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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #35

December 2002

Effective Date: January 1, 2003

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, toll-free at 1-800- 657-3659, 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 January 1, 2003 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 contains the following standard increases effective January 1, 2003:

- The Special Income Standard (SIS) for the SIS-EW program increases to $1,656. See §0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation--SIS-EW).

- The self-employment mileage rate DECREASES to 36 cents per mile. Also use this amount for reimbursing medical transportation providers who are eligible for reimbursement at the IRS rate. See §0911.09.03.09 (Self-Employment Transportation) and §0914.11 (Access Services)

- The minimum spousal asset allowance increases to $25,601. The maximum spousal asset allowance increases to $90,660. See §0909.25 (Spousal Asset Assessments).

- The percentage factor for calculating the Pickle disregard for the 1-1-2003 COLA increase is 1.014. See §0912.05.23 (Pickle Disregard).

- The maximum spousal income allowance increases to $2,267. See §0912.05.25.03 (Allocations-Community Spouse).

- The clothing and personal needs allowance increases to $72. The amount for certain veterans and surviving spouses of veterans who receive a monthly pension of $90 remains unchanged. See §0912.07.03 (Clothing and Personal Needs Allowance).

- The Blind and Disabled Student Child Disregard increases to $1,340 per month and $5,410 per year. See §0912.05.09.09 (Blind and Disabled Student Child Disregard).

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HIGHLIGHTED CHANGE #2: This manual letter adds information about MinnesotaCare Eligibility Group 4. This group was introduced in Bulletin 01-23-01 (DHS Implements New Eligibility Group for Some MinnesotaCare Parents) dated September 29, 2001. Because Group 4 status is used only to identify parents and caretakers eligible for enhanced federal funding and does not affect eligibility, it was not previously included in the manual. See Attachment A for a list 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 PROGRAMS MANUAL
MANUAL LETTER #35

ATTACHMENT A
REVISED AND DELETED SECTIONS

Revised Sections	Sections Deleted
0901	0901
0907	0907
0907.03	0907.03
0907.05	0907.05
0907.07	0907.07
0907.08	None (new)
0907.13	0907.13
0907.23.11	0907.23.11
0907.27	0907.27
0908.05	0908.05
0909.25	0909.25
0909.27.11.09	0909.27.11.09
0910	0910
0910.11	0910.11
0910.11.03	0910.11.03
0911.05.03	0911.05.03
0911.07.05	0911.07.05
0911.09.03.09	0911.09.03.09
0911.09.07	0911.09.07
0911.09.21	0911.09.21
0912.05.09.09	0912.05.09.09
0912.05.23	0912.05.23
0912.05.25.03	0912.05.25.03
0912.07.03	0912.07.03
0913	0913
0913.01.03	0913.01.03
0913.13.05	0913.13.05
0914.03.03	0914.03.03
0914.11	0914.11
0915.13	0915.13
0915.15	0915.15

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

§0907 (Eligibility Groups and Bases of Eligibility) under MinnesotaCare updates the text to reflect that there are 4 (rather than 3) eligibility groups.

§0907.03 (MinnesotaCare Eligibility Group 1) adds a cross reference to new section §0907.08 (MinnesotaCare Eligibility Group 4).

§0907.05 (MinnesotaCare Eligibility Group 2) adds a cross reference to new section §0907.08 (MinnesotaCare Eligibility Group 4). It revises text relating to parents and caretakers to reflect the addition of Group 4.

§0907.07 (MinnesotaCare Eligibility Group 3) adds a cross reference to new section §0907.08 (MinnesotaCare Eligibility Group 4) and removes 2 bullets that no longer apply.

§0907.08 (MinnesotaCare Eligibility Group 4) is a new section describing Group 4. Group 4 is designed to track parents and caretakers for whom DHS receives enhanced federal funding. Group 4 parents and caretakers are citizens or have immigration statuses qualifying for federal funding, and have family incomes over 100% FPG but no more than 200% FPG.

§0907.13 (MinnesotaCare Parents/Guardians/Caretakers adds that parents and caretakers who meet the criteria in §0907.08 (MinnesotaCare Eligibility Group 4).are assigned to Group 4. Other parents and caretakers and all legal guardians and foster parents who apply with the children living with them are assigned to Group 2.

§0907.23.11 (MA Waiver Programs: EW) updates the SIS to $1,656. See Highlighted Change #1.

§0907.27 (MA/GAMC Basis: IMD Residents) adds that people who meet all MA-EPD requirements but are residing in an IMD can remain on EPD (through program MA or IM) while residing in the IMD. They must continue to pay premiums. It clarifies that people who meet an MA basis but cannot get MA due to residence in an IMD are coded as program IM in MAXIS and MMIS. Program IM is part of GAMC but is tracked separately because eligibility for this group is determined using MA rather than GAMC rules. It clarifies that in addition to people placed in IMDs by health plans, people enrolled in health plans who are court ordered to IMDs remain enrolled in the health plan if the court determines the health plan is responsible for the placement costs.

§0908.05 (Determining MA/GAMC Household Size) adds an exception and cross-reference for MA-EPD to the instructions on determining household size for people whose eligibility is based solely on their own income and assets.

§0909.25 (Spousal Asset Assessments) increases the minimum and maximum spousal asset allowances. See Highlighted Change #1.

§0909.27.11.09 (Transfers After 4-13-96) updates the amount exempt from transfer consideration (unless the transfer is made during an existing penalty period) from $500 to $200 in any month. This change was effective July 1, 2002 but was inadvertently missed in this section.

§0910 (Other Health Coverage), §0910.11 (Employer Subsidized Insurance) and §0910.11.03 (18-Month Rule) add references to Group 4.

§0911.05.03 (Excluded Income-Program Provisions) under MA Method B adds income from the Mille Lacs Band of Ojibwe's Supplemental Elder Assistance Program as an exclusion for people using community budgeting.

§0911.07.05 (Unearned Income) adds extended income support payments from the Trade Adjustment Reconciliation Act as an example of countable unearned income. These payments are made to certain people whose job loss was related to foreign trade. They must have exhausted regular Unemployment Insurance benefits.

§0911.09.03 09 (Self-Employment Transportation) decreases the mileage rate to 36 cents per mile. See Highlighted Change #1.

§0911.09.07 (Student Financial Aid Program) adds to exclude training expenses paid on an enrollee's behalf through the Trade Adjustment Reconciliation Act.

§0911.09.21 (Tribal Land Settlements and Trusts) adds that payments from the Mille Lacs Band of Ojibwe's Supplemental Elder Assistance Program are excluded for MA for people using community budgeting. They are counted for long term care budgeting. These payments are made to tribal members age 65 and over who meet specific income and asset limits.

§0912.05.09.09 (Blind and Disabled Student Child Disregard) increases the monthly and annual limits. See Highlighted Change #1.

§0912.05.23 (Pickle Disregard) adds the 2003 disregard factor. See Highlighted Change #1.

§0912.05.25.03 (Allocations - Community Spouse) increases the maximum spousal income allocation. See Highlighted Change #1.

§0912.07.03 (Clothing and Personal Needs Allowance) updates the amount for 2003. See Highlighted Change #1.

§0913 (Premiums) adds under MA-EPD that the premium is adjusted at the time of the annual COLA increase.

§0913.01.03 (MA-EPD Premiums) updates the instructions to reflect that the premiums are now calculated on MAXIS. Instructions were previously issued through MAXIS and POLI TEMP. It adds that premiums are adjusted at the time of the annual COLA increase.

§0913.13.05 (Waiver Obligation–SIS EW) updates the SIS. See Highlighted Change #1.

§0914.03.03 (Managed Care Exclusions) adds Avera Health Plan to the list of state-certified HMOs and updates the names of 3 other plans. It deletes the 1st bullet under GAMC for IMD residents because the information is included earlier in the section. For both MA and GAMC, IMD residents are excluded from managed care unless they were enrolled in managed care at the time of IMD admission and the health plan is responsible for the cost. This includes court ordered placements.

§0914.11 (Access Services) decreases the mileage rate. See Highlighted Change #1.

§0915.13 (Enrollee Becomes Pregnant) adds to assign spouses of pregnant women with no other children to Group 4 if they meet Group 4 criteria.

§0915.15 (Change in Group Status) adds information on Group 4. When Group 4 parents and caretakers lose parental status, reassign them to Group 3 for the next available month. If they report an income decrease to below 100% FPG, reassign them to Group 2 for the next available month. Make group status changes because of increased income at the time of the next renewal.

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People's eligibility for the health care programs may vary depending on certain characteristics. The relevant characteristics vary by program but may include age, disability, pregnancy, and presence of children in the home.

MinnesotaCare:

All MinnesotaCare enrollees are assigned to 1 of 4 eligibility groups. Eligibility group status mainly affects insurance barrier requirements. Certain characteristics within groups such as pregnancy, age, and income may also affect benefits. See the following sections for more specific information:

§0907.09 MinnesotaCare Pregnant Women.
§0907.11 MinnesotaCare Children Under 21.
§0907.13 MinnesotaCare Parents/Guardians/Caretakers.
§0907.15 MinnesotaCare Adults Without Children.

Adults and children in the same household may be assigned to different eligibility groups. Re-evaluate group status at each renewal. Once people are assigned an eligibility group, their group status remains unchanged between renewals unless:

- They do not maintain continuous enrollment. For purposes of group status, continuous enrollment means that a person has been enrolled in MinnesotaCare without a break in coverage of one month or more.

OR

- They have a change in circumstances that results in a more favorable group status. This includes Group 2 parents or caretakers who report income decreases resulting in Group 4 status. See §0915.15 (Change in MinnesotaCare Eligibility Group).

OR

- A parent loses parental status.

OR

- A child turns age 21 and is not a dependent sibling.

OR

- A person age 21-24 loses dependent sibling status.

EXCEPTION:

Children who were enrolled in the Children's Health Plan on or before 6-30-93 who have maintained continuous enrollment retain Group 1 status until they reach age 21. See §0907.03 (MinnesotaCare Eligibility Group 1).

See §0907.03 (MinnesotaCare Eligibility Group 1), §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4).

M. S. 256L.02 subd. 4
M. S. 256L.03 subd. 1, 3, and 5

MA:

Each person must meet a basis of eligibility for MA. A basis of eligibility is a set of characteristics such as age, disability, or family status. The bases of eligibility are based on federal eligibility categories. See §0907.17 (MA/GAMC Bases of Eligibility).

GAMC:

People who do not meet a basis of eligibility for MA may be eligible for GAMC. See §0907.17 (MA/GAMC Bases of Eligibility).

MinnesotaCare:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4).

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 the appropriate group depending on their current circumstances. See §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4). 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:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.03 (MinnesotaCare Eligibility Group 1), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4).

Group 2 includes:

- Children under 21 with family income over 150% FPG.

  EXCEPTION:

  Children under 21 who were enrolled in the Children's Health Plan on or before 6-30-93 who have maintained continuous enrollment may have family income over 150% FPG and retain Group 1 status. See CONTINUOUS ENROLLMENT in §0902.07 (Glossary: Client...) and §0907.03 (MinnesotaCare Eligibility Group 1).

- Parents or relative caretakers of dependent children with incomes at or below 100% FPG or over 200% FPG. Assign parents with incomes over 100% FPG but no more than 200% FPG to Group 4 if they are citizens or have an immigration status that qualifies them for FFP. See §0907.08 (MinnesotaCare Eligibility Group 4).

NOTE:

Always assign pregnant women to Group 2. Husbands of pregnant women may be either Group 2 or Group 4.

- Non-citizen parents or relative caretakers with incomes at or below 275% FPG who do not have an immigration status that qualifies them for FFP. See §0906.03.05 (Non-Citizens Ineligible for Federal Funding).

- Legal guardians and foster parents.

- Adult dependent siblings.

Re-evaluate group status for the next available month or at the time they apply for MinnesotaCare coverage on their own case when people enrolled in Group 2:

- Reach age 21

OR

- Are no longer part of a family with children

OR

- No longer have dependent sibling status.

Assign these people to Group 3 if eligibility continues. If people who originally enrolled in Group 2 reapply after losing coverage for 1 month or more, re-evaluate group status based on current circumstances.

EXAMPLE:

Joe and Susan Brown and their children, Emily, age 19 and Bruce, age 18, have a family income of 225% FPG. Their family income has been above 150% FPG throughout their enrollment in MinnesotaCare. All household members have Group 2 status.

EXAMPLE:

Emily Brown has reached age 21 and moved out of her parents' household. She requests to end coverage on her parents case and begin her own MinnesotaCare case. Re-evaluate her group status when her application is processed. Since she is now an adult in a household with no dependent children, assign her to Group 3. As long as Emily has remained continuously enrolled, she will be allowed to remain enrolled in MinnesotaCare even if she is over income. If she does have income over the MinnesotaCare income standard for Group 3 and 10% of her gross annual income is equal to or more than the annual premium for a MCHA policy with a $500 deductible, send an 18-month notice of disenrollment from MinnesotaCare. See §0912.03.03 (MinnesotaCare Excess Income).

EXAMPLE:

Bruce Brown has now turned 21. He remains in the household with his parents and meets the definition of an adult dependent sibling. Bruce and his parents may remain assigned to Group 2 as long as Bruce continues to meet the definition of an adult dependent sibling.

EXAMPLE:

Bruce moves out of his parents' household. Assign his parents to a non-parent major program (BB or XX) and group 3 status for the next available month with 10-day notice. When Bruce submits an application for coverage

on his own MinnesotaCare case, re-evaluate his group status and assign him to Group 3.

When Group 2 parents report an income decrease that results in meeting Group 4 critieria, change group status for the 1st available month. Act on income increases at the time of the next renewal.

Generally, Group 2 members cannot have current health insurance and cannot have had health insurance in the 4 months prior to enrollment in MinnesotaCare. They may be subject to restrictions on current and past availability of employer subsidized insurance (ESI). See §0910 (Other Health Coverage) for detailed instructions on which insurance barriers apply to Group 2 individuals.

The income limit at application for Group 2 is 275% FPG. People who maintain continuous enrollment can have income over the limit and remain enrolled. For people who are over income, determine if 10% of annual income is equal to or above the annual premium for a policy with a $500 deductible available through MCHA. If 10% of annual income is equal to or above the household's MCHA premium, give the household 18 months notice of disenrollment from MinnesotaCare. See §0912.03.03 (MinnesotaCare Excess Income).

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

MA/GAMC:

No provisions.

MinnesotaCare:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.03 (MinnesotaCare Eligibility Group 1), §0907.05 (MinnesotaCare Eligibility Group 2) and §0907.08 (MinnesotaCare Eligibility Group 4).

Group 3 includes adults who:

- Are not dependent siblings

AND

- Are not pregnant.

AND

- Do not have children under 21 (including foster children or children under guardianship in the household) or adult dependent siblings living with them.

This includes adults previously enrolled in Group 2 or Group 4 who have lost their parental status.

EXAMPLE:

John, age 26, is applying for MinnesotaCare for the first time. He has no children under 21 in his household. Assign John to Group 3.

EXAMPLE:

Mary and Joe are Group 2 parents. Their children have left the household. Since Mary and Joe no longer have minor children or dependent siblings in their household, assign them to Group 3 for the 1st available month with 10-day notice.

Group 3 members are subject to all the insurance barriers. See §0010 (Other Health Coverage).

The income limit for Group 3 at initial enrollment is 175% FPG. People who remain continuously enrolled and have income above the limit may remain enrolled if 10% of annual income is less than the premium for a policy with a $500 deductible available through MCHA. See §0912.03.03 (MinnesotaCare Excess Income).

M. S. 256.9354 subd. 1 and 5
M. S. 256.9357 subd. 1, 2, and 3
M. S. 256.9366 subd. 1, 2, 3, and 4

MA/GAMC:

No provisions.

MinnesotaCare:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.03 (MinnesotaCare Eligibility Group1), §0907.05 (MinnesotaCare Eligibility Group 2), and §0907.07 (MinnesotaCare Eligibility Group 3).

Group 4 includes parents and relative caretakers who:

- Have household incomes over 100% FPG but at or below 200% FPG.

AND

- Are U. S. citizens or have an immigration status that qualifies for federal financial participation (FFP). See §0906.03.03 (Qualified Non-Citizens).

Group 4 is used to identify parents and relative caretakers for whom DHS receives enhanced federal funding. Use MMIS major program FF for all group 4 enrollees.

Except for citizenship/immigration status and income, Group 4 parents and caretakers have the same eligibility requirements as Group 2 parents and caretakers. See §0907.05 (MinnesotaCare Eligibility Group 2) and §0907.13 (MinnesotaCare Parents and Caretakers).

See §0907.05 (MinnesotaCare Group 2) for information on when to re-evaluate group status when people lose parent or caretaker status.

MA/GAMC

No provisions.

MinnesotaCare:

MinnesotaCare parents, guardians, foster parents, or relative caretakers have either Group 2 or Group 4 status. Group 4 includes parents and caretakers with incomes over 100% FPG but no more than 200% FPG who are citizens or have an immigration status that qualifies for FFP. Children previously enrolled in Group 1 who become adults and are caretakers of children also have Group 2 or Group 4 status. See §0907.05 (MinnesotaCare Eligibility Group 2) and §0907.08 (MinnesotaCare Eligibility Group 4).

See §0908.03 (Determining MinnesotaCare Household Size) to determine who may qualify as a legal guardian or relative caretaker.

Parental, guardianship, and relative caretaker status affect MinnesotaCare eligibility in the following ways:

- MinnesotaCare parents and relative caretakers who are U.S. citizens or have a qualified immigration status and have incomes equal to or less than 275% FPG qualify for federal financial participation. Those with incomes over 100% FPG but no more than 200% FPG qualify for enhanced federal funding. Parents and relative caretakers with incomes over 275% FPG or who do not have a qualified immigration status and all legal guardians and foster parents qualify only for state-funded MinnesotaCare.

  See §0906.03.13 (MinnesotaCare Major Programs) for more information.

- MinnesotaCare parents, legal guardians, and relative caretakers have some benefit limitations, deductibles, and co-payments which vary depending on household income.

  - Parents, legal guardians, and relative caretakers whose total household income is over 175% but less than or equal to 275% FPG have a $10,000 limit on inpatient hospital benefits. They do not have hospital co-payments.

  - Parents, legal guardians, and relative caretakers whose household income is equal to or less than 175% FPG are not subject to a $10,000 limit on inpatient hospital benefits and do not have hospital co-payments.

- Parents, legal guardians, and relative caretakers and foster parents who apply with the children in their care have limited dental coverage and have co-payments for some services, including prescriptions and eyeglasses, regardless of income.

▸ All MinnesotaCare parents, legal guardians, and relative caretakers, and foster parents who apply with the children in their care are considered family households and are subject to the family income limit of 275% FPG. See §0912 (Income Eligibility).

▸ Adults who care for children under 21 who live with them but who are not the biological or adoptive parent, stepparent, legal guardian, relative caretaker, or foster parent of any of the children are not considered to be a member of a family with children. See §0907.15 (MinnesotaCare Adults Without Children).

When adults lose parent or caretaker status, change eligibility to the appropriate non-parent major program (BB or XX) and Group 3 status effective the 1st available month after the change.

M. S. 256L.04 subd. 13

MA:

See §0907.19.07 (MA Families & Children: AFDC-Related Adults).

GAMC:

See §0907.25.03 (GAMC Basis: Families With Children).

MinnesotaCare:

No provisions.

MA:

The Elderly Waiver (EW) provides MA funding for home and community-based services for people who would otherwise need nursing facility care. Covered home care services include:

- Adult day care.
- Respite care.
- Homemaker services.
- Adult foster care (other than room and board costs).
- Extended home health.
- Case management.
- Equipment and supplies not covered by MA, Medicare, or the client. The equipment and supplies must help keep the client out of a nursing facility.
- Companion services.
- Extended personal care.
- Home-delivered meals.
- Caretaker training and education.
- Assisted living.
- Residential care.
- Extended transportation.
- Chore services

To receive EW services, a person must meet ALL of the following conditions:

- Have a Long Term Care Consultation (LTCC) screening.
- Require a nursing facility level of care (NF-I or NF-II).
- Be able to remain in the community rather than a nursing facility.
- Choose community care.
- The cost to MA for community-based services must cost less than institutional care.
- Be eligible for MA.

There are 2 income limits for EW. People with incomes equal to or less than the Special Income Standard (SIS) are eligible for EW without an MA spenddown. They must contribute any income over the maintenance needs allowance and other applicable deductions to the cost of services received under EW. This is known as the waiver obligation.

The SIS for 1-1-03 through 12-31-03 is $1,656 for all EW applicants or enrollees, regardless of marital status or household size. The SIS for 1-1-02 through 12-31-02 is $1,635. The maintenance needs allowance for 7-1-02 through 6-30-03 is $741 regardless of marital status or household size. Treat each person as a household of 1.

To determine eligibility for the SIS EW program, add together all monthly gross income of the applicant or enrollee before any exclusions. Do not include the income of the person's spouse. If the applicant or enrollee's gross income is equal to or less than the SIS, see §0913.13.05 (Waiver Obligation--SIS EW).

People with income equal to or less than the SIS but greater than the maintenance needs allowance may choose to receive services through Alternative Care (AC) rather than through SIS EW if they meet the eligibility requirements for both programs. See §0918.05 (Alternative Care - AC). However, people in this category who choose AC are NOT eligible for MA with a spenddown, with one exception as described in §0913.13.07 (Relationship Between EW and AC).

If income exceeds the SIS, single people and married couples who both receive EW must qualify under the applicable Method B income standard. See §0912.07.100 (100% of FPG), §0912.07.075 (75% of FPG) and TE02.07.117 (Single Elderly Waiver). Use a household size of 1 and Method B budgeting when both spouses receive EW services (as well as for single EW clients). Set the case up using a community spenddown. Treat the projected amount of EW services for the month as a medical bill incurred on the 1st day of the month.

Use a household size of 1 for MA and the Medicare Supplement Programs for the non-EW spouse when 1 spouse receives EW and the other receives MA.

For more information on community spenddowns see

§0913.05.05	Use of 6-Month and LTC Spenddowns
§0913.05	Which Spenddown Type to Use
§0913.11	Manual Monthly Spenddown Calculation
§0913.09	Automated Monthly Spenddown Calculation

Use an LTC spenddown for people with a community spouse who does not receive EW. See §0913.05 (Which Spenddown Type to Use) and §0913.13.03 (LTC Spenddown--EW With Community Spouse). If the person's available income exceeds the monthly EW charges, determine eligibility using a combined LTC/Medical spenddown. See §0913.15 (Combination LTC/Medical Spenddown).

The asset limit for EW is $3,000 for a household of 1. When both spouses receive EW, each has an asset limit of $3,000. If 1 spouse has assets over $3,000 and the other spouse has assets under $3,000, the spouse with excess assets may transfer assets to the other spouse.

Consider people who receive home care services through EW and who have a community spouse not receiving EW to be long term care spouses. An LTC spouse or a community spouse can request an asset assessment to determine what amount of the couple's marital assets are protected for the community spouse and when MA eligibility may begin for the LTC spouse. The asset assessment can be completed when the following conditions occur:

- The LTC spouse has had a LTCC screening.

AND

- The LTC spouse requires a nursing facility level of care.

AND

- Home care services began prior to the LTCC date and are anticipated to continue for at least 30 consecutive days after the LTCC date.

OR

- Home care services which are anticipated to last for at least 30 consecutive days will begin within 90 days of the LTCC date.

The community spouse of a person receiving EW services is entitled to a community spouse asset allowance. See §0909.25 (Spousal Asset Assessments).

If a need exists, the community spouse and certain family members who live with the LTC and community spouse may be entitled to an allocation from the income of the LTC spouse. See §0912.05.25 (Allocations).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

The following people who live in an Institution for the Treatment of Mental Diseases (IMD) have a basis of eligibility for MA:

- Children up to age 21 who are living in an IMD certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). See §0907.19.03 (Families and Children Basis: Child Under 21).

- People up to age 22 who have received inpatient psychiatric hospital services continuously since before their 21st birthday and who were eligible for MA on their 21st birthday while living in an IMD certified by JCAHO.

- People who receive MA, are enrolled in managed care, and were placed in an IMD by the health plan, or for whom the health plan pays court-ordered costs. See §0914 (Service Delivery). These people remain enrolled in the health plan with the same budget as they had before placement.

- People age 65 and over. See §0907.21.03 (MA/Medicare Supplement Basis: Age 65 & Over).

Use Method B for all IMD residents who are eligible for MA.

Asset limit for people age 21 and over who are not on MA-EPD:

- $3,000 for a household of 1.
- $6,000 for a household of 2.
- $200 for each additional household member.

MA-EPD:

- $20,000

No asset limit for children under 21.

Income standard for people who are not on MA-EPD:

100% of FPG. See §0912.07.100 (100 Percent of FPG Standards).

People with incomes greater than 100% FPG may be eligible by spending down to 75% FPG (70% FPG through 6-30-02). See §0912.07.075 (75 Percent of FPG Standards).

MA-EPD:

No income limit. People with incomes equal to or greater than 100% FPG must continue to pay the MA-EPD premium while residing in an IMD.

Except for enrollees whose IMD costs are the responsibility of a health plan (including court ordered placements for which the health plan is responsible), use a long term care spenddown if MA is paying the cost of care in the IMD. See §0913.13 (Long Term Care Spenddown Calculation).

People who are eligible for MA while living in an IMD are eligible for all MA covered services. If MA is not paying the cost of care in the IMD, the person is eligible for all MA covered services incurred in addition to facility costs, such as doctor and dental visits.

MA pays the cost of care for individuals up to age 21, or up to age 22 if they meet the conditions earlier in this section, only in the state Regional Treatment Centers (RTCs).

People who meet an MA basis of eligibility but are ineligible for MA solely because they live in an IMD are eligible for GAMC benefits plus special transportation. Because they are ineligible for FFP due to residing in an IMD, these benefits are funded through GAMC, but the major program is IM on MAXIS and MMIS. Their eligibility is determined using MA income and asset limits. Determine the MA basis of eligibility and apply the appropriate income standard, asset limit, and method. See §0907.19 (MA Families and Children Bases), §0907.21 (MA Basis: Age 65 and Over/Blind/Disabled), and §0909.05 (Asset Limits).

EXAMPLE:

Mary, age 35, receives MA for herself and 2 children. She is placed in an IMD for an estimated stay of 3-4 months. She is ineligible for MA solely due to IMD residence. Determine eligibility for program IM eligibility using the MA Parent/Caretaker asset limit ($6,200 for Mary and 2 children) and income limit (100% of FPG). Use Method A.

People who are eligible for program IM are eligible for MA if they have been discharged from the IMD or are on convalescent or conditional leave. See §0906.09.01 (Institutional Residence --MA/GAMC).

People who are enrolled in program IM solely due to IMD residence are also ineligible for the Medicare Supplement Programs. Reimburse cost-effective Medicare premiums for this group. See §0910.05.05 (Medicare Premium Payment).

People who are otherwise eligible for MA-EPD but cannot get MA due to residing in an IMD may be eligible for program IM. Use MA-EPD asset limits and premium determination rules. See §0907.21.07.05 (MA for Employed Persons with Disabilities). Recalculate the premium if the MA-EPD enrollee is on a medical leave from employment of up to 4 months or has decreased wages while residing in the IMD. See §0907.21.07.06 (MA-EPD Employment Definition) and §0913.01.03 (MA-EPD Premiums).

GAMC:

People who reside in an IMD and do not have a basis of eligibility for MA are eligible for GAMC. Use Method B.

Asset limit:

- $1,000 per household.

See §0909.05 (Asset Limits).

Income standard:

75% FPG (70% FPG through 6-30-02). See §0912.07.075 (75 Percent of FPG Standards).

EXAMPLE:

Peter, age 40, resides in an IMD. He is single with no children and is not blind or disabled. Use GAMC Method B asset and income limits to determine GAMC eligibility.

People who qualify for GAMC under a GAMC-only basis of eligibility are eligible for all GAMC covered services. The IMD costs are not a GAMC covered service and will be paid through other funding, such as GRH, other state programs, or private pay. The IMD resident is eligible for GAMC services such as doctor and dentist visits that are not included in the IMD treatment plan.

MinnesotaCare:

No provisions.

MA/GAMC:

Include any of these people who live with an adult in that adult's household size:

- The person's spouse. Do not consider spouses in the same long term care facility to be living together even if they are in the same room.

- Biological or adoptive children under age 21 who live with the person or are considered temporarily absent from the parental home, such as students included on the parent's case.

- Biological or adoptive children under age 21 of the person's spouse who live in the household with the MA applicant and spouse or are considered temporarily absent.

EXCEPTION:

Do not include children under 21 who live with parents in the parents' household if the child is or has been married, is on active duty with the armed services, or has been declared emancipated by a court.

- An unborn child or children (if a multiple pregnancy is verified), if the person is a pregnant woman or the spouse of a pregnant woman.

EXAMPLE:

Kelly, age 30, lives with her husband Jason, her daughter from a previous marriage, and Jason's son from a previous marriage. Kelly is pregnant and expecting a medically-verified single birth. Kelly and Jason each have a household size of 5: Kelly, spouse, child, stepchild (because the stepchild is the financial responsibility of the spouse), and unborn child.

Do not include children other than biological or adoptive children of the person or person's spouse (such as grandchildren, nieces, nephews) in an adult's household size.

Include any of these people who live with a child in that child's household size:

- The child's biological or adoptive parents.
- Other children who are included in the parent's household size.

EXCEPTION:
Do not include parents or their other children in the child's household size if the child is or has been married, is on active duty in the armed services, or has been declared emancipated by a court.

- A stepparent if a biological or adoptive parent also lives in the home.
- Children of a stepparent who live in the home or are temporarily absent.
- An unborn sibling or half-sibling with whom the child shares a legally established common parent. Count multiple siblings if a multiple pregnancy is verified.
- The child's spouse.
- The child's minor children and unborn children if the child is pregnant.

EXAMPLE:
Allie lives with her mother, Kelly, her stepfather, Jason, and Jason's son Garrett. Kelly is pregnant and expecting a medically verified single birth. Both Allie and Garrett have a household size of 5: self, parent, stepparent, stepsibling, and unborn half-sibling.

EXAMPLE:
Megan, age 18, lives with her parents, her sister, and Megan's 2-year-old son. Megan has a household size of 5: Megan, parents, sibling, and Megan's minor child. Megan's parents each have a household size of 4: parent, spouse, and children. Megan's sister has a household size of 4: sister, parents, and sibling. Megan's son has a household size of 2: son and Megan.

Use a household size of 1 if:

- A person's eligibility is based solely on the his/her own income and assets without regard to responsible relatives with whom he/she lives, except for MA-EPD. This includes a child with TEFRA eligibility and a blind or disabled child ages 18 to 21 whose eligibility is based only on the child's income and assets.

NOTE: Count the income of the spouse of a disabled person ages 18 to 21, regardless of whether the person lives with his/her parents. Use a household size of 2.

See §0913.01.03 (MA-EPD Premiums) for MA-EPD household composition.

- A child does not live with a natural or adoptive parent. This is true even if the child lives with siblings. Do not count non-parental relative caretakers in the child's household size, including stepparents if there is no biological or adoptive parent in the home.

  EXAMPLE:

  Betsy and Sarah are minor siblings who live with their aunt. Both children have a household size of 1. The aunt is also a household size of 1 if she requests MA for herself.

  EXAMPLE:

  Greg lives with his stepfather. His mother does not live in the home. Greg and his stepfather each have a household size of 1.

Use a household size of 1 in determining asset limits for LTCF residents beginning:

- The 1st full month after admission to the LTCF for a client with no community spouse.

- The month of institutionalization for the client with a community spouse.

Use a household size of 1 for an LTC spouse when determining asset limits beginning the month the LTC spouse begins receiving home care services through elderly waiver.

See §0913.13 (Long Term Care Spenddown Calculation) for LTC income limits.

If children alternate living with separated or divorced parents, consider them to be in the household in which they spend the most time. If the time is equally divided, consider them to be in the household in which they live on the date of application. Do not consider them to be members of both households in the same month. Also see §0908.13.03 (Temporary Absence--MA/GAMC).

Consider people under house arrest to be household members.

MinnesotaCare:

No provisions.

MA:

The following provisions apply to married people when 1 spouse:

- Begins a period of institutionalization, in any state, anticipated to last at least 30 consecutive days on or after 10-1-89.

OR

- Was screened by the Long Term Care Consultation (LTCC) team on or after 7-1-91 and was receiving or is anticipated to begin home care services within 90 days of the LTCC and will continue for at least 30 consecutive days. See CONTINUOUS PERIOD OF INSTITUTIONALIZATION in §0902.07 (Glossary: Client...) for instructions on determining 30 consecutive days. Verify the anticipated duration of home care services through the agency providing the services or the LTCC team.

An asset assessment is a snapshot of all non-excluded assets owned by either or both of the spouses at the time of the 1st continuous period of institutionalization in any state. People are not required to complete an asset assessment before applying for MA. However, because the asset assessment determines the amount of assets to be attributed to each spouse and does not change from the date of the 1st continuous period of institutionalization, it may be easier to complete at that time.

Do not require people to divide assets between the spouses at the time of the asset assessment. The asset assessment is an estimate of the amount of assets each spouse can retain when the LTC spouse applies for MA. Determine the amount of assets to attribute to each spouse at the time of application.

Complete an asset assessment at the request of either an LTC or community spouse on or after the date that 1 spouse:

- Begins residing in a long term care facility (LTCF).

OR

- Has had a LTCC and begins receiving home care services which would be covered by the Elderly Waiver (EW) program if the person was eligible for MA for a period expected to last at least 30 consecutive days. See CONTINUOUS PERIOD OF INSTITUTIONALIZATION in §0902.07 (Glossary: Client...) for instructions on determining 30 consecutive days.

EXAMPLE:

John enters an LTCF in 1998. His wife Greta continues to reside in the community. John and Greta do not expect to need MA for John's care for approximately 2 years. They request an asset assessment to help them plan for John's care. Complete the assessment as of the date John entered the LTCF.

Require an asset assessment at the time of application for MA if an assessment was not previously completed in any state, or if a previously completed assessment is not available.

Use the Asset Assessment Form (DHS 3340). The effective date of the assessment is the earliest of the 1st day of the 1st continuous period of:

- Admission to a medical hospital.

OR

- Admission to a nursing facility (NF).

OR

- Receipt of home care services that would be covered by Elderly Waiver (EW) or Alternative Care (AC) program, or the LTCC date, whichever is later.

Use the same asset assessment at every application where you calculate a community spouse asset allowance.

EXAMPLE:

Norman is admitted to a medical hospital on June 2, 1996. On July 7, he enters an LTCF for convalescent care. He is discharged to his home on October 10, 1996. He does not apply for MA for any part of this period. On November 2, 1996, he is readmitted to the LTCF. His wife remains in the community. They apply for MA for Norman on September 15, 1997. Base the asset assessment on assets owned by Norman and his wife on June 2, 1996.

Count the equity value of all non-excluded assets in the assessment. Count annuities if they have not been annuitized, they are in the free look period, or they have a commuted cash value as defined in §0909.23 (Annuitites). Also count the corpus of a trust set up for the sole benefit of the community spouse even if disbursements began before the date of the asset assessment.

Do not consider the availability of an asset when completing an assessment. Only consider availability at application when determining which assets count toward the applicant's asset limit. Verify all assets included in the assessment at the time of the assessment, initial application, and the 1st annual renewal. If you discover previously unreported assets at the time of application, revise the asset assessment to include those assets if they were owned at the beginning of the 1st continuous period of institutionalization.

Estimate the community spouse asset allowance as follows:

1. Total the equity value of all non-excluded assets owned by either spouse on the effective date of the assessment. Do not count:

   - The homestead.
   - Personal and household goods.
   - 1 vehicle. For purposes of an asset assessment, exclude 1 vehicle regardless of use or value. Do not apply the criteria in §0909.15 (Vehicles).
   - Capital assets necessary to operate a trade or business.
   - The cash surrender value of life insurance policies with total face value of $1,500 or less per person, OR the first $1,500 of an irrevocable burial agreement for people who do not have life insurance with total face value of $1,500 or less. Do not designate other assets as burial funds as part of the asset assessment. See §0909.17.03 (Determining the Burial Fund Exclusion).
   - Other excluded assets. See §0909.11 (Excluded Assets) and §0909.11.01 (Additional Excluded Assets for Method A/B).

2. Divide the total countable assets in half.

3. Compare the figure in step 2 to the minimum/maximum asset allowance in effect at the time you process the assessment. If the applicant applies at a later date, use the current minimums and maximums in effect on the date of application.

4. If half of the total countable assets are:

- Less than the minimum asset allowance, the estimated allowance is the minimum asset allowance.
- More than the minimum asset allowance but less than the maximum asset allowance, the estimated asset allowance is half of the total countable assets.
- More than the maximum asset allowance, the estimated asset allowance is the maximum asset allowance.

Minimum/maximum asset allowance figures for people who begin their 1st period of institutionalization or home care services anticipated to last at least 30 consecutive days are:

	Minimum	Maximum
1-1-03 - 12-31-03	$25,601	$90,660
1-1-02 - 12-31-02	$25,247	$89,280
1-1-01 - 12-31-01	$24,607	$87,000
1-1-00 - 12-31-00	$23,774	$84,120
1-1-99 - 12-31-99	$23,171	$81,960
1-1-98 - 12-31-98	$22,828	$80,760
1-1-97 - 12-31-97	$22,336	$79,020
1-1-96 - 12-31-96	$21,685	$76,740
1-1-95 - 12-31-95	$21,156	$74,820
7-1-94 - 12-31-94	$20,540	$72,660
1-1-94 - 6-30-94	$14,532	$72,660
1-1-93 - 12-31-93	$14,148	$70,740

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Use the following steps to determine the ineligibility period for transfers made on or after 4-13-96:

1. If the total amount transferred for less than fair market value in any month by the client and spouse combined does not exceed $200 for the month ($500 before 7-1-02), disregard that amount and do not calculate a penalty period.

   EXCEPTION:

   If $200 or less ($500 or less for transfers before 7-1-02) is transferred during a pre-existing penalty period, include the value of such transfers in the penalty period calculation.

2. If the amount transferred for less than fair market value is greater than $200, ($500 before 7-1-02), determine a penalty period based on the total value of all uncompensated transfers made during that month. Do not disregard the 1st $200 ($500 before 7-1-02) transferred.

3. If the total uncompensated value of assets transferred in a month by the client and spouse combined is greater than $200 ($500 before 7-1-02), divide the uncompensated value by the statewide average monthly payment rate for nursing facility care (SAPSNF) in effect on the date of the client's application.

   Effective 7-1-02, the SAPSNF is $3,702. From 7-1-01 through 6-30-02, the SAPSNF is $3,572.

4. Do NOT truncate partial months. Apply a partial month of ineligibility for MA payment of long term care services to both applicants and recipients.

   If the transferred amount is LESS than the applicable SAPSNF, deny eligibility for long term care services equal to the amount transferred. The result is the dollar amount of long term care services the client is responsible for before MA eligibility for long term care services can begin.

If the transferred amount is MORE than the applicable SAPSNF and a fractional part of a month remains after calculating a period of ineligibility, multiply the remainder (rounded to hundredths) by the applicable SAPSNF.

Truncate that result. The result is the dollar amount of long term care services the client is responsible for in the last partial month of ineligibility.

5. Add the amount determined in step 4 to the client's long term care spenddown or medical spenddown, whichever applies, for the partial month of ineligibility. This is the client's total liability for the partial month.

   Eligibility for payment of long term care services begins after that amount has been incurred by the client. If a client does not incur long term care services equal to or greater than his/her total liability, do NOT carry the penalty over to the next month.

   Open MA for all other services during a full or partial month penalty period.

GAMC:

See §0909.27.11 (Improper Transfer Ineligibility). For GAMC transfers, the SAPSNF is $3,102 effective 7-1-02 ($2,918 from 7-1-01 through 6-30-02).

Availability of other health coverage may affect people's eligibility for MinnesotaCare. Availability of other coverage does not affect eligibility for MA or GAMC. However, when people who have other coverage also have coverage under any of the 3 health care programs, the other health coverage is usually the payor of 1st resort. Notify the Benefit Recovery Section when people have other health coverage. See §0910.05 (Current Health Insurance), §0910.13 (Third Party Liability) and §0914.03 (Service Delivery - People W/Other Coverage).

MinnesotaCare:

Eligibility for MinnesotaCare may be affected by current health coverage, coverage in the preceding 4 months, and coverage or access to coverage through employer subsidized insurance (ESI). These regulations are often called insurance barriers and exist to prevent both individuals and employers from dropping private health insurance coverage in favor of MinnesotaCare.

Whether someone with current or past coverage can qualify for MinnesotaCare depends on several factors, including:

- Whether the person is an adult or dependent child.
- The person's status at the time of initial MinnesotaCare enrollment.
- The type of coverage available. See §0910.09 (Determining if Someone Is Underinsured).
- The portion of the cost of coverage paid by the employer. See §0910.11.05 (Determining the Employer Contribution).
- Whether an employer has dropped ESI in the past 18 months. See §0910.11 (Employer Subsidized Insurance).

See §0907 (Eligibility Groups and Bases of Eligibility).

Some people may be subject to some of the insurance barriers and be exempt from others. See §0910.05 (Current Health Insurance), §0910.07 (4-Month Rule), and §0910.11 (Employer Subsidized Insurance).

Generally, children with Group 1 status may have had other coverage in the preceding 4 months and may have current or past access to ESI. They may also have current coverage if they are underinsured. See §0907.03 (MinnesotaCare Eligibility Group 1).

Parents who have children with other health coverage must assign their children's rights to coverage to DHS as a condition of eligibility. People assign their rights by signing the application. Adults who refuse to assign the rights of other household members for whom they are legally able to assign rights are not eligible for MinnesotaCare. Do not sanction children whose parents refuse to assign their rights to insurance or other third party liability.

People must cooperate with the MinnesotaCare agency and the state Benefit Recovery Section (BRS) in identifying potential sources of other health coverage. Applicants and enrollees must provide information on other health insurance which is or may be available to them or their dependents, regardless of whether the applicant or enrollee is the policy holder.

All children may have had access to ESI through a previous employer or a current employer who dropped health care coverage in the preceding 18 months. Children with Group 2 status cannot have had coverage in the past 4 months. They cannot have current coverage or have had access to ESI through a current employer in the past 18 months. See §0907.05 (MinnesotaCare Eligibility Group 2) and §0910.11.03 (18-Month Rule).

Group 2, Group 3 and Group 4 adults are subject to all of the insurance barriers. They cannot have current coverage or current access to ESI, cannot have had coverage in the preceding 4 months, and cannot have had access to ESI in the preceding 18 months if the employer dropped coverage. See §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3), and §0907.08 (MinnesotaCare Eligibility Group 4).

M.S. 256L.07 subd. 2, 3

MA/GAMC:

Availability of other health coverage does not affect people's eligibility for MA or GAMC. People who have other health coverage must assign their rights to coverage to DHS as a condition of eligibility. People assign their rights by signing the CAF or HCAPP. Adults who refuse to assign their rights or the rights of other household members for whom they are legally able to assign rights are not eligible for MA or GAMC. Do not sanction children whose parents refuse to assign their rights to insurance or other third party liability.

People must cooperate with the county agency and the state Benefit Recovery Section (BRS) in identifying potential sources of other health coverage. Applicants and enrollees must provide information on other health insurance which is or may be

available to them or their dependents, regardless of whether the applicant or enrollee is the policy holder.

EXAMPLE:

Heather, age 17, applies for MA for herself. She does not live with either parent. She thinks she may be covered on her father's group insurance plan. Heather must provide as much information as she can about the insurance.

People may be required to enroll in or maintain group or private health insurance if it is cost effective. See §0910.05 (Current Health Insurance) and §0910.05.03 (Health Insurance Premium Payment).

MinnesotaCare:

Employer subsidized insurance (ESI) is coverage for which an employer pays at least 50% of the cost of coverage. See §0910.11.05 (Determining the Employer Contribution). People with Group 2, Group 3 or Group 4 status who have current coverage or access to employer subsidized insurance are ineligible for MinnesotaCare. Do not consider distance to providers enrolled in the ESI plan in determining whether people have access to ESI.

If ESI becomes available to current MinnesotaCare enrollees with Group 2, Group 3 or Group 4 status, they may not refuse the coverage to remain eligible for MinnesotaCare. They are ineligible regardless of whether they actually accept the ESI.

People with Group 2, Group 3 or Group 4 status who have been offered ESI by a current employer in the preceding 18 months are ineligible for MinnesotaCare. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 contains a provision to allow enrollment outside of the usual enrollment period for some people who lose other coverage. See §0910.11.03 (18-Month Rule).

People with Group 1 status may have access to ESI and are not required to accept it, regardless of whether it is considered underinsured. If they do have current ESI coverage, it must be considered underinsured.

EXAMPLE:

Gary and his family are enrolled in MinnesotaCare. They have Group 2 status. At the time of the annual renewal in July, the enrollment representative discovers that Gary had an opportunity to enroll the entire family in ESI at the time of his employer's annual enrollment 6 months earlier in January. He chose not to accept the coverage. Terminate MinnesotaCare for the 1st month for which you can give 10-day notice. Advise Gary to ask his employer if he can enroll in ESI without waiting for the next open enrollment period since he has lost his MinnesotaCare coverage. The family will remain ineligible for MinnesotaCare as long as they have Group 2 status and the employer continues to offer ESI.

EXAMPLE:

Tim's employer offers ESI to Tim, his wife Nancy, and their 2 children. They can sign up for the insurance annually in April. They apply for MinnesotaCare on July 7, 2 months after Tim's open enrollment period ended. Tim and

Nancy are ineligible for MinnesotaCare because a current employer offered ESI within the past 18 months. The children are eligible if they have Group 1 status (family income equal to or less than 150% FPG).

See also:

§0910.09 (Determining if Someone Is Underinsured)
§0907.03 (MinnesotaCare Eligibility Group 1)
§0907.05 (MinnesotaCare Eligibility Group 2)
§0907.07 (MinnesotaCare Eligibility Group 3)

Access to ESI is not a mandatory verification. Do not request verification of access to ESI if the applicant/enrollee has answered "no" to the insurance question(s) on the application, and there is no information known to the agency to conflict with the client's response(s).

Verify access to ESI only when:

- The information about access to ESI provided by the applicant/enrollee is incomplete

OR

- The information about access to ESI is inconsistent with other information known to the agency

AND

- The applicant/enrollee is unable to provide the information or explain the inconsistency.

Consider information about access to ESI to be inconsistent with other information known to the agency if:

- It differs from information included in case specific documents or other case specific data previously collected from the applicant or enrollee

OR

- It differs from information commonly known to workers in the state or local county agency. To be considered commonly known, the information must be available to all workers in the agency. DHS recommends that agencies develop lists of employers known to offer ESI.

Contact the applicant/enrollee by phone, in person or by mail to provide the information or explain the inconsistency before requesting verification from the

employer or union. If you include a request for verification with mail contacts, allow the applicant/enrollee to contact the worker to provide the information or explain the inconsistency before requiring verification from the employer or union.

If the applicant/enrollee is unable to provide the information or explain the inconsistency, request verification from the employer or union. Accept a written statement from the employer or union, a Request for Verification of Employer Insurance (DHS-3348) completed by the employer or union, verbal verification from the employer or union, or other verification. Do not contact the employer or union without written consent from the applicant or enrollee.

EXAMPLE:

Paula applies for MinnesotaCare on March 15. Paula appears to meet all eligibility requirements based on the information on the application. She has submitted 30 days of paystubs for her current wage job. Paula indicates on her application that she does NOT work for an employer who offers health insurance. The worker notes that Paula's employer is a local company known to the agency to offer ESI to employees and their families.

The worker phones Paula, explains that her employer is known to offer insurance, and asks her if there is some reason why she might not have been offered insurance. Paula explains that since she is a temporary worker, hired only for the busy summer season, she is not eligible for any employee benefits. The worker enters a case note about their discussion and approves Paula as pending awaiting payment.

EXAMPLE:

Jack applies for MinnesotaCare for himself and his family on January 3. The question about insurance access on the application is blank. Jack works full time for an employer. His wife is self-employed. There are no income verifications submitted with the application. The worker tries to phone Jack to get an answer for the insurance question, but is unable to reach him by phone.

The worker pends Jack and his family for Incomplete Application, noting that income and insurance information are missing. See MMIS User Manual, MinnesotaCare section I-16-5, for information on correct MMIS codes. The worker requests income verification and includes a Request for Verification of Employer Insurance (DHS 3348) and a note to Jack requesting that he either contact the worker to discuss the insurance question or give the verification form to his employer to complete.

Jack calls the worker several weeks later and states that his employer does not offer health insurance. He faxes copies of his paystubs and tax forms as income verification. The family meets all income and eligibility requirements for MinnesotaCare. Approve the case as pending awaiting payment.

If Jack submits income verification but does not contact the worker to discuss the insurance question or submit the employer form, MMIS will automatically deny the application in 60 days.

M.S. 256L.07 subd. 2
Minnesota Rule 9506.0010 subp. 9
9506.0020 subp. 1e
9506.0030 subp. 2b

MA/GAMC:

No provisions.

MinnesotaCare:

In addition to the limitations on current coverage or access to ESI, adults who lost coverage or access to ESI because the employer chose to drop coverage in any of the 18 months prior to the month of application are ineligible for MinnesotaCare.

EXCEPTION:

People who lost ESI due to the employer dropping the coverage are exempt from this barrier if they were previously enrolled in MinnesotaCare and reapply within 6 months of MinnesotaCare termination.

Adults who lost coverage or access to ESI for any other reason are not subject to this restriction. Children under 21, regardless of group status, are exempt from this restriction even if ESI was lost because the employer dropped coverage.

Apply the 4-month rule if people had ESI coverage in the 4 months preceding application but no longer have it. See §0910.07 (4-Month Rule).

People with Group 2, Group 3 or Group 4 status who have been offered ESI by a current employer in the preceding 18 months are ineligible for MinnesotaCare. At application, renewal, or on receipt of new information, deny or cancel coverage for Group 2, Group 3 or Group 4 applicants or enrollees who have had access to ESI from a current employer within the past 18 months. Do not apply this restriction to Group 1 applicants or enrollees. See §0910.11 (Employer Subsidized Insurance).

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides special enrollment periods for employees and dependents who have access to ESI. People may enroll in a health plan outside of the open enrollment period if:

- They were eligible to enroll in ESI when it was first offered but declined because they had other coverage.
- They lose other health care coverage.
- They add dependents due to marriage, birth, adoption or adoptive placement.

Special enrollment may be available to people who declined ESI when it was first offered because they had MinnesotaCare and people whose MinnesotaCare coverage ends. If people are terminated from MinnesotaCare because a current employer offered ESI within the past 18 months, advise them to request enrollment under the employer's plan within 30 days of MinnesotaCare termination to avoid a break in coverage. If there is a break in coverage, the person will not get credit for MinnesotaCare coverage to reduce a pre-existing condition exclusion.

A Certificate of Creditable Coverage (COCC) will be issued automatically 2 months after MinnesotaCare ends. See §0916.23 (Certificates of Creditable Coverage). If the former enrollee needs the COCC sooner, request one following your agency's procedures.

M. S. 256L.07 subd. 2

MA/GAMC:

The availability of ESI does not affect people's eligibility for MA and GAMC. However, people must enroll in cost-effective coverage as a condition of eligibility for adults. See §0910.05.01 (Current Health Insurance--MA/GAMC). HIPAA allows current and former MA/GAMC enrollees to enroll in an employer's plan outside of the open enrollment period under the same conditions as MinnesotaCare.

People whose MA or GAMC ends will receive a COCC automatically 2 months after termination. See §0916.23 (Certificates of Creditable Coverage). If the former enrollee needs the COCC sooner, request one following your agency's procedures.

See §0911.05 (Excluded Income) for general provisions which apply to all programs.

MinnesotaCare:

Also exclude income from the following sources:

- Earned income of full- or part-time students under age 19.

- Infrequent or irregular income. Income is infrequent or irregular if it is not possible to anticipate receiving it. Count income that applicants/enrollees regularly receive at least annually.

  EXAMPLE:

  The Brown family receives $10,000 every December from Mrs. Brown's parents. Count this money as income.

  EXAMPLE:

  Sarah received a $500 gift from her uncle last year. She explains that it was a one-time gift because her uncle sold some stock. Do not count this income.

- Lump sum income. Generally, lump sums are one-time, non-recurring payments. Examples include winnings, inheritances, insurance settlements, and retroactive payments.

  EXAMPLE:

  Household is approved for social security survivors' benefits because of the death of the father. They receive a lump sum of $5,000 for previous months and ongoing benefits of $1,000 per month. Exclude the $5,000 retroactive payment.

  EXAMPLE:

  Enrollee receives a cost of living adjustment to his wages effective July 1. He receives a retroactive payment for July and August on his September 1 paycheck. Exclude the portion of the pay check that covers the retroactive pay increase.

  EXAMPLE:

  Enrollee wins $4,000 at a casino. Exclude the winnings.

Some lump sums, such as winnings over a given amount, may be taxable. If an applicant or enrollee's tax forms include a lump sum, subtract the lump sum from the adjusted gross income unless the household anticipates receiving income from the same source in the next year. See §0911.11 (Computing Countable Income--MinnesotaCare).

Some other types of income may be partially excluded. See the sections on specific types of income for more information.

M. S. 256.9354 subd. 4a

MA/GAMC:

METHOD A:

Exclude irregular cash gift income totaling $30 or less per calendar quarter for each person whose income is counted. Count gifts the client receives on a regular basis or which exceed $30.

EXAMPLE:

Martha applies for MA for herself and her children. Her parents give her $25 per month to help with expenses. Count this gift because Martha receives it regularly.

EXAMPLE:

Jennifer receives MA for herself and her 2 sons. Jennifer reports on her 6-month income review that she and the children each received $25 as a birthday gift. Exclude this income because it totals less than $30 per person per quarter and is received infrequently.

METHOD B:

Exclude irregular or infrequent earned income that does not exceed $10 per calendar month. This exclusion is applied to the combined total irregular/infrequent earned income of all people whose income is being considered. If the total amount of irregular/infrequent income exceeds $10 in a given month, this exclusion does not apply.

EXAMPLE:

Betsy reports receiving $8 for babysitting a neighbor's child. She does not babysit regularly. Exclude this income because it is irregular and is less than $10.

Exclude irregular or infrequent unearned income that is received no more often than once per calendar quarter from 1 source. Apply this exclusion to irregular/infrequent unearned income received from each separate source. The income received from each source must not total more than $20 in the month received to be excluded under this provision. The same type of income may be received more than once in a calendar quarter as long as it is not from the same source. This exclusion is applied to the combined total irregular/infrequent unearned income of all people whose income is being considered.

EXAMPLE:

Herman and Sheila receive MA using a manual monthly spenddown. See §0913.11 (Manual Monthly Spenddown Calculation). They report on their monthly income report for April that they received $25 as an anniversary gift from friends. Herman received $10 for his birthday from his mother. They do not expect to receive additional gifts during the calendar quarter.

Count the $25 gift as unearned income because it exceeds $20. Exclude the $10 gift because it is from a different source and is under $20.

Except for long term care budgeting, exclude income from the Mille Lacs Band of Ojibwe Elder Supplemental Assistance Program. See §0911.09.21 (Income From Tribal Land Settlements and Trusts).

Consider the following types of income as unearned income for all of the health care programs. Some programs may exclude all or part of a particular type of payment. See the specific income sections for more information.

- Alimony.
- Child support. See §0911.09.11 (Child Support Income) and §0911.09.11.01 (Child Support Income--MA/GAMC).
- Annuity and pension payments.
- Disability benefits. This does not include sick pay based on accrued time. See §0911.07.03 (Earned Income).
- Retirement, Survivor's, and Disability Insurance (RSDI). See §0911.09.15 (Income From RSDI and SSI) and §0911.09.15.01 (Income From RSDI and SSI--MA/GAMC).
- Supplemental Security Income (SSI). See §0911.09.15 (Income From RSDI and SSI) and §0911.09.15.01 (Income From RSDI and SSI--MA/GAMC).
- Retirement benefits from public or private sources, such as Railroad Retirement or private pension.
- Unemployment Insurance (UI, previously known as Reemployment Insurance).
- Extended income support payments through the Trade Adjustment Reform Act of 2002. These payments are available to certain workers participating in training when the job loss was related to foreign trade. Workers must exhaust regular UI benefits before becoming eligible for TAA payments.
- Workers' Compensation.
- Veteran's Benefits.
- Trust disbursements.
- Severance pay, if not based on accrued leave time.

- Tribal per capita payments from casinos. Also see §0911.05 (Excluded Income).

- Regularly received gifts. Also see §0911.05 (Excluded Income).

- Countable interest and dividends, if not earned as part of a self-employment operation. See §0911.05 (Excluded Income), §0911.09.19 (Interest and Dividends), and §0911.09.03 (Self-Employment Income).

- Countable assistance payments income. See §0911.09.13 (Assistance Payments Income).

MinnesotaCare:

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

MA/GAMC:

Do not allow the cost of travel between the self-employed person's home and place of business as a business expense. Personal use of transportation is not a business expense.

Prorate the expense of transportation used for self-employment and personal needs based on the percentage of use for each.

Transportation expenses include:

- Gas and oil costs.
- Parking fees.
- Car insurance.
- Car repairs.
- Interest payments on a car loan.

METHOD A:

Allow the IRS mileage rate (also known as the flat rate) for self-employment transportation. Effective January 1, 2003, the rate is 36 cents per mile. The rate for 2002 was 36.5 cents per mile. Use the flat rate even if itemized self-employment transportation costs exceed the flat rate amount.

METHOD B:

Self-employed people may use the flat rate deduction or itemize actual transportation expenses. If an applicant or enrollee chooses the flat rate, use this amount even if greater than actual itemized transportation expenses.

MinnesotaCare:

Exclude all student financial aid and state work study income for undergraduate students.

Exclude training expenses paid through the Trade Adjustment Reform Act of 2002.

For graduate students:

- Count as earned income graduate student fellowships, internships, stipends, teaching assistant income, or any other financial aid that requires the student to work in order to receive the aid. Do not allow deductions for educational expenses from earned income.

- Exclude all Title IV financial aid and income from Bureau of Indian Affairs (BIA) student assistance programs. Title IV aid includes:

  - PELL or BEOG grants.
  - Presidential Access Scholarships (Super PELL).
  - Supplemental Education Opportunity Grants (SEOG).
  - Minnesota State Scholarships and Grants.
  - Stafford Loan (formerly Guaranteed Student Loan).
  - PLUS loans.
  - Perkins Loans (formerly NDSL).
  - SLS (formerly ALAS).
  - Robert C. Byrd Honor Scholarships.
  - Federal work study income.
  - Bureau of Indian Affairs Grant Program.
  - High School Equivalency Program (HEP).
  - College Assistance Migrant Program (CAMP).
  - Upward Bound (Trio Grants).
  - National Early Intervention Scholarship and Partnership Program.
  - Robert E. McNair Post-Baccalaureate Achievement.

- Count as unearned income any non-Title IV or BIA aid such as graduate student scholarships, stipends, or other types of grants that do not require teaching or research or any other similar work. Allow a deduction for necessary educational expenses such as:

  - Tuition.

- Mandatory fees.
- Course and lab fees.
- Books.
- Transportation to and from school. Use the same transportation expense rate as allowed for self-employment transportation.
- Supplies and equipment required for course work.
- Child care costs incurred while at school and in transit.

For this purpose, necessary educational expenses do NOT include living expenses.

Consider counted graduate student financial aid when it is available to meet the client's educational expenses. Budget it over the months it is intended to cover, whether or not the client attends school. To arrive at a monthly amount to budget:

1. Subtract allowable educational expenses for a given period of time (quarter, semester, year) from a graduate student's non-excluded financial aid received to cover the same period of time.

2. Divide the result by the remaining number of months in the period.

3. Add this amount to the household's gross income.

If the client receives the aid before the school year begins, do not budget the income until the period it is intended to cover. If the financial aid was received prior to application, do not budget it for that period.

MA/GAMC:

METHOD A:

Follow MinnesotaCare.

METHOD B:

Exclude the following financial aid. DO NOT deduct allowable student expenses from the excluded aid.

- Financial aid loans, including loans from the Tribal Development Student Assistance Revolving Loan Program.

- Title IV financial aid in the month the client receives it.

- Financial aid used to fulfill an approved Plan to Achieve Self-Support (PASS) for disabled or blind people. See §0912.05.11 (Plan to Achieve Self-Support).

- Training expenses paid through the Trade Adjustment Reform Act of 2002. |

Count all other financial aid as income in the month received. Deduct allowable expenses.

Consider student financial aid available to the client when the client or client's representative actually receives it

In addition to the allowable expenses listed under Method A, allow the following expenses as deductions from all non-excluded sources of student aid:

- Work expenses and deductions from work study income.
- Any impairment-related expenses necessary to attend school or perform school work.

For veterans' benefits, determine which portion is designated as educational assistance benefits and exclude it as educational benefits. Treat the remaining amount of the benefit as unearned income.

Exclude most income from American Indian tribal land settlements and some income from interest in tribal trust and other restricted Indian lands.

Exclude the 1st $2,000 a person receives each year from his or her interest in Indian trust land or other restricted Indian lands.

Also exclude American Indian tribal land settlements as income if the Public Law awarding the settlement directs its exclusion. The following settlements are excluded as income from all programs:

- Any funds distributed per capita under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations.

- Payments to members of the White Earth Band from the White Earth Reservation Land Settlement Act of 1985 (Public Laws 99-264, 100-153, and 100-212).

Count per capita payments made to members of the Grand Portage and Fond Du Lac Bands of Chippewa Indians as unearned lump sum payments and as a resource thereafter.

Exclude per capita payments made to members of the Bois Forte Band of Chippewa.

Count tribal payments that are not derived from land settlements, such as per capita earnings from casino profits, as unearned income in the month received.

EXCEPTION:

Exclude payments from the Mille Lacs Band of Ojibwe Elder Supplemental Assistance Program for people who do not use long term care budgets. Count them for people residing in long term care and using long term care budgets and people receiving EW. These payments are made to tribal members age 65 and over who meet the program's income and asset limits.

Contact the Health Care Programs Policy Center for information on payments from settlements not listed. Include the Public Law number if known.

MinnesotaCare:

No provisions.

MA:

Method A:

No provisions.

Method B:

Allow this disregard from earned income when a client meets all 3 of these conditions:

- Is under age 22.
- Is certified as blind or disabled by the Social Security Administration or the State Medical Review Team.
- Is expecting to attend school at least 1 month in the next calendar quarter, or did attend school at least 1 month of the current calendar quarter.

Limit the disregard to a maximum of $1,340 per month up to a maximum of $5,410 in calendar year 2003 ($1,320 per month up to a maximum of $5,340 in calendar year 2002). Apply the disregard only to the blind or disabled student's earned income. Do not apply it to the income of other people whose income is deemed to the student.

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

METHOD A:

No provisions.

METHOD B:

Clients who meet certain conditions are deemed to be receiving SSI benefits for purposes of determining MA eligibility. These clients may apply the Pickle disregard to their income.

To be eligible for the Pickle disregard, clients must meet ALL of the following conditions:

- Currently receive or be entitled to receive RSDI benefits.
- Were eligible for 1619(b) or were eligible for and received SSI, MSA, or 1619(a) benefits while concurrently entitled to or receiving RSDI in any month since April 1977.
- Lost eligibility for SSI, MSA, 1619(a) or 1619(b) for any reason.

Clients may be entitled to but not actually receive RSDI benefits for the month for which RSDI eligibility is approved. RSDI benefits are paid in the month following the month they cover. Entitlement to RSDI in a month in which the enrollee received SSI, MSA or 1619(a) or was eligible for 1619(b) qualifies the individual for the Pickle disregard.

EXAMPLE:

John is open on MA and received SSI in June. Effective June 1, John became entitled to RSDI benefits. He received his 1st RSDI check in July for June. Because John was entitled to RSDI on June 1, SSA determines that John's income is over the SSI income standard and he loses SSI benefits beginning July 1. John is eligible for the Pickle disregard because he was entitled to RSDI benefits in June while receiving SSI.

When clients eligible for the Pickle disregard have a spouse or parent receiving RSDI, consider the parent or spouse's RSDI income available to the client. Allow the Pickle disregard from the spouse's or parent's RSDI when determining the client's eligibility. Do not allow the Pickle disregard when determining the parent's or spouse's eligibility unless they also meet the Pickle eligibility conditions.

Subtract previous cost of living adjustments (COLAs) to determine the RSDI benefit of the client and responsible relative on the more recent of the following dates:

- The last month the applicant or enrollee was eligible for 1619(b) or was eligible for and received MSA, 1619(a) or SSI benefits concurrently with RSDI.

OR

- 7-1-82.

This is known as the Pickle threshold date.

Use the COLA chart below. Divide the client's current gross RSDI benefit by the percentage of the previous year's COLA. (This yields the RSDI level before the last COLA.) Repeat the computation for each RSDI COLA received since the client became ineligible for SSI or MSA.

Current Gross RSDI Amount 1.014 (1-03 RSDI increase)	=	Benefit Before 1-03 COLA
Current Gross RSDI Amount 1.026 (1-02 RSDI increase)	=	Benefit Before 1-02 COLA
Current Gross RSDI Amount 1.035 (1-01 RSDI increase)	=	Benefit Before 1-01 COLA
Current Gross RSDI Amount 1.024 (1-00 RSDI increase)	=	Benefit Before 1-00 COLA
Benefit before 1-00 COLA 1.013 (1-99 RSDI increase)	=	Benefit Before 1-99 COLA
Benefit before 1-99 COLA 1.021 (1-98 RSDI increase)	=	Benefit Before 1-98 COLA

Benefit before 1-98 COLA = Benefit before 1-97 COLA
1.029 (1-97 RSDI increase)

Benefit before 1-97 COLA = Benefit before 1-96 COLA
1.026 (1-96 RSDI increase)

Benefit before 1-96 COLA = Benefit before 1-95 COLA
1.028 (1-95 RSDI increase)

Benefit before 1-95 COLA = Benefit before 1-94 COLA
1.026 (1-94 RSDI increase)

Benefit before 1-94 COLA = Benefit before 1-93 COLA
1.030 (1-93 RSDI increase)

Benefit before 1-93 COLA = Benefit before 1-92 COLA
1.037 (1-92 RSDI increase)

Benefit before 1-92 COLA = Benefit before 1-91 COLA
1.054 (1-91 RSDI increase)

Benefit before 1-91 COLA = Benefit before 1-90 COLA
1.047 (1-90 RSDI increase)

Benefit before 1-90 COLA = Benefit before 1-89 COLA
1.04 (1-89 RSDI increase)

Benefit before 1-89 COLA = Benefit before 1-88 COLA
1.042 (1-88 RSDI increase)

Benefit before 1-88 COLA = Benefit before 1-87 COLA
1.013 (1-87 RSDI increase)

Benefit before 1-87 COLA = Benefit before 1-86 COLA
1.031 (1-86 RSDI increase)

Benefit before 1-86 COLA = Benefit before 1-85 COLA
1.035 (1-85 RSDI increase)

Benefit before 1-85 COLA = Benefit before 1-84 COLA
1.035 (1-84 RSDI increase)

Benefit before 1-84 COLA = Benefit before 7-82 COLA
1.074 (7-82 RSDI increase)

The difference between the current RSDI benefit and the RSDI computed from the COLA chart is the Pickle disregard.

Compare the client's net countable income after subtracting all earned and unearned disregards, including the Pickle disregard, to the current year's SSI federal benefit rate (FBR). If income is below the SSI FBR, the client meets the income requirement to be deemed an SSI recipient and is eligible for MA with no spenddown.

If net income is over the SSI FBR, determine the current MSA rate that would apply if the client applied for MSA. See the DHS Combined Manual for MSA standards. If the income after subtracting all earned and unearned income disregards including the Pickle disregard is less than the MSA rate, the client meets the income requirement to be deemed an SSI recipient and is eligible for MA with no spenddown.

Use the SSI or MSA standard for a couple when married clients live together, and 1 or both of them meet the disability and resource criteria for SSI eligibility. The MSA standard for a client in group residential housing is the group residential housing rate plus the personal needs allowance. Use the MSA standard for a person living with others for an unmarried client who has minor children.

In addition to meeting the income requirement, the client must meet an MA basis of eligibility and must be within MA asset limits.

If a client is determined eligible for the Pickle disregard in the threshold month, disregard all RSDI COLAs beginning with the 1st COLA received after the threshold month.

EXAMPLE:

Bart received RSDI and SSI concurrently through July 1997. He lost SSI beginning in August 1997. July 1997 is the Pickle threshold month. The worker disregards RSDI COLA increases for January 1998 and each year thereafter to determine the amount of the Pickle disregard. After applying the Pickle disregard and all other earned and unearned income disregards, Bart's income is greater than the SSI FBR but less than the MSA benefit rate. Bart is eligible for the Pickle disregard if he continues to meet an MA basis of eligibility and has assets within MA limits.

If the client's countable income after applying all earned and unearned income disregards including the Pickle disregard is greater than both SSI or MSA standards, do not apply the Pickle disregard to income when determining eligibility.

Determine whether clients potentially eligible for the Pickle disregard become eligible when MSA, SSI, or RSDI standards increase, or when their circumstances change.

For MAXIS system instructions, see TEMP manual TE02.07.067 (Entering Pickle Cases).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Also see §0912.05.25 (Allocations) and §0912.05.25.05 (Allocations--Other Relatives).

To calculate the amount of a client's allocation deduction for a spouse:

1. Determine the community spouse's total gross earned and unearned income. (Include income from income-producing assets.) Do not allow MA disregards and exclusions. Add all income received less often than monthly during a calendar year and divide by 12 to determine a monthly figure. Consider interest earned to be income.

   VA Aid and Attendance benefits are not available for the needs of relatives unless the VA office grants an apportionment. Consider only the apportioned amount as income to the relative.

2. Determine the monthly total of these shelter expenses for the community spouse:

   - Rent or mortgage payments.
   - Real estate taxes.
   - Homeowner's or renter's insurance.
   - Required maintenance charges for a cooperative or condominium.
   - A utility allowance. Use $262 for residences billed for heating and/or cooling. For residences not billed for heating or cooling, allow $75 for electricity and $25 for phone service. Reduce the utility allowance by the amount of any utility expenses included in a required cooperative or condominium maintenance charge.

3. Subtract $448 beginning 7-1-02 ($436 from 7-1-01 through 6-30-02) from the total of expenses in step 3. The result is the excess shelter allowance.

4. Add $1,493 beginning 7-1-02 ($1,452 from 7-1-01 through 6-30-02) to the excess shelter allowance. The result, up to a limit of $2,267 ($2,232 from 1-1-02 through 12-31-02), is the maximum monthly income allowance to the community spouse.

   If there is a court order for support in excess of $2,267 ($2,232 from 1-1-02 through 12-31-02), use the court-ordered figure as the maximum amount.

5. Subtract the net available income of the community spouse (determined in step 1) from the monthly amount in step 4. The result is the actual allocation deduction amount.

EXAMPLE:

Norma resides in an LTCF. Her husband Leo resides in the community. Leo receives RSDI of $700 per month and a private pension of $300 per month. He has a savings account which earned interest of $600 for the most recent calendar year. He pays rent of $400 per month plus electricity, which includes air conditioning, and phone. He pays $300 per year for renter's insurance. Norma receives RSDI of $800 per month.

Determine Leo's maximum allocation as follows:

1. Determine Leo's total gross monthly income by adding the RSDI amount of $700, the pension amount of $300, and $50 per month interest ($600 divided by 12). Total monthly income is $1,050.

2. Determine Leo's monthly shelter expenses by adding rent of $400, utility allowance of $262, and $25 per month ($300 divided by 12) for renter's insurance. Total shelter expenses are $687.

3. Subtract $448 from $687. The result, $239, is the excess shelter amount.

4. Add $239 to $1,493. The result, $1,732, is the maximum monthly allocation amount.

5. Subtract Leo's monthly income of $1,050 from $1,732. The result, $682, is the actual allocation amount. Allow this amount in Norma's LTC budget. See §0913.13 (Long Term Care Spenddown Calculation).

If the allocation amount causes significant financial hardship for the community spouse due to exceptional circumstances, you may increase the amount on a temporary basis. Verify the spouse is making reasonable efforts to resolve the situation (for example, seeking more affordable housing). Also see §0909.25.05 (Transfer of Income Producing Asset to Spouse) for the possibility of transferring income producing assets to the community spouse.

If the community spouse wants to apply for MA, an allocation may cause income to exceed the MA standard. The spouse may either:

- Meet a spenddown using the allocated income.

OR

- Request a decrease or end to the allocation. This will increase the LTCF spouse's monthly LTC spenddown.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

An LTC spenddown or an LTC/Medical spenddown may include a clothing and personal need allowance. For 2002, the allowance is $71 for all clients except certain veterans and surviving spouses of veterans. For 2003, the allowance is $72 for all clients except certain veterans and surviving spouses of veterans. Veterans who have no spouse or dependent children and surviving spouses of veterans with no dependent children, and who receive a monthly veterans pension of $90, have a personal need allowance of $90. See §0913.13 (Long Term Care Spenddown Calculation) and §0913.15 (Combination LTC/Medical Spenddown).

GAMC:

No provisions.

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, the annual increase in the FPG standards, or the annual COLA increase.

MinnesotaCare:

No provisions.

MA:

Apply these instructions only to the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program.

To determine the premium amount for a MA-EPD applicant or enrollee:

1. Total all earned and unearned income of the applicant or enrollee. Exclude income sources listed in §0911.05 (Excluded Income). Exclude the income of the person's spouse. Count the income of biological or adoptive parents who live with MA-EPD applicants or enrollees who are ages 16 and 17.

2. Determine if total gross income is less than 100% FPG based on the household size. See §0912.07.100 (100 Percent of FPG Standards). Unless both spouses are applying for or enrolled in MA-EPD, determine the household size as you would for any MA applicant or enrollee. See §0908.05 (Determining MA/GAMC Household Size). Count spouses and children in the household size even though spousal income is not deemed.

   If both spouses are applying for or enrolled in MA-EPD, consider each as a household of 1, or more if there are children in the home. If there are mutual children, count them in both spouses' household sizes.

   If total gross income is less than 100% FPG, there is no premium.

3. If income equals or exceeds 100% FPG, MAXIS will calculate the premium on the EBUD panel. See TE09.13.05 (HCRW: Premiums for MA-EPD).

EXAMPLE:

Joe applies for MA-EPD. He is single and has gross earnings of $300 per month. He receives RSDI of $700 per month based on disability. He would have a spenddown for MA because his countable net income exceeds the applicable standard for a household of 1. He has a premium for MA-EPD because his gross income of $1,000 exceeds 100% FPG.

EXAMPLE:

Amanda has earned income of $2,500 per month. She is certified disabled by SMRT. She has not received SSI for several years because of her income. She lives with her husband Dave, who is not disabled. Dave has earned income of $1,000 per month. To determine MA-EPD eligibility and premium amount, use only Amanda's income of $2,500 and a household size of 2. She will have a premium since her earnings of $2,500 exceed 100% FPG for a household of 2.

EXAMPLE:

Shannon and Matt, a married couple, apply for MA-EPD. Shannon is self-employed as an in-home day care provider with net income of $625 per month. She receives RSDI of $800 per month based on disability. Matt has earned income of $3,000 per month and is certified disabled by SMRT. They have joint assets of $25,000, or $12,500 each, which is within the $20,000 asset limit for each spouse.

MAXIS will determine eligibility and premium amount separately for each spouse, using each spouse's income and a household size of 1. Both Shannon and Matt will have a monthly premium because each has income exceeding 100% FPG.

If Shannon and Matt have a mutual child in the home, determine eligibility separately for Shannon and Matt using each spouse's income and a household size of 2.

If the applicant or enrollee has a premium, send a MAXIS E-Mail to the Special Recovery Unit (SRU) at MAXIS E-Mail group MADE. Include the applicant's name, case number, PMI number, billing address, representative payee if applicable, premium begin date, premium amount, and dates of the 6-month certification period. Indicate if the initial premium(s) were paid to the county agency, and if so, for which month(s). After receiving the MAXIS E-Mail, SRU will initiate billing and collect the premiums.

Determine the premium at application, 6-month review, renewal, and at the time of the annual COLA increase. Do not change the premium at other times unless the client reports a change that would result in a decreased premium. See §0913 (Premiums and Spenddowns). If a reported change results in a decreased premium, E-Mail MADE. Include the same information required for an initial premium, as well

as the new premium amount and the effective date of the change. SRU will bill the new amount on the next billing cycle. SRU will not decrease the premium retroactively except in the case of worker error.

To maintain a consistent premium for current and future months, when calculating income for MA-EPD:

- Use actual income received in any retroactive months
- Anticipate income for current and future months by multiplying biweekly income by 2.16 and weekly income by 4.3.

See Temp Manual TE09.20 (HCRW: MA-EPD Income Calculation).

When enrollees who were eligible for MA-EPD without a premium have a change that results in a premium at the time of the 6-month or annual renewal, leave MA-EPD open while premium billing is initiated or updated.

SRU will send separate invoices for the initial premium, including the month of application and any retroactive months, and for subsequent monthly premiums. Applicants must pay the initial month's premium within 30 days of the date of the invoice. If payment is not received by the due date, SRU will notify the worker to deny the application.

Eligibility cannot be approved until the initial premium has been paid. Counties may choose to collect the initial premium to expedite processing. Use Attachment E in Bulletin #99-16-6 dated July 21, 1999 (Legislature Approves New MA Option for Employed Persons with Disabilities). Fill in the client's legal name and address, date, due date, amount due, and check number. Staple the client's check to the lower portion of the invoice and mail it to:

DHS - MA-EPD
PO Box 64836
St. Paul, MN 55164-0836

Give the client the upper portion of the invoice. Retain a copy of the entire invoice in the case file. Approve MA-EPD if the client meets all other eligibility factors.

When DHS collects the premium, pend the application awaiting payment of the initial premium. SRU will send MAXIS E-mail to the financial worker when the initial payment is received. SRU will specify whether the payment includes any retroactive months. Once the premium is paid, coverage is effective the 1st day of the month of application. Applicants must pay premiums for each retroactive month before coverage can be approved for those months.

Once coverage is approved, SRU will bill subsequent months' premiums approximately 6 weeks before the 1st day of the month the premium covers. Payment is due approximately 2 weeks before the 1st day of the covered month. For example, SRU will mail the bill for August coverage on or about June 4 with a due date of July 15.

SRU will notify the worker if the enrollee fails to pay the premium. If SRU notifies you that an applicant has failed to pay a premium by the due date without good cause, terminate MA-EPD with 10-day notice. Determine if the person is eligible for MA under another basis before terminating. SRU does not notify workers when current enrollees pay premiums.

DHS will determine whether a person has good cause for non-payment following the guidelines in §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

Premium payments are applied first to the current month's premium. DHS applies payments exceeding that amount first to any overdue amounts and then as a credit toward future premiums.

Premiums may be refunded to enrollees with a credit balance if:

- The enrollee has died. The enrollee's estate will receive the refund.
  OR
- MA-EPD coverage is terminated.
  OR
- The enrollee has entered a long term care facility and is expected to remain for at least 30 consecutive days.

If any of the above conditions apply, send MAXIS E-mail to mail group MADE. If there is a credit balance, DHS will issue a refund within 60 days.

DHS SRU will reconcile premiums against the cost of coverage for all enrollees 18 months after the coverage month. If the premium paid exceeds the cost of coverage, DHS will credit the excess to the client's account or issue a refund if the client is no longer enrolled in MA-EPD.

EXAMPLE:

Donald is eligible for MA-EPD with a monthly premium of $92 beginning August 1, 1999. In February 2001, DHS SRU determines that Donald received only $62 in MA-EPD services for August 1999. If Donald is still enrolled in MA-EPD, the difference of $30 will be credited to his account. If he is no longer enrolled, he will receive a refund.

See §0913 (Premiums and Spenddowns) for information on acceptable premium payment methods and procedures for dishonored payments.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People with income equal to or less than the Special Income Standard (SIS) are eligible for the SIS EW program. See §0907.23.11 (MA Waiver Programs: EW).

Follow the steps below to determine eligibility under SIS EW:

1. Total all gross earned and unearned income of the EW applicant or enrollee. Include excluded and non-excluded types of income. Do not include spousal income.

2. Compare the result to the SIS. See SPECIAL INCOME STANDARD in §0902.37 (Glossary: Sole...). The SIS for 1-1-03 through 12-31-03 is $1,656. The SIS for 1-1-02 through 12-31-02 is $1,635.

   If the EW applicant or enrollee's income exceeds the SIS, the person is not eligible for SIS EW. Determine eligibility using a community or LTC spenddown, depending on whether the person has a community spouse. See §0913.05.05 (Use of 6-Month and LTC Spenddowns).

   If income is equal to or less than the SIS, proceed to step 3.

3. Allow the deductions from income listed in §0913.13 (Long Term Care Spenddown Calculation).

   EXCEPTION:

   Instead of the clothing and personal needs allowance or maintenance of home allowance in item 3, deduct the SIS EW maintenance needs allowance.

   See MAINTENANCE NEEDS ALLOWANCE in §0902.21 (Glossary: Insurance...). The maintenance needs allowance for 7-1-01 through 6-30-02 is $722. The maintenance needs allowance for 7-1-02 through 6-30-03 is $741.

   The result is the EW applicant or enrollee's monthly waiver obligation. See WAIVER OBLIGATION in §0902.41 (Glossary: Underinsured...). If there is no income remaining after allowable deductions, the person is eligible for EW with no spenddown or waiver obligation.

SIS EW clients do not have to meet the waiver obligation in full each month to remain eligible. Enrollees whose monthly waiver costs are less than their total monthly waiver obligation may keep the excess income and continue to receive waiver and MA services.

If both spouses are receiving or applying for EW, determine eligibility separately for each spouse. If 1 spouse is eligible under SIS EW and the other is not, compute a waiver obligation for the SIS EW spouse and a spenddown for the non-SIS EW spouse, using a household size of 1 for each spouse.

EXAMPLE:

Ethel is single. She receives gross RSDI of $700. After deducting her Medicare premium and the maintenance needs allowance, there is no income remaining. She is eligible for SIS EW with no waiver obligation.

EXAMPLE:

Tony is single and has gross income of $1,200. He is covered by Medicare Part A and B. After deducting his Medicare premium of $54.00 and maintenance needs allowance of $741, he has income of $405 remaining. This is his waiver obligation.

EXAMPLE:

Julie and John, a married couple. both receive EW services. Julie has gross RSDI of $880 and John has gross RSDI of $840. Both have Medicare premiums deducted. Determine eligibility for each spouse using a household size of 1 and the individual income. Since both have gross income less than the SIS, both will be eligible for SIS EW. Deduct the Medicare premium and maintenance needs allowance from each spouse's income to determine the waiver obligation for each.

If one spouse has gross income over the SIS, compute a spenddown for that spouse using Method B budgeting and the appropriate income standard for a household size of 1.

If 1 spouse is eligible under SIS EW and the other spouse resides in a nursing facility or medical institution, compute separate LTC budgets for each spouse, allowing the personal needs allowance for the LTC spouse and the monthly maintenance needs allowance for the EW spouse. Do not allow spousal allocation.

EXAMPLE:

Mike and Susan are a married couple. Mike resides in a LTCF facility and receives gross RSDI of $1,450. Susan receives EW services and has gross RSDI of $500. Compute an LTC spenddown for Mike allowing the clothing and personal needs allowance. Compute a waiver obligation for Susan using the monthly maintenance allowance. Since Susan's income is less than the maintenance needs allowance, she has no waiver obligation. She cannot receive a spousal allocation from Mike.

If a person who is eligible under SIS EW has a community spouse, use LTC budgeting with a household size of 1, allowing the maintenance needs allowance for the EW spouse. Allow spousal allocation to the community spouse if requested. If the community spouse applies for MA, use a household size of 1. The community spouse may refuse the allocation if it is to his/her benefit. See COMMUNITY SPOUSE in §0902.07 (Glossary: Client...) for a definition and §0912.05.25.03 (Allocations--Community Spouse) for instructions on computing the allocation amount.

EXAMPLE:

George receives EW services. His gross income of $1,495 is less than the SIS, so he is eligible under the SIS EW. His wife Martha does not receive MA. She receives RSDI of $376. George may allocate income to Martha to bring her up to the basic spousal needs allowance. After deducting his Medicare premium, monthly maintenance needs allowance, and spousal allocation, he has no waiver obligation.

EXAMPLE:

Jack receives EW services. His gross income is less than the SIS, so he is eligible under the SIS EW. His wife, Jill, lives with him and does not receive EW services. She is considered a community spouse. Jill's income is less than the basic spousal needs allowance. Jill may request a spousal allocation from Jack. If the allocation results in a spenddown she cannot meet, she may refuse the allocation. This will result in a larger waiver obligation for Jack. Help them determine which is more advantageous.

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 for which the health plan is responsible. 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).

  Avera Health Plan of Minnesota
  Blue Plus
  First Plan of Minnesota
  Group Health, Inc.
  HealthPartners, Inc.
  Itasca Medical Care
  Medica Health Plans
  Metropolitan Health Plan
  PreferredOne Community Health Plan
  Sioux Valley Health System
  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).

Also exclude the following groups from enrollment in GAMC managed care:

- 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).

Access services are transportation and other enabling services to help enrollees obtain medically necessary health care. County agencies and MinnesotaCare Operations must provide access services to enrollees who are eligible for access services and who do not receive the service through a health plan.

Access services plans must cover reimbursement for the following items:

- Costs of transportation to receive medical services. Enrollees must use the most cost-effective available means of transportation. Reimbursable costs include:

  - Mileage reimbursement for vehicle use of 20 cents per mile to enrollees who transport themselves.

  - Mileage reimbursement at the current IRS rate to volunteer drivers registered with the county who use their vehicles to transport enrollees. Effective January 1, 2003, the IRS rate is 36 cents per mile. The rate for 2002 was 36.5 cents per mile.

    Access plans must specify whether people other than registered volunteers who transport enrollees, such as friends or relatives, receive 20 cents or the current IRS rate per mile.

  - Actual cost of parking.

  - Actual cost of taxicab, bus or other commercial carrier when this is the most cost-effective means available.

  - Ambulance transportation from a non-enrolled provider when the ambulance is medically necessary. If the ambulance provider is enrolled in the Minnesota Health Care Programs, the provider will bill DHS directly for the services.

    Access plans must specify whether reimbursement is available for no-load transportation. No-load transportation means mileage incurred when the enrollee is not in the vehicle, such as the distance traveled to pick up enrollees.

  Do not allow the following transportation costs in access plans:

  - Special transportation. Special transportation providers are enrolled in Minnesota Health Care Programs. DHS will reimburse the providers directly unless the cost is included in a per diem payment to an ICF-MR facility.

- Transportation to a health care site for detention ordered by a court or law enforcement agency unless an ambulance is medically necessary.

- Transportation to an alcohol detoxification facility unless detoxification is medically necessary.

- Additional charges for luggage, stair carry of the enrollee, airport surcharge or other airport, bus or railroad terminal services.

- Federal or state sales or excise taxes on ambulance service.

- Transportation to services that are not covered under Minnesota Health Care Programs. The service does not have to be billed to DHS or obtained from an enrolled provider. However, both the service and the provider must be eligible for enrollment and coverage under Minnesota Health Care Programs. Consult the Provider Manual on the DHS Web Site or the Provider Help Desk at 1-800-366-5411 for more information on services allowed and provider enrollment under Minnesota Health Care Programs.

  EXAMPLE:

  Jordan is enrolled in MA and receives psychotherapy at the VA hospital. The service is not billed to MA because the VA has separate funding. The psychotherapist and the service provided meet the requirements for enrollment and reimbursement in Minnesota Health Care Programs. Jordan's transportation costs are eligible for reimbursement if they meet the requirements of the local agency's access plan.

- Lodging if necessary for the enrollee to obtain services outside the local area. The local agency must prior authorize charges over $50 per night.

- Meals if necessary to obtain services. Maximum reimbursement amounts are

  Breakfast- $5.50
  Lunch- $6.50
  Dinner- $8.00

- Transportation, meals and lodging for people required to accompany the enrollee to obtain services or whose involvement in a treatment program is part of the enrollee's written treatment plan.

- Interpreter services for hearing impaired people to obtain services at the local agency or from a provider with fewer than 15 employees. Providers with at least 15 employees and prepaid health plans must provide these services. Required services include sign language interpreters, oral or lip-reading interpreters, and interpreters for people who are deaf/blind.

Access plans must require receipts for commercial carrier transportation, meals, parking (other than parking meters) and lodging.

Access plans must require prior authorization for:

- Lodging and meal expenses for people accompanying the enrollee.

- Transportation and related expenses outside the local trade area, as defined by the local agency. Access plans may require prior authorization within the local trade area at county option.

- Transportation if the local agency determines the enrollee has misused transportation in the past.

Access plans may not require prior authorization for emergency services.

MinnesotaCare:

Pregnant women and children under age 21 are entitled to receive access services. MinnesotaCare enrollees who are eligible for access services and who receive case services at MinnesotaCare county enrollment sites receive access services under the county agency's access plan. MinnesotaCare enrollees who are eligible for access services and who receive case services at MinnesotaCare Operations receive access services through MinnesotaCare Operations' access plan.

Follow your agency's access plan when enrollees request access services. Explain prior authorization requirements, limitations on services and billing procedures. Provide written information on your agency's access plan to people eligible for access services.

MA and GAMC:

All MA and GAMC enrollees are eligible for access services. People enrolled in managed care plans may receive some services through the health plan and other services through the county agency's access plan. In general, health plans must provide their members with:

- Sign language and foreign language interpreters if needed to receive medical services.
- Reimbursement for transportation and child care if needed for a state appeal hearing related to the health plan's denial, reduction or termination of a health service.
- Common carrier transportation to receive medical services.

Health plans are not required to provide:

- Reimbursement to enrollees for personal mileage or parking unrelated to an appeal.
- Lodging, meals or out-of-state airfare related to obtaining medical services.

County agencies are responsible for services in their access plans that are not covered by the health plans.

Follow your agency's access plan when enrollees request access services. Explain prior authorization requirements, limitations on services and billing procedures. County agencies must provide written information on their access plans to all enrollees.

When you are notified of the possible pregnancy of a child under age 21 living with parents through reports from a source other than the enrollee or household, do not contact the enrollee or household. Enter a case note regarding the information received and the source.

When a child under age 21 reports a pregnancy:

- Provide information about how the pregnancy will affect the household's premium or MA eligibility, the date the premium notice will show the new amount, if appropriate, and that the premium or other change notice will not show the reasons for the change.

- Inform her that verification of pregnancy is required. See §0907.09 (MinnesotaCare Pregnant Women) and §0907.19.05 (MA Basis: Pregnant Women). Offer to send a Pregnancy Verification Form (DHS 3236) and ask if she prefers to receive the form at an address other than the case mailing address.

- If the child is age 18 or over, explain that information about pregnancy is private and cannot be shared with other household members unless she signs a Consent Form (DHS 2243a). Do not share information about the pregnancy with other household members without a signed Consent Form.

- If the child is under 18, explain that data privacy laws dictate what information about a child can be shared with parents and other family members. Inform her that you will not disclose the information unless you have reason to believe her health is in danger. If the child states that you can share the information with others in the household, record this in case notes. You do not need a Consent Form to share pregnancy information for a child under age 18.

Enter case notes for all contact with the household. If another household member inquires about a premium or eligibility change resulting from the reported pregnancy of a child, do not disclose the pregnancy unless you have a signed Consent Form if the child is age 18 or over, or the child is under age 18 and has stated that you may share the information. If you cannot disclose the pregnancy, inform the caller that a change was reported by a member of the household, but that you cannot discuss the change due to data privacy laws.

MinnesotaCare:

Take the following steps when an enrollee reports a pregnancy. If you become aware of a pregnancy through a health plan, provider, or another MinnesotaCare enrollment site or county agency, contact the enrollee for date of diagnosis and estimated date of delivery before taking these steps.

1. Enter the necessary information on MMIS to change the woman's status to pregnant woman effective the 1st of the month the pregnancy was diagnosed or the date the woman last became active, whichever is later. Do not change the status to pregnant woman effective the month of conception unless you verify that the pregnancy was diagnosed by a medical professional during that same month. MMIS will increase the household size by the number of expected fetuses. Do not include the unmarried father of the expected child even if he is living with the mother.

   If you first become aware of a pregnancy after the birth, change the woman's status to pregnant woman for the birth month only, unless you receive verification that the woman's pregnancy was diagnosed by a medical professional in an earlier month. Do not consider the birth itself to be a "diagnosis" for any previous months.

   Pregnant women who meet the MA citizenship and residency requirements will be eligible for federal funding. See §0907.09 (MinnesotaCare Pregnant Women).

2. Review the woman's group status. A Group 3 woman with no other children will become a Group 2 parent effective the month the pregnancy is diagnosed. Assign the pregnant woman's husband to Group 2 or Group 4 depending on citizenship/immigration status and income. See §0907 (Eligibility Groups and Bases of Eligibility) and §0915.15 (Change in MinnesotaCare Eligibility Group).

3. Request medical verification of the pregnancy. See §0907.09 (MinnesotaCare Pregnant Women) for a list of verification sources. If the household fails to submit verification within 30 days of the request, send a notice informing the household that the woman, and her husband if applicable, will lose pregnant woman status if verification is not received within 30 days of the 2nd notice.

EXAMPLE:

Cindy and her husband Bruce enrolled in MinnesotaCare as Group 3 adults without children in May with income of 150% FPG. On August 15, Cindy reports that her pregnancy was confirmed at the doctor's office on August 12. Her estimated date of conception is July 7 with a due date of April 4. Change Cindy's status to pregnant woman and assign Cindy to Group 2 and Bruce to Group 4 effective August 1. Request verification of the pregnancy. If Cindy fails to submit verification within 30 days of the request, send a notice

informing her that she will lose pregnant woman status and she and Bruce will be reassigned to Group 3 unless she submits verification within 30 days. If she fails to submit verification within 30 days of the 2nd notice, change the status back to Group 3 adults effective the 1st available month.

Any co-payments paid by the pregnant woman after the date the pregnancy is diagnosed may be refunded. If a woman wants to be refunded co-payments, instruct her to request the refund from the provider to whom the co-payment was paid. Co-payments incurred between the month of conception and the month of diagnosis are not eligible to be refunded.

M.S. 256L.03 Subd. 1a and 1b

MA:

Women who become pregnant while receiving MA under any basis of eligibility become eligible under the pregnant woman basis from the date of conception through the 60-day postpartum period. Require verification of pregnancy. If you receive a report of a pregnancy-related health services claim through MMIS, follow up with the client.

Women receiving MA using Method B due to blindness or disability who become pregnant may choose to continue using Method B. Explain to the woman that the pregnant woman basis has a higher income standard. Flag the case to ensure that MA remains open if the woman becomes ineligible for MA using Method B.

GAMC:

Women who become pregnant while receiving GAMC become eligible for MA without a new application. See §0904.05.05 (When Not to Require an Application). See §0907.19.05 (MA Basis: Pregnant Women) for more information on eligibility requirements.

MinnesotaCare:

All MinnesotaCare enrollees are assigned to an eligibility group. See §0907 (Eligibility Groups and Bases of Eligibility). People maintain their eligibility group status between renewals unless:

- Their MinnesotaCare enrollment ends for 1 month or more.

OR

- They become eligible for a more favorable group status while enrolled in MinnesotaCare because of a change in circumstances.

OR

- A parent loses parental status.

OR

- A person turns age 21 and is not a dependent sibling.

OR

- A person ages 21-24 loses dependent sibling status.

EXCEPTION:

Children who were enrolled in the Children's Health Plan on or before 6-30-93 retain Group 1 status until they reach age 21 as long as they maintain continuous enrollment. See CONTINUOUS ENROLLMENT in §0902.07 (Glossary: Client...) and §0907.03 (MinnesotaCare Eligibility Group 1).

Changes in group status include:

- Children who initially enroll as Group 2 gain Group 1 status if their household income drops to 150% FPG or below. They will retain Group 1 status as long as they remain continuously enrolled and income remains below 150% FPG.

- Adults enrolling for the 1st time and Group 2 or Group 4 adults will never gain Group 1 status. Group 1 adults lose Group 1 status if they are disenrolled from MinnesotaCare for 1 month or more or at the time of the next renewal, whichever is earlier.

- Group 2 or Group 4 parents who lose their parental status due to no longer having children or dependent siblings in the home become Group 3 effective the 1st available month with 10-day notice.

- Group 3 women who become pregnant gain Group 2 status effective with the month the pregnancy is diagnosed. Their husbands gain either Group 2 or Group 4 status. They retain this status as long as the woman is pregnant or they have a dependent child in the home. If the woman is no longer pregnant and there is no dependent child in the home, review group status for the woman the month after the post partum period ends and for the spouse the first available month following the end of the pregnancy with 10-day notice.

- Group 3 adults gain Group 2 or, for certain parents and relative caretakers, Group 4 status if their natural or adoptive child, stepchild, or legal ward under 21 moves into the household. Group 3 adults who are relative caretakers or foster parents gain Group 2 or, for certain relative caretakers, Group 4 status if they apply with a dependent child in their home for whom they have primary responsibility. See §0907.08 (MinnesotaCare Eligibility Group 4) for a definition of Group 4 parents and relative caretakers. Always use Group 2 for foster parents and legal guardians.

- Group 2 parents and caretakers who report income decreases gain Group 4 status effective the 1st available month if the new income and the citizenship/immigration status meet Group 4 criteria. See §0907.08 (MinnesotaCare Eligibility Group 4). Reevaluate group status based on increased income at the time of the next annual renewal.

EXAMPLE:

Mary is a single adult enrolled in Group 3. She reports and verifies that she is pregnant. Her income is 225% FPG. She now has Group 2 status and will retain this status as long as she is pregnant or has a dependent child living with her.

EXAMPLE:

Stuart is enrolled as a Group 2 child with his parents. His mother calls between renewals to report that the household income has decreased. She verifies the new income, which is now below 150% FPG. Change Stuart's status to Group 1.

EXAMPLE:

Monica is enrolled as a Group 3 adult. She reports that her 12-year-old son, who was living with his grandmother, has returned to live with her and she would like to add him to her case. Her income is 175% FPG. Change Monica's status to Group 4. See §0915.03 (Adding a Person to the Household).

EXAMPLE:

Greta is enrolled as a Group 2 parent with income between 200-275% FPG. She reports an income decrease. Income is now between 100-200% FPG. Greta is a U. S. citizen. Assign her to Group 4 effective the 1st available month.

EXAMPLE:

Norman is enrolled as a Group 4 parent. He reports an income increase. Income is now over 200% FPG. Reevaluate group status at the time fo the next renewal.

M.S. 256.9354 subd. 1.

MA/GAMC:

See §0915.15.01 (Change in MA/GAMC Basis of Eligibility).