully meet the new HCBS federal rule. The law applies to people getting foster care, adult day, supported living, day training and habilitation, prevocational, and structured day services. These additional rights include people's right to have choices about how they want to be involved in their community, and the right to privacy, including the right to have a lock on the bedroom door. The law also includes other rights, such as the right to use common areas of the home, the right to have access to food at any time, the right to choose their roommate and the right to have visitors at any time. When a provider admits a person, it must give the person a copy of his or her rights and information about his or her right to file a complaint.
- A provider that provides adult foster care services to Elderly Waiver (EW) program participants must have a policy for ending a person's foster care services that promotes care continuity and service coordination. The provider must give a copy of the policy to a resident each year. The provider cannot end services unless it is necessary for health and safety reasons, the provider was not paid or is ending operation, or the resident is no longer eligible for the EW program. Before ending adult foster care services, the provider must take steps to try to avoid ending the services and document those steps. A provider that plans to end a person's services must notify the person and his or her case manager at least 30 days before. The person has the right to appeal.

- For people who live in a housing-with-services setting and also get services from a home care provider that has an arrangement with the setting, the housing provider must include notice of the resident rights in the contract it has with each resident. These people include those whose services are funded by HCBS waivers. Any change to these rights must be based on an assessed need of the person for health and safety reasons.

Increase in certain people's budgets for Consumer-Directed Community Supports (CDCS) under the HCBS waiver programs for people with disabilities

- By September 30, 2017: An increased CDCS budget will be available to a person leaving an institution or crisis residential setting. The increase will be available when the person is not offered available and appropriate services within 60 days of approval for discharge, and when the cost of needed services is more than the person's existing CDCS budget before the increase. The amount of the increased budget will be no more than the cost of appropriate services provided in a noninstitutional setting.
- Starting later of October 1, 2017, or upon federal approval: A CDCS participant whose service and support plan identifies a need for services or supports to increase employment opportunities, to support transition to settings that are not provider owned or operated, or to develop and implement a positive behavior support plan can have up to a 30 percent increase to his or her individual CDCS budget. This budget increase is available if the person can show he or she will have to leave CDCS because the CDCS budget is not enough to buy services or supports. If you think this policy applies to you, contact your waiver case manager.

Changes to estate recovery and liens

MA estate recovery and liens changed. Before the change, the state and local agencies could claim against estate property of a deceased MA member, or against estate property of the MA member's surviving spouse, to repay the costs of all MA services the member received at 55 years old and older before January 1, 2014. Beginning July 1, 2017, agencies can still claim against estate property to repay the costs of MA services received at 55 years old or older before January 1, 2014, but they are limited to recovering the costs of a subset of MA services called "long-term services and supports." For more information, go to <https://mn.gov/dhs/ma-estate-recovery/>.

Changes to MinnesotaCare

Change in coverage of special education services, started July 1, 2017

MinnesotaCare does not cover special education services.

Change in benefit set for 19- and 20-year-olds, starting January 1, 2018

People who are 19 and 20 will get the adult benefit set in MinnesotaCare rather than the child benefit set. For the few people who have MinnesotaCare on a fee-for-service basis, this change took effect July 1, 2017.

Changes to MA and MinnesotaCare

Information about managed care, already started

- DHS must provide a potential managed care enrollee with all this information: basic features of getting managed care services; who cannot enroll in managed care, who must enroll, and who may choose to enroll; length of enrollment and the right to disenroll; each managed care plan's (health plan's) service area; covered services; each health plan's provider directory and list of covered drugs; cost-sharing requirements; requirements for access to service; health plans' responsibility to coordinate care; and health plans' performance on quality indicators.
- Managed care plans (health plans) must provide an enrollee with an enrollee handbook that explains benefits and how and where to get them, cost sharing, how transportation is provided,

and similar information. They also must provide provider directories and a list of covered drugs. When a provider ends its contract with a health plan, the plan must try to notify each enrollee who had the provider for primary care or saw the provider regularly. If an enrollee asks, a health plan must provide the plan's physician incentive plan.

DHS and health plans must provide the information above in a way that makes it easy to get and understand. They must put the information on their websites and provide it in paper form if an enrollee asks for that. Language help and help with getting information in alternative formats must be available for free.

Changes in timelines for appealing health plan decisions, starting January 1, 2018

Currently when a member appeals a managed care plan's (health plan's) decision, the member can appeal to the health plan within 90 days of the decision or appeal directly to the state within 30 days of the decision, or up to 90 days with a good reason. Starting with health plan decisions dated January 1, 2018, or later, the member must appeal to the health plan first, within 60 days of the decision. After the appeal to the health plan is completed and if the member is not satisfied, the member has 120 days from the health plan's determination to appeal to the state.

Periodic data matching, starting April 1, 2018

The start date of periodic data matching was changed from March 1, 2016, to April 1, 2018. We will match data to identify members in the MNsure system who may not meet the eligibility criteria for the public health care program they are enrolled in. We will match data for MA and MinnesotaCare members using available electronic data at least once during each member's 12-month period of eligibility.

Support system for managed care enrollees, starting January 1, 2019

DHS must have a system that provides support to managed care enrollees and potential enrollees before and during enrollment in a managed care plan (health plan). The system must provide access to counseling on choosing a plan, help people understand plan enrollment, give an access point for complaints, provide information about appeal rights, and help people with the appeal process if they ask for help.

Changes to treatment for substance use disorders

Coverage of comprehensive assessment, peer recovery support services, and care coordination, starting later of July 1, 2018, or upon federal approval

MA will cover comprehensive assessment, peer recovery support services, and care coordination.

- A person will be able to go directly to a substance use disorder (SUD) treatment provider to get a comprehensive assessment to get SUD treatment services authorized. This process will eventually replace the current “Rule 25” process for accessing services, although counties and tribes will continue to be able to provide Rule 25 assessments for placement in treatment while we transition to the new process for getting into treatment. A person will be able to choose his or her own provider for service, although provider network requirements are unaffected by this change.
- Peer recovery support services include education; advocacy; mentoring by sharing personal recovery experiences; attending recovery and other support groups with a person; going with a person to appointments that support recovery; helping a person access resources to get housing, employment, education, and advocacy services; and helping a person transition from treatment into the recovery community.
- Care coordination includes things like working with significant others to help plan treatment; coordinating and following up for medical services in the treatment plan; and helping with referrals for health, economic assistance, social, and housing services.

Coverage of withdrawal management, starting later of July 1, 2019, or upon federal approval

MA will cover withdrawal management. Two new levels of detoxification services will be available:

- Clinically managed withdrawal management is a residential setting with staff that includes at least a medical director, licensed practical nurse, and alcohol and drug counselor. A licensed practical nurse must be on site 24 hours a day, seven days a week. A qualified medical professional must be available by phone or in person for consultation 24 hours a day.
- Medically monitored withdrawal management is a residential setting with 24-hour registered nurse staffing, a medical director on site daily, and a full-time alcohol and drug counselor.

A person admitted to either of these two levels of service gets medical observation, evaluation, and stabilization services during detoxification; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment for substance use disorder (SUD) for referral and placement into SUD treatment if appropriate.

800-657-3739 or 651-431-2670

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ደብዳቤ የሚተረጎም ለአስተርጓሚ ክፍለ-ገቢ ወይም ወደተጻፈው የሰልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သ့ဟ်သးဘဉ်တက့ၢ်. ဝဲန့ၢ်လိၣ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်စိတခါအံၤန့ၣ်,ကိးဘဉ်လိတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າທາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la' aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA1 (9-15)



For accessible formats of this publication or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service.