STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
444 LAFAYETTE ROAD
ST. PAUL, MN 55155-3848

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #34

November 2002

Effective Date: December 1, 2002

TO: MinnesotaCare Operations
County Agencies
and Other Manual Holders

SUBJECT: Revised Material for the MDHS Health Care Programs Manual

The material issued with this manual letter contains new and revised information for the Health Care Programs Manual. Changes are identified by a vertical line in the right margin. Deletions are identified by a double vertical line.

This information is available in other forms to people with disabilities by calling 651- 296-8517 (voice), toll-free at 1-800-657-3659, 7-1-1, or contact us through the Minnesota Relay Service at 1-800- 657-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service) .

New material issued with this manual letter is effective December 1, 2002 unless otherwise noted. Please review the entire manual letter for a complete description of new and changed material.

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HIGHLIGHTED CHANGE #1: This manual letter adds information on the MA for Breast and Cervical Cancer (MA-BC) program. This material was previously issued in Bulletin #02-21-07 (Medical Assistance Coverage for Women Screened by the Minnesota Breast and Cervical Cancer Control Program) dated June 20, 2002 and was effective July 1, 2002. See Attachment A for a list and description of sections affected by this change.
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HIGHLIGHTED CHANGE #2: This manual letter revises material related to the elimination of the MinnesotaCare grace month. This material was previously issued in Bulletin # 02-23-01 (Elimination of MinnesotaCare Grace Month) dated May 1, 2002 and was effective July 1, 2002. See Attachment A for a list and description of sections affected by this change.
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See Attachment A for a description of other changes in this manual letter.

Address individual case policy questions to:
Health Care Programs Policy Center
Fax# 651-215-9438 or 1-888-234-5189

Sincerely,

BRIAN OSBERG
Assistant Commissioner Health Care

MDHS HEALTH CARE MANUAL
MANUAL LETTER #34
ATTACHMENT A
REVISED AND DELETED SECTIONS

Revised Sections	Sections Deleted
0901	0901
0904.05	0904.05
0904.07	0904.07
0904.07.03	0904.07.03
0904.07.09	0904.07.09
0905	0905
0905.03	0905.03
0905.03.01	0905.03.01
0906.03.07	0906.03.07
0906.09.01	0906.09.01
0906.11.01	0906.11.01
0907.03	0907.03
0907.19.05	0907.19.05
0907.19.13	None (new)
0907.21.07.05	0907.21.07.05
0909.03	0909.03
0909.15	0909.15
0909.17	0909.17
0909.27.01	0909.27.01
0910.03.03	0910.03.03
0911.05	0911.05
0911.07.03	0911.07.03
0911.09.03.17	0911.09.03.17
0911.09.13	0911.09.13
0912.05.09	0912.05.09
0913	0913
0913.19.03	0913.19.03
0913.19.05	0913.19.05
0913.21	0913.21
0914	0914
0914.03.03	0914.03.03
0914.03.03.03	0914.03.03.03
0914.03.05.03	0914.03.05.03
0914.03.15	0914.03.15
0914.03.17	0914.03.17
0915.11	0915.11
0915.11.03	0915.11.03
0915.11.05	0915.11.05
0916.15	0916.15
0917.11	0917.11

§0901 (Table of Contents) adds a new section.

§0904.05 (Health Care Application Forms) adds information on the application/renewal form for women with breast and cervical cancer (MA-BC) and the Title IV-E Foster Care Supplement to the Health Care Programs Application (DHS 3478). See §0907.19.13 (MA for Breast/Cervical Cancer MA-BC) for more information on the use of the MA-BC form.

The Title IV-E supplement form is designed to be used with the HCAPP to determine whether children in foster care are eligible for reimbursement through Title IV-E. This form was introduced to counties in an April 29, 2002 memo from the University of Minnesota Eligibility Determination Training Project.

§0904.07 (Accepting and Processing Applications) clarifies that authorized representatives may always choose to apply in the authorized representative's county of residence, as well as in the client's county of residence OR the client's county of financial responsibility. It adds that authorized providers may take applications and grant presumptive eligibility for MA-BC. See Highlighted Change #1.

§0904.07.03 (Date of Application) adds information on the date of application for MA-BC.

§0904.07.09 (Eligibility Begin Date) adds information on the eligibility begin date for MA-BC.

§0905 (Reviews and Renewals) clarifies not to require a renewal form for MA for children eligible for Title IV-E foster care payments if there is already a HCAPP and Title IV-E Foster Care Supplement to the Heath Care Programs Application on file.

§0905.03 (Renewal Timelines) updates material to reflect the elimination of the MinnesotaCare grace month.

§0905.03.01 (Annual Renewal Timelines--MA/GAMC) adds to use the MA LTC Eligibility Form (DHS 2128) for people who reside in long term care facilities and receive MSA for personal needs and people who reside in group residential housing facilities and receive EW with GRH payments. It adds information on renewals for MA-BC. It updates the name and form number of the renewal form sent for people who receive MA automatically with cash to the Combined Application Form (CAF, DHS 3469).

§0906.03.07 (Lawful Permanent Residents With Sponsors) adds that women receiving MA-BC are exempt from sponsor deeming requirements.

§0906.09.01 (Institutional Residence–MA/GAMC) adds supervised furlough for juveniles to the bullet on parole and supervised release.

§0906.11.01 (Social Security Number–MA/GAMC) adds to the 3rd bullet not to require SSNs from non-immigrant pregnant women. It adds a 5th bullet stating that RMA applicants and

enrollees are not required to provide or apply for SSNs. These are not policy changes but were not previously specified in this section.

§0907.03 (MinnesotaCare Eligibility Group 1) changes the instructions to state that you review group status for the 1st available month after the 21st birthday when Group 1 children turn age 21. This change was inadvertently omitted from the other changes on this topic in Manual Letter #33.

§0907.19.05 (MA Basis: Pregnant Women) updates the spenddown standard to 100% of FPG. This change was effective July 1, 2002 but was missed in previous updates.

§0907.19.13 (MA for Breast/Cervical Cancer MA-BC) is a new section with information on coverage for women screened as needing treatment for breast or cervical cancer. See Highlighted Change #1.

§0907.21.07.05 (MA for Employed Persons with Disabilities) adds that people who are otherwise eligible for MA-EPD while residing in an IMD may be eligible for program IM.

§0909.03 (Exemptions From Asset Limits) adds MA-BC to the list of groups exempt from MA asset limits. It clarifies that the 1st bullet applies only to people who receive MA automatically with a cash program.

§0909.15 (Vehicles) adds under MinnesotaCare and Method A to exclude the highest valued vehicle(s) used for employment or seeking employment, regardless of which vehicle(s) are actually used for this purpose.

§0909.17 (Burial Funds/Life Insurance: Fund Types) adds that since term insurance has no cash value, it is not counted as an asset.

§0909.27.01 (MA Transfers) clarifies the instructions for evaluating transfers made by a community spouse after MA has been approved for the LTC spouse. In most cases, these transfers will result in a penalty period for the LTC spouse. If a community spouse submits evidence that a transfer was done for another valid purpose (excluding preserving the estate, avoiding probate or lowering taxes), submit a Policy Interpretation. This clarification was previously relayed in MAXIS E-Mail #5507238 dated September 3, 2002.

§0910.03.03 (Other Coverage–Prescription Drug) clarifies that the 4 months in which a person must be without other drug coverage are the 4 months preceding the 1st month of PDP enrollment.

§0911.05 (Excluded Income) under the bullet describing payments to victims of Nazi persecution adds that MinnesotaCare follows Method A in treating WUV payments to victims of Japanese persecution as unearned income. It changes the name of the Food Stamp program to Food Support Program.

§0911.07.03 (Earned Income) moves the items listed under MA/GAMC to the general provisions. These income types are considered earned income for MinnesotaCare as well as MA/GAMC.

§0911.09.03.17 (Roomer/Boarder Income) updates the Method A boarder deduction to $139 per month and the roomer/boarder deduction to $210 per month effective October 1, 2002.

§0911.09.13 (Assistance Payments Income) changes references to Food Stamps to Food Support Program and changes policy to state that MinnesotaCare excludes all Food Support payments, including those issued as part of a cash grant. It adds an exception under Method B that cash assistance such as MSA for personal needs is counted in long term care budgets.

§0912.05.09 (Earned Income Disregards–Method A) clarifies that pregnant women, infants through the month of their 2nd birthdays, and children ages 6 through 18 using the 170% FPG standard do not get an earned income disregard. The disregard is included in the standard. If they must spend down to 100% FPG because income exceeds the higher standard, allow the 17% earned income disregard.

§0913 (Premiums and Spenddowns) updates material related to the elimination of the MinnesotaCare grace month and updates the address for forwarding premium payments received by county agencies.

§0913.19.03 (When to Interrupt 6-Month Cert. Period) adds an exception to the 5th bullet for women who are exempt from completing renewals when the 60-day post partum period ends.

§0913.19.05 (When Not to Interrupt 6-Month Cert. Period) adds 2 new bullets at the end. Do not interrupt the 6-month budget period when people on regular MA become eligible for TMA or TYMA or vice versa.

§0913.21 (Allowable Medical Bills to Meet Spenddown) clarifies that if people have enough other expenses to meet a spenddown, they can choose to be reimbursed for cost effective health insurance premiums rather than applying them toward the spenddown. It removes MAXIS instructions and codes that no longer apply due to the rewrite throughout the section.

§0914 (Service Delivery) adds new managed care counties effective November 1, 2002.

§0914.03.03 (Managed Care Exclusions) eliminates children in foster care and in need of protection from the list of exclusions. The phased-in enrollment period for these groups ended October 31, 2002. They are now mandatory enrollees. It adds women receiving MA for Breast and Cervical Cancer (MA-BC) as an exclusion. It clarifies that the health plan must approve placement in an RTC, including court-ordered placements, for people who enter RTCs to remain enrolled in managed care.

§0914.03.03.03 (Managed Care Voluntary Enrollment) removes children in foster care and in need of protection since these groups are now mandatory. It adds new MSHO counties and adds to request a statement from the enrollee or AREP if a voluntary enrollee asks to disenroll from managed care. It adds a reference to MnDHO.

§0914.03.05.03 (Managed Care Enrollment Presentations) removes 2 forms from the education

packet list and updates a form number.

§0914.03.15 (Managed Care Adjustments) deletes instructions to request manual adjustments for children who turn age 2 on the 1st day of the month, as this is no longer necessary.

§0914.03.17 (Managed Care County Transfers) deletes material on considering moves of less than 2 months to be temporary.

§0915.11 (Fail to Pay Premium/Voluntary Cancellation), §0915.11.03 (Fail to Pay Premium/PWs and Infants), §0915.11.05 (Fail to Pay Premium/Reinstatement), §0916.15 (Premium Notices) and §0917.11 (Continuation of Benefits) contain updates related to the elimination of the MinnesotaCare grace month.

The Health Care Application (HCAPP, DHS 3417) allows people to apply for any or all of the health care programs on 1 form. It is available for downloading on the DHS web site at www.dhs.state.mn.us. The HCAPP is for people not residing in a long term care facility or receiving services through the elderly waiver who want to apply only for MA, GAMC, and/or MinnesotaCare. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).

The HCAPP sets the date of application and requests information on eligibility factors. See §0904.07.03 (Date of Application).

The cover includes the DHS address and a space for the county agency name and address. The post office will return undeliverable applications to DHS. DHS will forward the application to the appropriate site.

The Rights and Responsibilities page of the HCAPP is detachable. Applicants should retain this page. Return the page if an applicant submits it with the HCAPP.

The HCAPP contains questions needed to determine eligibility for all of the health care programs. Many questions apply to all 3 programs. Some apply only to 1 or 2 programs or to certain populations.

County agencies also use the HCAPP with the Title IV-E Foster Care Supplement to the Health Care Programs Application (DHS 3478) to determine eligibility for Title IV-E for children in placement. If the child is IV-E eligible, MA is automatic. If there is no IV-E eligibility, the agency uses the HCAPP to determine MA eligibility. See §0907.19.03.03 (MA Basis: Children in Foster Care).

The Long Term Care Application (DHS 3342) is designed for people residing in a long term care facility or requesting services through the Elderly Waiver (EW). Provide the DHS 3342 to people who ask to apply for long term care services. However, do not require the DHS 3342. Accept a HCAPP or CAF. Accept the DHS 3342 from people who are requesting health care but do not receive long term care services if they submit one instead of a HCAPP or CAF. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).

The Minnesota Medical Assistance Breast and Cervical Cancer Coverage Group Application/Renewal, known as the MA-BC Application/Renewal Form (DHS 3525), is used for women who are screened and found to need treatment through the Minnesota Breast and Cervical Cancer Control Program (MBCCCP). See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC).

Accept all signed and dated applications. Follow up with the applicant to obtain any missing

information. See §0904.07.05 (Application Follow Up).

People scheduled for release from correctional institutions may apply for health care 30 days before their scheduled release date. Department of Corrections (DOC) case managers assist the inmate in completing the HCAPP and the Individual Discharge Information Sheet (IDIS) (DHS 3443). The case manager sends the HCAPP and IDIS to the county in which the inmate resided before entering the correctional system unless:

- The previous county of residence is unknown or the inmate came from another state. The case manager sends the HCAPP and IDIS to the county in which the inmate plans to live.

- The inmate requests MinnesotaCare or is clearly ineligible for MA/GAMC due to income or assets. The case manager sends the HCAPP and IDIS to MinnesotaCare Operations.

Pend applications received from DOC case managers until the release date. See §0904.07.07 (Pending the Application).

Although the HCAPP, CAF and Long Term Care applications are each designed for specific populations, accept any DHS-approved health care application. See §0904.05 (Health Care Application Forms).

MinnesotaCare:

People may mail, fax, or bring the application to MinnesotaCare Operations or to a county agency. If a county agency that is not a MinnesotaCare enrollment site receives an application for someone who is requesting only MinnesotaCare, the county agency will forward the application to MinnesotaCare Operations.

If MinnesotaCare Operations receives an application from someone who is requesting only MA or GAMC, forward it to the person's county of residence.

Minnesota Rule 9506.0030 Subp. 1
M.S. 256L.05 Subd. 1

MA/GAMC:

In most cases, people file applications for MA or GAMC with their county of residence. When the county of financial responsibility is different from the county of residence, people may file the application with the county of financial responsibility. People may file applications at other locations in the following situations:

- People requesting only MA or GAMC may mail an application to MinnesotaCare Operations. If MinnesotaCare Operations receives an

application for someone requesting only MA or GAMC, MinnesotaCare Operations will forward the application to the county of residence.

- Residents of Regional Treatment Centers (RTCs) may file applications with the RTC reimbursement officer. The RTC reimbursement officer will take the application and forward it to the county of residence for processing.

- Authorized representatives applying on someone's behalf may apply in the client's county of residence, the authorized representative's county of residence, or the county of financial responsibility if different. See §0904.11 (Authorized Representatives) and §0906.07 (County Residence).

  Forward the case to the client's county of residence after processing.

- Children and pregnant women who are applying only for MA may apply at locations other than the county agency. Some hospitals and clinics are mandatory outstation locations. Accept applications filed at outstation locations in your own and other counties.

Counties with outstation locations must work with the outstation site to ensure that applications are available. No interview is required. See §0904.07.05 (Application Follow Up). Outstation staff may assist applicants in completing the forms and obtaining verifications, or county agencies may supply staff on request.

- Authorized providers may accept applications and determine presumptive eligibility for MA for Breast and Cervical Cancer (MA-BC). See §0907.19.13 (MA for Breast and Cervical Cancer MA-BC).

The date of application determines the order in which MinnesotaCare Operations processes applications. It also determines the earliest possible beginning date of coverage for MA or GAMC. See §0904.07.09 (Eligibility Begin Date).

Record the application receipt date on the application form. Use of a date stamp is recommended.

MinnesotaCare:

The date of application is:

HCAPP SUBMITTED TO MINNESOTACARE OPERATIONS OR A COUNTY AGENCY

- The date a signed and dated HCAPP containing at least the applicant's name and address is received by MinnesotaCare Operations or by a county agency, regardless of whether the county agency is a MinnesotaCare enrollment site. Accept faxed applications to set the application date and determine initial eligibility.

  County agencies transfer applications to DHS when the county agency is not an enrollment site, or when a type 3 enrollment site receives applications from people who are not current contacts. See §0904.03.03 (MinnesotaCare Enrollment Sites) for a description of enrollment site types.

CAF SUBMITTED TO COUNTY AGENCY

- The date of application is the date a signed and dated CAF Page I is submitted to a county agency for applicants who request MA or GAMC on a CAF. If there is no MA or GAMC eligibility OR the applicant specifically requests MinnesotaCare only on a CAF, use the CAF to determine MinnesotaCare eligibility. Do not require a HCAPP. County agencies that are not MinnesotaCare enrollment sites will forward the CAF to MinnesotaCare Operations if there is no eligibility for MA or GAMC.

  If the application originally submitted to the county agency is a long term care application, use the date of the LTC application as the MinnesotaCare application date.

ACTIVE MA OR GAMC CASE CLOSED

- County agencies that are MinnesotaCare enrollment sites will determine MinnesotaCare eligibility for enrollees who lose MA or GAMC because of income or assets using available information in the case file. The date of the MinnesotaCare application is the date of the most recent application, annual renewal, or 6-month renewal.

- County agencies that are not MinnesotaCare enrollment sites transfer cases for enrollees who lose MA or GAMC because of income or assets to MinnesotaCare Operations. See §0904.05.05 (When Not to Require an Application). The date of application is the date of the most recent application or renewal form on file.

RENEWAL SUBMITTED IN THE 11 MONTHS BEFORE REAPPLICATION

- If a terminated household reapplies within 11 months of submitting a renewal form, the date of application is the date the renewal form was received.

Pend unsigned applications and return them to the household for signature.

MinnesotaCare Operations processes applications in the order received. Applications forwarded from the county agency are placed in order according to the date the county received them.

Process MinnesotaCare applications received by DHS or a county enrollment site within 30 days of the application date. Process applications forwarded to DHS from county agencies within 30 days of the date MinnesotaCare receives the application from the county. In all cases, the eligibility begin date is the 1st of the month following receipt of the initial premium payment, unless a household member is hospitalized on that date. See §0904.07.09 (Eligibility Begin Date).

M.S. 256L.05 subd. 4

MA:

The date of application is the date a county agency, MinnesotaCare, an RTC reimbursement officer, or a designated outstation receives a signed and dated request including at least the applicant's name and address. The request may be a CAF Page I, HCAPP, Long Term Care application, or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF, HCAPP or LTC application completed to the best of the applicant's ability before eligibility can be determined.

The date of application for MA-BC for women approved for presumptive eligibility is the date the provider grants presumptive eligibility. The date of application for women not approved under presumptive eligibility is the date the county agency receives the MA-BC Application/Renewal Form (DHS 3525). See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC).

Although the HCAPP and Long Term Care application are designed to meet the needs of specific populations, accept any DHS-approved health care application. Process MA applications within the following time frames:

- 15 days for a pregnant woman. If the woman requests an in-person interview, schedule the interview within 5 days of the date of application. Determine eligibility within 10 days of the date of the interview.
- 60 days for people whose eligibility is based on disability.
- 45 days for all other applicants.

For applications received from MinnesotaCare, the processing time frames begin the date the county agency receives the application.

GAMC:

The date of application is the date a county agency, MinnesotaCare, an RTC reimbursement officer, or a designated outstation receives a signed and dated request including at least the applicant's name, address, and social security number if required. The request may be a CAF Page I, HCAPP, LTC application, or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF or a HCAPP completed to the best of the applicant's ability before eligibility can be determined.

If applicants are unable to submit a written request for GAMC because of illness or incapacity, a health care provider may submit the request on their behalf. Accept all applications or written requests submitted by providers to set the date of application. Assume that the applicant was unable to submit the request. The provider does not have to be the applicant's authorized representative. The applicant or an authorized representative must submit a completed application before eligibility can be determined.

Process GAMC applications within 45 days.

ELIGIBILITY BEGIN DATE 0904.07.09

For MinnesotaCare, the eligibility begin date depends on the date the agency receives the 1st premium payment. For MA and GAMC, the eligibility begin date depends on the date of application, the date all eligibility factors are met, and whether eligibility is retroactive.

In most cases, people cannot be open on more than 1 health care program in the same month. When an applicant is already open on 1 program and requests a different program, the begin date of the new program must be coordinated with the termination date of the 1st program. When processing an application, always check MMIS to see if any members of the household are active on another health care program. Check the status of each household member. If people are open on another program, ensure that the applicant understands they cannot remain open on both programs and that their coverage may change. Coordinate opening and closing dates with the other program. See §0904.09 (Shared and Transferred Applications).

MinnesotaCare:

The eligibility begin date is the 1st day of the month following the month in which the agency receives the initial premium payment. The payment must be received by noon on the last working day of the month for eligibility to begin the following month.

For people who are hospitalized on the date coverage would otherwise begin, eligibility begins the 1st day of the month after discharge from the hospital.

M.S. 256L.05 subd. 3

MA:

The earliest possible begin date is the 1st day of the month 3 months before the month of application for people who request retroactive coverage. People must meet all of the eligibility factors, including having an MA basis of eligibility, in each of the retroactive months. Determine eligibility for each month in the retroactive period for which people request coverage. People may be eligible for some but not all months in the retroactive period.

EXAMPLE:

Georgia, age 23, applies for MA-PW on March 25. Her estimated date of conception is February 15. February is the earliest possible month of MA-PW eligibility. She is requesting retroactive coverage to December. She did not meet an MA basis of eligibility in December or January. GAMC allows only 1 month of retroactive coverage. Georgia is not eligible for December and January. Determine MA eligibility beginning in February.

Check MMIS to see if any household members had active MinnesotaCare spans during the retroactive months. For household members who were active on MinnesotaCare, the earliest begin date is the 1st of the month after MinnesotaCare is closed.

If any household members had pending, but not active, MinnesotaCare spans during the retroactive months, they may be eligible for MA for those months. Notify the MinnesotaCare representative when you approve MA.

For people who are not requesting or are not eligible for retroactive coverage, the begin date of eligibility is the 1st day of the month of application or the date all eligibility factors are met, whichever is later. People do not have to be eligible in the month of application. Eligibility may begin at a later date if the applicant meets all eligibility factors by the end of the processing period.

EXAMPLE:

Elmer applies for MA on November 25. He will be 65 on December 10. He does not meet an MA basis for November. He has countable assets of $2500. He has no medical bills for November and does not wish to reduce to $1000 for GAMC eligibility. He is requesting MA effective December 1. Approve the November 25 application effective December 1 if Elmer meets all eligibility factors.

Deny the application if you are unable to confirm eligibility by the end of the processing period.

The earliest date of eligibility for MA-BC is 3 months before the date of application or the 1st day of the month in which the woman was screened under MBCCCP, whichever is later. Women who are granted presumptive eligibility for MA-BC must be found eligible for ongoing MA-BC before retroactive eligibility is granted. See §0907.13.19 (MA for Breast /Cervical Cancer (MA-BC).

GAMC:

The earliest possible begin date is the 1st day of the month 1 month before the month of application for people who request retroactive coverage. People must meet all of the eligibility factors in the retroactive month. They must not have been open on MinnesotaCare in the retroactive month.

People who met an MA basis of eligibility in any of the 3 months before the month of application may be eligible for retroactive MA coverage in those months.

EXAMPLE:

Eleanor applies for GAMC on March 25. She is requesting retroactive coverage to December. She lives with her daughter, Amy, who turned 18 on December 10 and is not in high school. Eleanor met an MA-AFDC related basis in December since Amy met the definition of a dependent child. Eleanor does not have an MA basis beginning in January. Determine MA eligibility for December only. Determine GAMC eligibility beginning in February. Eleanor is not eligible for January coverage because she did not meet an MA basis in that month and GAMC coverage is limited to 1 month before the month of application.

Check MMIS to see if any household members had active MinnesotaCare spans during the retroactive month. For household members who were active on MinnesotaCare, the earliest begin date is the 1st of the month after MinnesotaCare is closed.

If any household members had pending, but not active, MinnesotaCare spans during the retroactive month, they may be eligible for GAMC for that month. Notify the MinnesotaCare representative when you approve GAMC.

For people who are not requesting or are not eligible for retroactive coverage, the begin date of eligibility is the 1st day of the month of application or the date all eligibility factors are met, whichever is later. People do not have to be eligible in the month of application. Eligibility may begin at a later date if the applicant meets all eligibility factors by the end of the processing period.

All of the health care programs require annual eligibility renewals. Most MA and GAMC cases require income reviews more often than annually, depending on client circumstances.

Approve renewed coverage for people who remain eligible as a result of the renewal process. Terminate coverage for those who are no longer eligible.

MinnesotaCare:

Require a signed Minnesota Health Care Programs Renewal Form (DHS 3418) from all active households every 12 months. Accept and process faxed renewal forms. See §0905.03 (Renewal Timelines) for follow up procedures for faxed renewals. The renewal month is 12 months after the month in which the case was initially pended awaiting payment, regardless of the month coverage begins. The renewal month remains unchanged from year to year as long as the case remains active without a break.

EXAMPLE:

The Andrew family is pended awaiting payment on February 12. MinnesotaCare receives their initial premium payment on February 20, and the case becomes active beginning in March. The Andrew family's renewal month is February. MMIS shows a redetermination date of February 28.

EXAMPLE:

The Burns family is pended awaiting payment on February 12 MinnesotaCare receives their initial premium payment on March 3, and the case becomes active beginning in April. The Burns family's renewal month is February. MMIS shows a redetermination date of February 28.

EXCEPTION:

If an incarcerated individual is removed from an active household at another household member's request and chooses to be opened on a new case, the renewal date on the new case must be the same as the original household's renewal date. Contact the MMIS Help Desk to set the renewal date. If the person is still incarcerated at the time of renewal, cancel coverage. See §0908.13 (Temporary Absence--MinnesotaCare - Part I) and §0915.05 (Removing a Person From the Household).

M.S. 256L.05 subd. 3a
Minnesota Rule 9506.0020 subp.6, 7

MA/GAMC:

Require a complete signed and dated renewal from all active households every 12 months. Accept and process faxed renewals. See §0905.03.01(Annual Renewal Timelines--MA/GAMC) for follow up procedures for faxed renewals.

Apply the following EXCEPTIONS to the 12-month renewal timeline:

- Renew pregnant women the month following the month in which the 60-day postpartum period ends, UNLESS:
  -The woman was on MA before becoming pregnant
  OR
  -One or more household members are currently open on MA under the same basis of eligibility that would apply to the pregnant woman.

  Women meeting either of these conditions are eligible without a spenddown until the next regularly scheduled renewal.

  For women who must be renewed at the end of the post-partum period, determine continued eligibility from information in the case record. Request additional information from the enrollee if needed. Approve continued eligibility if the woman is eligible under another basis.

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See §0907.19.05 (MA Basis: Pregnant Women).

- Renew infants under 2 who are eligible as auto newborns the month following the month of their 2nd birthday. See §0907.19.05.03 (MA Basis: Auto Newborn).

- Do not require a renewal form from people receiving extended MA unless a regular 12-month renewal is due when extended MA ends. Re-evaluate eligibility for MA under another basis. See §0907.19.11.03 (Extended MA for MFIP: 2nd 6 Months) and §0907.19.11.07 (Extended MA for MA-Only: 2nd 6 Months).

- Do not require a renewal form to recertify people eligible for MA under Title IV-E or State adoption assistance. Verify the renewal of the adoption agreement annually. See §0907.19.03.05 (MA Basis: Adoption Assistance).

- Do not require a renewal form to recertify children in foster care who are eligible for MA because they receive Title IV-E funding if there is a HCAPP and Title IV-E Foster Care Supplement to the Health Care Programs Application on file. Follow your county social service unit's procedures for

recertifying children for IV-E.

- For people enrolled in the Prescription Drug Program, the renewal is due at the same time as the annual renewal for QMB and SLMB. See §0907.21.09.11 (Medicare Supplement Programs: PDP).

For all others, the renewal month is:

- 12 months after the 1st month of the certification period for households who have not had an annual renewal since the most recent application.

  EXAMPLE:

  The Barnes family applied for MA in May and requested consideration of retroactive coverage back to February. They met a spenddown and were opened effective March 10. Their renewal date is February 1.

OR

- 12 months following the effective date of the last annual renewal for households who have been continuously active since the last renewal.

When members of 1 household apply at the same time but are opened on different dates, assign the entire household the earliest renewal date. See §0904.07.09 (Eligibility Begin Date).

EXAMPLE:

Bill and Julie Cole apply for GAMC for themselves and MA for their children in June. They request retroactive coverage. The children are approved effective March 1. Bill and Julie are approved effective May 1. The household's renewal date is March 1.

Do not require a separate renewal form for people who receive MA or GAMC with cash. Use the CAF Recertification Form (DHS 3217). Use the Medical Assistance Long Term Care Eligibility Recertification Form (DHS 2128) for clients in long term care. For all others, use the Minnesota Health Care Programs Renewal Form (DHS 3418). Also see §0905.03.01 (Annual Renewal Timelines--MA/GAMC).

MinnesotaCare:

MMIS sends renewal forms to enrollees approximately 10 weeks before the end of the renewal month. The renewal packet includes the following forms:

- Minnesota Health Care Programs Renewal Form, DHS 3418.
- System-generated MinnesotaCare Notice of Renewal.
- Return envelope.
- Important Information Flyer for Non-English Speaking enrollees.

Enter the receipt date on MMIS as soon as you receive renewal forms from the enrollee. MMIS will automatically generate a termination notice if the renewal has not been processed by the renewal month cutoff date.

Process renewals in the order they are received. Give priority to processing renewals to avoid a gap in coverage. Enrollees must complete the renewal process by the last day of the renewal month (shown on MMIS as the redetermination date) to remain covered. They must also pay the new premium for the next month by the last day of the renewal month.

If the renewal is received in the month following the renewal month, treat the renewal form as a new application. If a terminated household reapplies more than 1 month after they submit a renewal form, contact the household to update the information on the renewal form. Do not require a new application if the renewal was completed in the 11 months preceding reapplication. See §0904.05.05 (When Not to Require an Application).

If possible, process the renewal before the cutoff date to ensure continuous coverage. If the renewal form is received in the renewal month and contains all information needed to determine continued eligibility but you do not have all required verifications, approve continued eligibility with delayed verification if the household has not been approved under delayed verification in the past 12 months. Send the household the Renewal Delayed Verification Letter (DHS 3424) to notify them that they must submit required verifications by the end of the month following the renewal month for coverage to continue. Send 10-day notice to close if the household does not submit verifications or they indicate ineligibility.

EXAMPLE:

Marissa's renewal month is October. MMIS shows a redetermination date of October 31. She submits her renewal form on October 10 but does not include income verification. The renewal form contains sufficient information to determine continued eligibility and premium amount. Update the delayed verification field on the MMIS RIND screen and continue eligibility for November. Send Marissa a DHS 3424 advising her that she must submit verifications by November 30 for eligibility to continue. If she has not submitted verifications by November 30 or they indicate ineligibility, terminate coverage effective December 31 allowing for 10-day notice.

If submitted verifications result in a greater or lesser premium amount than the amount determined under delayed verification, follow the same procedures as for applicants. See §0904.13.05 (Delayed Verification - MinnesotaCare).

If the renewal form is received the month before the renewal month, use standard processing procedures. Contact the enrollee to obtain any missing information. If a renewal is held for additional information, the household has until the last working day of the renewal month to provide the necessary information to ensure continuous coverage. If the household returns the renewal and all required information by the end of the month but the worker has not had time to process it, contact MMIS User Services to extend the renewal for an additional month at the old premium rate.

EXAMPLE:

The Barrett family's renewal month is July. MMIS shows a redetermination date of July 31. MMIS mails the renewal packet on May 15. The renewal form was returned on June 12. The worker is unable to reach the Barretts by phone and requests additional information on June 13. The information has not been received by June cutoff, so the worker closes the case for incomplete renewal (C 48) with an end date of July 31 on the MMIS RELG screen. At July cutoff, MMIS also closes the case for non-payment of the August premium. The information is not received by July 31 and the case closes. The information is received on August 8 and the worker pends the case awaiting payment for September. The family will be without coverage for August. Coverage will resume for September if the premium payment is received by noon on the last working day of August. MMIS will enter a new redetermination date of August 31 of the following year.

If the family returned the information on the last working day of July but the worker did not have time to process the renewal until August, contact the family with the new premium amount. Ask if they wish to have August

coverage. If they do not want coverage for August, pend awaiting payment for September 1. If they do want coverage for August, request a systems change to continue coverage for August.

EXAMPLE:

The Smith family's renewal month is September. MMIS shows a redetermination date of September 30. MMIS mails the renewal form on July 15. The family returns a competed renewal form on July 29. The receipt date is entered on MMIS. The worker processes the renewal on August 18. The worker determines that the family remains eligible and enters necessary information on MMIS to continue eligibility and recalculate the premium. MMIS sends a premium notice reflecting the new amount for October. If the family is now eligible for a lesser benefit set, the new benefit set will be effective in October.

EXAMPLE:

The Jones family's renewal month is October. MMIS shows a redetermination date of October 31. MMIS mails the renewal on August 15. The family has not returned the renewal form as of October cutoff. MMIS generates a termination notice for failure to renew and non-payment. The family returns a complete renewal form and all verifications on October 17. The worker processes the renewal on October 20. The worker determines that the family remains eligible and enters the necessary information in MMIS to continue eligibility and recalculate the premium. MMIS sends a premium notice reflecting the new amount for November and December the same day. The family remains active as long as the November premium is received by the last working day of October.

EXAMPLE:

The Baer family's renewal month is January. MMIS shows a redetermination date of January 31. MMIS mails the renewal packet on November 15. The family has not returned the renewal form as of cutoff on January 17. MMIS generates a termination notice for non-payment of February premium and failure to renew effective January 31. The family returns the renewal form on the morning of January 31. If the family remains eligible, update MMIS information including income and approve the results. Unless the family pays the February premium on January 31 or has a credit, MMIS will cancel the household for nonpayment of the February premium They will be eligible for the reinstatement option. If you cannot determine continued eligibility from the available information on the renewal form, request the missing information and leave the end date of January 31 on the MMIS RELG screen.

The family will be without coverage until they are determined eligible and pay the premium.

If the renewal was received via fax and includes all information and verifications needed to determine renewed eligibility, continue coverage. The household must submit the original renewal form within 30 days from the date of the fax. If the household fails to submit the original renewal form, send 10-day notice to terminate coverage for the 1st available month.

If the renewal was received via fax and processed using delayed verification procedures, the household must submit the original renewal form, along with the delayed verifications, by the end of the month following the renewal month for eligibility to continue.

M.S. 256L.05 subd. 3a
Minnesota Rule 9506.0020 subp. 6, 7
Minnesota Rule 9506.0040 subp. 1

MA/GAMC:

See §0905.03.01 (Annual Renewal TIME LINES--MA/GAMC).

MinnesotaCare:

See §0905.03 (Renewal Timelines).

MA/GAMC:

MAXIS mails renewals for households who are not required to report monthly around the 15th of the 2nd month before the month the renewal is due. For monthly reporters, MAXIS mails the form around the 27th of the 2nd month before the month the renewal is due. See §0905.07 (Monthly Reporting) for information on monthly reporters.

EXAMPLE:

Ethel is on MA and is not a monthly reporter. Her renewal is due December 1. MAXIS will mail the renewal on or around October 15.

MAXIS determines which renewal form to send according to what program(s) the household receives.

- For people residing in long term care facilities or receiving EW services, MAXIS sends the MA-LTC Eligibility Form (DHS 2128).This includes LTC residents who receive MSA for personal needs and EW enrollees residing in GRH facilities and receiving GRH payments.

- For people who receive MA automatically with cash, MAXIS sends the Combined Application Form (CAF, DHS 3469). Follow the timelines and procedures for the appropriate cash program.

EXCEPTION:

Use the DHS 2128 for people who reside in LTC and receive MSA for personal needs. This group is not automatically MA-eligible.

- For people receiving only MA or GAMC, MAXIS sends the Minnesota Health Care Programs Renewal Form (DHS 3418) and a return envelope.

- For people who receive MA or GAMC separately from cash assistance but who are also receiving cash or Food Support, MAXIS sends the CAF if the recertifications and renewals for all programs are due at the same time.

See TEMP Manual TE02.07.366 (Eligibility Review Forms--Health Care Prog's) if the recertifications are due at different times.

EXCEPTION:

MAXIS does not send renewal forms for the MA-BC basis of eligibility. See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC). Mail an MA-BC Application/Renewal Form (DHS 3525) and Certification of Further Treatment Required (DHS 3525A) to MA-BC enrollees on the 15th day of the 2nd month before the renewal is due.

Do not require an in-person interview as part of the renewal process for MA/GAMC.

County agencies may request the reimbursement officer to obtain information necessary to renew the eligibility of Regional Treatment Center residents.

Terminate benefits if a household fails to complete the appropriate renewal form or fails to provide mandatory verifications before the last day of the certification period. Enter an I (incomplete) in the Review Status field on the MAXIS REVW screen. If the agency has not received the renewal form, leave the code as N. MAXIS will generate a notice of termination 10 days before the end of the certification period.

If the renewal form was received by fax, the household must submit the original renewal form within 30 days of the date of the fax for eligibility to continue. Send 10-day notice to terminate for the 1st available month if the household fails to submit the original form.

People enrolled in managed care who do not complete the renewal process by the end of the certification period receive an extra month of eligibility. See §0914.03.19 (Managed Care: 1-Month Rolling Eligibility).

- If the household turns in the renewal form before the last day of the certification period but does not provide all needed information or verifications, OR the agency does not have time to act on the form in time to reinstate coverage for the following month, the case remains closed unless the client is entitled to 1-month rolling eligibility. Reinstate the case if the household completes the renewal process during the next month and the agency determines that eligibility continues.

- If the household turns in the renewal form after the end of the certification period or rolling month, process as a new application. See §0904 (Applications). Do not require the household to complete a new application if they submit the Minnesota Health Care Programs Renewal Form (DHS 3418) as the renewal form. If the household submits a Recertification Form or Long Term Care Recertification Form after the end of the certification period or

rolling month, require a CAF, HCAPP or LTC Application.

EXAMPLE:

Margaret's renewal is due February 1. She is not enrolled in managed care. She submits a completed renewal form on January 15 but does not include verification of income. Request the missing verifications. Enter an I in the review status field on the MAXIS REVW screen. If Margaret does not submit verification by 10-day notice cutoff, MAXIS will generate a termination notice. If you receive the verifications before the end of February and Margaret remains eligible, reinstate eligibility for February.

EXAMPLE:

Herbert's renewal is due March 1. The renewal form has not been received as of 10-day notice cutoff. The review status field remains coded N. MAXIS generates a termination notice for March. Herbert returns the renewal form on March 5. Process as a new application.

If the unit applies for Food Support on the Recertification Form (DHS 3217), treat this as an application. If the unit requests cash, require a CAF and interview.

Deem the income and assets of people who signed an affidavit of support (I-864) for immigrants who entered the U.S. or adjusted their status on or after 12-19-97. Deeming rules apply to immigrants with family- or employment-based codes on the I-551 card. See §0906.03.07.07 (Family/Employment Based Immigration Codes). Apply sponsor deeming to immigrants with employment-based codes only if the U.S. citizen or lawful permanent resident sponsor is a relative who employs the immigrant or has at least a 5% ownership interest in a business that employs the immigrant. Do not apply sponsor deeming to other businesses or corporations.

Do not apply sponsor deeming provisions to the following groups:

- Refugees or asylees. See §0906.03.11.05 (Refugees) and §0906.03.11.07 (Asylees/Deportation Withheld).
- EMA/EGAMC clients. See §0907.29 (Medical Emergency Programs).
- Women who receive MA under the breast and cervical cancer basis (MA-BC). See §0907.19.13 (MA Basis: Breast/Cervical Cancer MA-BC).

Deem all of the income and assets of the sponsor and the sponsor's spouse to each immigrant covered by the affidavit who applies for federally funded MA, state-funded MA (program N), GAMC, or MinnesotaCare. Continue to deem income and assets until the sponsored immigrant naturalizes, earns 40 qualifying work quarters, leaves the U.S., or dies.

A qualifying work quarter is a calendar quarter during which the immigrant had covered employment under the Social Security Act. Also count spouse's quarters earned during the marriage toward the immigrant if the spouses are still married or the spouse has died. Count parents' quarters earned while the immigrant was under age 18. Do not allow credit for any quarter beginning after 12-31-96 in which the person earning the credit also received assistance from a federal means-tested program (MFIP or another state's TANF program, Food Stamps, MA, or SSI).

The Social Security Administration has developed an automated system to verify information on social security credits on an overnight basis. See TE02.12.15 (SVES Quarters of Coverage) and the Combined Manual.

Deem all of the income and assets of the sponsor and the sponsor's spouse to each immigrant covered by the affidavit regardless of whether the sponsor actually contributes income to the immigrant. Do not prorate income if there is more than 1 sponsored immigrant. Do not prorate or allow any deductions for the needs of the sponsor, spouse, or other household members. Do not count the sponsor or sponsor's family members in the immigrant's household size.
EXCEPTION:

If the immigrant or his/her children have been battered or subjected to extreme cruelty, deem only any income or assets the sponsor or sponsor's spouse actually contributes to the immigrant and his/her children. To qualify for a deferment of sponsor deeming rules, the immigrant or his/her children must meet ALL the following conditions:

- They have Battered Status granted by the INS
  OR
  The county or MinnesotaCare operations determines the immigrant or children have been battered or subjected to extreme cruelty. For county and MinnesotaCare operations, require a statement of abuse from the client OR other documentation, such as:

  - Police, government agency, or court records.
  - Statement from a battered women's shelter staff or sexual assault or domestic violence advocate with knowledge of circumstances or credible evidence that supports a sworn statement.
  - Statement from a professional from whom the applicant or enrollee has sought assistance about the abuse.
  - A sworn (notarized) statement from any other person with knowledge of the circumstances or credible evidence that supports a sworn statement.

  A client with an approved claim of good cause for non-cooperation with medical support may use the same documentation to verify domestic abuse. See §0906.13.07 (Good Cause Determination).

AND

- They are not living with the batterer.

AND

- There is a substantial connection between the need resulting from the battery and the need for coverage through the health care programs. See §0906.03.07.05 (Substantial Connection--Battery).

Allow the deferment of sponsor deeming for 12 months after you determine that the immigrant or his/her children have been battered or subjected to extreme cruelty. Extend the 12-month deferment if:

- The immigrant or children continue to have a need related to the battery

AND

- They have either an order for protection or an INS determination

AND

- The sponsor is the batterer.

EXCEPTION:

Do not deem sponsor's income and assets if the immigrant needs placement in a facility and placement is jeopardized by the sponsor's failure or inability to provide support. This includes situations where the client cannot locate the sponsor. Count only any income the sponsor actually contributes to the immigrant. Require the client to explain why the sponsor is not providing support.

For applicants or enrollees who are subject to sponsor deeming rules, request a copy of the Affidavit of Support to verify the sponsor's identity and obtain a release of information to contact the sponsor. Deny or terminate health care coverage for immigrants who refuse to supply sponsor information or sign the release.

If the client and/or sponsor is unable to supply a copy of the affidavit, give the client INS Form G-639. Instruct the client to have the form notarized. Submit the form to the INS requesting a copy of the affidavit. Pay any required INS fees from MA administrative funds.

Send the Sponsor Letter (DHS 3453) to remind sponsors of their legal obligation to provide support and request verification of the sponsor's and sponsor's spouse's income and assets. Deny or terminate health care coverage for the immigrant if the sponsor fails to respond to the Sponsor Letter or fails to provide verifications.

If the sponsor provides verification, deem the income and assets of the sponsor and the sponsor's spouse to each immigrant covered by the affidavit. Count sponsor income as unearned income.

MinnesotaCare:

See §0906.11 (Social Security Number--MinnesotaCare).

MA:

Applicants or enrollees who do not provide or apply for an SSN are ineligible with the following EXCEPTIONS:

- Children eligible as auto newborns are not required to apply for or provide a SSN through the end of the month of their 2nd birthday. See §0907.19.05.03 (MA Basis: Auto Newborn).

- Children meeting all other eligibility requirements are eligible even if their parents refuse to provide or apply for SSNs for them. The parents are ineligible.

- Undocumented people and non-immigrants who are applying for or enrolled in EMA and undocumented and non-immigrant pregnant women applying for or enrolled in MA program N are not required to provide SSNs.

- Adults who refuse to obtain SSNs are eligible if they provide convincing evidence that the refusal is based on well established religious objections. A person who claims this exemption must show membership in a recognized sect or division. A statement that the person objects to obtaining a SSN for religious reasons or other personal beliefs is not sufficient.

  Examples of convincing evidence include but are not limited to proof of filing for a waiver with the IRS using Form 4029 or statements from leaders of the recognized sect or division. If you are uncertain whether evidence submitted by a person claiming this exemption is sufficient, submit a Policy Interpretation.

- Refugee Medical Assistance (RMA) applicants and enrollees are not required to apply for or provide SSNs. See §0907.21.13 (MA Basis: Refugee medical Assistance - RMA).

Use the SSA/DHS data exchange to verify the social security number for all applicants or enrollees. Enter each person's reported social security number (SSN) and appropriate code on the MAXIS STAT/MEMB panel. Do not require people to submit documents to verify the number pending verification through the data exchange.

The computer system will verify the social security number by entering a validation

code on the MAXIS STAT/MEMB panel. If the client information does not match the social security number, you will get a DAIL/DAIL message. The message will list the discrepancy. Clarify the information by comparing the information on the STAT/MEMB panel to the case file or by contacting the client for more information. You may ask the client to submit documents if necessary to clarify the discrepancy. Do not deny or terminate MA if the client is unable to submit documents containing the SSN.

If applicants or enrollees do not have or do not know their SSNs:

1. Get a completed or partially completed and signed Application for Social Security Number (SS-5) for each person without a reported SSN.

2. Highlight areas on the SS-5 that are not complete.

3. Enter the MAXIS Person Master Index (PMI) number in the NPN block at the bottom of the SS-5.

   2 4 0 (3 digit state code)
   ___ ___ ___ ___ ___ ___ ___ ___ (8-digit PMI number, including zeros added to the beginning of the number as fillers).

   EXAMPLE:
   If the PMI is 12345, the PMI for the SS-5 is 240-00012345.

4. Keep a photocopy of the signed SS-5 in the case file.

5. Tell the client to mail or take the SS-5 form with supporting evidence to the local Social Security Administration office. The client must be able to verify age, identity, and lawful non-citizenship status. The SS-5 form describes acceptable types of supporting evidence.

After SSA assigns a number, the data exchange system will supply the number to MAXIS. Follow up at the time of the scheduled recertification if no number has been assigned. Have the client complete a new SS-5 if necessary.

A parent may request a Social Security Number (SSN) for a newborn child on the birth certificate application. The state vital statistics office forwards the birth registration data to the Social Security Administration (SSA), where an SSN is issued and a Social Security card is sent to the parent(s) for the child.

Accept form SSA-2853-OP4 (Information About When You Will Receive Your Baby's Social Security Card) as verification that an SSN application has been made. Retain the form or a copy of the form in the case file.

Remind the parent(s) that they must report the SSN to the county agency when the number is received. The SSN assigned to the child will not be included on the SSA/DHS tape exchange.

GAMC:

GAMC applicants and enrollees must provide SSNs with the following exceptions:

- Undocumented and non-immigrant people applying for or enrolled in EGAMC.

- Undocumented and non-immigrant people who are eligible and applying for or enrolled in ongoing GAMC, including people who are applying for or receiving ongoing GAMC due to receiving care and rehabilitation services from the Center for Victims of Torture. See §0907.25 (GAMC Bases of Eligibility) and §0907.25.07 (GAMC Basis: Victims of Torture).

- People who provide convincing evidence that their refusal to obtain a SSN is based on well established religious objections. See MA.

MinnesotaCare:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.05 (MinnesotaCare Eligibility Group 2), and §0907.07 (MinnesotaCare Eligibility Group 3).

Group 1 includes:

- Children under 21 whose family income is below 150% FPG.

- Children who have been continuously enrolled in Group 1. This includes children who were originally enrolled in the Children's Health Plan who have maintained continuous enrollment. Continuous enrollment means enrollment in MinnesotaCare or MA/GAMC without a break in coverage of 1 month or more. See CONTINUOUS ENROLLMENT in §0902.07 (Glossary: Client...) Re-evaluate the group status of 21-year-olds currently assigned to Group 1 for the 1st available month following the 21st birthday. Assign them to Group 2 or Group 3 depending on their current circumstances. See §0907.05 (MinnesotaCare Eligibility Group 2) and §0907.07 (MinnesotaCare Eligibility Group 3). People age 21 and over cannot have Group 1 status beyond the month in which they turn age 21.

EXAMPLE:

Bobby was enrolled in Group 1 as a child in a family with total income at or below 150% FPG. Re-evaluate group status at the time of each renewal. If family income remains at or below 150% FPG, Bobby will retain Group 1 status. If family income has increased beyond 150% FPG, assign Bobby to Group 2.

EXAMPLE:

Charles was enrolled in the Children's Health Plan in 1990 at the age of 8. He was terminated from MinnesotaCare effective June 1, 1994, and applied for MA on June 10, 1994. He was enrolled in MA from June 1994 until December 31, 1995. He reapplied for MinnesotaCare on December 10, 1995, and was re-enrolled effective January 1, 1996. Charles has maintained continuous enrollment since he had no break in coverage. Charles's family's current income is now over 150% FPG. He retains Group 1 status. If he continues to be continuously enrolled until age 21, re-evaluate his group status for the 1st available month after his 21st birthday.

EXAMPLE:

In 1995, Betty enrolled in MinnesotaCare with her parents. Based on the

household income at the time of enrollment, Betty was assigned to Group 1. In 1996, Betty and her parents ended their MinnesotaCare coverage. They reapply in 1998. Determine Betty's group status based on the household income at the time of re-application.

Generally, children with Group 1 status are exempt from the insurance barrier requirements. See §0910 (Other Health Coverage) for a detailed description of the insurance barriers and to whom they apply.

The income limit for children to have Group 1 status is 150% FPG. Children in households with income between 150% and 275% FPG have Group 2 status except for children who were enrolled in the Children's Health Plan on or before 6-30-93 who have maintained continuous enrollment. See §0912 (Income Eligibility).

M. S. 256L.04 subd. 1 and 7
M. S. 256L.07 subd. 1

MA/GAMC:

No provisions.

MinnesotaCare:

See §0907.09 (MinnesotaCare Pregnant Women).

MA:

All pregnant women have a basis of eligibility for MA program MA or program NM. See §0906.03 (Citizenship and Immigration Status). The pregnancy must be verified by a physician, registered nurse, licensed nurse midwife or physician's assistant. If the pregnancy has already been verified by MinnesotaCare or a cash program, do not require additional verification.

Pregnant non-immigrants and undocumented non-citizens are eligible for program NM through the 60-day postpartum period. They may be eligible for EMA for labor and delivery costs. It is not necessary to change pregnant women's eligibility from NM to MA for labor and delivery. MMIS will identify any emergency claims and submit them to EMA.

Eligibility may begin on the 1st day of the verified month of conception, but no sooner than 3 months before the month of application.

Use Method A.

There is no asset limit for pregnant women.

Consider the pregnant woman to be a household of 2, or more if she is expecting a medically verified multiple birth.

The income standard for pregnant women (program MA and program NM) is 275% of FPG (MAXIS Standard C). See §0912.07.275 (275 Percent of FPG Standards). Women with income in excess of this standard must spend down to100% of FPG (MAXIS Standard E) to qualify. See §0912.07.100 (100 Percent of FPG Standards).

Expedite applications from pregnant women. See §0904.07.03 (Date of Application). Allow pregnant women who want to apply for MA-only to file an application at certain locations other than the county agency. See §0904.07 (Accepting and Processing Applications).

If a woman applied before or after the end of her pregnancy and was eligible for any month of the pregnancy or the 60-day postpartum period, her eligibility continues through the last day of the month in which the 60-day postpartum period ends. The pregnancy can end with birth, abortion, miscarriage, or stillbirth. Once you determine verified eligibility as a pregnant woman, do not consider changes in income, assets,

or household composition during the pregnancy or 60-day post partum period.

Assess continued MA eligibility for women during the 60-day post partum period. If the woman was on MA before she became pregnant, OR other household members are on MA with the same basis that would apply to the woman after pregnancy, continue eligibility with no spenddown without further review until the next regularly scheduled review date. For other women, redetermine eligibility using information in the case record. Request other information from the woman if necessary. If eligibility continues under another basis, leave MA open under the new basis. If eligibility does not exist under another basis, close MA on the last day of the month after the 60-day post partum period. See §0905 (Reviews and Renewals).

Children up to age 2 born to a woman eligible for MA (including DV eligibility) at the time of the birth have a basis of eligibility which is not dependent on the mother's continued eligibility, as long as the child continues to live with the mother. This includes children born to women who applied after the birth and were made eligible retroactively to the date of birth or before. See §0907.19.05.03 (MA Basis: Auto Newborn).

EXAMPLE:

Christine applies for MA when she is 3 months pregnant. She is single and has no other children. She is found eligible for MA-PW. She marries the child's father 3 months later. His income combined with Christine's exceeds the income limits. Do not terminate Christine's MA. If she applies for continued MA at the end of the 60-day postpartum period, consider her husband's income. The child remains eligible through the month of the 2nd birthday, if living with Christine, without regard to Christine or the father's income.

DV EXCEPTIONS:

If a woman found eligible for MA-PW using delayed verification (DV) is determined ineligible when the verification is received or fails to submit verification, end MA-PW status for the 1st month for which you can give 10-day notice unless the woman gave birth during the DV month. Women who give birth during the DV month remain automatically eligible through the 60-day post partum period. Children born to the woman during the DV month remain eligible as auto newborns. See §0904.13.05.01 (Delayed Verification--MA/GAMC).

Pregnant women approved under DV who do not give birth during the DV month are not automatically eligible through the post partum period. If these women fail to

submit verification or are found ineligible for MA-PW based on verifications, terminate MA for the 1st month for which you can give 10-day notice unless there is verified eligibility under another MA basis or under GAMC. Children born after MA is terminated are not eligible as auto newborns.

EXAMPLE:

Lynda applies for MA-PW and is approved under DV effective June 1. Her due date is October 10. She submits income verification on June 25. Her current and anticipated income is above the 275% FPG standard for a pregnant woman. She cannot meet a spenddown and is not eligible under another basis or health care program. Terminate MA effective August 1 (the 1st month for which you can give 10-day notice).

If Lynda gave birth in June, she would remain eligible through August (60-day post partum period). The child would be eligible as an auto newborn.

Do not require a pregnant woman to cooperate with any paternity or medical support matter for any child in her household during the pregnancy or 60-day postpartum period. See §0906.13.03.03 (Medical Support Referral--Newborns).

EXAMPLE:

Maureen receives MFIP and MA for herself and her son Patrick. On May 15, she reports she is pregnant and due in November. On June 10, the child support officer reports that she is not cooperating in establishing paternity for Patrick. Do not terminate Maureen's MA for non-cooperation. Follow MFIP rules to determine her continued eligibility for cash. At the end of the 60-day postpartum period, she must cooperate with the child support office if she wants continued MA for herself.

Require pregnant women to cooperate with TPL and tort requirements as a condition of initial and continued eligibility. See §0910 (Other Health Coverage).

EXAMPLE:

Greta is pregnant and applies for MA. She has insurance through her job which will cover some of the pregnancy costs. The insurance is determined to be cost effective. The county must pay the premiums and Greta must keep the insurance as long as it remains cost effective and available to her. Terminate or deny MA if Greta refuses to cooperate with the cost effectiveness determination or with keeping the cost effective coverage in effect.

NOTE:

Do not consider leaving employment or taking a maternity leave as non-cooperation.

Apply state residency requirements to pregnant women. See §0906.05.03 (State Residence--MinnesotaCare Families, MA).

EXAMPLE:

Marlene is 6 months pregnant and has been receiving MA for 4 months. She reports she is moving to Utah permanently. Terminate MA effective the 1st month for which you can give 10-day notice following the move.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Women who have been screened and found to need treatment for breast or cervical cancer, including precancerous conditions and early stage cancer, may be eligible for MA-BC if they:

- Have been screened by the Minnesota Breast and Cervical Cancer Control Program (MBCCCP) and used program funds to pay for the screening

AND

- Need treatment, including diagnostic services to determine the extent and course of treatment for breast or cervical cancer, including precancerous conditions and early stage cancer

AND

- Are under age 65

AND

- Are not eligible for MA under any of the following bases:

  -Parents/Caretakers. See §0907.19.07 (MA Families and Children Basis: Parents/Caretakers).
  -Children Under Age 19. See §0907.19.03 (MA Families and Children Basis: Child Under 21.
  -Pregnant Women. See §0907.19.05 (MA Families and Children Basis: Pregnant Women).
  -Blind or disabled receiving SSI, OR who have income at or below 100% FPG and are eligible for the Disabled Adult Children Disregard, Widow/Widowers' Disregard, or Pickle Disregard. See §0912.05.19 (Disabled Adult Children Disregard), §0912.05.17 (Widow and Widower's Disregard) and §0912.05.23 Pickle Disregard).
  -1619(a) or (b). See §0907.21.07.03 (MA Basis: 1619a and b).
  -Blind or disabled and receiving MSA . See §0907.21.11 (MA Basis: MSA Recipients).
  Women who are eligible for MA under a basis not listed above may choose to enroll in either regular MA or MA-BC.

AND

- Are not covered by any of the following other creditable health insurance plans:
  -Group health plans, unless the plan does not cover the needed cancer treatment
  -Individual health insurance coverage, unless the plan does not cover the needed cancer treatment.

-Medicare
-MA
-Armed forces insurance (CHAMPUS/TRICARE, CHAMPVA).
-MCHA. See §0918.11 (Minnesota Comprehensive Health Association).

AND

- Have an immigration status that qualifies them for either federally-funded MA (program MA) or state-funded MA (program NM). See §0906.03 (Citizenship and Immigration Status). MA-BC is federally funded for women who have an MA qualifying status and state-funded for those who have a program NM status.

Women who meet all of these conditions are eligible for all MA-covered services for as long as they need treatment. There is no income or asset limit.

Providers who participate in MBCCCP may choose to register with DHS to become presumptive eligibility providers for MA-BC. See POLI TEMP TE02.07.444 (Presumptive Eligibility Providers for MA-BC) for a list of authorized presumptive eligibility providers.

Authorized providers will determine presumptive MA-BC eligibility for Minnesota women who:

- Complete 1 of the following MBCCCP forms: Enrollment form, Return Visit Form or Colposcopy Program Form. These forms were included with Bulletin #02-21-07 (Medical Assistance Coverage for Women Screened by the Minnesota Breast and Cervical Cancer Control Program) dated June, 20, 2002. They do not have DHS form numbers.

AND

- Have been screened through MBCCCP and need treatment for breast or cervical cancer, including precancerous conditions and early stage cancer.

AND

- Are under age 65

AND

- Have no health coverage

After determining presumptive eligibility, the provider will:

- Obtain the client's signed consent to share the MBCCCP form with the county agency.
- Complete a Temporary Medical Assistance Authorization (DHS 3525B) and fax a copy to the county's designated MA-BC staff: along with the completed

MBCCCP form.

- Give the applicant the Enrollee Copy of the DHS 3525B as temporary proof of eligibility until she receives a Minnesota Health Care Programs ID Card and a Minnesota Medical Assistance Breast and Cervical Cancer Coverage Group Application/Renewal (MA-BC Application/Renewal, DHS 3525) to complete and return to the county agency within 30 days. The date of application is the date the provider grants presumptive eligibility.

MBCCCP providers who choose not to determine presumptive eligibility may give applicants a copy of their MBCCCP form and an MA-BC Application/Renewal to submit to their county agency, or they may forward the completed forms to the county agency. The date of application is the date the county agency receives the MA-BC Application/Renewal.

COUNTY ACTION: PRESUMPTIVE ELIGIBILITY

Approve MA-BC effective the 1st day of the month presumptive eligibility was determined by the provider. Complete the approval on MAXIS and MMIS the day you receive the forms from the provider. Do not approve retroactive coverage until the woman is determined eligible for ongoing MA-BC.

Allow the applicant 30 days from the date of the Temporary Medical Assistance Authorization to submit a completed MA-BC Application/Renewal. Terminate MA-BC for the 1st month for which you can give 10-day notice if you do not receive the completed MA-BC Application/Renewal or another approved DHS health care application form by the due date. Do not terminate MA-BC before the end of the 30-day period, even if the woman submits a completed application immediately and is found to be ineligible.

COUNTY ACTION: ONGOING MA-BC

Review the MA-BC Application/Renewal to determine if the applicant is potentially eligible for MA under 1 of the bases listed at the beginning of this section. If the applicant appears to have an MA basis, compare the income on the MBCCCP form to the income limit for the applicant's basis and household size. If the applicant appears to be eligible without a spenddown, contact the applicant by phone to obtain additional information to determine MA eligibility. Send the applicant a HCAPP to complete and return if you are unable to contact the applicant OR if the additional information collected appears to support MA eligibility.

For applicants who were found presumptively eligible, continue MA-BC until you receive the HCAPP or until the end of the presumptive eligibility period. For applicants who were not found presumptively eligible, pend the MA-BC application. See §0904.07.07 (Pending the Application). Deny MA-BC if the applicant fails to return the HCAPP within 45 days.

Enroll women who are eligible for MA without a spenddown in regular MA using the appropriate basis. If they become ineligible for regular MA at a later date, redetermine eligibility for MA-BC. Require verification of the continuing need for treatment if the MBCCCP form is more than 12 months old.

For women who are not eligible under another mandatory MA basis, determine eligibility for MA-BC. Request verification of immigration status for women who report they are non-citizens. Do not require sponsor information for MA-BC. If the applicant reports other health care coverage, contact her to determine if it is creditable coverage. Do not require verification if she states he insurance does not cover her cancer treatment. Enter insurance information in MMIS and determine if the premium is cost effective. Follow §0910.05.01 (Current Health Insurance–MA/GAMC).

Review MA-BC eligibility annually. Mail an MA-BC Application/Renewal and a Certification of Further Treatment Required (DHS 3525A) following the timelines in §0905.03.01 (Annual Renewal Timelines--MA/GAMC). Redetermine MA under another basis for MA-BC enrollees who report they are no longer in need of treatment for breast or cervical cancer, including precancerous conditions and early stage cancer.

MinnesotaCare:

No provisions.

MA:

The Medical Assistance for Employed Persons with Disabilities (MA-EPD) program provides MA coverage to certain employed disabled people who would not otherwise be eligible.

The following groups are not eligible for MA-EPD:

- People age 65 and older.
- People under age 16.

Consider people to be under age 65 through the month of the 65th birthday. See §0915.15.01 (Change in MA/GAMC Basis of Eligibility). Consider people to be age 16 beginning with the month of the 16th birthday.

- SSI recipients.
- People with 1619(a) or (b) status. See §0907.21.07.03 (MA Basis: 1619 A and B).
- People ineligible for GRH who reside in a GRH facility and whose MA spenddown is fully met with remedial care costs.
- People who reside in a long term care facility and are expected to remain for at least 30 consecutive days.

People who are terminated from SSI, RSDI or 1619(a) or (b) benefits because of excess income, assets or other non-disability factors may be eligible if they meet all other eligibility factors.

People may not be eligible for MA-EPD concurrently with the following programs:

- The EW and AC waivers. These waivers are limited to people age 65 and over. See §0907.23.11 (MA Waiver Programs: EW) and §0918.05 (Alternative Care - AC).
- QI. See §0907.21.09.09 (Medicare Supplement Programs: QI). QI and MA-EPD may overlap only when a QI enrollee requests retroactive coverage for

MA-EPD. If MA-EPD eligibility will continue, close QI for the 1st month for which you can give 10-day notice.

- GAMC.

- MinnesotaCare. MA-EPD may overlap with non-federally funded MinnesotaCare. Close MinnesotaCare for the 1st available month after approving MA-EPD. Do not charge MA-EPD premiums for the month(s) of overlap.

- Refugee Medical Assistance (RMA). See §0907.21.13 (MA Basis: Refugee Medical Assistance - RMA).

- QWD. See §0907.21.09.07 (Medicare Supplement Programs: QWD).

- Prescription Drug Program. See §0907.21.09.11 (Medicare Supplement Programs: PDP).

NOTE:

People who are otherwise eligible for MA-EPD while residing in an IMD may be eligible for program IM. See §0907.27 (MA/GAMC Basis: IMD Residents)

MA-EPD may not be the right choice for all employed people with disabilities. Determine eligibility for regular MA first. People with net countable incomes equal to or less than 100% FPG for their household size qualify for MA without a spenddown if they meet other MA eligibility requirements, including asset limits. People with incomes equal to or greater than 100% FPG will have a premium for MA-EPD. Allow people who qualify for both regular MA and MA-EPD to choose between them. Because the premium amount is less than the spenddown for the same income level, MA-EPD will usually be more beneficial for employed people with disabilities who have regular medical expenses.

Employed people with disabilities may be eligible for MA-EPD if they meet all of the following conditions. This includes people who receive waivered services through CAC, CADI, MRRC and TBI. See §0907.23 (MA Waiver Programs).

- Are certified disabled by SSA or SMRT or who have been certified by the county case manager as eligible to receive services through the MR/RC waiver. See §0907.23.05 (MA Waiver Programs: MR/RC). People who are in non-pay status for RSDI continue to be certified disabled by SSA during

the period of non-pay status. Do not refer these people to SMRT. Refer people whose SSI, RSDI, 1619(A) or 1619 (b) benefits are terminated, and people with no current disability certification from either SSA or SMRT. For MA-EPD only, SMRT will determine disability without regard to the person's earnings level. See §0906.15 (Disability Determinations).

People who are eligible for Medicare Part B must enroll as a condition of MA-EPD eligibility. Approve MA-EPD for Part B eligibles who failed to enroll. Require them to enroll during the next general enrollment period (January-March of each year) as a condition of continued eligibility. Reimburse Part B premiums for people who are not eligible for QMB or SLMB. See §0910.05.05 (Medicare Premium Payments).

- Receive earned income from employment or self-employment. See §0907.21.07.06 (MA-EPD: Employment Definition) for a definition of earned income for MA-EPD.

- Have countable assets equal to or less than $20,000, excluding retirement accounts and medical expense accounts. Exclude spousal assets, including the spouse's share of jointly held assets. Follow all other Method B asset exclusions. See §0909.11 (Excluded Assets) and §0909.11.01 (Additional Excluded Assets for Method A/B) for more information. Follow other asset policies in §0909 (Assets), including verification, availability, asset reduction, and treatment of specific types of assets.

  When an MA-EPD enrollee stops working for any reason, continue to apply the MA-EPD asset rules and $20,000 limit when determining regular MA eligibility for up to 12 months after the person loses MA-EPD status.

- Pay premiums if required. People with incomes less than 100% FPG do not have premiums. See §0912.07.100 (100 Percent of FPG Standards).

  People with incomes equal to or greater than 100% FPG have a sliding scale monthly premium based on income and household size OR the monthly cost of MA-EPD services, whichever is less. Count only the MA-EPD applicant or enrollee's income, unless the applicant or enrollee is age 16 or 17 and lives with 1 or both biological or adoptive parents. Deem parental income in those cases. Follow §0908.05 (Determining MA/GAMC Household Size) to determine the household size, except for married couples who both apply for MA-EPD. Use a household size of 1, plus children, for each spouse. See §0913 (Premiums and Spenddowns) and §0913.01.03 (MA-EPD Premiums).

People may be eligible for MA-EPD concurrently with QMB and SLMB. See §0907.21.09.03 (Medicare Supplement Programs: QMB) and §0907.21.09.05 (Medicare Supplement Programs: SLMB).

MinnesotaCare:

Exclude the value of assets for:

- All children under age 21, regardless of whether they are applying as part of a household with members age 21 and over or separately.

- All pregnant women, regardless of age, through the end of the 60-day post partum period. Begin considering assets for women age 21 and over at the end of the post partum period.

Apply the asset limits to all other people age 21 and over, including dependent siblings.

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MA:

Exclude the value of assets for:

- People who are eligible for automatic MA with MSA, RCA, GRH or IV-E foster care payments. Apply the limits of the applicable cash program. Do not apply the MA limits unless people are ineligible for cash and request MA only, or their MA eligibility is determined separately from cash (such as MSA for personal needs in long term care facilities or EW eligibility for GRH enrollees).

- People receiving TMA or TYMA. See §0907.19.11.03 (TYMA: 2nd 6 Months).

- Children under age 21, regardless of their basis of eligibility.

- Pregnant women through the 60-day post partum period and women who are eligible for MA with the elimination of the post partum review. See §0907.19.05 (MA Basis: Pregnant Women).

- People with 1619(a) or 1619(b) status. See §0907.21.07.03 (MA Bases: 1619 A and B).

- Women eligible for MA-BC. See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC).

GAMC:

Do not apply the asset limits to people applying for or receiving GAMC automatically with GA.

MinnesotaCare and MA/GAMC Method A:

Exclude 1 vehicle for each household member of legal driving age used for employment or seeking employment. This includes vehicles used for employment or job search by household members who are not requesting or are not eligible for coverage. Exclude the highest valued vehicle(s), regardless of which vehicles the employed household members actually drive to work.

EXAMPLE:

Jon and Marie apply for MinnesotaCare for themselves, their 19-year-old son Ben, and their 17-year-old daughter Jessica. Jon and Marie have an asset limit of $30,000. Ben and Jessica have no asset limit. Jon and Ben are employed full time. Marie was laid off from her previous job and is seeking employment. Jessica is a full-time student and is employed part time. The family owns 4 vehicles. Exclude the equity value of all vehicles. If only 3 household members are employed or seeking employment, exclude the equity value of the 3 highest valued vehicles.

Exclude vehicles used in a trade or business if the equity value combined with other assets of the trade or business does not exceed $200,000. See §0909.11.03 (Excluded Assets for Self-Support).

Count the equity value of non-excluded vehicles. Use the information reported by the client to determine the fair market value and encumbrances. If the client does not supply a value, use the NADA trade-in value. If the client disputes the NADA value, accept the client's statement of the vehicle's value.

A vehicle may be any conveyance used on air, land, or water. It need not be licensed.

MA/GAMC Method B:

Exclude a vehicle used as the client's principal place of residence.

Exclude vehicles necessary for self-support. See §0909.11.03 (Excluded Assets for Self-Support).

Exclude 1 vehicle if any household member needs it for 1 or more of the following reasons:

- For employment.
- To get medical treatment for a specific or regular medical problem.

- It has been modified for operation by or transportation of a disabled person.

- It is needed to perform essential daily activities because of climate, terrain, distance, or similar factors.

Exclude only 1 vehicle under this provision even if the household has more than 1 vehicle meeting 1 or more of the conditions for exclusion. Count the equity value of other vehicles toward the asset limit.

EXAMPLE:

Mr. and Mrs. Jones apply for MA for themselves and their 17-year-old son, Dick. The family owns 3 vehicles. Mrs. Jones and Dick are both employed. Mr. Jones has a disability and receives regular medical treatment. Although all 3 vehicles meet an exclusion category, only 1 can be excluded under these provisions under Method B. Exclude the vehicle with the highest equity value. Count the equity value of the other 2 vehicles toward the asset limit.

Because of Minnesota's climate, vehicles that are not used for employment or medical care can usually be excluded for use in essential daily activities. However, if the household has no vehicle meeting 1 or more exclusion conditions, exclude the 1st $4,500 of the market value of 1 vehicle.

EXAMPLE:

Mavis, age 85, lives alone and receives MA. She no longer drives but has a vehicle registered to her. Her daughter takes her shopping and to perform other daily activities, using the daughter's car. Mavis's car has a value of $5,000 with nothing owed on it. Since the car does not meet any of the exclusion criteria, it cannot be totally excluded. Exclude the 1st $4,500 of the market value. Count the remaining $500 toward the asset limit.

A vehicle may be any conveyance used on air, land, or water. It need not be licensed.

Use the NADA trade-in value to determine the FMV of all non-excluded vehicles. To determine the equity value, subtract the balance owed on secured loans from the FMV. A secured loan is any loan for which the vehicle is held as collateral and/or the lender holds title to the vehicle.

Exclude up to $1,500 in burial funds for each applicant or enrollee, his/her spouse and MA-eligible dependent children. Spouses (including community spouses of clients who reside in LTC or receive services through the Elderly Waiver (EW) do not have to be MA-eligible to receive the burial fund exclusion. Dependent children (including those living with the community spouse of an LTC or EW client) must be MA-eligible to receive the burial fund exclusion. Do not count the value of burial space items toward the exclusion. See §0909.17.05 (Burial Space Items).

There are several types of burial funds. Evaluate all types owned by a client according to the specific provisions for that type of fund. Common types of burial funds include:

- Life insurance. The face value of life insurance is the policy's death benefit at the time of purchase. The amount payable at the time of death may exceed the face value because of dividends and increased cash surrender value.

  EXAMPLE:

  Opal purchased a $1,000 life insurance policy in 1974. In 1999, the amount payable on death including dividends and other additions is $1,400. The policy's face value is $1,000.

  The cash surrender value is the amount the policy owner would receive if the policy were cashed in. Term policies have a face value but do not have a cash surrender value. Therefore they are not counted as assets.

- Insurance and annuity funded burials. An insurance funded burial is a life insurance policy with an irrevocable designation of a funeral provider as the beneficiary. The face value, or death benefit, of the policy will be paid to the funeral provider in exchange for the provision of agreed-upon goods and services. The irrevocable designation must be attached to the life insurance policy. Because Minnesota law allows people to change funeral providers, the designation must state, Any funeral provider whose interest may appear, irrevocably. The statement of goods and services to be provided may be revocable or irrevocable. Because the policy's benefits have been irrevocably assigned to the funeral provider, the cash surrender value is no longer available to the policy owner.

- Annuity funded burials are similar arrangements with the goods and services funded by purchase of an annuity. By irrevocably designating a funeral provider as the beneficiary, the annuity owner gives up all rights to receive income from the annuity.

- Insurance and annuity funded burials may be for any amount, although the MA burial exclusion is limited to $1,500. They may include items such as flowers and obituary notices in addition to professional services and burial space items. Amounts in excess of the burial exclusion are an unavailable asset.

  Determine if clients received adequate compensation for the value of an irrevocably designated life insurance policy or annuity. The client received adequate compensation if:

  - The statement of goods and services is for the same amount as the purchase price of the life insurance policy or annuity.

  AND

  - The burial agreement does not fund items already covered by a previous burial agreement.

  If these conditions are not met, determine whether the client has made an improper transfer. See §0909.27 (Asset Transfers) and §0909.27.01 (MA Transfers--Cont.)

  EXAMPLE:

  Jane purchases a $5,000 life insurance policy to fund a burial agreement. She has a statement of goods and services with a funeral home which includes $2,000 for professional services, $2,000 for a casket, and $1,000 for a burial plot and marker. Jane already owns a plot and marker. Consider the $1,000 as an improper transfer.

See the program-specific instructions at the end of this section for additional requirements for insurance- and annuity-funded burials for people who use MA or GAMC Method B.

- Burial agreements. Burial agreements require that a specified amount be deposited with a funeral director to be used for funeral expenses. The agreement may cover funeral and professional services, burial space items, or both. The money is usually held in trust by a bank or other financial institution unless the agreement is funded by an insurance policy or annuity.

  Burial agreements may be revocable or irrevocable. The money is payable on death to the funeral director. If the agreement is irrevocable, it cannot be withdrawn before the depositor's death.

Irrevocable burial agreements can be written in any amount. However, under Minnesota law, irrevocable burial agreements set up by a Minnesota funeral director are only irrevocable up to $2,000. Depositors may legally withdraw amounts over $2,000 regardless of the terms of the agreement. Irrevocable burial agreements set up in another state are considered irrevocable up to the full amount allowed under that state's laws.

- Other assets. If a balance of the $1,500 burial fund exclusion remains after applying the face value of life insurance and irrevocable burial funds according to §0909.17.03 (Determining the Burial Fund Exclusion), the client can apply the assets listed below toward the balance of the burial fund exclusion. Do not apply the value of any other property toward the exclusion.

  - CSV of life insurance policies.
  - Dividends from life insurance policies.
  - Revocable burial agreements.
  - Revocable burial trusts.
  - Other revocable burial agreements (including the value of certain installment sales contracts for burial spaces).
  - Cash.
  - Financial accounts (for example, savings or checking accounts).
  - Other financial assets with a definite cash value (stocks, bonds, certificate of deposit-CD, trusts).

MinnesotaCare and MA/GAMC Method A:

Follow general provisions.

MA/GAMC Method B:

In addition to the requirements in the general provisions, insurance-and annuity-funded burials must irrrevocably designate the person's estate as the contingent beneficiary to the extent the proceeds are not used for payment of selected burial expenses.

MinnesotaCare:

No provisions.

MA:

In addition to the circumstances in §0909.27 (Asset Transfers), a transfer may occur by any action which causes an asset to which a person or a person's spouse is entitled not to be received by the person or the person's spouse. This includes:

- Waiving the right to or refusing to accept an inheritance (also known as refusing to elect against a will). However, if refusing to elect against a will allows greater income or assets for the client, it is not considered an improper transfer. Look at the total circumstances to allow the greater in income or assets for the client. The signing of a consent not to elect against a will is not considered a transfer at the time of signing, but may be considered an improper transfer at the time of death depending on the circumstances.

- Waiving pension income or diverting it to a trust or similar device for the benefit of another. See §0909.21.09 (Trusts Established on or After 8-11-93).

- Refusing to take affordable legal action to obtain court-ordered payment that is not being paid, such as child support or alimony.

- Not accepting or taking action to obtain personal injury settlements.

- Personal injury settlements diverted by a defendant into a trust or similar legal device to be held for the benefit of the plaintiff, unless the exception for a disabled person applies. See §0909.21 (Trusts).

The transfer of a homestead or any non-excluded asset BEFORE 8-11-93 is improper if:

- It occurred within 30 months before application, while the application is pending, or during MA eligibility.

AND

- It was transferred at less than fair market value.

The transfer of a homestead or any non-excluded asset ON OR AFTER 8-11-93 is improper if:

- For transfers into irrevocable trusts, all or part of which can never be distributed to or for the benefit of a person or the person's spouse, it occurred within 60 months before MA application for or receipt of long term care services. See §0909.27.07 (Transfer Lookback Period) and §0909.21.09 (Trusts Established On or After 8-11-93).

- For transfers into revocable trusts to someone other than the client or for the benefit of the client, it occurred within 60 months before MA application for or receipt of long term care services. See §0909.27.07 (Transfer Lookback Period) and §0909.21.09 (Trusts Established on or After 8-11-93).

OR

- For all other transfers, it occurred within 36 months before MA application for or receipt of long term care services, or during MA eligibility for long term care services.

Presume the purpose of the transfer was to obtain or maintain payment of long term care services. This includes transfers made by the community spouse after MA has been approved for the LTC spouse. Even though assets have been allocated to the community spouse, there is always a potential for the assets to become available to the LTC spouse in the future. If the community spouse of a person receiving LTC services makes a transfer, require the community spouse to demonstrate that the transfer was done for a valid purpose that does not affect the LTC spouse's MA eligibility. Transfers made to preserve the estate for the heirs, avoid probate or reduce taxes are always improper. Calculate a penalty period for the LTC spouse unless it appears the transfer was done for another valid purpose. In that case, submit a policy interpretation to the Health Care Policy Center for a determination. See §0909.27.11 (Improper Transfer Ineligibility) to calculate the improper transfer penalty. You may waive the penalty for an improper transfer of assets based on undue hardship. See §0909.31 (Waiver of Asset Rules).

GAMC:

See §0909.27 (Asset Transfers).

MinnesotaCare:

No provisions.

MA:

No provisions for MA, QMB, SLMB, QWD and QI. For the Prescription Drug Program (PDP), consider the following types of coverage to be prescription drug coverage in determining whether an applicant has current coverage or has had coverage in any of the 4 months preceding the 1st month of PDP enrollment:

- Prescription drug coverage available through a health plan or HMO.

- Medicare supplemental policies (Medsup or Medigap) where the enrollee has opted for prescription drug coverage through a rider or selected drug coverage as an option.

Basic Medicare supplement plans and health insurance plans without drug riders do not provide prescription drug coverage. Minnesota law requires that these policies include the following warning on the 1st page of the contract:

Notice to Buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you. Please ask for further details.

Advise applicants who are unsure whether their policies include prescription drug coverage to check the policy to see if it contains this warning.

People currently enrolled in MA without a spenddown or MinnesotaCare are ineligible for PDP. See §0907.21.09.11 (Medicare Supplement Programs: PDP). Enrollment in MA or MinnesotaCare in the 4 months preceding the month of application is NOT a barrier to PDP enrollment.

Do not consider the following types of coverage to be prescription drug coverage when determining eligibility for PDP:

- Access to prescription drug discount cards. Examples include:

  -Discount cards provided by insurance companies only to people who opt for health insurance without a prescription drug rider.
  -Discounts offered by pharmacies to encourage people to use their prescription services.
  -Discount cards offered through prescription “clubs”.

-Discount cards offered through senior organizations or other associations.

- Access to prescription drugs through pharmaceutical manufacturers' prescription drug patient assistance programs.
- Access to facilities which provide prescription drug coverage to people who qualify, such as veterans' medical centers, Indian Health Centers, and community clinics.
- Auto, homeowner's or other liability insurance that pays prescription drug costs resulting from an accident.
- Workers' Compensation coverage for prescription drug costs resulting from a work-related injury.
- CHAMPUS/TRICARE.
- Basic Medicare supplement plans required by law to provide 80 percent coverage for physician-prescribed diabetic equipment and supplies and injectable insulin.
- UCare for Seniors Classic Plan for people who were enrolled in both PDP and the UCare Classic Plan on March 1, 2001. This exception expires on June 30, 2003.

See §0907.21.09.11 (Medicare Supplement Programs: PDP).

GAMC:

No provisions.

Exclude income from the following sources in determining eligibility for all health care programs:

NOTE:

Some types of income that are otherwise excluded may be counted for long term care budgeting. See §0913.13 (Long Term Care Spenddown Calculation).

- Children's Nutrition Act.
- Benefits from the Women, Infant, and Children (WIC) nutrition program.
- Benefits from the National School Lunch Act.
- Benefits from the Food Support Program issued in the form of coupons or Electronic Benefit Transfer (EBT) payments.
- Benefits from the State Food Programs provided to non-citizens or vouchers from the Minnesota Grown Program. See §0918.17 (Food Stamps and Related Programs).
- Loans which the applicant or enrollee has a written obligation to repay, except some student loans. See §0911.09.07 (Student Financial Aid Income).
- The principal portion of repayments on a loan owed to the applicant or enrollee. Interest payments received by the applicant or enrollee are counted.
- Reverse mortgages.
- Payments from the Low Income Home Energy Assistance Program (LIHEAP).
- Amounts an applicant or enrollee receives which are related to shared living expenses and are solely to pay a portion of another person's living expenses. For example, exclude payments a person receives from a roommate for a portion of the rent to be forwarded to the landlord. Do not apply this exclusion to payments people receive from renting or providing room and board in property they own. See §0911.09.03.17 (Roomer/Boarder Income).
- Rental payments made directly to a landlord through the Housing and Urban Development (HUD) agency, including Section 8 payments made through the Housing and Redevelopment Authority.
- Refunds or rebates from HUD for excess rents charged.
- Security deposit refunds and utility deposit refunds whether paid by the applicant or another party, including the Emergency Assistance (EA) or Emergency General Assistance (EGA) programs.
- Cash from the sale of the client's property or assets, regardless of whether the asset was excluded. This includes money withdrawn from savings accounts or other liquid assets for living expenses. This does not apply to some business capital gains. See §0911.09.03 (Self-Employment Income). It does not apply to interest or dividends regularly earned on assets and paid to the

household. Count these payments as income.

EXAMPLE:

An enrollee receives $3,000 from the sale of his car. Exclude this money as income.

EXAMPLE:

A household withdraws $300 each month from a savings account and uses it to pay rent. Exclude this money as income.

EXAMPLE:

A household receives a quarterly dividend payment of $65 from stocks they own. Count this payment as income. Also see §0909 (Assets) for information on treating cash from the sale of property as assets for MA and GAMC.

- Payments to replace personal or real property made by public agencies, issued by insurance companies, awarded by a court, or issued through public appeal.
- Payments received and used for care and maintenance of a 3rd party beneficiary who is not a household member. This includes payments for the care of foster children who live in the household.
- Federal and state adoption assistance payments, except for state adoption assistance payments which continue beyond age 21. See §0911.09.13 (Assistance Payments Income).
- Tax refunds, credits, and rebates. Tax refunds include:
  - Federal and state withholding refunds.
  - Homeowner/Renter Property Tax Refund.

  Tax credits include:
  - Earned Income Credit (EIC).
  - Federal Child Care Credit.
  - Minnesota Working Family Credit.

  Tax rebates include amounts returned to individual taxpayers based on federal or state taxes paid, such as the 1999 sales tax rebate authorized by the Minnesota legislature.
- Payments by the vocational rehabilitation program administered by the state under Minnesota Statutes, chapter 268A, except those payments that are for current living expenses.
- Relocation Assistance for displaced persons under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, the Housing and Redevelopment Act of 1965, or the Housing Act of 1965.
- Payments made under the Radiation Exposure Compensation Act (Public Law

101-426).

- Mandatory salary reduction amounts for military service personnel which are used to fund the G.I. Bill (Public Law 99-576).
- Payments from the Consumer Support Grant (CSG) program.
- Federal payments issued due to a presidential declaration of disaster. Federal payments include, but are not limited to, grants from the Federal Emergency Management Agency (FEMA).
- Disaster assistance provided by states, local governments, and disaster relief organizations such as Red Cross and Salvation Army.
- Payments made to people because of their status as victims of Nazi persecution. This includes reparation payments the Federal Republic of Germany makes to certain survivors of the Holocaust, and Netherlands' Act (WUV) payments to victims of Nazi (German) persecution. Exclude all WUV payments for Method B. Count WUV payments to victims of Japanese persecution as unearned income for Method A and MinnesotaCare.
- Family Support Grant Payments.
- Benefits and payments provided to volunteers through the Domestic Volunteer Service Act., which includes:
  - Title I:
    - Volunteers in Service to America (VISTA). Also exclude Americorps VISTA payments.
    - University Year for Action (UYA).
    - Urban Crime Prevention Program.
  - Title II:
    - Retired Senior Volunteer Program (RSVP).
    - Foster Grandparent Program.
    - Older Americans Community Service Program.
    - Senior Health Aides.
    - Senior Companions.
  - Title III:
    - Service Corps of Retired Executives (SCORE).
    - Active Corps of Executives (ACE).

  Count payments to people administering VISTA who are civil service employees as earned income for all programs.

- Reimbursements for expenses, other than normal living expenses. This includes reimbursements from employment and training programs such as JTPA, volunteer service programs, county social services programs, jury duty, employment, and reimbursements for medical expenses.
- Payments made under the Vietnamese Commandos Compensation Act.

- Payments made under Public Law 104-204 on behalf of children of Viet Nam veterans who are born with spina bifida.
- Blood Product Litigation settlement payments.
- Payments made to compensate crime victims for losses resulting from the crime.
- Settlements to hemophiliacs under the Ricky Ray Hemophilia Relief Act of 1998.
- Federal and non-federal matching funds deposited into Individual Development Accounts (IDAs). See §0902.19 (Glossary: In-Kind....) for a definition of IDAs.
- Certain payments made by tax-exempt organizations to or for the benefit of children with life-threatening conditions. Apply this exclusion to cash payments of up to $2,000 per calendar year and to the total value of in-kind gifts. This includes gifts to the child's parents for the child's benefit and indirect benefits to other family members, such as payment to accompany the child on a trip. Count the amount of total cash payments that exceed $2,000 in a calendar year. Count the value of in-kind gifts converted to cash unless the gift could be excluded as an asset under other provisions.

  The Make-A-Wish Foundation is an example of an organization meeting the criteria for exclusion. If an organization's status is unclear, ask if the organization is a section 501 © (3) organization under the Internal Revenue Code of 1986 and is exempt from taxation under Section 501 (a). Accept the organization's statement that the gift was made based on a child's life-threatening condition.

See §0911.05.03 (Excluded Income--Program Provisions) for additional types of income excluded for each program.

Consider the following types of income as earned income for all of the health care programs except MA-EPD:

- Wages.
- Commissions.
- Tips.
- Jury duty pay.
- Picket duty pay.
- Severance pay, if based on accrued leave time.
- Vacation pay.
- Sick pay, if based on accrued or earned time.
- Compensation from the employer's vacation donation program, if paid and taxed in the same manner as the employee's usual pay.
- Blood and blood plasma sales.
- Royalties and honoraria which result from the client's work or service.
- Wages paid to participants in programs carried out under the Community Service Employment Program (Title V of the Older Americans Act), which includes the Experience Works (formerly Green Thumb) program and the Senior Aides Program.
- Wages paid through the National and Community Service Act of 1990 under Title I, which includes the following programs:

  - Serve-America.
  - Higher Education Innovative Projects.
  - Conservation and Youth Service Corps.
  - National and Community Service Models.

  Count benefits other than wages paid through the programs listed above as unearned income. Exclude reimbursements for expenses.

- AmeriCorps living allowances. Exclude in-kind AmeriCorps benefits. See §0911.09.17 (In-Kind Income).

See §0907.21.07.06 (MA-EPD: Employment Definition) for a definition of earned income for MA-EPD.

MinnesotaCare:

Consider all income from self-employment or an owned business as earned income. Consider distributive profits paid to children through a partnership as unearned income unless the child performs labor for the partnership. See §0911.09.03 (Self-Employment Income).

Consider housing allowances paid in cash to members of the clergy as earned income. Exclude housing provided directly without charge, such as use of a parsonage, as in-kind income.

M. S. 256L.01 subd. 4 & 5
Minnesota Rule 9506.0040 subp. 2

MA/GAMC:

Follow general provisions.

MinnesotaCare:

Follow §0911.09.03 (Self-Employment Income) and §0911.09.03.03 (Self-Employment Income--MinnesotaCare).

MA and GAMC:

If a client receives payments for lodging, meals, or related services from people living in the client's home, the income is roomer/boarder income. Households with roomer/boarder income are self-employed. Count the income as earned income.

- A roomer lives with the household and pays for lodging only.
- A boarder eats with the household and pays for meals only.
- A roomer and boarder lives AND eats with the household and pays for lodging AND meals.

Roomer/boarder income is different from rental property or from shared living expense income. For information on rental property income, see §0911.09.03.13 (Rental Income). For information on shared living expense income, see §0911.05 (Excluded Income).

METHOD A:

Allow a flat rate deduction for each roomer/boarder:

- Roomer: $71 per month.
- Boarder: $139 per month.
- Roomer and boarder: $210 per month.

Subtract the flat rate deduction for each roomer/boarder from total roomer/boarder income to get gross self-employment income.

METHOD B:

Allow the following expenses for a roomer/boarder:

- Roomer: The verified expense of providing the room.
- Boarder: The verified expense of providing the food.
- Roomer and boarder: The verified expense of providing the room and board.

Deduct expenses, up to the amount of the income, to get gross self-employment income. To determine the expense of providing a room, prorate the total shelter

expenses based on the ratio of the number of rooms for rent to the total rooms in the house. Do not include bathrooms. Do not include attics or basements unless they are converted to living spaces.

MinnesotaCare:

Count payments from the MFIP, GA, MSA, and Refugee Cash Assistance (RCA) programs as unearned income to the household.

Exclude foster care and relative custody assistance payments. See §0911.05 (Excluded Income).

Exclude Food Support Program payments issued in the form of coupons, through an electronic benefit system, or as the food portion of a cash grant.

MA/GAMC:

Exclude all assistance payments as income to the household, including:

- Cash program payments such as MFIP, Diversionary Assistance, GA, MSA, and RCA.

EXCEPTION:

Count cash payments, such as MSA grants for personal needs, when using long term care budgeting. See §0913.13 (Long Term Care Spenddown Calculation).

- The value of Food Support Program payments, whether received in the form of coupons, electronic transfer payments, or cash.

- Vendor payments made on behalf of the household, such as:

  - Emergency payments made by EA or EGA.

  - MSA or GRH payments made directly to a facility.

METHOD A:

- Exclude foster care, relative custody, and adoption assistance payments.

METHOD B:

- Exclude foster care payments.

- Exclude relative custody assistance payments as income to the relative. Count them as unearned income to the child.

- Exclude adoption assistance payments for children up to the age of 21 as

income to the child and parents. In rare circumstances, state adoption assistance payments can be continued up to the age of 22. If payments continue beyond age 21, count the payment as income to the child.

MinnesotaCare:

No provisions.

MA:

METHOD A:

Subtract the following earned income disregards from the monthly earned income of anyone whose income is considered in determining eligibility. See §0908.07 (Household Composition: Deeming).

Children ages 2-5	Subtract 21% of gross earned income using 170% FPG standard.
Children ages 19 and 20 and parents/caretakers	Subtract 17% of gross earned income.
Children under age 19 with spenddowns	.

There is no earned income disregard for children ages 6-18 using the 170% FPG standard.

Do not reduce earned income to less than $0 or use earned income disregards to reduce unearned income.

EXAMPLE:

Jeanna applies for MA for herself and her son. She is employed part-time earning $200 per month. She receives RSDI of $400 per month for her son. Deducting the 17% earned income disregard reduces her net earned income to $166. Jeanna pays dependent care expenses of $175 per month while she is at work. Her countable earned income is zero. Do not deduct an additional $9 from the RSDI income.

Pregnant women and infants through the month of their 2nd birthday and children ages 6 through 18 whose income is equal to or below the applicable standard (275% FPG for pregnant women; 280% FPG for children through the month of their 2nd birthday; 170% FPG for children ages 6 through 18) do not receive an earned income disregard because the disregard is included in the standard. See §0912.05.05 (Work Expense Deductions).

If a pregnant woman has earned income while receiving MA using the 275% FPG standard, the disregard cycle continues to run. This also applies to a spouse or parent whose income is deemed to a pregnant woman, infant under age 2 or child ages 6 through 18. This does NOT apply to infants who are automatically eligible because they

were born to an MA-eligible woman because no income is deemed to these infants. See §0907.19.05.03 (MA Basis: Auto Newborn).

If the pregnant woman or infant's income exceeds the 275% or 280% FPG standard after applying the work expense deduction 0912.05.05 (Work Expense Deduction), the 17% disregard may be used to spend down to 100% of the FPG standard. See §0912.05.05 (Work Expense Deductions) and §0912.07.100 (100 Percent of FPG Standard).

EXAMPLE:

Stella, a single woman with no other children, applies for MA/PW in April. Her child is due July 15. She is employed and is not requesting retroactive MA because the health insurance she has through her employer has covered all her bills to date. Her income is under 275% FPG. Stella begins a maternity leave on June 30 and receives her last pay check on July 7. She returns to work on September 15 and receives her 1st pay check on September 22.

Although Stella does not receive an earned income disregard while eligible for MA/PW because her income is less than 275% FPG, count April, May, June, and July as the 4 months of the 17% disregard because Stella received earned income in each of those months.

EXAMPLE:

Paula, a single woman with no other children, applies for MA/PW in June. Her child is due in August. She began a maternity leave in May because of pregnancy complications. She received her last pay check in May and began receiving payments from a disability insurance policy in June. She is not requesting retroactive coverage. Do not count the months in which she receives MA/PW and has no earned income as months of the disregard cycle. Begin the cycle when Paula returns to work if she is still receiving or requesting MA.

If a child ages 6 through 18 has income that exceeds 170% FPG, the 17% disregard may be used to spend down to 100% FPG. See §0912.07.100 (100 Percent of FPG Standard).

For all others, each person whose earned income is considered in determining eligibility is eligible for earned income disregards. Employed people in the same household can be eligible for the earned income disregards concurrently or at different times.

Also see §0912.05.09.03 (Earned Income Disregard Cycle--Method A).

GAMC:

Apply an earned income disregard to the earned income of all household members whose

income is used to determine GAMC eligibility using Method A. The amount of the disregard is $30 +1/3 of earned income remaining after the $90 work expense deduction in 0912.05.05 (Work Expense Deduction) for the 1st four months. After the 4-month cycle ends, limit the disregard to $30 for the next 8 consecutive months. The $30 cycle continues to run even if there is no earned income or the person is no longer on GAMC. See §0912.05.09.03 (Earned Income Disregard Cycle--Method A).

For information about spenddowns, see §0913.03 (Spenddowns--MA/GAMC).

MinnesotaCare:

All MinnesotaCare enrollees must pay a premium to establish and maintain coverage. MMIS computes the premium amount based on the household size, income, and number of people covered. The MinnesotaCare program pays the rest of the enrollee's cost of coverage through the Health Care Access Fund.

Premiums are computed and billed on a monthly basis. Most enrollees make monthly payments. However, enrollees may choose to pay premiums in advance for up to 1 year.

Enrollees may pay premiums by check, money order, automatic withdrawal, payroll deduction, or through the tax refund premium payment plan. See §0913.02 (Premium Payment Options). DHS collects and posts all initial and ongoing payments regardless of the household's choice of enrollment site. If you receive a premium at the county agency in error, forward it to DHS-MinnesotaCare, attn. Cashier, PO Box 64834, St. Paul, MN 55164-0834. Return initial premium payments received with applications to the applicants. Inform applicants that they will receive a First Premium Notice if their applications are approved.

Once the initial payment is received and a case becomes active, monthly premiums are billed approximately 6 weeks before the 1st day of the coverage month and are due approximately 2 weeks before the 1st day of the coverage month. For example, MMIS sends October premium billings on August 15. The October premium is due by the September cutoff date (approximately September 15). If the premium has not been received by the September cutoff date, MMIS sends an overdue notice and a cancellation notice effective the end of the current month.

Except for pregnant women and children under 2, coverage is terminated unless the payment is received by noon on the last business day before the coverage month. For example, if the October premium payment has not been received by September 15, MMIS sends a cancellation notice. Coverage terminates September 30 unless the October payment is received by noon on the last business day of September. Households canceled only for nonpayment may be reinstated back to the date of cancellation if they pay all billed premiums by noon on the 20th day following cancellation. See §0915.11.05 (Fail to Pay Premium/Reinstatement). Households who are not reinstated must serve a 4-month penalty period unless they show good cause for nonpayment. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

Treat a dishonored payment as failure to pay the MinnesotaCare premium. This

includes checks returned for insufficient funds and returned automatic bank withdrawals. Enrollees must replace dishonored payments by a guaranteed form of payment (cashier's check, money order or cash). If the household fails to make a guaranteed replacement payment, coverage will terminate and the household must serve a 4-month penalty period unless they show good cause for non-payment. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

Require a guaranteed form of payment ONLY for dishonored payments. Do not require a guaranteed form of payment for any other current or future premiums owed. If an enrollee's premium payment check is returned for non-sufficient funds (NSF) or an automatic bank withdrawal has been returned, MMIS User Services will return the check or other bank documentation with a letter requiring a guaranteed form of payment and will send the enrollment representative a copy of the screen print. Document the returned payment in case notes.

EXAMPLE:

MinnesotaCare receives Joe's September premium payment on August 15. On August 29, MMIS User Services is notified that Joe's check was returned for NSF. MMIS User Services returns the check to Joe with the MS-0811/J. requesting guaranteed payment. MMIS will terminate Joe's coverage for nonpayment if he fails to replace the NSF check with a guaranteed form of payment and he will be subject to a 4-month penalty period. If Joe does replace the NSF check with a guaranteed form of payment, reinstate coverage.

Take action to change the premium amount:

- At the time of the annual renewal if the household's income or household size has changed. See §0905 (Reviews and Renewals) and §0915.07 (Change in Income).

- At any time the household reports a change in income that results in a lower premium amount. See §0915.07 (Change in Income).

- When the household size changes. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).

- When household member is removed from coverage.

- The income guidelines change because of a change in law or the annual update of the federal poverty guidelines.

MMIS will make mass changes resulting from a change in law on the new FPG guidelines automatically. In all other situations, the representative must enter the required information for MMIS to recalculate the premium.

M. S. 256L.06 subd. 3
Minnesota Rule 9506.0040 subp. 6, 7

MA/GAMC:

See §0913.03 (Spenddowns--MA/GAMC) for spenddown information.

Some people enrolled in MA for Employed Persons with Disabilities (MA-EPD) must pay monthly premiums. See §0913.01.03 (MA-EPD Premiums) and §0913.02 (Premium Payment Options).

Take action to change the premium amount:

- At the time of the 6-month review or annual recertification.
- When an enrollee reports decreased income and/or increased household size, resulting in a lower premium.
- When the income guidelines change because of a change in law or the annual increase in the FPG standards.

MinnesotaCare:

No provisions.

MA/GAMC:

Also see §0913.19 (Shortened Spenddown) and §0913.19.05 (When Not to Interrupt 6-Month Cert. Period).

Interrupt a 6-month income certification period and begin a new 6-month income certification period:

- When a previously scheduled cash, MA, or Food Stamp annual recertification is due during a current income certification period. Complete the recertification and begin a new income certification period with the recertification month.

  EXAMPLE:

  William and Patsy and their 3 children are receiving Food Stamps and MA. They were approved for Food Stamps effective June 13. They applied for MA the following March and were approved effective March 3 with a 6-month spenddown. The Food Stamp recertification is scheduled for June. The MA income certification period is March-August.

  Redetermine eligibility for both Food Stamps and MA for June. Interrupt the existing MA certification period and begin a new income certification period for June-November. The next Food Stamp and MA annual recertification will be due at the same time in the following June.

  Calculate a new spenddown amount and satisfaction date for March, April, and May using actual income for those months. Apply the same bills as were used to calculate the original spenddown. Notify William and Patsy if the calculation results in an earlier satisfaction date, or a decreased recipient amount on the original satisfaction date, so they can notify appropriate providers to bill MA. Do not adjust the spenddown if the calculation results in a later satisfaction date or increased recipient amount on the original satisfaction date.

- When a MinnesotaCare renewal is due during an existing MA or GAMC certification period for other household members. Do not adjust the MA or GAMC certification period if some or all household members receive cash or

Food Stamps with a different recertification date. Align the MA or GAMC certification period with the cash or Food Stamps recertification. Do not adjust a MinnesotaCare renewal date to align with any other programs.

EXAMPLE:

Leo and Prudence apply for MA and Food Stamps for themselves and their 2 children. Both programs are approved effective July 1. Leo and Prudence apply for MinnesotaCare for themselves the following March and are approved as pending awaiting payment in April. Their MA is terminated effective April 1. The children remain on MA and the entire household remains on Food Stamps. The MA and Food Stamp recertifications will be due in July. The MinnesotaCare renewal will be due in April. Do not adjust the MA certification period to align with the MinnesotaCare renewal.

EXAMPLE:

Larry and Liz apply for MA for themselves and their 3 children. MA is approved for the entire household effective April 1. No one in the household is open on cash or Food Stamps. MA is terminated for Larry and Liz effective October 1 because they can no longer meet a spenddown. The children remain on MA without a spenddown. Larry and Liz apply for MinnesotaCare for themselves in November and are approved as pending awaiting payment in December.

Interrupt the children's existing October-March MA certification period and begin a new certification period for December-May. If the children remain eligible for MA at the time of the 6-month income review, the MA and MinnesotaCare renewals will be due at the same time the following December.

- When adding a person, except a newborn, who increases the household size. Do not interrupt the certification period or recalculate the spenddown when adding a newborn who was already included in the household size as an unborn. The newborn is eligible without a spenddown through the month of the 2nd birthday if the conditions in §0907.19.05.03 (MA Basis: Auto Newborn) are met.

  For all others, end the current 6-month income certification period for the existing household on the last day of the month before the month the new member is added. See §0915.03.01 (Adding a Person to the Household--MA/GAMC) and §0908.05 (Determining MA/GAMC Household Size).

When the existing household has a 6-month spenddown, compute a shortened spenddown for the existing household when the certification period is interrupted. Also compute a shortened spenddown for the new member using a household size of 1. For the new member, the shortened spenddown runs from the 1st retroactive month requested through the month before the month the new member is added to the existing household. This will include the month the new member enters the household if he/she enters after the 1st of the month.

For additional information, see TEMP Manual TE02.07.229 (Adding People to the MA/GAMC Household).

EXAMPLE:

Rita applies for MA for herself and her 3 children in June. They are found eligible without a spenddown effective July 1. Rita's husband, Ron, returns home on September 15 and completes an addendum to be added to MA October 3. Interrupt the income certification period for Rita and the children and begin a new income certification period beginning in October. Use both Rita's and Ron's incomes and a household size of 5.

If Ron requests MA retroactive to July, determine his eligibility for July, August, and September using a shortened certification period. Use only Ron's income and a household size of 1. Ron may choose to use either a monthly spenddown or a shortened 6-month spenddown if he has a basis of eligibility for MA. If he has no MA basis and is eligible for GAMC, he must use a shortened 6-month spenddown.

- When a person who was included in the existing household size but did not request MA now requests MA for a period BEFORE the household's current income certification period. The new income certification period will begin on the 1st day of the earliest requested retroactive month for all household members. The added member is subject to the spenddown type selected by the household at the time the last certification period was approved. Redetermine the entire household's eligibility using an income certification period starting with the new member's earliest eligible retroactive month.

EXAMPLE:

Mike applied for MA for his 2 children in April. He did not request MA for himself because he had other coverage. The children were

found eligible with no spenddown and an income certification period of April-September.

On June 5, Mike requests MA for himself retroactive to March for some bills not covered by his other insurance. Determine eligibility for Mike and his children as follows:

1. Redetermine eligibility using an income certification period for the entire household of March-August based on actual and anticipated income for those months. If Mike has a spenddown, he may choose either a 6-month or a 1-month spenddown because he has a basis of eligibility for MA and the children had no spenddown for any month in the original certification period. See §0913.05 (Which Spenddown Type to Use). Use Mike's bills and any bills the children incurred before becoming eligible for MA to meet the spenddown.

2. If Mike is eligible without a spenddown or can satisfy the spenddown for the new period, end the children's existing income certification period effective July 1 and include them with Mike in the new certification period.

- When a client's automatic MA eligibility ends, such as infants, MSA, IV-E, or 60-day postpartum unless the woman meets the requirements to eliminate the postpartum review. In that case, do not interrupt the budget period. See §0905 (Reviews and Renewals).

- When a client in a single person household dies, end the current income certification period on the last day of the month in which the death occurred. Recalculate the spenddown and satisfaction date using the shortened spenddown period.

EXAMPLE:

Roger receives MA with a 6-month spenddown and an income certification period of May-October. Roger died on September 12. Terminate MA on the date of death.

Recalculate Roger's eligibility for a 5-month period using his income from May 1 through September 12. If the calculation results in an earlier satisfaction date, notify Roger's representative so that appropriate providers can bill MA.

MinnesotaCare:

No provisions.

MA/GAMC:

Also see §0913.19 (Shortened Spenddown) and §0913.19.03 (When to Interrupt 6-Month Cert. Period).

Do not interrupt an income certification period:

- When an MA-only person becomes eligible for automatic MA with cash assistance (MSA, GRH, GA). The income certification period will include MA-only months and automatic months. Recompute the spenddown for the MA-only months using the applicable MA standard and income. See §0912.07 (Income Standards). For the cash eligibility months, enter the appropriate cash ELIG type and standard on MAXIS.

  EXAMPLE:

  Patrick receives MA as a disabled person with a 6-month spenddown and an income certification period of April-September. He became eligible for MSA and automatic MA on June 1.

  Calculate a shortened spenddown and new satisfaction date for April and May. Use Patrick's actual income for April and May and the MA spenddown that applies for those months. The difference between his countable net income for those 2 months and the 2-month standard is the shortened spenddown amount. Notify Patrick if the calculation results in an earlier satisfaction date or decreased recipient amount on the original satisfaction date so he can advise appropriate providers to bill MA.

When applicants for a type of cash assistance that includes automatic MA also request retroactive MA, begin the certification period with the retroactive month in which eligibility began. The initial income certification period will include MA-only months and automatic months. For the MA-only months in the retroactive period, use the applicable MA standard and income based on the household composition during the retroactive period. See §0912.07 (Income Standards). For the cash eligibility months, enter the appropriate cash eligibility type and standard on MAXIS.

EXAMPLE:

Patrick applies for MSA on July 10. He requests retroactive MA for May and June. He is found eligible for MSA effective July 10 with automatic MA effective July 1.

To determine retroactive MA for May and June, use actual income and the MA income standard for those 2 months. If income exceeds the standard, Patrick may choose to either meet the spenddown on a monthly basis for those months or to meet the combined 2-month spenddown amount (shortened 6-month spenddown).

For the cash assistance months of the certification period (July-October), enter countable income of $0 and the appropriate MSA eligibility type for the remaining months in the certification period.

- When a client enters or leaves an LTCF. See §0913.17 (Begin/End Use of LTC Spenddown - Part 1), §0913.17.01 (Begin/End Use of LTC Spenddown - Part 2), and §0913.17.03 (Begin/End Use of LTC Spenddown - Part 3).

- When QMB, SLMB or QI eligibility is added to MA. Do not change the certification period or recalculate the spenddown when someone who is active on MA becomes eligible for QMB, SLMB or QI during the certification period. Begin QMB, SLMB or QI in the 1st eligible month.

- When a household size decreases because a person dies or leaves a current MA household. Recalculate the current 6-month income certification period.

EXAMPLE:

Luke and Laura and their two children are active on MA. Luke and Laura have an automated monthly spenddown and the children have no spenddown. Their current income certification period is March-August. Luke leaves the home on June 4.

Recalculate Laura and the children's eligibility for July (the month after Luke left the home) and August. Decrease the household size to 3 and drop Luke’s income. Change the spenddown for Laura effective July 1. If the new calculation results in a spenddown for the children, they must use the same spenddown type as Laura for the remainder of the certification period.

- When a client's income changes. Redetermine eligibility for the current 6-month certification period.

- When a person who was included in the existing household size but did not request MA or GAMC now requests MA or GAMC within the same income certification period. The added member is subject to the spenddown type selected by the household at the time the last certification period was approved. The added member may request to be added up to 3 months before the month they make the request for MA and up to 1 month for GAMC.

  EXAMPLE:

  Theresa and David applied for MA for their two children on July 8. They did not request coverage for themselves. The children were approved with no spenddown effective July 1 with a certification period of July-December. In September, Theresa requests MA for herself and David because of bills they incurred starting in late July.

  Determine eligibility for Theresa and David using the original certification period. If they have a spenddown under the income standard that applies to them, they may have a later opening date than the children.

- When a client's eligibility changes from MA-EPD to regular MA, resulting in a lower income standard. Redetermine eligibility for the remaining months of the certification period using a monthly spenddown.

  EXAMPLE:

  Mark is enrolled in MA-EPD with a certification period of September-February. He stops working for non-medical reasons and receives his last pay check in December. He continues to receive RSDI in excess of the income standard for regular MA. Use a monthly spenddown for January and February.

- When people on regular MA become eligible for TMA or TYMA.

- When people on TMA or TYMA become eligible for regular MA.

MinnesotaCare:

No provisions.

MA/GAMC:

Use health care expenses in the order listed below to meet medical spenddowns. See §0913.13 (Long Term Care Spenddown Calculation) for expenses used to meet a long term care spenddown. Use medical expenses incurred by clients, their legal dependents, or financially responsible relatives who live with them. Legal dependents and responsible relatives DO NOT have to be applying for or eligible for MA/GAMC for the client to use their medical expenses.

Use the actual amount billed for the service rather than what MA/GAMC will pay. The client must verify health care expenses.

Deduct expenses in the following order:

1. Deduct Medicare and health insurance premiums, including MinnesotaCare premiums, for any member of the household if the premiums are paid by the client or a financially responsible relative living with the client and will not be reimbursed by MA, QMB, SLMB, QI, or otherwise paid through the Buy-In or reimbursed as cost-effective. See §0910.05.05 (Medicare Premium Payment) and §0910.05.03 (Health Insurance Premium Payment).

   If the client has enough medical expenses other than health insurance and Medicare premiums to meet the spenddown, the client may choose to be reimbursed for cost effective premiums rather than applying them to the spenddown. If the client chooses to apply them to the spenddown, they will be deducted 1st.

   When calculating a 1-month spenddown, deduct the insurance premium on the 1st day of the month in which the premium is due. If the client is expected to pay Medicare premiums each month, allow the Medicare premium as an automated monthly spenddown expense. Allow health insurance premiums as automated monthly spenddown expenses if you verify that they are paid monthly. Verify the payment at the 6-month income review and at the annual recertification. See §0913.09 (Automated Monthly Spenddown Calculation).

   When calculating a 6-month spenddown, deduct Medicare premiums and all other health insurance premiums for any member of the household which were due during the month of application and any of the 3 retroactive months on the 1st day of the 1st retroactive month for which the client is requesting

MA or GAMC. Do not deduct Medicare or health insurance premiums paid after the month of application as an expense for 6-month spenddowns. Only use indemnity policy premiums to meet spenddowns if the policy benefits are limited to medical payments for medical expenses. Insurance premiums used to meet medical spenddowns do not have to be cost effective.

2. On the 1st day of the 6-month or 1-month spenddown period, deduct the unpaid balance of medical expenses incurred prior to the income certification period that the client is obligated to pay. The medical expense may be an expense charged directly to the person by a medical provider, an expense which a medical provider has transferred for collection to a person or agency actively pursuing the collection, or a loan payment owed to a person, financial institution, or credit company for which the loan proceeds were specifically paid to a medical provider.

   These expenses must have:

   - Been incurred by the client, the client's dependent if the dependent is included in the client's household size or would have been included in the household size if the client had applied when the bill was incurred, the client's siblings, half-siblings, and step-siblings who are included in the client's household size, or the client's spouse or parent (including stepparent) if the spouse or parent's income is actually used to determine eligibility. See §0908.05 (Determining MA/GAMC Household Size).

   AND

   - Been incurred before the current income certification period.

   AND

   - NOT been used to calculate a spenddown during a prior income certification period, whether or not the calculation resulted in the spenddown being met, unless eligibility for the entire income certification period was denied.

   AND

   - NOT been MA/GAMC covered services incurred in a prior period of MA/GAMC eligibility.

3. Deduct the following expenses on the 1st day of the 6-month or 1-month spenddown period.

   - Non-reimbursable bills incurred during the income certification period not covered by MA/GAMC or reimbursable under the MA

Administrative Fund which were NOT reimbursed or paid from the fund, such as transportation. See COVERED SERVICES and TRANSPORTATION COVERAGE in the Minnesota Health Care Programs Provider Manual for information on expenses eligible for reimbursement. See NON-REIMBURSABLE EXPENSES in §0902.27 (Glossary: Non-Citizen...) and MEDICALLY NECESSARY in §0902.23 (Glossary: Managed Care...) For more information on which expenses can be allowed as spenddown deductibles.

For ongoing non-reimbursable expenses, verify the need for the item at each annual review unless the doctor's recommendation specifies a shorter period.

- Expenses other than health insurance incurred during the income certification period by dependents or financially responsible relatives who are not requesting or on MA/GAMC. Include both reimbursable expenses (which can be paid through MMIS) and non-reimbursable expenses (which are not covered by MA/GAMC or cannot be paid through MMIS). Include bills paid by MinnesotaCare for family members for whom DHS does not receive FFP. See §0913.21.05 (MinnesotaCare Expenses to Meet Spenddown) for instructions on which MinnesotaCare expenses are allowable.

- The following medical expenses incurred by the client or financially responsible relatives:
  - Allowable medical care costs for clients in GRH settings.

  To determine the amount of remedial care expenses to allow toward the spenddown for GRH residents who are not eligible for the GRH cash program:
  1. Subtract the current clothing and personal needs allowance in §0912.07.03 from the 75% of FPG standard for 1 in §0912.07.075. This is the MA room and board rate.
  2. Subtract the result from step 1 from the GRH negotiated rate. This is the remedial care amount.
  3. Apply the amount from step 2 to the spenddown.

- Alternative Care (AC). See §0913.21.03 (Determine Net Medical Expense) and §0913.13.07 (Relationship Between AC and SIS-EW) for information on when AC expenses can be applied to the spenddown.
- Minnesota Children Special Health Needs (MCSHN).

- Insurance Extension Program.

4. Deduct, on the 1st day of the 1-month spenddown, hospital bills paid by MinnesotaCare for MinnesotaCare recipients who are applying for MA to pay the hospital bill. See §0913.21.07 (MinnesotaCare Inpatient Hospitalization) for specific instructions on MinnesotaCare enrollees who apply for MA to help with hospital costs.

   MinnesotaCare enrollees are not eligible for GAMC to help pay hospital costs incurred while they were active on MinnesotaCare.

5. Deduct MA/GAMC covered services incurred by the client during the 6-month or 1-month income certification period in chronological order by date of service. Include waivered services received through the CAC, CADI, EW, and MR waivers, the net amount of the MSHO spenddown, and Child Welfare/Targeted Case Management expenses. Also include prescription costs paid by the Prescription Drug Program (PDP) and PDP deductibles. MMIS will apply the client's out-of-pocket prescription costs to both the PDP deductible and the spenddown until the spenddown is met. Once the spenddown is met for a given month, the deductible no longer applies.

   Although MA and GAMC may limit how often they will pay for some services, and require prior authorization limits for others, do not apply these limits when determining what expenses are acceptable to meet a spenddown.

People enrolled in Minnesota health care programs receive medical services in 1 of 2 ways:

- Managed care. In a managed care system, DHS contracts with a health plan to provide services to people enrolled in MA, GAMC, or MinnesotaCare. The health plan must provide most services covered by the program the person is enrolled in. DHS pays a fixed monthly fee, called a capitation payment, to the health plan. Enrollees must receive services through their health plans. MA services that are not covered in the managed care contract will be billed under fee-for-service.

  All MinnesotaCare enrollees receive services through managed care. Some MA and GAMC enrollees receive services through managed care depending on the county they live in and whether they are excluded from managed care. See §0914.03.03 (Managed Care Exclusions).

  The following are managed care counties for MA and GAMC as of 11-1-02:

  > Aitkin, Anoka, Becker, Benton, Brown, Carlton, Carver, Chippewa, Chisago, Clay, Cook, Cottonwood, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, LeSueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, Mille Lacs, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, St. Louis, Scott, Sherburne, Sibley, Stearns, Steele, Swift, Wabasha, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine.

  The following are managed care counties except for dental services. MA, GAMC and MinnesotaCare clients in these counties who are enrolled in managed care receive dental services through fee-for-service. The health plans are not responsible for dental services or transportation to dental appointments. The health plans provide all other managed care services:

  > Cass, Crow Wing, Morrison, Todd, Wadena

  In most counties, managed care enrollees choose 1 of 2 or more health plans. If required, enrollees must also choose specific clinics within the health plan network. See §0914.03.05 (Managed Care Enrollment Process) and §0914.03.05.01 (Managed Care Enrollment Process--MA/GAMC).

  Managed care enrollees receive a Minnesota Health Care Programs

Identification Card and an identification card from the health plan. See §0914.07 (Minnesota Health Care Programs Card).

- Fee-for-service. MA and GAMC enrollees who are not enrolled in a managed care plan receive medical services on a fee-for-service basis. MinnesotaCare enrollees do not receive care through fee-for-service on an ongoing basis, but may be enrolled in fee-for-service for a limited period in some circumstances. See §0914.05 (Fee-for-Service). In a fee-for-service system, people may receive services from any provider who is enrolled as a Minnesota Health Care Programs provider. Providers bill DHS for each service provided. DHS makes payments for approved services at a predetermined rate.

  Fee-for-service enrollees receive a Minnesota Health Care Programs Identification Card. See §0914.07 (Minnesota Health Care Programs Card).

MinnesotaCare:

There are no exclusions. All MinnesotaCare enrollees must receive services through managed care. People may be enrolled in fee-for-service for a limited period in certain circumstances. See §0914.05 (Fee-for-Service).

M.S. 256L.12 subd. 3

MA/GAMC:

Exclude the following groups from managed care enrollment in MA and GAMC:

- People who receive Refugee Cash Assistance or Refugee Medical Assistance. See §0907.21.13 (MA Basis: Refugee Medical Assistance - RMA).

- Residents of state institutions, including Regional Treatment Centers (RTC), Institutions for Mental Disease (IMD), and state-operated long term care facilities who reside in the institution at the time of initial enrollment. People already enrolled in managed care who enter state institutions will remain enrolled their health plans if the placement has been approved by the health plan.. This includes court-ordered placements. See §0906.09.01 (Institutional Residence--MA/GAMC) and §0907.27 (MA/GAMC Basis: IMD Residents). NOTE: Do not exclude residents of Ah Gwah Ching Nursing Facility and Woodhaven Senior Community under this basis.

- People who have private health insurance through the following HMOs certified by the Department of Health. These people may voluntarily enroll in managed care IF THE PRIVATE HMO IS THE SAME AS THE HEALTH PLAN THE CONSUMER WILL SELECT UNDER PMAP. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

  Blue Plus
  First Plan of Minnesota
  Group Health, Inc.
  HealthPartners
  Itasca Medical Care
  Medica
  Metropolitan Health Plan
  PreferredOne Community Health Plan
  Sioux Valley Health Plan of MN
  UCare Minnesota

- People eligible with all spenddown types except LTC-only spenddowns. See

§0914.03.25 (Minnesota Senior Health Option - MSHO) for information on people with spenddowns who may voluntarily enroll.

- People who receive EMA or EGAMC. See §0907.29 (Medical Emergency Programs).

- People under age 65 who are eligible for MA due to blindness or disability. See §0907.21.05 (MA/Medicare Supplement Basis: Blindness) and §0907.21.07 (MA/Medicare Supplement Basis: Disability). This includes people with blindness or disabilities who receive services under the CAC, CADI, MR/RC and TBI waivers. See §0907.23 (MA Waiver Programs).

- People who are terminally ill with a medical prognosis of 6 MONTHS OR LESS to live and who, at the time of notification of mandatory health plan enrollment, have a permanent relationship with a primary physician who is not part of any available managed care health plan.

- People who are enrolled in the SIS EW program with gross incomes greater than the maintenance needs allowance but less than or equal to the Special Income Standard. These people may enroll in managed care voluntarily. SIS EW enrollees with incomes less than the maintenance needs allowance must enroll in managed care.

- People eligible for QMB, SLMB, QWD, or QI only (eligibility types BQ, BS, BW, DS, DQ, DW, EQ, ES, 1B, 1D, 1E, 2B, 2D, and 2E). See §0907.21.09 (MA Basis: Medicare Supplement Programs).

- People who, at the time of notification of mandatory enrollment in managed care, meet ALL the following:

  - Have a communicable disease.
  - Have a prognosis of a terminal illness (may exceed 6 months) because of the communicable disease.
  - The disease and prognosis are verified by a written statement from a licensed physician based on a current medical examination.
  - Currently have a primary physician who is not a participating provider in an available managed care health plan.
  - The physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient stopping recommended medication or other health services.

- Children who are identified to DHS as having severe emotional disturbance (SED) and who are eligible to receive MA-covered mental health case management services.

  These children may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

- Adults who are identified to DHS as having serious and persistent mental illness (SPMI) and who are eligible to receive MA-covered mental health case management services.

  These adults may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

- American Indians living on an Indian reservation, if the tribal government of that reservation chooses to exclude these people.

- Women receiving MA under the MA-BC basis. See §0907.19.13 (MA for Breast/Cervical Cancer MA-BC).

Exclude the following groups from enrollment in GAMC managed care:

- GAMC recipients in Institutions for Mental Diseases (IMDs). See §0906.09.01 (Institutional Residence--MA/GAMC) and §0907.27 (MA/GAMC Basis: IMD Residents).

- GAMC recipients eligible for Medicare benefits.

- GAMC recipients living in nursing facilities.

- GAMC enrollees receiving care and rehabilitation services from the Center for Victims of Torture (CVT). See §0907.25.07 (GAMC Basis: Victims of Torture).

MinnesotaCare:

All managed care education is done by mail. See §0914.03.05 (Managed Care Enrollment Process).

Minnesota Rule 9506.0200 subp. 3a, c, 4a, c
Minnesota Rule 9506.0400 subp. 2

MA/GAMC:

Managed care county agencies may conduct in-person presentations as part of the eligibility interview for people who are required to have a face-to-face interview or who request one. See §0904 (Applications).

Include the following information in managed care presentations:

- How a health plan works.
- The exclusion groups.
- The enrollment form.
- The requirement to choose a health plan and to return the enrollment form within 30 days of the presentation date.
- Random assignment.
- Each health plan and network available in the county.
- Covered and non-covered services.
- Enrollment effective dates.
- A description and instructions on use of the health plan ID card and the Minnesota Health Care Programs card.
- How to receive emergency care outside of the health plan service area.
- Benefit coordination with primary insurance, Medicare, or private HMO coverage.
- Transportation cost reimbursement procedures.
- First year change option and yearly open enrollment.
- Enrollee rights to services provided by health plan patient representatives, county advocates, and state ombudsmen.
- Enrollee right to file an appeal with the state agency.
- Multi-language notification.

Clients may choose health plans and complete the enrollment forms at the time of the presentation. They may also take the forms with them and return them within 30 days.

If a client who is scheduled for a managed care presentation fails to attend, mail an enrollment packet as soon as possible after the missed presentation.

Include the following information in managed care education packets:

- Your Guide to Health Plan Enrollment (DHS 3354)
- Pre-Enrollment Questionnaire (DHS 3354C)
- Managed Care Enrollment Form (DHS 3289)
- Rights and Responsibilities Brochure (DHS 3214)
- Health Plan Options Sheet (order from your county's DHS Enrollment Coordinator)
- Cover Letter (print at county from INFOPAC for mail-out packets only)
- Health plan primary care network listing (PCNL) for each available health plan in the county.
- The following county-specific information. Materials other than the return envelope must be approved by DHS:

  - A county contact sheet listing where to call with questions.
  - A prepaid return envelope.

MAXIS interfaces the following information with MMIS for managed care purposes:

- Address.
- Date of birth.
- Sex.
- Medicare Part A and Part B coverage.
- Servicing and financially responsible counties.

Enter the following information on MMIS. MMIS uses this information and the MAXIS information above to determine the health plan capitation rate.

- Living arrangement.
- Spenddown type.
- Eligibility type and major program.

Managed care counties must complete the appropriate MMIS screens with either an exclusion span or an enrollment span. Contract numbers are the provider numbers of the health plans which serve the managed care counties. Each county will have a list of the health plan provider numbers for that county. See the MMIS User Manual I-13-3 and the Managed Care Manual section 4.02.01.

If a client has not chosen a health plan when MA or GAMC is approved, code RENR with exclusion reason YY (Delayed Decision). Complete the RTRK panel. Follow

your county's procedures for entering enrollment information on MMIS when people choose a health plan.

If you receive the enrollment form and can enter the information on MMIS on or before the managed care enrollment cutoff date, the enrollment will be effective the 1st day of the next month. If you cannot enter the information on MMIS until after the managed care enrollment cutoff date, the enrollment will become effective the 1st day of the next available (or 2nd) month.

If a client has not chosen a health plan before the counter on the RTRK panel reaches 30 days, MMIS will assign a default plan.

Delay initial enrollment of a hospitalized recipient into managed care until the 1st of the next available month after discharge.

See MAXIS/MMIS CALENDAR in the TEMP Manual index for the monthly calendar of managed care cutoff dates.

People who are found eligible for MA or GAMC will receive medical care through fee-for-service for any months before health plan enrollment. See §0914.05 (Fee-for-Service).

MinnesotaCare:

An adjustment is either:

- Making a capitation payment to a health plan for a current or past month.

OR

- Recovering a capitation payment from a health plan.

Request adjustments in the following situations:

- When a newborn is added to a health plan retroactively. See §0914.03.13 (Adding/Removing People From Managed Care). If the newborn is added to the case within 90 days of the date of birth, request an adjustment for the month of birth and any other months for which a capitation payment has already been made for the rest of the household. If the newborn is added more than 90 days from the date of birth, request an adjustment for the birth month only.

- When an enrollee is hospitalized on the effective date of a change in health plans. In this case DHS will recover the capitation payment made to the new plan and will make a retroactive capitation payment to the previous plan.

- When necessary to maintain continuous coverage, continuity of care, or to resolve a service issue. Refer these requests to appropriate staff. Decisions are made on case-by-case basis.

Do not make an adjustment when there has been a systems, coding, or enrollment form error. The household's enrollment will be changed for the next available month.

M.S. 256L.12

MA/GAMC:

Request adjustments from the DHS managed care unit when:

- People are enrolled into health plans incorrectly and retroactive disenrollment would result in continuity of care issues. If there are no service issues, disenroll the person for the next available month.

- People are disenrolled from health plans incorrectly.

- People are hospitalized on the effective date of an enrollment change.
- MA enrollees are incarcerated at the time of initial managed care enrollment.

NOTE: Incarcerated GAMC enrollees remain in the health plan.

- The mother of a newborn is enrolled in managed care and the newborn is not enrolled within 90 days of the date of birth.

If the change is for a future month and no erroneous capitation payment has been made, delete the incorrect span or change the incorrect information on the RPPH panel. EXCEPT for certain newborns, you may not retroactively enroll or disenroll a client. See instructions for adding newborns under §0914.03.13 (Adding/Removing People From Managed Care).

A request does not guarantee an adjustment will be made. The DHS Managed Care unit reviews each request on a case-by-case basis based on federal and state law and health plan contract terms.

MinnesotaCare:

Follow §0914.03.07 (Health Plan Changes) when MinnesotaCare enrollees move to another county.

MA/GAMC:

When managed care enrollees move between counties, the new county of residence determines whether health plan enrollment is mandatory. See §0906.07 (County Residence).

Remind enrollees that if they seek non-emergency services outside the health plan service area, the health plans may require providers to request authorization from the plan. Enrollees who do not follow health plan provisions may be responsible to pay for medical services received.

See TEMP Manual TE02.07.413 and TE02.07.414 (Managed Care Health Plans) for a list of plans available in each managed care county.

When an enrollee moves from a managed care to a non-managed care county, it is not necessary for the transferring county to update the RPPH screen. The MMIS system will close the enrollment span on RPPH at the next capitation. A worker in a non-managed care county may receive an edit on MMIS which prevents updates. If this occurs, update RPPH by entering an end date in the PPHP Managed Health Care Enrollment span for the next available month.

When an enrollee moves from a managed care county to another managed care county in which the enrollee's health plan is not available, it is not necessary to update RPPH before transferring the case on SPEC/XFER in MAXIS. MMIS will close the enrollment span on RPPH at the next capitation run. These clients will be reported on the county's Potential Enrollee Report. Refer the client to a managed care presentation or mail a managed care education packet as soon as possible. (In conversion counties, after receiving a transferred case, refer the recipient for a managed care presentation as soon as possible. Every effort should be made to avoid a gap in managed care coverage. If this is not possible, MA or GAMC fee- for-service will cover intervening months)

When an enrollee moves from a managed care county to another managed care county and the same health plan is available, continue enrollment in the same health plan at the time of the transfer. The enrollment span on RPPH remains open, and there will be 1 continuous span for both counties. The receiving (servicing) county does not have to make a referral for a managed care presentation.
If an enrollee requests a change in health plan when moving to another county, allow

the change if the enrollee makes the request within 60 days of the move date. Refer clients requesting changes to a managed care presentation or mail a managed care education packet. The enrollee must complete and return a new enrollment form. See §0914.03.07 (Health Plan Changes).

When an MA or GAMC enrollee moves from a non-managed care county to a managed care county, refer the person for a managed care presentation as soon as possible. Follow the same procedures as for other new enrollees. See §0914.03.05.01 (Managed Care Enrollment Process--MA/GAMC) and §0914.03.05.03 (Managed Care Enrollment Presentations.

MinnesotaCare:

People who fail to pay premiums by the last day of the month the premium is due and people who request voluntary cancellation are ineligible to re-enroll in MinnesotaCare for 4 months unless they show good cause for non-payment or voluntary cancellation. People who pay all billed premiums by the 20th day following cancellation may be reinstated. See §0915.11.05 (Fail to Pay Premium/Reinstatement).

Good cause means circumstances beyond an enrollee's control or that the enrollee could not reasonably foresee which resulted in the enrollee being unable or failing to pay the premium or requesting voluntary cancellation. Good cause circumstances include but are not limited to:

- Serious physical or mental illness.
- The enrollee voluntarily drops MinnesotaCare believing that other health coverage is available, and the other coverage does not materialize.
- The enrollee does not receive a regular source of income on which s/he depended to pay the premium.

Good cause does not include choosing to pay other household expenses instead of the premium.

Make good cause determinations on a case by case basis based on the evidence the enrollee submits. Notify enrollees of their right to appeal if the agency does not find good cause. Continue benefits pending the outcome of the appeal unless the enrollee requests in writing not to have benefits continued. Require payment of all missed premiums to continue benefits. See §0917 (Appeals).

MMIS will automatically terminate coverage effective the last day of the month after the premium due date. If the agency determines that good cause exists without an appeal, require payment of all due premium(s) before reactivating coverage.

If the agency does not find good cause and the household does not appeal, the household must wait 4 calendar months beginning with the 1st month of disenrollment before re-enrolling.

EXAMPLE:

Jerry's August premium notice is mailed on June 15. No payment has been received as of cutoff on July 17. MMIS generates a cancellation notice for

Julyt 31. No payment has been received as of noon on the last working day of July. Jerry's coverage ends July 31. He cannot re-enroll until December unless he becomes eligible for reinstatement by paying all billed premiums during the 20-day reinstatement period. August, September, October, and November are his penalty months.

If Jerry does not pay the due premiums during the reinstatement period but shows good cause and then pays the due premiums, reinstate coverage for August. If Jerry files a timely appeal of a finding of no good cause, does not request that benefits stop pending appeal and pays the due premiums, reinstate coverage for August. If the appeal decision finds that Jerry had good cause, coverage continues as long as Jerry pays the premiums. If the agency is upheld in the appeal, begin a penalty period in accordance with the appeal decision.

Do not require a new application for re-enrollment unless more than 11 months have elapsed since the household last completed an application or previous renewal form. Instruct enrollees canceled for non-payment who have completed a HCAPP or renewal form in the 11 months before the end of the penalty period to call to request re-enrollment at the beginning of the 4th month. Update income and other pertinent information on the most recent application. Re-evaluate group status based on current circumstances.

If you receive a HCAPP before the 4th month of the penalty period, deny the application using MMIS code 42 (Penalty Period). Send the Review Delay Letter (DHS 3399) advising the household to contact the agency at the beginning of the 4th month to reactivate the application.

If you receive a renewal form during the penalty period and the household has not completed a HCAPP or renewal form in the past 11 months, send the household the DHS 3399 and a HCAPP to complete and return.

Process applications received in the 4th month of the penalty period. Approve applicants who meet all eligibility requirements as pending awaiting payment for coverage to begin effective the 1st day of the 5th month.

Forgive any premiums included in an approved bankruptcy order. Request a copy of the final order to verify whether the MinnesotaCare premium is included in the list of debts to be forgiven. Do not forgive premiums not specifically listed.

Do not cancel a pregnant woman for non-payment of premiums during the pregnancy

and 60-day postpartum period. See §0907.09 (MinnesotaCare Pregnant Women). Also do not cancel a child under age 2 for non-payment of premiums. Cancel other household members if appropriate. See §0915.11.03 (Fail to Pay Premium/PW's and Infants).

Household members who were not enrolled in MinnesotaCare when the penalty period began are not subject to the 4-month penalty period.

EXAMPLE:

Joan and Louie are enrolled in MinnesotaCare with their son Paul. Their daughter Jasmine receives MA. MinnesotaCare is canceled for failure to pay premium effective June 30. Jasmine's MA ends August 1. Jasmine is eligible for MinnesotaCare effective August 1 if she meets all eligibility requirements.

If you are notified that an enrollee's premium check has been returned for non-sufficient funds (NSF), return the check with a letter requesting payment by money order or cashier's check. MMIS will terminate coverage and impose a 4-month penalty period if the enrollee fails to replace the NSF check with a guaranteed form of payment. See §0913 (Premiums and Spenddowns).

M. S. 256L.06 subd. 3
Minnesota Rule 9506.0040 subp. 6

MA:

People with incomes over 100% FPG must pay monthly premiums to be eligible for the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program. DHS bills and collects MA-EPD premiums and determines if a client has good cause for non-payment based on the guidelines listed in the MinnesotaCare section of this chapter. If DHS determines the client has good cause for non-payment, MA-EPD eligibility continues. A finding of good cause does not relieve the client's obligation to pay the premium. Deny or terminate MA-EPD for people who fail to pay without good cause. If the client later pays the premium in full, reinstate coverage back to the date of termination. SRU will send MAXIS E-mail to notify the financial worker of the good cause decision and whether the premium payment is made.

Refer clients who are unable to pay the premium by the due date or wish to claim good cause to DHS SRU at 1-800-657-3762 or (651) 296-6607. The client or financial worker may submit a written request to:

DHS Special Recovery Unit
444 Lafayette Road

St. Paul, MN 55155-3863

or fax to (651) 282-6744. The written request should include the client's legal name, PMI number, mailing address and phone number, reason for requesting good cause, and supporting documentation. SRU will provide the client with written notice of the decision within 30 days. Clients may appeal a finding that good cause does not exist.

GAMC:

No provisions.

MinnesotaCare:

Do not cancel pregnant women during the pregnancy or postpartum period or infants under age 2 for failure to pay premiums. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation). Cancel other household members who fail to pay their premiums without good cause. Make a request to forgive the portion of the past due payments attributed to the pregnant woman or infant under age 2 for covered months in the past at any of the following times:

- The other household members wish to re-enroll after their 4-month penalty period.

EXAMPLE:

Sally is pregnant and is enrolled in MinnesotaCare with her family. Her portion of the family's $112 monthly premium is $20. The rest of the household is canceled for non-payment of the $112 June premium at the end of May. Sally's coverage continues. The family does not pay her $20 premium for June, July, August, or September. On September 18, Sally asks to have MinnesotaCare reopened for the rest of the household effective October 1, the end of their 4-month penalty period.

Make a request to forgive Sally's unpaid premiums ($80, or $20 per month for June through September). The October and November premiums remain at $20 and are not adjusted. Do not make a request to forgive the October premium. The other household members will automatically become active October 1 if they pay the October premium of $20 by the end of September. The next premium cycle, for December, will reflect the household's ongoing monthly premium of $112.

- The household wishes to add new members or new coverage for existing household members.

EXAMPLE:

Krystle is pregnant and enrolled in MinnesotaCare. She fails to pay her June premium. Coverage continues. On July 3, she reports that her son has moved in with her and asks to add him to her coverage effective August 1. Make a request to forgive Krystle's June and July premiums. The August premium is not adjusted. Do not make a request to forgive the August premium. Pend the son awaiting payment and advise Krystle that she must pay the August premium by the last day of July to get coverage for her son. If Krystle's son is added before the July billing date, the September premium billing will reflect the new ongoing premium amount for both household members.

- At the end of the pregnant woman's 60-day postpartum period or when an infant turns age 2.

Do not make a request to forgive payments attributed to the pregnant women or infant at any time other than those listed. Do not make a request to forgive the PW's or infant's payments for future months.

In the last month of a pregnant woman's 60-day postpartum period, MMIS will create a worker message to alert the enrollment representative that the postpartum period is ending at the end of the month and the woman will be changed to a new major program effective the first of the next month. Make a request to forgive all unpaid premiums that have accumulated since the enrollee was designated as pregnant on MMIS that were not previously forgiven. This includes unpaid premiums for the months of pregnancy and unpaid premiums for the woman's 60 day postpartum period.

- If the premium due for the month following the post partum period is paid by noon on the last business day of the month, the woman may remain enrolled in MinnesotaCare. At the next renewal, redetermine eligibility of all household member and apply the All or Nothing Rule. If the household does not qualify based on the All or Nothing Rule, only the infant may remain enrolled in MinnesotaCare. See §0907.09.03 (MinnesotaCare Auto Newborns) and §0908.11 (All or Nothing Rule).

EXAMPLE:

Wilma is a pregnant woman enrolled in MinnesotaCare with her husband Tom. Their monthly premium is $20. Tom's MinnesotaCare is canceled for non-payment on July 31. Wilma continued to receive coverage throughout her pregnancy. On September 15, Wilma gave birth to her son Sam. Sam was enrolled in MinnesotaCare effective September 1 as an auto newborn. On November 17, MMIS created a worker message alerting the enrollment representative that Wilma's 60-day postpartum period is ending. Request an adjustment to forgive Wilma's premiums for July, August, and September and Wilma's portion of the premiums for October and November ($50, Wilma's monthly portion of $10 for 5 months).

Wilma must pay her premium for December and the premium due for Sam. If the December premiums are paid by noon on the last business day of the month, Wilma's coverage will continue. If the December premiums are not paid by noon on the last business day of the month, Wilma will be canceled

for non-payment on December 31 and she will have to serve a 4-month penalty period. Sam remains eligible as an auto newborn.

MMIS will create monthly worker messages to identify infants who are turning 2 in the current month for whom a premium payment has not been made. Before billing in the month of the infant's 2nd birthday, make a request to forgive the infant's portion of any unpaid premiums that were not previously forgiven. This includes the infant's unpaid premiums through the month in which the child turns 2.

At billing cutoff in the month the child turns 2, the household must pay the premium for the next month. Payment must be received by noon on the last business day of the month. If the premium is paid, the infant will continue MinnesotaCare coverage. If the premium is not paid, the infant will be canceled at the end of the month and will be required to serve a 4-month penalty period.

Sam was enrolled in MinnesotaCare on September 1, 1998. His mother Wilma was canceled on November 30 because she did not begin paying premiums when her postpartum period ended. Sam remained enrolled in MinnesotaCare, and the family has not paid premiums for him during his enrollment.

Sam turned 2 on September 15, 2000. Before the September billing, request an adjustment to forgive Sam's portion of the unpaid premiums ($4 per month) for October 1998 through September 2000.

If the premiums are forgiven before September billing, the premium due on September 15 will include $4 for Sam's October coverage and $4 for November coverage. If the October premium is paid by noon on the last business day in September, Sam will remain enrolled. If the premium is not paid by noon on the last business day of September, Sam will disenrolled for non-payment of premiums and must serve a 4-month penalty period.

M.S. 256L.15

MinnesotaCare:

Reinstate MinnesotaCare back to the date of closing for households who:

- Were canceled only for nonpayment of premiums

AND

- Pay all billed premiums by the end of the 20th calendar day after disenrollment. The month following disenrollment is called the reinstatement month. If the 20th day falls on a weekend or holiday, the household must pay all billed premiums by the end of the following business day.

MMIS sends a notice on the 1st day of the reinstatement month to households who are canceled for non-payment. The notice informs the household of the reinstatement option and includes the total amount due and the due date. If all billed premiums are received by the due date, MMIS reinstates coverage back to the date of cancellation and sends each enrollee a letter explaining that MinnesotaCare has been reinstated. Enrollees receive coverage through fee-for-service for the reinstatement month. MMIS will reenroll them in their previous health plan beginning the month after reinstatement.

Enrollees who are canceled for nonpayment and another reason are not eligible for reinstatement. Other household members are eligible for reinstatement if they were canceled only for nonpayment. MMIS will calculate the amount due based on the number of people who had coverage during the cancellation month and the number who could have coverage in the reinstatement month and the following month.

EXAMPLE:

Mike, Judy and their daughter Debbie are enrolled in MinnesotaCare with a monthly premium of $100. MinnesotaCare is canceled effective July 31 due to nonpayment of the August premium. Mike's coverage also ends because he has access to ESI. Judy and Debbie would be eligible beginning August 1 with a premium of $67 per month. On August 1, MMIS generates a notice informing the household that they must pay $134 ($67 for August and $67 for September) by August 20 to have coverage reinstated for Judy and Debbie. If payment is received by the due date, MMIS will reinstate coverage for Judy and Debbie back to August 1.

Track cases for enrollees who cancel for nonpayment and noncooperation with medical support. The child support indicator on the MMIS RIND screen cannot be changed during the 20-day reinstatement period. See the MMIS User Manual and Bulletin #00-23-1 (DHS Introduces MinnesotaCare Reinstatement for Payment of Past Due Premiums) dated June 7, 2000 for further information.

If a household asks to add new members during the 20-day reinstatement period, the new member must pay all billed premiums during the 20-day period to reinstate household coverage and begin coverage the following month for the new member. After the 20-day period, the new member must pay only the new member's future premium to begin coverage for the new member.

EXAMPLE:

Sally and John's MinnesotaCare coverage ends on April 30 due to nonpayment of the May premium. On May 5, John requests to add his daughter Melanie, who has moved into the household. Melanie is determined eligible and is approved as pending awaiting payment. MMIS automatically changes the pending awaiting payment span to denied for nonpayment. The household must pay the May and June premiums during the 20-day reinstatement period for John and Sally to be reinstated effective May 1 and Melanie's coverage to begin June 1. After the 20-day reinstatement period, the household must pay the future month's premium for Melanie only to begin Melanie's coverage beginning the month after payment is received. Enter a new pending awaiting payment span for Melanie. John and Sally will have a 4-month penalty period unless they show good cause for nonpayment.

If an enrollee is approved for MA during the 20-day reinstatement period and pays the MinnesotaCare premiums, MMIS will not automatically reinstate MinnesotaCare. MMIS will generate a worker message for the worker to follow up with the enrollee to confirm that they want continued MA. The MinnesotaCare re-bill procedure will recalculate the premium and create a credit.

If the reinstatement month is the renewal month, MMIS will send a closing notice to enrollees who have not paid all billed premiums by the reinstatement month billing date advising them that they must pay all billed premiums and submit a completed renewal by the 20th to be eligible for reinstatement.

EXAMPLE:

Joelle's MinnesotaCare coverage is canceled for nonpayment on July 31. Her renewal date on MMIS is August 30. If she has not paid the August premium by billing on August 15, MMIS generates a notice advising her that she must pay the premiums and submit her renewal by August 20 to be eligible for reinstatement. The notice also advises her that she will be canceled for failure to renew if she fails to submit the renewal. If she pays the premium but fails to submit the renewal, no further notice is required.

MinnesotaCare:

See §0916.05 (Notice of Approval) for information on initial premium notices. MMIS generates monthly premium notices for all households on the cutoff date. The premium amount is based on the information MMIS has on income, household size, and number covered as of the date the notice is issued. Any changes entered after cutoff are reflected in the next month's billing.

MMIS generates replacement premium notices to change the premium amount when there is a change between the time an initial premium notice is generated and the initial premium payment is received. This occurs when:

- There has been a change in income which results in a change in premium since the initial premium notice was generated.
- Someone is added to the household before the initial premium payment is received.
- Someone is removed from the household before the initial premium payment is received.

MMIS generates overdue premium notices when no payment has been received by the premium due date.

EXAMPLE:

August premium notice is mailed on June 15. No payment has been received as of July 15. MMIS generates the premium notice for September with PAST DUE text included for the August premium and a Cancellation Notice for Non-Payment of Premiums effective July 31.

See §0913 (Premiums and Spenddowns).

MA/GAMC:

No provisions.

Unless an enrollee requests otherwise in writing, continue coverage if the request for an appeal is received before the effective date of the action or within 10 days after the date the notice is mailed, whichever if later. If the end of a notice period falls on a weekend or holiday, consider an appeal the unit makes on the next working day to be timely for the purpose of continued benefits.

See the MinnesotaCare section for information on continued coverage when the appeal is based on cancellation for non-payment.

Notify people that they will be required to repay benefits continued while the appeal is pending if they lose their appeal. Also notify people that they must continue to pay premiums or meet a spenddown if applicable.

If a change not related to the issue under appeal occurs while benefits are continuing, notify the enrollee of any adverse action. Take the action unless it is also appealed.

EXAMPLE:

A MinnesotaCare enrollee appeals the removal of a household member from coverage based on availability of other insurance. At the enrollee's request, coverage is continued for the entire household, including the member with other insurance, while the appeal is pending. The household must continue to pay the premium for the entire household.

While the appeal is pending, a new member with income moves into the household resulting in an increased premium. Increase the premium unless the household files a separate appeal of that action.

EXAMPLE:

An MA household appeals an increased spenddown due to increased income. At the household's request, coverage is continued at the old spenddown amount while the appeal is pending. Before the appeal is heard, the household fails to submit a scheduled recertification. Send a notice of termination for failure to comply with recertification requirements. Terminate MA unless the household submits a complete recertification before the effective date of termination OR appeals the termination.

MinnesotaCare:

Inform enrollees who wish to continue benefits while an appeal is pending that they must continue to pay premiums. For adverse actions other than cancellation for non-payment, all premiums that are due must be paid before the effective date of the proposed action or within 10 days after the date the notice is mailed, whichever is later, for benefits to continue. For cancellation for non-payment, coverage will be reinstated if all due premiums are paid within 20 days after the effective date of cancellation.

EXAMPLE:

MinnesotaCare sends Rob a cancellation notice on December 15 due to the availability of other insurance. Rob wishes to appeal the cancellation. In order to continue benefits pending the appeal, he must pay the January premium by the last working day in December.

EXAMPLE:

MinnesotaCare sends Mary a cancellation notice for non-payment of her December premium on November 15. If Mary sends the premium by the last working day of November, her coverage will be continued. If she does not send the premium, her coverage will be canceled effective December 1. If she appeals the cancellation and wishes to continue benefits, she must pay the December and January premiums by December 10.

If the appeal involves a dispute about the amount of the premium, require the enrollee to pay the premium that was in effect before the action being appealed while the appeal is pending.

EXAMPLE:

Based on income information submitted with the annual renewal, MinnesotaCare determines that the McDonald family's premium will increase from $49 to $82 per month effective February 1. Mr. McDonald appeals the increased premium. Continue coverage at $49 per month while the appeal is pending. If the appeal decision upholds the increased premium beginning Febraury 1, the McDonalds will have to pay the $33 per month difference for all months when the appeal was pending for coverage to continue.

If the enrollee loses an appeal of cancellation for non-payment of premium and coverage was continued during the appeal, begin the 4-month penalty period with the 1st available month after you receive the appeal decision. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

EXAMPLE:

Sally appealed her March 1 cancellation for non-payment and requested coverage while the appeal was pending. She paid the March premium by March 10 and also paid all premiums due while the appeal was pending. On April 24, MinnesotaCare receives an appeal decision upholding the cancellation. Sally has paid the May premium and the cap payment for May has gone out. Begin the 4-month penalty period in June. If the appeal decision had been received on April 15, the penalty period would begin in May.

MA/GAMC:

Follow general provisions.