

This version of the manual is no longer in effect as of December 1, 2006.

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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #41

June 2004

Effective Date: July 1, 2004

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 in this manual letter is effective July 1, 2004 unless otherwise noted.

HIGHLIGHTED CHANGE #1: This manual letter contains updated income standards. All income standards except the clothing and personal needs allowance increased effective July 1, 2004, based on the 2004 federal poverty guidelines.

Apply the new standards when determining MA or GAMC eligibility for any month beginning with July. For new and pending applications with budget periods beginning before July, use the previous standards for all months through June and the new standards beginning with July.

EXAMPLE:

Joe applies for MA in June, requesting retroactive coverage to April. His standard is 100% FPG for a household of 1. To determine eligibility for the April-September budget period, compute the 6-month standard by using \$749 for April-June (100% FPG through June 30, 2004) and \$776 for July-September (100% FPG effective July 1, 2004). The applicable 6-month standard is \$4,575. If his anticipated income for the 6-month period is equal to or less than \$4,575, there is no spenddown. If anticipated income exceeds \$4,575, compute the 6-month spenddown amount using \$562 for April-June (75% FPG through June 30, 2004) and \$582 for July-September (75% FPG effective July 1, 2004).

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If Joe uses a monthly spenddown, use \$562 for April, May and June and \$582 for July, August and September.

The Method A standard for children ages 2-18 reduces from 170% FPG to 150% FPG effective July 1, 2004. Apply a \$90 standard work expense deduction to each person's earned income when determining a child's eligibility under the 150% FPG standard. See Bulletin # 04-21-05, 2003 Legislative Changes Affecting Medical Assistance Effective July 1, 2004, dated May 27, 2004. For applications processed in June and later, use the higher standard when determining eligibility for months before July and the lower standard for months beginning with July.

The Method B RSDI COLA disregard ends with RSDI benefits received in July. Use the actual gross RSDI amount (less any special disregards such as Pickle, Widows/Widowers etc.) beginning with July.

Use the new standards for MinnesotaCare applications and renewals beginning with July. New premium amounts are also effective July 1.

HIGHLIGHTED CHANGE #2: This manual letter includes the following annual July updates:

- The maintenance needs allowance for SIS-EW increases from \$752 to \$766. See §0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation: SIS-EW).
- The SAPSNF increases from \$3,848 to \$4,111 for MA and from \$3,171 to \$3,434 for GAMC. See §0909.27.11 (Improper Transfer Ineligibility), §0909.27.11.03 (Transfers Before 8-11-93), §0909.27.11.05 (Transfers 8-11-03 Through 8-31-94), §0909.27.11.07 (Transfers 9-1-94 Through 4-13-96) and §0909.27.11.09 (Transfers After 4-13-96).
- The basic shelter allowance for determining the community spouse allocation increases to \$469. The minimum monthly allowance the community spouse and dependents living with the community spouse increases to \$1,562. See §0912.05.25.03 (Allocations Community Spouse) and §0912.05.25.05 (Allocations Other Relatives).
- MCHA premiums used to determine continued MinnesotaCare eligibility for households with incomes above the limits increase. See §0912.03.05 (Annual MCHA Premiums).
- The parental fee schedule changed July 1, 2003, but has not previously been updated in the manual. See §0906.13.09 (Parental Fees).

HIGHLIGHTED CHANGE #3: This manual letter updates instructions for evaluating MinnesotaCare cases when income increases beyond the applicable standard. See §0912.03 (MinnesotaCare Income Eligibility), §0912.03.03 (MinnesotaCare Excess Income), and §0915.07 (Changes in Income). These changes were previously relayed in Bulletin # 04-21-01, 2003 Legislative Changes Effective February 1, 2004, Affecting MinnesotaCare, dated March 8,

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2004, and were effective February 1, 2004.

See Attachment A for a description of other changes in this manual letter.

Submit health care eligibility policy questions through the HealthQuest system.

Sincerely,

BRIAN OSBERG
Assistant Commissioner Health Care

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HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #41
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REVISED AND DELETED SECTIONS

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§0905.03 (Renewal Timelines) clarifies the MinnesotaCare mailing schedule in the 1st sentence.

§0905.05 (Annual Renewal–Eligibility) updates the instructions for acting on cases with excess income. See Highlighted Change #3.

§0905.09 (6-Month Reporting) clarifies that people who report monthly for MFIP do not have to submit 6-month reviews for MA. It adds MFIP as an example of a type of unvarying unearned income.

§0906.07.03.03 (County Financial Responsibility Disputes) is a new section with information on asking DHS for a formal determination when counties are unable to agree on financial responsibility. The instructions parallel those in the Combined Manual for cash and Food Stamps. There is no new policy in this section.

§0906.13.09 (Parental Fees) updates the formula for computing parental fees with the changes that were effective July 1, 2003. See Highlighted Change #1.

§0906.15 (Disability Determinations) removes an obsolete reference to GAMC disability determinations for undocumented and non-immigrant people. This population became ineligible for GAMC effective July 1, 2003.

§0907.19.03 (Families and Children Basis: Child Under 21) changes the income standard for eligibility without a spenddown for children ages 2-18 from 170% FPG to 150% FPG. See Highlighted Change #1.

§0907.19.07 (Families & Children: Parents/Caretakers) updates the asset standards. This change was effective July 1, 2003 but was inadvertently not updated.

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§0907.21.13 (MA Basis: Refugee Medical Assistance RMA) removes a reference to refugee extended medical. There is no longer a separate program or eligibility type known by this term.

§0907.23.11 ((MA Waiver Programs: EW) updates the maintenance needs allowance. See Highlighted Change #2.

§0908.09 (Who Must Be Excluded From the Household) changes the 2nd bullet under MinnesotaCare from children under age 25 to children under age 21. This changed when the dependent sibling group was eliminated.

§0909.07 (Jointly Owned Assets) adds that some jointly titled assets may remain fully available to the original owner, with a cross reference to §0909.09 (Availability of Assets).

§0909.09 (Availability of Assets) adds that in some cases, further information may be needed to determine the availability of a jointly owned asset when one owner refuses access to another. This may occur when an elderly parent puts an adult child's name on an asset for convenience, and the child then refuses access when the parent applies for MA..

§0909.27.11 (Improper Transfer Ineligibility), §0909.27.11.03 (Transfers Before 8-11-93), §0909.27.11.05 (Transfers Before 8-11-93 Through 8-31-94), §0909.27.11.07 (Transfers 9-1-94 Through 4-13-96), and §0909.27.11.09 (Transfers After 4-13-96) update the MA and GAMC SAPSNFs. See Highlighted Change #2.

§0909.27.13 (Improper Transfers-Onset of Ineligibility) updates an example to match current policy. It adds instructions for partial month penalties under GAMC.

§0911.07.05 (Unearned Income) adds that a deduction for costs necessary to secure payments, such as attorney's fees withheld from a Workers' Compensation check, can be deducted from unearned income.

§0911.09.03.05 (Self-Employment Income–MA/GAMC) adds information on capital gains for Method A. This information was previously included only in the farm income section, but applies to other self-employment as well.

§0911.09.15.05 (Lump Sum RSDI and SSI Payments) adds a cross reference to §0911.09.23 (Lump Sum Income).

§0911.09.23 (Lump Sum Income) clarifies and updates the instructions for budgeting unanticipated lump sums received during a certification period.

§0911.11.03 (Computing Countable Income–MA/GAMC) removes an obsolete reference to using actual income for the retroactive months for GAMC. GAMC no longer allows retroactive coverage effective October 1, 2003.

§0912 (Income Eligibility) corrects outdated material on the income standards.

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§0912.03 (MinnesotaCare Income Eligibility) and §0912.03.03 (MinnesotaCare Excess Income) update the instructions to reflect changes in policy when income increases beyond the applicable limit. See Highlighted Change #3.

§0912.03.05 (Annual MCHA Premiums) updates the amounts. See Highlighted Change #2.

§0912.05.03 (Determining Net Income) and §0912.05.05 (Work Expense Deductions) add to apply a \$90 deduction from earned income when determining eligibility for a child ages 2-18 under the 150% FPG standard. See Highlighted Change #1.

§0912.05.09 (Earned Income Disregards—Method A) updates the income standard for children ages 2-18 to 150% FPG. See Highlighted Change #1.

§0912.05.25.03 (Allocations Community Spouse) and §0912.05.25.05 (Allocations Other Relatives) update the basic shelter allowance and minimum monthly income allowance for the community spouse. See Highlighted Change #2.

§0912.07 (Income Standards) changes the income standard for children ages 2-18 to 150% FPG. See Highlighted Change #1. It adds the standard for GHO to GAMC.

§0912.075, §0912.100, §0912.120, §0912.135, §0912.150, §0912.175, §0912.185, §0912.200, §0912.275, and §0912.280 (FPG standards) are updated with new amounts. §0912.170 (170 Percent of FPG standards) is deleted. See Highlighted Change #1.

§0913.03 (Spendedowns—MA) eliminates GAMC from the title since GAMC no longer has spenddowns. It updates an example and changes the income standard for children ages 2-18 to 150% FPG. See Highlighted Change #1.

§0913.05 (Which Spenddown Type to Use) changes the income standard for children ages 2-18 to 150% FPG. See Highlighted Change #1.

§0913.13.05 (Waiver Obligation: SIS-EW) updates the maintenance needs allowance. See Highlighted Change #2.

§0913.17.03 (Begin/End Use of LTC Spenddown—Part 3) clarifies when to end the LTC spenddown when a client with no community spouse leaves LTC placement.

§0913.19.05 (When Not to Interrupt 6-Month Cert. Period) adds a separate section for GAMC. Since GAMC no longer has spenddowns, some of the instructions that were previously combined with MA no longer apply.

§0914.09 (Estate Claims) removes the statement under GAMC that claims are filed only for GAMC paid after age 55. Claims can be filed for payments received at any age.

§0915.07 (Change in Income) updates the instructions to reflect changes in policy when income increases beyond the applicable limit. See Highlighted Change #3.

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MinnesotaCare:

MMIS sends renewal forms to enrollees approximately 10 weeks before the **MMIS redetermination date**. The renewal packet includes the following forms:

- ▶ Minnesota Health Care Programs Renewal Form, DHS 3418.
- ▶ System-generated MinnesotaCare Notice of Renewal.
- ▶ Return envelope.
- ▶ Important Information Flyer for Non-English Speaking enrollees.
- ▶ Health Care Coverage in Minnesota (DHS 3416).

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

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

If the renewal is received in the renewal month, treat the renewal form as a new application. If a terminated household reapplies more than 1 month after they submit a renewal form, contact the household to update the information on the renewal form.

Do not require a new application if the renewal was completed in the 11 months preceding reapplication. See §0904.05.05 (When Not to Require an Application).

If possible, process the renewal before the cutoff date to ensure continuous coverage.

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

EXAMPLE:

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

If the family returned the information on the last working day of July but the worker did not have time to process the renewal until August, contact the family with the new premium amount. Ask if they wish to have August coverage. If they do not want coverage for August, pend awaiting payment for September 1. If they do want coverage for August, request a systems change to continue coverage for August.

EXAMPLE:

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

EXAMPLE:

The Jones family's renewal month is November. MMIS shows a redetermination date of October 31. MMIS mails the renewal on August 15. The family has not returned the renewal form as of October cutoff. MMIS generates a termination notice for failure to renew and non-payment. The family returns a complete renewal form and all verifications on October 17. The worker processes the renewal on October 20. The worker determines that

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the family remains eligible and enters the necessary information in MMIS to continue eligibility and recalculate the premium. MMIS sends a premium notice reflecting the new amount for November and December the same day. The family remains active as long as the November premium is received by the last working day of October.

EXAMPLE:

The Baer family's renewal month is February. MMIS shows a redetermination date of January 31. MMIS mails the renewal packet on November 15. The family has not returned the renewal form as of cutoff on January 17. MMIS generates a termination notice for non-payment of February premium and failure to renew effective January 31. The family returns the renewal form on the morning of January 31. If the family remains eligible, update MMIS information including income and approve the results. Unless the family pays the February premium on January 31 or has a credit, MMIS will cancel the household for nonpayment of the February premium. They will be eligible for the reinstatement option. If you cannot determine continued eligibility from the available information on the renewal form, request the missing information and leave the end date of January 31 on the MMIS RELG screen. The family will be without coverage until they are determined eligible and pay the premium.

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

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

MA/GAMC:

See §0905.03.01 (Annual Renewal Time Lines--MA/GAMC).

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MinnesotaCare:

When processing a renewal:

- ▶ Review case information. Check to make sure the address listed on the renewal form matches the one shown on MMIS. If different, contact the household if necessary to clarify the information. If the household has moved, record the new address on MMIS.
- ▶ Check to see if anyone has moved in or out of the household. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household). Also review eligibility for each person remaining in the household.
- ▶ If the household reports someone is pregnant, request verification of pregnancy. Treat the pregnant household member as a pregnant woman. See §0907.09 (MinnesotaCare Pregnant Women).
- ▶ Review the insurance information. Apply the rules for the household's current group status to determine if all covered individuals remain eligible and if any previously excluded individuals may now be eligible. See §0907 (Eligibility Groups and Bases of Eligibility) and §0910 (Other Health Coverage). If the household has current insurance that is not shown on MMIS, obtain all necessary information and submit a HIIF to Benefit Recovery.
- ▶ Obtain current income verification. Enter the new income amount on MMIS to calculate the new premium. See §0911 (Income) and §0912 (Income Eligibility).

For households who were determined to have income over the limit at the last renewal but were found eligible for **the MCHA exemption** under §0912.03.03 (MinnesotaCare Excess Income), compare the household's current income to the appropriate standard as well as to the applicable MCHA premium.

-If income remains above 275% FPG for families with children AND 10% of the income **is now** greater than the MCHA premium for the family in §0912.03.05 (Annual MCHA Premiums), send the MinnesotaCare Over Income Letter (DHS 3407). Also send the form Private Health Insurance in Minnesota (DHS 3416).

-If the income is now equal to or less than the applicable standard, OR 10%

of the household's income remains equal to or less than the appropriate MCHA premium, send the MinnesotaCare Income Change Evaluation Letter (DHS 3408) advising the household that the children's coverage will continue.

For households with children who are in the 12-month extension period, compare the household's current income to the appropriate standard as well as to the applicable MCHA premium.

-If the household's income is now equal to or less than the applicable standard, OR 10% of the household's income is now equal to or less than the appropriate MCHA premium, send the MinnesotaCare Income Change Evaluation Letter (DHS 3408) advising the household that coverage will continue.

-If the household's income remains greater than 275% FPG, continue coverage for the remainder of the 12-month extension period.

If the income of a household with children has dropped below 150% FPG, determine the effect on the household's group status and insurance requirements. See §0907 (Eligibility Groups and Bases of Eligibility) and §0910 (Other Health Coverage).

- ▶ Determine if there have been any changes in parental or medical support status. Send a referral or notify the local county IV-D office of changes as appropriate. Review good cause determinations if needed. See §0906.13 (Assigning Rights to Medical Support).
- ▶ Obtain the original renewal form if the form was received by fax. See §0905.03 (Renewal Timelines).
- ▶ If the renewal is unsigned, return the signature page to the household and ask them to return it. All enrollees age 18 and older who are requesting health care for themselves must sign the renewal form annually unless there is an authorized representative. If there is, only the authorized representative's signature is required as long as signatures are on file for all household members age 18 and over. Send a photocopy of the renewal form to enrollees age 18 and over and authorized representatives who did not sign the form. Eligibility will end for enrollees who have not provided required signatures by the renewal due date and those whose eligibility is affected by the All or Nothing Rule. See §0908.11 (All or Nothing Rule).

EXAMPLE:

Karen, Paul and their 3 children are all enrolled in MinnesotaCare. Their renewal month is December. They return the renewal form on November 9 without Karen's signature. The worker sends a photocopy of the renewal form requesting that Karen sign and return it by November 19. If Karen does not return the signed photocopy, eligibility will end for both her and Paul effective November 30 because Paul cannot be enrolled without Karen under the All or Nothing Rule. Eligibility continues for the children with Paul's signature.

See §0905.03 (Renewal Timelines) if you do not have enough information to redetermine eligibility and premium amount.

Terminate eligibility for household members who no longer qualify for MinnesotaCare. MinnesotaCare Operations will send the renewal to the household's county of residence if the household notifies MinnesotaCare that they wish to be considered for MA or GAMC. County agencies that are MinnesotaCare enrollment sites will determine MA/GAMC eligibility for people who no longer qualify for MinnesotaCare. See §0904.09.03 (Transfers From MinnesotaCare to MA/GAMC).

M.S. 256L.05 subd. 3a and 4

Minnesota Rules 9506.0020 subp. 6 and 7

MA/GAMC:

For people receiving Title IV-E or state adoption assistance, verify annually that the adoption assistance agreement remains in effect. Review the health insurance information. If health insurance information has changed, enter the new information in the TPL subsystem on MMIS. Close out the outdated information. See §0910 (Other Health Coverage).

For other renewals:

- ▶ Review the renewal form. Contact the household to complete missing items or request additional information. Obtain all required signatures. See §0905.03.01 (Annual Renewal Timelines--MA/GAMC).
- ▶ Check to see if anyone has moved in or out of the household. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).
- ▶ Check to see if anyone is pregnant. If yes, request verification of pregnancy.

Once the pregnancy is verified, treat the pregnant household member as a pregnant woman. See §0907.19.05 (MA Basis: Pregnant Women).

- ▶ Review the health insurance information. Obtain new health insurance information if the household has obtained other health coverage or the coverage has changed.
- ▶ Review asset information. Request verification of liquid assets if total reported assets are within \$300 of the asset limit unless you have received verification as part of an application or review for another program within the last 30 days. Advise people with excess assets of the need to reduce. See §0909.29.03 (Excess Assets--Enrollees). Follow up on reported transfers that may affect eligibility. See §0909.27 (Asset Transfers).

For LTC clients with community spouses, verify that all assets allocated to the community spouse have been legally transferred to the community spouse at the time of the first annual recertification. After the first renewal, verify liquid assets only if the LTC spouse's total countable assets are within \$300 of the asset limit.

- ▶ Obtain current income verification. Redetermine income eligibility for each person who is requesting continued coverage. Change spenddown amount or type if applicable. See §0913.05 (Which Spenddown Type to Use).
- ▶ Obtain the original renewal form if the form was received by fax. See §0905.03.01 (Annual Renewal Timelines--MA/GAMC).
- ▶ Determine if there have been any changes in parental or medical support status. Enter new information on MAXIS. If necessary, send new information to the local county IV-D office. Review good cause determinations if needed. See §0906.13 (Assigning Rights to Medical Support).
- ▶ Determine if any GAMC enrollees meet the mandatory MinnesotaCare referral criteria. See §0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals).
- ▶ Review managed care status.

Terminate coverage for people who no longer qualify for MA or GAMC under any basis of eligibility. If the household completed a Minnesota Health Care Programs Renewal Form, county agencies that are MinnesotaCare enrollment sites will evaluate

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ANNUAL RENEWAL--ELIGIBILITY

0905.05

MinnesotaCare eligibility or transfer the application to MinnesotaCare Operations based on the household's choice of enrollment site. County agencies that are not MinnesotaCare enrollment sites will forward the renewal to MinnesotaCare Operations as an application. See §0904.09.05 (Transfers From MA/GAMC to MinnesotaCare).

MAXIS will send notice of termination or changes in eligibility. See §0916 (Notices).

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MinnesotaCare:

No provisions.

MA:

Require a Minnesota Health Care Programs Income Renewal Form (DHS 3440) or Long Term Care Renewal Form (DHS 2128) and proof of current income at 6-month intervals beginning with the month of initial eligibility for all enrollees EXCEPT:

- ▶ People who report income monthly for MA, food stamps or a cash program. Use the information on the monthly reports to complete the MA review. See §0905.07 (Monthly Reporting).
- ▶ People who receive MA or GAMC automatically with MSA, GRH or GA.
- ▶ People who are exempt from completing annual renewals, such as children who receive adoption assistance and auto newborns. See §0905 (Reviews and Renewals).
- ▶ People who receive only unvarying unearned income, such as RSDI, private pensions, veterans' benefits, MFIP, and other unvarying payments that are expected to continue indefinitely.
- ▶ People whose only source of income is from an excluded source, such as SSI and excluded student financial aid. See §0911.05 (Excluded Income).
- ▶ People who report no income.

EXAMPLE:

Seth's only sources of income are SSI and RSDI in the same amount each month. Do not require him to submit 6-month income renewals.

NOTE:

Apply these exceptions to the Medicare Supplement Programs and the PDP as well as to regular MA. Do not require 6-month renewals for QMB, SLMB, QWD, QI or PDP enrollees who meet any of the above criteria.

When approving the new 6-month budget period for people exempt from submitting 6-month renewals, base eligibility on information in the case record or available from other sources, such as BNDX and SDX. People with spenddowns who are exempt from 6-month renewals may be required to submit documentation of medical

expenses if needed to determine continued eligibility for the next 6-month budget period.

Require all other households to complete 6-month renewals. Enrollees who are subject to 6-month income renewals and who report assets within \$300 of the asset limit must also verify assets at 6-month intervals. These enrollees must complete a Minnesota Health Care Programs Income and Asset Renewal Form (DHS 3441) or Long Term Care Renewal Form.

EXAMPLE:

Mario and Louise receive MA. Mario's only income is SSI. Louise is employed, and her income is considered in determining Mario's SSI eligibility and benefit level. Require income renewals at 6-month intervals to determine Louise's continued eligibility. Also review assets if total assets reported at the time of the last application are \$5,700 or more (within \$300 of the asset limit for a household of 2).

Review eligibility for enrollees who report receipt of lump sums or additional assets.

Six-month reporting enrollees must return a complete report form by the 8th day of the 6th month of the budget period. If you do not receive the form, MAXIS will send the Notice of Late or Incomplete Household Report Form or Income Renewal (DHS 2414) on the 16th day of the month. If the enrollee does not submit a complete Minnesota Health Care Programs Income Renewal Form or Income and Asset Renewal Form by the cutoff date in the 6th month, MAXIS will autoclose the case. Reinstate coverage if you receive the report form by the end of the month and the household remains eligible.

NON-LONG TERM CARE CASES:

All non-exempt enrollees must complete a Minnesota Health Care Programs Income Renewal Form (DHS 3440) for the 6-month income renewal **or** a Minnesota Health Care Programs Income and Asset Renewal (DHS 3441) for income and assets renewals.

MAXIS will attach instructions for income or income and asset renewals to the renewal form.

Require verification of current income (previous 30 days) to determine eligibility for the next 6-month budget period. Do not require enrollees to verify all income for the

previous 6-month period. MA does not reconcile actual income against income used in a projection. Base projections on the most accurate information available at the time of the renewal. Also see §0911.11.03 (Computing Countable Income--MA/GAMC).

For people on an automated monthly spenddown, require verification of income received in the 5th month of the certification period. See §0913.09 (Automated Monthly Spenddown Calculation).

If the household is no longer eligible for MA due to income or assets, refer the case for a MinnesotaCare determination within 5 days. If your county is not a MinnesotaCare enrollment site, send the most recent application and renewal form along with the current income or income/asset renewal and verifications to MinnesotaCare Operations. See §0904.09.05 (Transfers from MA/GAMC to MinnesotaCare) for additional information to include with the transfer.

LONG TERM CARE CASES:

All non-exempt enrollees must complete a Long Term Care Renewal Form (DHS 2128) for the 6-month renewal of assets and/or income and the annual renewal. MAXIS will attach instructions for 6-month income or income and asset renewals to the renewal form.

GAMC:

Follow MA for non-long term care cases, EXCEPT do not require 6-month asset renewals.

There are no reviews or renewals for GAMC Hospital Only (GHO) cases.

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COUNTY FINANCIAL RESPONSIBILITY DISPUTES

0906.07.03.03

MinnesotaCare:

No provisions.

MA/GAMC:

DHS will make determinations of financial responsibility when counties do not agree. The servicing county must determine eligibility and approve coverage before requesting a determination of responsibility.

After approving MA or GAMC, refer the case to the county you believe to be responsible within 60 days. The county you believe to be responsible has 30 days to accept or reject financial responsibility. Failure to respond within 30 days makes the receiving county financially responsible. If the receiving county rejects responsibility and the sending (servicing) county disagrees, the receiving county must give DHS evidence clearly showing why it rejects financial responsibility. Send copies to the servicing county.

The servicing county has 15 days from the date it gets the evidence disputing financial responsibility to send its position and supporting evidence to DHS. If the servicing county does not submit its position, DHS will issue a binding opinion based on the evidence submitted by the county claimed to be responsible.

When an active enrollee moves to a new county and the counties disagree on whether and when financial responsibility should transfer, either county may request a determination from DHS..

Send evidence to:

Appeals and Regulations Division
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3813

Within 60 days after receiving evidence from the county claimed to be responsible, DHS will issue an order to the county it finds financially responsible. If either county disagrees with the order, it may appeal to the district court within 30 days of the order's issuance. The county must follow the order pending the district court's decision.

When counties send disputes to DHS within the time frames listed in this section, reimbursement from the financially responsible county starts with the date of application or eligibility. If counties send the dispute late, reimbursement begins with the submission date.

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COUNTY FINANCIAL RESPONSIBILITY DISPUTES

0906.07.03.03

If the non-responsible county has not received federal and state reimbursement, the financially responsible county must reimburse the non-responsible county for the total amount paid. When a county receives federal and state reimbursement, the financially responsible county must pay only the county share, if any.

Counties may submit questions about financial responsibility through the HealthQuest system. However, HealthQuest does not resolve disputes between counties. Follow the procedures in this section if the counties do not agree.

MinnesotaCare:

No provisions.

MA:

In some instances, parents who do not live with their minor children who get MA, or whose income and/or assets are not considered in determining MA eligibility for children who live with them, are liable for a fee to reimburse part of the child's MA costs. DHS assesses and collects the fees for disabled children who are on TEFRA, receive services through the home- and community-based waivers, or are in 24-hour out-of-home placement on MA. The county assesses and collects MA parental fees in all other cases, including fees for non-disabled children in out-of-home placement.

Assess parental fees when:

- ▶ A child in the community lives apart from both parents and there is no court order for medical support. If there is a court order (including an order specifically stating that medical support is reserved) for either parent, refer that parent to IV-D if appropriate. See §0906.13 (Assigning Rights to Medical Support) and §0906.13.03 (Medical Support Referrals). Pursue a parental fee for the other parent.
- ▶ A child is in foster care placement. Follow the rules of the Title IV-E program when the cost of care is paid by IV-E. Follow the first bullet above for children in non-IV-E placements.

Refer cases to DHS for collection of parental fees when:

- ▶ Parental income and assets are not counted in determining MA eligibility for a child living with the parents. This includes:
 - Children eligible under TEFRA.
 - Children who receive waived services under one or more of the following waivers: Mental Retardation or a Related Condition (MR/RC); Community Alternatives for Chronically Ill Individuals (CAC); Community Alternatives for Disabled Individuals (CADI); or Traumatic Brain Injury (TBI). See §0907.23 (MA Waiver Programs).
- ▶ A child open on MA is in a 24-hour care facility outside the home with a diagnosis of mental retardation or a related condition, severe emotional

disturbance, or a physical disability. DHS assesses and collects fees for these disabled children if MA is open, regardless of whether MA pays for the cost of care. **Examples of facilities where DHS collects the fees include ICF-MR and Rule 5 facilities.**

When DHS collects the fees for a disabled child in out-of-home placement for whom the county also pays placement costs from social services funds, the county may not charge an additional fee. At the end of each fiscal year, DHS sends a report to all counties identifying children for whom DHS is assessing a parental fee. Each county reports the amount of social services funds paid on behalf of the children listed. The county must deduct any money it has retained to reduce social services costs, such as RSDI, from the total expenditures. DHS will reimburse the county for its unrecovered expenditures up to the amount DHS has collected from the parents.

- ▶ Disabled children in RTCs if MA pays for the cost of care. DHS will assess and collect the parental fees for these children. If a child in an RTC is not disabled OR MA does not pay for the cost of care in the RTC, refer income information to the RTC. The RTC will determine the responsible relative's reimbursement amount. For minors in a Residential Treatment Center (RTC), parents can be billed for up to 10% of the per diem rate.

Give a copy of form DHS 2977 (Important Notice and Parental Fee Worksheet) to all parents of children for whom DHS will collect fees. Explain to parents that their liability for parental fees begins with the first month in which MA is effective or waived services are received. Parents may be liable for fees through the month of the child's 18th birthday.

Enter the proper eligibility type on MMIS to enable DHS to bill and collect a parental fee.

Do not deny or terminate assistance because a parent refuses to provide necessary information or does not pay the contribution amount. Legal action may be taken against parents who refuse to provide DHS with requested information. Parents can be required to reimburse the full amount of MA expended.

DHS uses the following formula to compute parental fees for disabled children. Counties may use this formula to assess parental fees for social services costs but are not required to do so.

1. Begin with the parent(s)' adjusted gross income (AGI) as reported on the previous year's Federal Tax Form 1040 (line 33) or 1040A (line 18). Do not include income of stepparents.
2. If the child lives with the parent(s), subtract \$2,400 from the AGI of the parent(s) with whom the child lives.
3. If the parents live apart, subtract any court ordered child support paid for the child receiving services from the AGI of the parent(s) paying the support.
4. Compare the result to the federal poverty guideline for the family size. Count the child receiving MA services in the family size. Also count parents and dependents up to age 21. Do not count stepparents in the household size.

The parental fee schedule effective July 2003 is:

AGI	Monthly Fee
less than 100% FPG	None
100% FPG-174% FPG	\$4.00
175% FPG-374% FPG	Sliding scale from 1% to 7.5% of AGI.
375% FPG-674% FPG	7.5 % of AGI
675% FPG-974% FPG	10% of AGI
975% FPG and up	12.5 % of AGI

Divide annual fees by 12 to arrive at a monthly fee for billing purposes. Increase the monthly fee by 5% if the parents fail to obtain health insurance coverage for the child that is available through an employer at an annual cost to the parent(s) of no more than 5% of the family's federal adjusted gross income.

Parental fee amounts change each fiscal year due to annual changes in the Federal Poverty Guideline.

In addition to parents with AGI less than 100% FPG, parents are NOT responsible for a parental fee if:

- ▶ Parental rights have been terminated.
- ▶ The child on MA is emancipated. See EMANCIPATED MINOR in §0902.11 (Glossary: Effective...).

This version of the manual is no longer in effect as of December 1, 2006.

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PARENTAL FEES

0906.13.09

- ▶ The child receives state or Title IV-E adoption assistance.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People must be certified as blind or disabled to receive MA or the Medicare supplement programs using a blind or disabled basis of eligibility or to receive waived services based on disability. See §0907.21.05 (MA/Medicare Supplement Basis: Blindness), §0907.21.07 (MA/Medicare Supplement Basis: Disability), and §0907.23 (MA Waiver Programs).

There are 2 ways in which people may be certified:

- ▶ Certification by the Social Security Administration. SSA makes determinations of blindness and disability as part of the eligibility determination for SSI and RSDI benefits.
- ▶ Certification by the State Medical Review Team (SMRT). SMRT makes blindness and disability determinations for people who are ineligible for SSI or RSDI for reasons other than lack of blindness or disability and for people whose application for SSI or RSDI is pending. SMRT also makes level of care determinations for TEFRA. See §0907.23.09 (MA Waiver Programs: TEFRA).

In most cases, SMRT uses the same blindness and disability criteria as SSA. For the special category for disabled children, SMRT uses the childhood disability criteria in effect before the changes in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). See §0907.21.07.07 (Special Category: Disabled Children).

Disabled clients not receiving SSA benefits must apply if they appear eligible, or appeal if their RSDI or SSI benefits are terminated or denied based on a finding that they are not sufficiently disabled. If SMRT certifies disability pending the SSA determination and SSA denies disability, continue benefits pending the outcome of the appeal to SSA. This can continue until SSA has denied 2 appeals of the denial of the initial application. If SSA denies the 2nd appeal, provide timely notice and close MA unless another basis of eligibility exists.

Refer cases to SMRT when there has been no disability determination by the Social Security Administration and the disability is expected to last 12 months or longer.

The following conditions are considered likely to be permanent by SSA. They are known as the Medical Improvement Not Expected (MINE) list. People with 1 of these conditions have a high likelihood of being found disabled by the SSA and SMRT. The reference codes are for SSA pamphlet "Disability Evaluation Under Social Security" which has more detailed information.

Use the MINE list as a guide in assessing potential disability certification. However, do not limit SSA or SMRT referrals to people with conditions on the MINE list.

1. Arthritis of 1 major joint in each upper extremity (1.04).
2. Disorders of the spine (arthritis manifested by ankylosis or fixation at 30 degrees or more) (1.05A).
3. Amputation or permanent loss of use of two limbs (1.09).
4. Amputation of leg at hip (1.10A).
5. Amputation of leg or foot because of diabetes or peripheral vascular disease (1.10B).
6. Statutory blindness unless due to cataracts or detached retina (markedly reduced ability to see, not correctable by surgery, glasses, or other treatment) (2.02, 2.03A/B).
7. Loss of visual efficiency (visual efficiency of better eye after best correction is 20% or less) (2.03C, 2.04).
8. Hearing loss not restorable by a hearing aid (2.08A/B).
9. Chronic obstructive airway disease (3.02).
10. Ischemic heart disease with chest pain of cardiac origin (4.04A/B).
11. Arteriosclerosis obliterans or thromboangiitis (4.13).
12. Chronic liver disease with esophageal varices resulting in massive hemorrhage or requiring shunt operation (5.05A/B).
13. Impaired renal function due to chronic progressive disease, incurable kidney disease resulting in severely reduced function which may require dialysis or transplant (6.02).
14. Diabetes mellitus with manifestation as required in section (9.08).
15. Central nervous system vascular accident, with manifestation as required in section (11.04).
16. Parkinsonian syndrome, with disturbance of movement, gait, or station as required in section (11.06).
17. Cerebral palsy, with manifestations as required in section (11.07).
18. Spinal cord or nerve root lesion resulting in paraplegia or quadriplegia (11.08).
19. Multiple sclerosis (11.09).
20. Amyotrophic lateral sclerosis (11.10).
21. Anterior poliomyelitis, with interference in swallowing, breathing, speech, or

-
- motor function as described in (11.11).
22. Muscular dystrophy (11.13).
 23. Degenerative disease, such as Huntington's Chorea, Friedreich's Ataxia, and spinocerebellar degeneration as required in section (11.17).
 24. Chronic brain syndrome (organic brain syndrome) with manifestations as required in section (12.02).
 25. Functional psychotic disorders if institutionalized in a licensed mental hospital for the past 12 months without releases that would indicate improvement (12.03).
 26. Functional non-psychotic disorders if institutionalized in a licensed mental hospital for the past 12 months without releases that would indicate improvement (12.04).
 27. Severe mental retardation, with manifestations as required in section (12.05A, 12.05B, 12.05C).
 28. Age 55 and over with a condition meeting requirements in 1 of these sections:
 - 1.03A Arthritis of major weight bearing joint.
 - 2.09 Organic loss of speech.
 - 3.04 Diffuse pulmonary fibrosis.
 - 4.04C/D Ischemic heart disease.
 - 3.05 Other restrictive ventilatory disorders.
 - 4.12 Chronic venous insufficiency.
 - 10.05 Scleroderma or progressive system sclerosis.
 - 11.15 Tabes dorsalis.
 - 11.16 Subacute combined cord degeneration.
 - 11.19 Syringomyelia.
 29. Age 55 and over with amputation of a limb.
 30. Age 55 and over with two substantiated myocardial infarctions.

See §0906.15.03 (Disability Determination/SMRT Referral).

GAMC:

No provisions.

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MinnesotaCare:

No provisions.

MA:

All children under 21 have a basis of eligibility for MA if they meet the citizenship/immigration requirements for either program MA or program NM. Undocumented children are not eligible for ongoing MA, but may be eligible for EMA. See §0906.03 (Citizenship and Immigration Status) and §0907.29.03 (Emergency MA).

Children under 21 who are also blind or disabled may be able to choose which basis of eligibility to use. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility). Children who are eligible under a deeming waiver, such as TEFRA, or who receive certain waived services such as MR/RC or CADI must use a disabled basis. See §0907.23 (MA Waiver Programs).

Use Method A for children using the Child Under 21 basis. Do not require verification of age.

Asset limit:

There is no asset limit for children under age 21.

Income limit:

For children ages 0-2 who are not eligible as auto newborn, the income standard is 280% FPG (MAXIS Standard K). See §0912.07.280 (280 Percent of FPG Standards). Children ages 0-2 with incomes over 280% FPG may be eligible by spending down to the 100% of FPG standard (MAXIS Standard E). See §0912.07.100 (100 Percent of FPG).

Children ages 0-1 who are born to a woman on MA or MinnesotaCare are eligible without regard to income if they continue to live with the mother. See §0907.19.05.03 (MA Basis: Auto Newborn).

For children ages 2 through 18, the income standard is **150 % of FPG (MAXIS standard G) effective July 1, 2004**. See §0912.150 (150 Percent of FPG). **The standard through June 30, 2004 was 170% FPG. Children with incomes over 150% FPG may be eligible by spending down to the 100% FPG standard (MAXIS Standard E).** See §0912.07.100 (100 Percent of FPG).

This version of the manual is no longer in effect as of December 1, 2006.

MDHS HEALTH CARE PROGRAMS MANUAL

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FAMILIES AND CHILDREN BASIS: CHILD UNDER 21

0907.19.03

For children ages 19-20, the income standard is 100% of FPG. See §0912.07.100 (100 Percent of FPG). Children ages 19-20 with incomes over this standard may be eligible by spending down to 100% of FPG.

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MinnesotaCare:

No provisions.

MA:

Caretakers (including parents) of children who meet the MA definition of a dependent child have a basis of eligibility for MA. See the MA definition of DEPENDENT CHILD in §0902.09 (Glossary: Denial...)

See RELATIVE CARETAKER in §0902.33 (Glossary: Quality...) for a list of caretakers who can qualify for a parent/caretaker basis. Non-parent relative caretakers do not have a parent/caretaker basis if a biological or adoptive parent is in the home. This includes stepparents.

EXAMPLE:

Ruth lives with her husband Sam and her child from a previous marriage, Jonah. They have no children in common. Sam does not meet a parent/caretaker basis because Ruth is in the home. If Ruth were not in the home, Sam could meet a parent/caretaker basis as an eligible relative caretaker.

Both biological or adoptive parents can meet a parent/caretaker basis if they live in the home. Only one non-parental caretaker can meet a parent/caretaker basis.

EXAMPLE:

Janelle lives with her husband Ron and her niece. Either Janelle or Ron (but not both) can meet a parent/caretaker basis. The second spouse must meet a different MA basis or be considered for GAMC.

If the parents are unmarried, paternity must be legally acknowledged or adjudicated for the father to have a parent/caretaker basis.

EXAMPLE:

Maria and Peter live with their baby, Clifford. Paternity has not been adjudicated, and Peter has not signed an Acknowledgment of Paternity. Maria has a parent/caretaker basis of eligibility for MA. Peter is not considered to be Clifford's legal parent and must meet another basis or be considered for GAMC.

If paternity is later adjudicated or legally acknowledged, both parents have a parent/caretaker basis.

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MDHS HEALTH CARE PROGRAMS MANUAL

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FAMILIES & CHILDREN: PARENTS/CARETAKERS

0907.19.07

Income limit: 100% of FPG (MAXIS standard E). See §0912.07.100 (100 Percent of FPG Standard). People with incomes over 100% FPG may be eligible by spending down to 100% of FPG.

Asset limit: ~~\$10,000~~/~~\$20,000~~. See §0909.05 (Asset Limits).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Refugee Medical Assistance (RMA) is a federally authorized program providing MA to refugees. To be eligible for RMA, refugees must meet ALL the following conditions:

- ▶ Have been in the U.S. 8 months or less.

AND

- ▶ Be ineligible for MA. Consider MA eligibility first. If refugees are ineligible for MA, send a notice denying MA. See §0916 (Notices).

AND

- ▶ Have 1 of the following immigration statuses:
 - Refugee. See §0906.03.11.05 (Refugees).
 - Asylee. See §0906.03.11.07 (Asylees).
 - Cuban and Haitian Entrant. See §0906.03.11.15 (Cuban/Haitian Entrants).
 - Amerasian. See §0906.03.11.17(Amerasian Immigrants).
 - Dependent children of people with any of the above statuses who live in the same household if the only parent or both parents in the household have refugee status. Children with a non-refugee parent in the household are not eligible for RMA.

NOTE:

Although federal RMA guidelines include dependent children, in practice these children will qualify for regular MA if they have a qualifying status. However, they may become eligible for RMA if income increases beyond the applicable standard for regular MA during the first 8 months of U.S. residence.

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- Victims of trafficking. See §0906.03.11.25 (Trafficking Victims).

People who adjust to LPR status also qualify if they previously held 1 of the statuses above and meet all other requirements, including being in the U.S. for less than 8 months.

AND

- ▶ Provide the name of their resettlement agency to the county human services agency.

AND

- ▶ Not be full-time students in an institution of higher learning, unless their enrollment is part of a state approved plan.

Refugees who meet these requirements are eligible for RMA for 8 months. Count the month they entered the U.S. or the month the INS granted asylum status, whichever is later, as month 1 of this period.

Refugees receiving RCA are automatically eligible for RMA if they are not eligible for regular MA. Consider eligibility for regular MA first. Refugees do not have to apply for RCA as a condition of eligibility for RMA.

The income and asset limits for RMA are the same as MA. Use Method A. See §0909.05 (Asset Limits) and §0912.07.100 (100% of FPG).

Base eligibility determinations on the income and resources on the date of application.

Exclude the same income as regular MA Method A. See §0911.05 (Excluded Income) and §0911.05.03 (Excluded Income--Program Provisions). In addition, disregard all new sources or amounts of income received or expected to be received after the date of application, including earnings from starting employment. Follow §0910.05.03 (Health Insurance Premium Payment) if the refugee has cost-effective health insurance available through employment.

EXAMPLE:

Josef, age 35, entered the U.S. as a refugee on April 10. He is single and has no dependent children. He applies for health care coverage on April 27. He does not meet an MA basis of eligibility. He had no income on the date of application. His only resource is \$300 in cash. The worker contacts Josef on

May 5 to follow up on information needed to process the application and learns that Josef began employment on May 1. His employer does not offer health insurance. If he meets all RMA requirements, base eligibility for the 8-month period on 0 income. Do not consider his earnings or require him to provide verification of his employment.

EXAMPLE:

Rolf, age 22, entered the U.S. as a refugee on July 25. He applies for RMA on August 10. He reports he is employed 20 hours per week at \$6.00 per hour. Project this income for the 8-month RMA eligibility period. Do not consider increases or new income sources that begin after the month of application.

Do not consider earnings from employment that begin or increase after approval of RMA. Refugees whose income increases beyond the RMA limits remain eligible for RMA until the end of the original 8-month eligibility period. Do not require RMA enrollees to report or verify employment.

Determine if MA eligibility continues under another basis at the end of the 8-month RMA period. Do not require a new application. Require verification of earnings if applicable. If there is no MA basis, review for MinnesotaCare or GAMC eligibility. See §0904 (Applications).

If refugees who receive regular MA become ineligible due to increased earnings, consider eligibility for Transition Year Medical Assistance (TYMA) first. See §0907.19.11 (Transitional/Transition Year MA). If there is no eligibility for TYMA and the refugee has been in the U.S. for less than 8 months, approve RMA for the remainder of the 8-month period without an eligibility determination.

EXAMPLE:

Sonja and her 2 children entered the U.S. as refugees on September 12. They were approved for MA effective September 1. Sonja reports beginning employment on October 5. Her earnings will exceed the MA standard for herself and the children. She does not meet the eligibility criteria for TYMA. Close MA November 1 and open RMA for the remainder of the 8-month period.

GAMC:

No provisions.

This version of the manual is no longer in effect as of December 1, 2006.

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 1-1-04 through 12-31-04 is \$1,692 for all EW applicants or enrollees, regardless of marital status or household size. The SIS for 1-1-03 through 12-31-03 is \$1,656. The maintenance needs allowance for 7-1-04 through 6-30-05 is \$766 regardless of marital status or household size. Treat each person as a household of 1. The maintenance needs allowance for 7-1-03 through 6-30-04 is \$752.

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 120% FPG for a household size of 1 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 first 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.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

Exclude the following people from the MinnesotaCare household:

- ▶ People who do not have a parental, marital, or legal guardian relationship with another household member.
- ▶ Children age 21 and over, even if living in the parental home and financially dependent.
- ▶ Foster children, unless they have been placed in the home for adoption OR the foster parents apply for MinnesotaCare for themselves and choose to include the child in their household size. Consider adoptive children as household members beginning the 1st day of the month of placement.

EXAMPLE:

Louis has been placed in the Johnson household as a foster child. This is not an adoptive placement. Louis receives MA and the Johnsons do not wish to apply for MinnesotaCare for him. Do not count Louis in the Johnson's household size.

- ▶ Emancipated minors and their spouses and children, even if living with the minor's parents.

EXAMPLE:

Ann, age 17, her husband Steve, and their son Mark live with Ann's parents. Because Ann is married, she is an emancipated minor. Ann, Steve, and Mark are a separate household of 3.

- ▶ Relative caretakers age 18 or older who reside in households with minor children and their biological or adoptive parents, stepparents, or legal guardians but do not have primary responsibility for a minor child in the household.

EXAMPLE:

Betty and her minor child Mark live with Mary, who is Mark's aunt. Because Mark's mother also resides in the home, Mary does not have primary responsibility for her nephew and may not be considered a relative caretaker. Consider Betty and Mark as a family with children. Consider Mary a separate household.

This version of the manual is no longer in effect as of December 1, 2006.

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- ▶ People incarcerated in correction/penal institutions and government controlled halfway houses.
 - ▶ Children in secure juvenile detention facilities, state owned and operated juvenile facilities and county owned and operated secure juvenile facilities.

People who are incarcerated and children residing in secure juvenile facilities may remain part of the household until the next renewal. See §0906.09 (Institutional Residence--MinnesotaCare).

MinnesotaCare requires certain household members to enroll if they are eligible. See §0908.11 (All or Nothing Rule).

MA/GAMC:

Exclude the following people who live with an adult from the adult's household size:

- ▶ The other parent of a child in the household if the parents are unmarried.

EXAMPLE:

Robin and Mark live with their son. They are unmarried. Paternity has been legally acknowledged. Robin and Mark each have a household size of 2. Do not include them in each other's household size.

- ▶ Children age 21 and over.
- ▶ Children under age 21 who are not the financial responsibility of the adult or the adult's spouse.

EXAMPLE:

Tina and her daughter live with her friend Jeff and his son. Do not include Jeff or his son in Tina's household size.

EXAMPLE:

Jeanne lives with her 17-year-old daughter Hannah and Hannah's infant son Josh. Do not count Josh in Jeanne's household size.

Exclude the following people who live with a child from the child's household size:

- ▶ Adults who live with the child and are not the child's biological or adoptive parent, or stepparent who lives with a biological or adoptive parent.

EXAMPLE:

Becky continues to live with her stepfather, Joe, following the death of her mother, Joe's wife. Becky has a household size of 1. Exclude Joe from her household size because there is no biological or adoptive parent in the home.

- ▶ Siblings, half-siblings, and stepsiblings if no biological or adoptive parent lives in the home.
- ▶ Siblings over age 21.

For both adults and children, exclude family members who do not live in the household for 1 full calendar month or more, unless the absence is considered temporary. See §0908.13.03 (Temporary Absence--MA/GAMC) and §0915.05.01 (Removing a Person From Household--MA/GAMC).

For LTCF residents, exclude the community spouse and children living with the community spouse from the household of the institutionalized spouse beginning the first day of the month in which 1 spouse enters an LTCF.

Exclude children under age 18 who are not living with a community spouse from the household of the institutionalized person effective the first full calendar month following the month a person enters an LTCF.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare/ MA Method A/ GHO:

When 2 or more people own an asset, apply the following rules to determine each owner's share:

- ▶ For bank accounts owned jointly by a child and an adult, count one-half the value toward the adult's asset limit.

EXCEPTION:

Exclude the full value of accounts established under the Uniform Gift to Minors Act or the Uniform Transfer to Minors Act.

- ▶ For savings bonds, divide the value among all owners listed, excluding those listed as POD beneficiaries.
- ▶ For bank accounts held jointly by adults, consider the entire balance to belong to each owner.

EXAMPLE:

Pam applies for MA. She is separated from her husband. They have joint checking and savings accounts. Count the entire balance of both accounts toward Pam's asset limit.

EXAMPLE:

Jolene applies for MA for herself and her daughter Marissa. Jolene's husband Bart is Marissa's stepfather. Jolene and Bart have a joint checking account. Consider the entire balance of the account to belong to Jolene. Marissa has no asset limit because she is a child under 21.

- ▶ For all other assets, consider each owner to own an equal share unless the applicant or enrollee documents a greater or lesser share of ownership.

EXAMPLE:

Joan applies for MA. She is separated from her husband. They are joint owners of a lake cabin. Presume that Joan owns one-half the equity value unless she documents a greater or lesser share. See §0909.09 (Availability of Assets) to determine whether to count the value toward Joan's asset limit.

EXAMPLE:

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Karen applies for GAMC. She inherited a parcel of land from her grandparents along with her parents and siblings. Her grandparents' will gives half ownership of the land to her parents with the remaining half divided equally among Karen and her 3 siblings. Consider Karen to own one-eighth of the equity value of the land. See §0909.09 (Availability of Assets) to determine whether to count the value toward Karen's asset limit.

MA METHOD B:/GAMC

When 2 or more people own an asset, apply the following rules to determine each owner's share.

- ▶ For jointly held checking accounts, savings accounts, certificates of deposit, savings certificate, or other time deposits, consider the entire balance to belong to each person, except when the other owner is an MA applicant or enrollee, or a responsible relative whose assets you deem available. In that situation, presume ownership of equal shares.

EXAMPLE:

Max and Louise are a married couple in long term care. They both apply for MA. They have a joint savings account. Consider one-half the balance to belong to each of them.

- ▶ For other assets, follow Method A.

In some cases, a jointly owned asset may remain fully owned by and available to the original owner even if a joint owner attempts to make the funds unavailable. See §0909.09 (Availability of Assets) for details.

Assets are available if the owner has both legal authority and actual ability to use them for self-support. Do not count assets that are legally unavailable.

Do not consider the terms of a premarital agreement in determining the availability of assets for a married couple.

When an applicant or enrollee owns an asset in whole or in part, presume that the value of the portion the client owns is available unless the client proves it is not. A client may prove unavailability by verifying a legal or actual barrier to disposal of the asset that cannot reasonably be overcome. If a client claims a legal barrier and its status is unclear, consult the Health Care Policy Center or refer the case to the county attorney for a legal opinion on availability.

EXAMPLE:

Jerry applies for GAMC. He is involved in a lawsuit, and a preliminary court ruling prevents him from selling or disposing of his assets pending further order of the court. Consider his assets unavailable. Consult the county attorney if the order is unclear. Review unavailability at each renewal and when you anticipate a change in availability

See §0909.07 (Jointly Owned Assets) to determine what portion of a jointly-owned asset is presumed to belong to each owner. Except for jointly owned bank accounts, consider an asset to be unavailable when:

- ▶ The permission of a joint owner is required to sell or dispose of the asset.

AND

- ▶ The joint owner is not a member of the household or a financially responsible relative whose assets are deemed to the MA/GAMC client.

AND

- ▶ The joint owner refuses to allow the sale or disposal of the asset.

EXAMPLE:

Marlene applies for MA for herself and her children. She is separated from her husband. They jointly own several acres of undeveloped land separate from their homestead. Marlene's husband will not agree to

list the land for sale. Consider the land as unavailable to Marlene unless her husband agrees to sell the land or a court awards the land to Marlene. Review unavailability at each renewal.

EXAMPLE:

William and Myrna are a married couple who reside together in the community. They jointly own an apartment building with an equity value of \$35,000. William applies for MA. Myrna does not apply and refuses permission to list the property for sale. Because Myrna is a spouse whose assets are deemed to William, her refusal to sell does not make the property unavailable. Count the full \$35,000 equity toward William's asset limit.

In some cases, a jointly owned account is still available even when another owner refuses access. Determine whether the account was titled jointly with the intent of allowing both parties full access.

EXAMPLE:

Steve opened a brokerage account in his name 10 years ago. Two years ago, he had some health problems and put his son Tom's name on the account so Tom could help manage the funds. Steve has continued to receive income from the account and has made deposits. Tom has not withdrawn or placed funds in the account. Steve applies for MA. The account balance exceeds the asset limits. Tom, as the joint owner, signs a statement that he will no longer allow Steve access to the account. Review the following factors:

- ▶ How the account is titled, and laws governing the type of account
- ▶ What agreements, if any, were signed when the account was opened or the 2nd owner's name was added
- ▶ What policies the financial institution has governing access by joint owners
- ▶ Who contributed to the account
- ▶ Who has had access to the account
- ▶ Who has received income and/or 1099 tax forms from the account
- ▶ Who gets the proceeds if the account is closed
- ▶ Whether the account has named death beneficiaries

Determine whether Steve still has access to the account. If he does not, evaluate whether placing Tom's name on the account was an improper transfer. Submit a HealthQuest with all available information if access is unclear.

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See §0909.25 (Spousal Asset Assessments) for treatment of assets when 1 spouse is applying for long term care services.

Consider real property not used as a home to be unavailable as long as the applicant or enrollee is making a good faith effort to sell the property. See §0909.13.03 (Real Property: Non-Homestead). Do not consider non-liquid personal property to be unavailable while for sale.

EXAMPLE:

Paul applies for GAMC. He owns a boat with equity value in excess of the GAMC asset limit. Paul must sell the boat and properly reduce the proceeds to be eligible for GAMC. See §0909.29 (Excess Assets--Applicants). Do not consider the boat unavailable while Paul has it listed for sale.

A community spouse's share of assets held by an LTCF resident are not available to the LTCF resident up to the date of the 1st recertification. See §0909.25.03 (Spousal Asset Allowance).

See §0909.21 (Trusts) and §0909.23 (Annuities) for information on determining the availability of these types of assets.

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MinnesotaCare:

No provisions.

MA:

Do not deny or terminate eligibility for MA due to excess assets when an improper asset transfer occurs. Determine the ineligibility period for the services listed below. The client is eligible for all other MA covered services that are not included in this list.

If the transfer occurred before 7-1-88, the client is ineligible for all MA services during the penalty period.

If the transfer occurred on or after 7-1-88, a client is eligible for MA but is not eligible for MA payment of the following services during the ineligibility period:

- ▶ Skilled nursing facility care.
- ▶ Intermediate care facility services.
- ▶ Community Alternative for Disabled Individuals (CADI) waivers.
- ▶ Community Alternative Care (CAC).
- ▶ Home and Community Based Waiver Services for Persons with Mental Retardation or Related Conditions (MR/RC & ACS).
- ▶ Elderly Waiver Services.
- ▶ Traumatic Brain Injury Waiver (TBIW).
- ▶ Nursing facility care in an inpatient hospital.

The client remains eligible for all other MA covered services not listed above.

For more information, see the following:

§0909.27.11.03	Transfers Before 8-11-93.
§0909.27.11.05	Transfers 8-11-93 Through 8-31-94.
§0909.27.11.07	Transfers 9-1-94 Through 4-13-96.
§0909.27.11.09	Transfers After 4-13-96.

A person who reapplies during the ineligibility period will not be eligible for MA payment of long term care services until the period expires.

When either spouse of a married couple transfers assets improperly, apply the penalty period as follows:

- ▶ Both spouses apply for MA:
 - When 2 spouses who are receiving LTC services have transferred jointly owned income or assets and apply for MA on the same day, divide the penalty between them equally even if they entered the LTCF on different dates.
 - When only 1 spouse is receiving LTC services, apply the entire penalty period to that spouse regardless of who owned the transferred asset.

- ▶ One spouse applies for MA:
 - When both spouses are receiving LTC services, apply the entire penalty period to the applicant regardless of who owned the transferred asset.

- ▶ One spouse currently receiving MA and subject to a penalty period at the time the other spouse applies for MA to receive LTC services:
 - When a spouse makes a transfer that results in a penalty for his/her spouse who is on MA in LTC, and later begins receiving long term care services himself/herself, any remaining penalty must be split evenly between the spouses.

When a community spouse improperly transfers assets after the asset assessment is completed and MA is open for the LTC spouse, determine whether to apply a penalty to the LTC spouse. Although the community spouse's assets are no longer considered available to the LTC spouse, an improper transfer will result in a penalty unless the community spouse can demonstrate that the transferred assets will never affect the LTC spouse's ability to obtain or maintain eligibility. See §0909.27.01 (MA Transfers--Cont.).

If the penalty period is not exhausted when the spouse's LTC services ends, the remaining balance goes back to the remaining LTC spouse.

Transferred assets returned completely or partially to the client will reduce or eliminate the amount of the transfer and reduce or eliminate the corresponding period of ineligibility for LTC services.

If the applicant or the applicant's authorized representative failed to report the transfer of assets at the time of application, a cause of action may exist against the person who

received the transferred assets if you approved MA and MA paid LTC services during a period of ineligibility. See §0909.27.13 (Improper Transfers - Onset Of Ineligibility).

GAMC:

There are no improper transfer provisions for GHO.

Other GAMC applicants or enrollees who make improper transfers during the lookback period or while receiving GAMC are ineligible for all GAMC services during the ineligibility period.

If an applicant or enrollee has improperly transferred an asset, the period of ineligibility is the number of months resulting from the following calculation:

1. Determine the uncompensated value of an improperly transferred asset. See §0909.27.09 (Determining Uncompensated Value).
2. Divide the uncompensated value of the asset by the statewide average monthly per person payment for skilled nursing facility care (SAPSNF) **for GAMC. This is not the same figure as the MA SAPSNF.** Use the amount in effect on the date of the client's application that covers the current application processing period or period of GAMC eligibility. Effective **7-1-04**, that amount is **\$3,434**. From **7-1-03** through **6-30-04**, the amount is **\$3,171**.

Apply a partial month of ineligibility to both applicants and enrollees. If the transferred amount is less than **\$3,434**, deny eligibility for payment of services equal to the amount transferred. If a fractional part of a month remains after calculating a period of ineligibility for a transfer of more than **\$3,434**, multiply the remainder (rounded to hundredths) by **\$3,434**. The result is the dollar amount of medical expenses the client is responsible for in the 1st month of possible eligibility.

There is no limit on the period of ineligibility.

If a client has excess assets, excess income, and transferred property, apply the transfer penalty first, reduce assets next, and then complete the income spenddown.

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MinnesotaCare:

No provisions.

MA:

For uncompensated transfers occurring before 8-11-93, the period of ineligibility is the lesser of 30 months or the number of months resulting from the following calculation:

1. Determine the uncompensated value of improperly transferred assets. See §0909.27.09 (Determining Uncompensated Value).
2. Divide the uncompensated value of the asset by the statewide average monthly payment rate for skilled nursing facility care (SAPSNF). Use the SAPSNF in effect on the date of the client's application that covers the current application processing period or period of MA eligibility. If someone has been on MA since before 7-1-90, the SAPSNF to use is \$2,177. Truncate partial months. If the amount improperly transferred is less than the SAPSNF, it does not affect eligibility.

Effective 7-1-04, the SAPSNF is \$4,111. From 7-1-03 through 6-30-04, the SAPSNF is \$3,848.

The 30-month maximum on penalty periods does not apply to transfers which were made on or after 8-11-93. See §0909.27.11 (Improper Transfer Ineligibility).

NOTE:

Because the maximum lookback period for transfers is 60 months, no transfers made on or after 8-11-98 will be subject to penalty.

GAMC:

See §0909.27.11 (Improper Transfer Ineligibility). For GAMC transfers, the SAPSNF is \$3,434 effective 7-1-04 (\$3,171 from 7-1-03 through 6-30-04). This is not the same as MA.

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MinnesotaCare:

No provisions.

MA:

Use the following steps to determine the ineligibility period for transfers occurring on 8-11-93 through 8-31-94:

1. Determine a penalty period for the total value of all uncompensated transfers made in each month in the lookback period separately by dividing the uncompensated amount by the monthly statewide average nursing home payment in effect on the date of the client's current application. Effective 7-1-04, the SAPSNF is \$4,111. From 7-1-03 through 6-30-04, the SAPSNF is \$3,848.
2. Chart out the months that each penalty period runs, beginning in the month each transfer(s) occurred. Look for any months that occur in more than one penalty period. These are considered OVERLAPPING penalty periods.
3. If none of the charted ineligibility periods overlap, begin each ineligibility period in the month each transfer (or transfers, if more than one transfer was made in a given month) transfer was made, and stop here. If any ineligibility periods overlap, go on to step 4.
4. If any of the penalty periods determined in step #2 overlap, including any calculated penalty period for uncompensated transfers in amounts less than the monthly statewide average nursing facility payment, add the values of all the uncompensated transfers made in the lookback period together, and re-calculate a single ineligibility period. Truncate a partial month when determining the actual ineligibility period.
5. Begin the ineligibility period in the month of the first uncompensated transfer during the lookback period. The ineligibility period runs for the period of time calculated in step 4.

GAMC:

See §0909.27.11 (Improper Transfer Ineligibility). For GAMC transfers, the SAPSNF is \$3,434 effective 7-1-04 (\$3,171 from 7-1-03 through 6-30-04). This is not the same as MA.

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MinnesotaCare:

No provisions.

MA:

Use the following steps for transfers made on or after 9-1-94 through 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 \$1,000 in total value for the month, disregard that amount and do not calculate a penalty period. Disregard transfers of \$1,000 or less made in any month after 9-1-94 even if the transfer occurred during a pre-existing penalty period.
2. If the amount transferred for less than fair market value is greater than \$1,000, determine a penalty period based on the total value of all uncompensated transfers made during that month. Do not disregard the first \$1,000 transferred.
3. If the total uncompensated value of assets transferred in a month by the client and spouse combined is greater than \$1,000, 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 7-1-04, the SAPSNF is \$4,111. From 7-1-03 through 6-30-04, the SAPSNF is \$3,848.

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

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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.

GAMC:

See §0909.27.11 (Improper Transfer Ineligibility). For GAMC transfers, the SAPSNF is \$3,434 effective 7-1-04 (\$3,171 from 7-1-03 through 6-30-04). The GAMC SAPSNF is not the same as MA.

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 first \$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 7-1-04, the SAPSNF is \$4,111. From 7-1-03 through 6-30-04, the SAPSNF is \$3,848.

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.

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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 \$3,434 effective 7-1-04 (\$3,171 from 7-1-03 through 6-30-04). **GAMC does not use the same SAPSNF as MA.**

MinnesotaCare:

No provisions.

MA:

The ineligibility period begins with the month after the month of the transfer, except for certain multiple transfers. See §0909.27.13.03 (Multiple Asset Transfers). If the transfer occurs via a personal check, the ineligibility period begins the month after the date the recipient's check clears the bank.

The transfer of real property is completed when both execution and delivery have been completed. Execution is the signing of the deed by the person selling (seller) or transferring (donor) the property. Delivery is giving the deed to the buyer or donee or the buyer's or the donee's representative or recording the deed in the county recorder's office. The transfer date is the earliest verified delivery date.

Refer cases to the county attorney to determine whether to file a cause of action against the person who received the transferred assets if:

- ▶ The applicant or the applicant's authorized representative failed to report a transfer of assets at the time of application, or the enrollee or authorized representative failed to report a transfer within 10 days

AND

- ▶ MA was approved and long term care services were paid by the MA program during a period of ineligibility

AND

- ▶ The person who received the transfer (the transferee) knew or should have known that the transfer was being made by a resident of a long term care facility or was receiving that level of care in the community at the time of the transfer.

OR

- ▶ The person who received the transfer knew of or should have known that the transfer was being made to assist the client to qualify for or retain MA eligibility.

OR

- ▶ The person who received the transfer actively solicited the transfer with the intent to assist the person to qualify for or retain eligibility for MA.

The maximum amount that can be collected under a cause of action is the cost of LTC services received during the period of ineligibility OR the value of the transferred asset, whichever is less. See §0909.27.09 (Determining Uncompensated Value).

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When an enrollee transfers assets resulting in a penalty period, determine the penalty period beginning with the month after the month of the transfer. Begin ineligibility for LTC services with the 1st month of the penalty period for which you can give 10-day notice. The notice must state that the enrollee will be ineligible for LTC services but may remain eligible for other MA services. Do not apply the penalty period retroactively.

EXAMPLE:

Myrtle resides in an LTC. On April 10, her authorized representative reports an asset transfer in **December** that would result in 5 months of ineligibility (January-May). Give 10-day notice to apply the remainder of the penalty to LTC services for May. Because the transfer was not reported timely, refer the case to the county attorney for a possible cause of action.

GAMC:

Begin the ineligibility period for enrollees in the month the transfer was reported or, if not reported, in the month the county agency discovers the transfer. Close the case for the first month for which you can give 10-day notice.

Begin the ineligibility period for applicants in the first month in which the client could have been eligible for GAMC payment of incurred medical expenses. **If there is partial month ineligibility, apply a penalty to services equal to the penalty amount.**

The period of ineligibility may exceed 30 months.

There is no ineligibility period for GHO.

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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.

Allow a deduction from unearned income for costs necessary to secure the payments, such as attorney's fees, if these costs are withheld from the ongoing payment under a legal agreement.

Do not allow a deduction for repayment of any other debt. See §0911.03 (Unavailable Income) for information on money withheld to recoup overpayments. Submit a HealthQuest if you are not sure whether to allow a particular deduction.

EXAMPLE:

William receives Workers Compensation (WC). The gross biweekly payment is \$720. \$140 is withheld for attorney's fees incurred when obtaining the WC benefits. William signed an agreement to allow repayment of the fees from his benefits, as a condition of the attorney accepting the case. Allow the \$140 deduction. William also has \$20 deducted for payment of an old credit card debt. Do not allow the \$20 deduction.

- ▶ 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

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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).

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See §0911.09.03 (Self-Employment Income) for general provisions which apply to all programs.

MinnesotaCare:

See §0911.09.03.03 (Self-Employment Income--MinnesotaCare).

MA/GAMC:

Use the previous year's tax returns to determine net self-employment income. Follow MinnesotaCare if the business did not file taxes or has had a substantial change since the last tax return was filed.

METHOD A:

The following expenses are non-allowable. Add these amounts to the net profit shown on the tax returns to determine countable self-employment income:

- ▶ Carry over net operating loss (NOL) from a previous tax year.
- ▶ Personal federal, state, and local income taxes.
- ▶ The self-employed client's share of FICA. Allow the employer's share of FICA payments made for employees who are not members of the MA or GAMC household.
- ▶ Money set aside for the self-employed person's own retirement.
- ▶ Work-related personal expenses.
- ▶ Payments on principal of loans. Allow interest payments as a self-employment expense.
- ▶ Capital expenditures. Capital expenditures are payments made to purchase or improve property with a useful life of more than 1 year.
- ▶ Charitable contributions.
- ▶ Depreciation.

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SELF-EMPLOYMENT INCOME--MA/GAMC

0911.09.03.05

- ▶ Wages or other benefits paid to a member of the MA or GAMC household, regardless of whether that person is applying for or receiving MA or GAMC.
- ▶ Any expenses not allowed by the IRS, unless specifically authorized by this manual.
- ▶ The costs of building an inventory. Deduct the cost of a product only after it sells.
- ▶ Personal business and entertainment expenses.

Count capital gains and losses if they are part of the self-employment operation. If they can be distinguished from other business income, count them only if the household expects similar gains or losses in the coming year.

If an applicant or enrollee operates more than 1 self-employment business, deduct a loss from 1 business from any profit of a 2nd business.

METHOD B:

Do not deduct expenses the IRS does not allow as a self-employment expense.

Deduct a self-employment loss from other household earned income.

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MinnesotaCare:

People may receive a 1-time payment covering several retroactive months when SSI or RSDI is approved. Do not count the retroactive payments received for a previous period.

EXAMPLE:

Roland is enrolled in MinnesotaCare. On his annual renewal due for December, he reports that he was approved for RSDI. He received a retroactive lump sum payment of \$3,000 in October covering the months of May-October. He will receive \$500 per month beginning in November. Do not count the \$3,000 in determining his eligibility or premium amount for the new eligibility period because it is a 1-time payment and will not be received during the next 12 months.

MA/GAMC:

METHOD A:

Exclude retroactive lump sum payments of SSI and all other lump sum income (including RSDI) of an SSI recipient even if the lump sum is a retroactive payment for a period for which the SSI recipient received MA. However, count any portion of an RSDI lump sum payment designated as dependent benefits as unearned income to the dependent in the month received.

Count retroactive lump sum RSDI payments for people who do not receive SSI as unearned income in the month received and an asset in the following month if retained.

METHOD B:

Exclude retroactive lump sum payments of SSI as income and assets in the month received.

Count retroactive RSDI lump sum payments as unearned income in the month received. See §0911.09.23 (Lump Sum Income) for more information on budgeting lump sums.

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Exclude as an asset for 6 months any retroactive SSI or RSDI lump sum payments if retained after the month of receipt. This includes money deposited in a separate dedicated account for the medical, health, educational and disability related needs of a child. Follow §0909.21.03 (Supplemental Needs Trusts) if the retroactive payment is issued under the Sullivan vs. Zebley decision and is used to fund a supplemental needs trust.

For Medicare Part B reimbursements for non-LTCF recipients:

- ▶ If Medicare Part B premiums paid by the client were used as an MA spenddown expense (this would occur when clients add SLMB coverage to MA retroactively), count the lump sum reimbursement as income in the month received. Do not count a lump sum Medicare Part B reimbursement when Part B was not used as a MA spenddown expense in the MA computation for the months which the reimbursement covers. See §0907.21.09.05 (Medicare Supplement Programs: SLMB) and §0910.05.05 (Medicare Premium Payment).

For Medicare Part B reimbursements for LTCF recipients:

- ▶ Count a lump sum Medicare premium reimbursement due to Buy-In eligibility in the month of receipt. This is because the gross RSDI amount is not budgeted for these clients until it is actually received. See §0913.13 (Long Term Care Spenddown Calculation) and §0910.05.05 (Medicare Premium Payment).

See §0902.21 (Glossary: Insurance...) for a definition of lump sums.

MinnesotaCare:

Exclude lump sum income. See §0911.05.03 (Excluded Income--Program Provisions).

Minnesota Rule 9505.0065 subp. 3b

MA/GAMC:

See §0911.09.15.05 (Lump Sum RSDI and SSI Payments) for instructions on treatment of lump sum retroactive payments from the Social Security Administration, including Medicare Part B reimbursements.

Treat other lump sums as income in the month received and an asset if retained beyond the month of receipt. Do not change eligibility or spenddown amounts for previous or current months, or for future months for which you cannot give 10-day notice, based on receipt of an unanticipated lump sum. Lump sums may affect eligibility after the month of receipt for people who have an asset limit if the lump sum creates excess assets. Lump sums may also result in termination of eligibility before the end of the 6-month budget period **for people who were open with 6-month spenddowns before receipt of the lump sum.**

EXAMPLE:

Maria, Lawrence, and their 2 children are eligible for MA without a spenddown for the current certification period of January-June. On May 5, they report they received a \$20,000 insurance settlement on April 25. Recompute eligibility for the current certification period. **If the lump sum creates a 6-month spenddown which they cannot meet, determine eligibility on a monthly basis for the remainder of the certification period. If anticipated monthly income remains below the appropriate standard for each household member, (100% FPG for Maria and Lawrence; 150% FPG for the children) income eligibility continues. If ongoing income is over the appropriate standard in one or more of the remaining months, use a manual monthly spenddown for those months. Review assets for Maria and Lawrence. Terminate their coverage if they do not properly reduce the excess. See §0909.29.03 (Excess Assets--Enrollees).**

If the case was open with a 6-month spenddown for January-June and the lump sum resulted in an increased spenddown, determine if the household has bills to meet the higher amount (such as unused old unpaid bills). If not,

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terminate MA effective June 1, the first month for which you can give 10-day notice.

EXAMPLE:

Brett is eligible for MA with a monthly automated spenddown for the current certification period of July-December. On September 10, he reports he won \$5,000 at a casino in August. It is not possible to increase his August spenddown retroactively. He must reduce assets to within the \$3,000 limit to retain eligibility for October. See §0909.29.03 (Excess Assets--Enrollees).

EXAMPLE:

Marcus is eligible for MA without a spenddown for the certification period of January-June. He is approved for RSDI in February and receives a lump sum retroactive payment of \$12,000. He is unable to meet a 6-month spenddown with the lump sum included. His ongoing RSDI amount exceeds the standard, but he has regular medical bills sufficient to meet a monthly spenddown for March-June. Since he previously had no spenddown, he can choose an automated monthly spenddown for the remainder of the budget period.

Count non-excluded lump sums when calculating the spenddown for the month of receipt for people who are eligible using a manual monthly or an LTC spenddown. Adjust the LTC spenddown if a lump sum is reported after the month of receipt.

NOTE:

If the lump sum creates a combination LTC/medical spenddown, adjust the LTC spenddown only. Do not establish a medical spenddown retroactively.

Allow the following deductions from the lump sum:

- ▶ Costs associated with getting the lump sum, such as attorney's fees.
- ▶ Any portion of the lump sum earmarked for and used to pay medical expenses not covered by insurance or any Minnesota health care program.
- ▶ Any portion of the lump sum recovered by Benefit Recovery.
- ▶ Any portion of the lump sum earmarked for and used to pay funeral and burial costs.

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

LUMP SUM INCOME

0911.09.23

Anticipate recurring income received less often than monthly when determining initial and continuing eligibility.

EXAMPLE:

Elmer receives RSDI monthly. He also receives a rental payment every June and December. His budget period is January-June. Count the RSDI and the rental payment in the 6-month certification period. If Elmer has a spenddown, help him choose the most beneficial method.

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MinnesotaCare:

See §0911.11 (Computing Countable Income--MinnesotaCare) and §0911.11.01 (Computing Income--MinnesotaCare - Part 2).

MA/GAMC:

Base eligibility on:

- ▶ Actual income received in the month(s) for which you are determining eligibility. Use this method for retroactive months and manual monthly spenddowns. See §0904.07.09 (Eligibility Begin Date) and §0913.11 (Manual Monthly Spenddown Calculation).

OR

- ▶ Income anticipated to be received in the month(s) for which you are determining eligibility. Use this method whenever you determine eligibility for a future month(s).

OR

- ▶ A combination of actual and anticipated income. Use this method for people requesting retroactive and continuing coverage.

EXAMPLE:

Abigail applies for MA in April. She is requesting retroactive coverage beginning in January. Her 6-month certification period is January-June. The worker processes the application on May 2. Determine eligibility for the certification period using actual income received in January, February, March, and April, and anticipated income for May and June.

When people who are approved for a type of cash assistance that includes automatic health care coverage request retroactive MA, use actual income for the retroactive months. The household will be automatically eligible for the cash months. See §0913.19 (Shortened Spenddown).

Use actual dollars and cents to calculate income. Truncate the final monthly figure.

When unvarying income is received monthly, such as RSDI or SSI, use the actual countable monthly benefit amount to anticipate income unless you know the amount will change during the certification period. When unvarying income is received more often than monthly, such as Reemployment Insurance:

- ▶ Multiply income received twice monthly by 2.
- ▶ Multiply income received every 2 weeks (biweekly) by 2.16, and income

received every week (weekly) by 4.3.

OR

- ▶ Determine the number of receipt dates expected during the remainder of the certification period. Multiply the biweekly or weekly amount by the number of receipt dates to anticipate the total for the certification period. Divide by the number of months in the period to determine a monthly amount (if necessary).

Use the method that most accurately reflects income expected during the certification period. In most cases, the results will be similar.

EXAMPLE:

Dave applies for GAMC in May. He is not requesting retroactive coverage. He receives Unemployment Insurance of \$125 per week every other Friday. He received a check on May 8 and expects his next check May 22. Based on this schedule, he anticipates receiving biweekly checks on the following dates for the remainder of the certification period: June 5 and June 19; July 3, July 17, and July 31; August 14 and August 28; September 11 and September 25; and October 9 and October 23. Anticipate income by either:

- Multiplying the biweekly payment of \$250 by 2.16 to arrive at a monthly average of \$540 and anticipated income of \$3,240 for the certification period.

OR

- Multiplying the total number of checks expected for the certification period of May-October (13) by the check amount (\$250) to anticipate income of \$3,250 for the certification period.

EXAMPLE:

Andrea applies for MA on April 5. She is requesting MA retroactive to January. She receives \$80 every Friday from her parents to help with living expenses. She received 5 checks in January, 4 each in February and March, and 1 so far in April. Anticipate weekly income by either:

- Multiplying the weekly payment by 4.3 to arrive at a monthly average of \$344 for April, May, and June. Determine income for the 6-month certification period by adding \$344 for April, May, and June to the actual amounts received in January, February, and March. \$400 (January) + \$320 (February) + \$320 (March) + \$344 + \$344 + \$344 results in anticipated income of \$2,072 for the certification period.

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COMPUTING COUNTABLE INCOME--MA/GAMC

0911.11.03

OR

- Determining the actual amounts expected to be received in April, May, and June and adding this total to the actual amounts received in January, February, and March. If there are 4 Fridays in April, 5 in May, and 4 in June, the anticipated amount is \$1,040 (13 x \$80). Adding \$1,040 + \$400 + \$320 + \$320 results in anticipated income of \$2,080 for the certification period.

Also see §0911.11.05 (MA/GAMC Varying Income).

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All of the health care programs consider countable income in establishing eligibility and benefit levels. All of the programs begin the determination with the household's countable income. See §0911 (Income).

MinnesotaCare considers the household's gross income to establish initial **and continuing** eligibility and to determine the premium amount. See §0912.03 (MinnesotaCare Income Eligibility).

MA and GAMC consider net income for most people. MA and GAMC income deductions and income standards vary among different populations. See §0912.05 (Determining Net Income).

Income standards for the health care programs are based on the federal poverty guidelines (FPG). These guidelines are updated annually by the federal government and are effective in **July** of each year. See §0912.07 (Income Standards).

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MinnesotaCare:

Compare applicants' countable gross income to the income limit that applies to their eligibility group status and household size. See §0907 (Eligibility Groups and Bases of Eligibility). There are 3 eligibility standards:

- ▶ 275% FPG for pregnant women and children under 21. See §0912.07.275 (275 Percent of FPG Standards).
- ▶ 275% FPG or \$50,000 gross annual income, whichever is less, for parents, caretakers, legal guardians and foster parents, except for pregnant women.
- ▶ 175% FPG for adults with no children in the household. Adults without children with incomes no greater than 75% FPG qualify for more benefits than those with incomes over 75% FPG. Adults without children with incomes over 75% FPG but no more than 175% FPG qualify for the MinnesotaCare Limited Benefit (MLB) set. See §0912.07.075 (75 Percent of FPG Standards) and §0912.07.175 (175 Percent of FPG Standards).

For households with minor children, also compare gross income to the 150% FPG standard. See §0912.07.150 (150 Percent of FPG Standards). This standard is not used to determine eligibility but affects the following factors:

- ▶ Children's group status and insurance barriers. See §0907 (Eligibility Groups and Bases of Eligibility) and §0910 (Other Health Coverage).
- ▶ Whether a child pays a fixed premium or a sliding scale premium. See §0913 (Premiums and Spenddowns).

Household income must be equal to or less than the income eligibility standard that applies at the time of initial enrollment. See §0912.03.03 (MinnesotaCare Excess Income) **for instructions on what action to take if income increases beyond the applicable limit after enrollment.**

If household composition changes from families and children to adults without children, or from adults without children to families with children, between the date the household submits an application and the date you process the application, use the household composition at the time of processing.

EXAMPLE:

MinnesotaCare receives an application for Penny and her 20-year-old son Jack

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MINNESOTACARE INCOME ELIGIBILITY

0912.03

on July 17. Jack turns 21 on August 2. The **worker** processes the application on August 10. Consider both Penny and Jack as Group 3 adults.

EXAMPLE:

Paula applies for MinnesotaCare for herself on July 17. On July 31, the court makes her the legal guardian of her 13-year-old niece. The **worker** processes the application on August 3. Apply the families and children income standard of 275% FPG or \$50,000 since this will be a families with children household on the date eligibility begins.

If people reapply after a break in coverage of 1 month or more, compare current income to the standard that applies to the household size and type. People are ineligible if current income exceeds the standards.

M. S. 256.9366 subd. 1

M. S. 256.9354 subd. 5

M. S. 256.9366 subd. 4

M. S. 256.9357 subd. 1

MA/GAMC:

No provisions.

MinnesotaCare:

At the time of renewal, **when increased income is reported**, or when a new household member is added to an existing case, evaluate households with gross annual income above the MinnesotaCare income standard for their household size. Terminate coverage for the **end of the month following the month in which excess income is determined** for:

- ▶ Adults without children whose income exceeds 175% FPG, including adults who lose parental status between renewals.
- ▶ **Parents and caretakers, other than pregnant women, whose gross annual income exceeds 275% FPG but is less than \$50,000.**

Terminate coverage for the first available month for:

- ▶ **Parents and caretakers, other than pregnant women, whose gross annual income exceeds \$50,000, regardless of whether income is over 275% FPG.**

Pregnant women with incomes over 275% FPG remain eligible through the end of the 60-day post partum period.

Take the following steps for all children under age 21 who report income over 275% FPG:

- ▶ **Determine if 10% of their gross annual income is less than the premium amount for a policy with a \$500 deductible available through Minnesota Comprehensive Health Association (MCHA). See §0912.03.05 (Annual MCHA Premiums). Include all household members in the household size whether or not they are enrolled in MinnesotaCare.**
- ▶ **If 10% of the income is equal to or greater than the annual MCHA premium, terminate coverage for the end of the month following the month in which excess income is determined.**
- ▶ **If 10% of the gross annual income is less than the household's MCHA premium, eligibility continues. This is known as the MCHA exemption.**
- ▶ **If income later increases so that 10% of the gross annual income is equal to or greater than the MCHA premium, the children lose the MCHA exemption. Send the MinnesotaCare Over Income Letter (DHS 3407) advising the household that their MinnesotaCare will end in 12 months. Start the 12-**

month notice period effective the 1st of the next month.

EXAMPLE:

A household consists of John, age 35, Abby, age 31, and their minor child, age 12. When the worker processes their renewal on March 15, the household's gross annual income is determined to exceed the MinnesotaCare income standard of 275% FPG for a family of 3. Gross income remains under \$50,000. Terminate coverage for the parents effective April 30 (the month following the month they are determined to have excess income). To determine continued eligibility for the child, calculate the household's annual MCHA premium by adding together the following amounts from §0912.03.05 (Annual MCHA Premiums):

For Abby, age 31, add the amount for an adult age 30 to 34.

For John, age 35, add the amount for an adult age 35 to 39.

For the dependent child, add the amount for a child under age 15.

Add these amounts to determine the household's annual MCHA premium.

Multiply the household's gross annual income by 10% and compare that figure to the MCHA premium. If 10% of the annual income is greater than the MCHA premium, terminate coverage for the child effective April 30. If 10% of the annual income is less than the MCHA premium, eligibility continues for the child.

When the child's next renewal is processed on March 15 of the following year, income has increased so that 10% of the annual income now exceeds the household's MCHA premium. Send the DHS 3407 notifying the household that the child's coverage will end in 12 months. The 12-month period begins April 1.

EXAMPLE:

Aman, his wife and 3 daughters receive MinnesotaCare. At the time of their annual renewal, processed on March 15, gross income exceeds \$50,000. It also exceeds the 275% FPG standard for the household size. Aman and his wife are no longer eligible for MinnesotaCare. Terminate their coverage effective March 31 (the first available month). The children may remain eligible if 10% of their gross income is less than the premium amount for an MCHA policy with a

\$500 deductible. If 10% of gross income is equal to or greater than the applicable MCHA premium, **terminate the children's coverage effective April 30.**

NOTE:

Until February 1, 2004, children whose income increased to over 275% FPG but who did not meet the MCHA exemption were eligible for an 18-month extended eligibility period. Children who were in an 18-month extended eligibility period on February 1, 2004, are entitled to complete the full 18-month period.

Take the following steps when a household that **receives the MCHA exemption later reports decreased income OR requests to add a new household member before the next renewal:**

- ▶ Determine if the new income amount remains equal to or greater than the appropriate standard. If the new income amount is now under the standard, send the MinnesotaCare Income Change Evaluation Letter (DHS 3408) to notify the household that they will not be closed.
- ▶ If income remains equal to or greater than the standard, determine if 10% of the new income amount **continues to be less** than the MCHA premium for their household. If **it is**, send the DHS 3407 to **let the household know** that they will **continue to receive coverage**. If **it is more** than the MCHA premium, send the DHS 3407 to let the household know that they will be closed in 12 months.

Take the following steps when a household that **receives the 12-month extension later reports decreased income OR requests to add a new household member before the next renewal**. Adults can be added to the household when a case is **over income**, but not to MinnesotaCare coverage, unless the new household member causes income to decrease below the applicable standard.

- ▶ **If the income is under the standard, end the 12-month over income period. Send the DHS 3408.**
- ▶ **If the income is over the standard and 10% of the new income amount is less than the MCHA premium, end the 12-month over income period. Send the DHS 3408.**

-
- ▶ If the new income is equal to or greater than the appropriate standard AND 10% of the new income is equal to or greater than the applicable MCHA premium, the household remains in the original 12-month over income period. Coverage for new members added to the household will end at the same time as the rest of the household.

Reevaluate the household's income at the next renewal, when a change in income is reported, or at the end of the 12-month extension period. See §0905.05 (Annual Renewal--Eligibility).

Reevaluate the household's income at the end of the 12-month extension period.

- ▶ If the household reports that employment and income have not changed, document in case notes and cancel MinnesotaCare for the first month for which you can give 10-day notice.
- ▶ If the household reports a change in employment or income, request verification of the new income for the past 30 days. Document the request in case notes. Allow the household 30 days to return the income verification.
- ▶ If the household fails to submit verification within 30 days of the request, cancel MinnesotaCare for Over Income for the first month for which you can give 10-day notice.
- ▶ If the household submits verification of new income within 30 days, determine if the new income is within MinnesotaCare limits.
 - If the household's income continues to be equal to or greater than the applicable standard AND 10% of the household's income continues to be equal to or greater than the household's annual MCHA premium, give the household 10-day notice and cancel MinnesotaCare at the end of the month. Mail a DHS 3408 with the results of the evaluation and a Certificate of Creditable Coverage (COCC) to the household. See §0916.23 (Certificates of Creditable Coverage).
 - If the household's income is less than the applicable standard OR 10% of the income is less than the household's annual MCHA premium, send the DHS 3408 to notify the household that they will not be canceled.

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MDHS HEALTH CARE PROGRAMS MANUAL

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MINNESOTACARE EXCESS INCOME

0912.03.03

Do not cancel pregnant women and infants who have auto newborn eligibility for being over income. See §0907.09.03 (MinnesotaCare Auto Newborns) and §0907.09 (MinnesotaCare Pregnant Women).

M.S. 256L.07 subd. 1b, c

MA/GAMC:

No provisions.

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MDHS HEALTH CARE PROGRAMS MANUAL

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ANNUAL MCHA PREMIUMS

0912.03.05

MCHA Annual Premiums effective 7-1-04:

For emancipated minors or children on their own MinnesotaCare case who are under age 15	\$2,119.68	
For emancipated minors or children on their own MinnesotaCare case who are age 15 to age 20	\$2,123.88	
For each adult age 21 to 29	\$2,123.88	
For each adult age 30 to 34	\$2,334.84	
For each adult age 35 to 39	\$2,522.04	
For each adult age 40 to 44	\$2,862.60	
For each adult age 45 to 49	\$3,534.24	
For each adult age 50 to 54	\$4,583.40	
For each adult age 55 to 59	\$5,786.40	
For each adult age 60 to 64	\$6,317.64	
For each adult age 65 and older	\$6,318.60	
For households with 1 dependent child	\$1,741.68	
For households with 2 dependent children	\$3,483.36	
For households with 3 or more dependent children	\$5,225.04	

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MinnesotaCare:

No provisions.

MA:

Also see §0912.05 (Determining Net Income).

METHOD A:

LTCF RESIDENTS:

See §0913.05 (Which Spenddown Type to Use) to determine who must use an LTC spenddown and the type of spenddown. Then allow the income deductions for the appropriate type of LTC spenddown.

See the following for more information about LTC spenddowns:

§0913.13	Long Term Care Spenddown Calculation.
§0913.15	Combination LTC/Medical Spenddown.
§0913.17	Begin/End Use of LTC Spenddown - Part 1.
§0913.17.01	Begin/End Use of LTC Spenddown - Part 2.
§0913.17.03	Begin/End Use of LTC Spenddown - Part 3.

NON-LTCF RESIDENTS:

1. Work expense deductions from earned income for
 - Children ages 2-18 using the 150% FPG standard.
 - Pregnant women and infants who are not eligible as auto newborns.See §0912.05.05.
2. Earned income disregard for
 - Children ages 19 and 20.
 - Parents and caretakers.
 - Children ages 2-18 with spenddowns.See §0912.05.09.
3. Dependent care deduction. See §0912.05.07.
4. Child support deduction. See §0912.05.27.

METHOD B:

MA FOR LTCF RESIDENTS AND PEOPLE RECEIVING ELDERLY WAIVER (EW) SERVICES WHO HAVE A COMMUNITY SPOUSE:

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See §0913.05 (Which Spenddown Type to Use) to determine who must use an LTC spenddown. Then allow the income deductions for the appropriate type of LTC spenddown.

See the following for more information:

§0913.13	Long Term Care Spenddown Calculation.
§0913.13.03	LTC Spenddown--EW With Community Spouse.
§0913.15	Combination LTC/Medical Spenddown.
§0913.17	Begin/End Use of LTC Spenddown - Part 1.
§0913.17.01	Begin/End Use of LTC Spenddown - Part 2.
§0913.17.03	Begin/End Use of LTC Spenddown - Part 3.
§0912.05.25	Allocations.

QMB OR SLMB FOR LTCF RESIDENTS:

1. Widow and widower's disregard. See §0912.05.17.
2. Pickle disregard. See §0912.05.23.
3. Disabled adult children disregard. See §0912.05.19.
4. QMB/SLMB/QI COLA disregard. See §0912.05.15.
5. Income used to fulfill an approved Plan to Achieve Self Support for disabled or blind people. See §0912.05.11.
6. Earned income disregard for blind or disabled student children. See §0912.05.09.09.
7. Standard disregard. See §0912.05.13.
8. The 1st \$65 of the earned income disregard. See §0912.05.09.05.
9. Work expense deduction for disabled clients. See §0912.05.05.
10. One-half the remaining earned income. See §0912.05.09.05.
11. Work expense deduction for blind clients. See §0912.05.05.
12. Spousal allocation. See §0912.05.25.03.
13. Family member allocation. See §0912.05.25.05.

MA FOR NON-LTCF RESIDENTS:

1. Disabled widow/widower disregard. See §0912.05.21.
2. Widow and widower's disregard. See §0912.05.17.
3. Pickle disregard. See §0912.05.23.
4. Disabled adult children disregard. See §0912.05.19.
5. Income used to fulfill an approved Plan to Achieve Self Support for disabled or blind people. See §0912.05.11.

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6. Earned income disregard for blind or disabled student children. See §0912.05.09.09.
7. The 1st \$65 of the earned income disregard. See §0912.05.09.05.
8. Work expense deduction for disabled clients. See §0912.05.05.
9. One-half the remaining earned income. See §0912.05.09.05.
10. Work expense deduction for blind clients. See §0912.05.05.

QMB OR SLMB FOR NON-LTCF RESIDENTS:

1. Widow and widower's disregard. See §0912.05.17.
2. Pickle disregard. See §0912.05.23.
3. Disabled adult children disregard. See §0912.05.19.
4. QMB/SLMB/QI COLA Disregard. See §0912.05.15.
5. Income used to fulfill an approved Plan to Achieve Self Support for disabled or blind people. See §0912.05.11.
6. Earned income disregard for blind or disabled student children. See §0912.05.09.09.
7. Standard disregard. See §0912.05.13.
8. The 1st \$65 of the earned income disregard. See §0912.05.09.05.
9. Work expense deduction for disabled clients. See §0912.05.05.
10. One-half the remaining earned income. See §0912.05.09.05.
11. Work expense deduction for blind clients. See §0912.05.05.

GAMC:

No provisions.

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MinnesotaCare:

No provisions.

MA:

METHOD A:

To determine whether children ages 2-18 meet the 150% FPG standard, subtract \$90 from the earned income of the child and the earned income of each person whose income is deemed to the child. Subtract the first \$90 of each person's gross earnings. Do not reduce income to less than 0.

EXAMPLE:

Tracy applies for MA for her 4-year-old son, Alex. Tracy earns \$1,500 per month. Alex earns \$80 per month as a child model. Subtract \$90 from Tracy's income, leaving \$1,410. Also deduct any child care or court ordered child support she pays. See §0912.05.07 (Dependent Care Deduction) and §0912.05.27 (Child Support Deduction). Count 0 earned income for Alex.

If a child ages 2-18 does not meet the 150% FPG standard, do not allow the \$90 work expense when determining whether the child can spend down to 100% FPG.

For pregnant women and infants through the month of their 2nd birthday who are not eligible as auto newborns:

1. Subtract the amounts below from earned income only. Do not allow any other deductions.

Household Size	Work Expense Deduction for Pregnant Women and Infants
1	\$136
2	\$140
3	\$145
4	\$149
5	\$156
6	\$161
7	\$165

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8	\$170
9	\$177
10	\$181
Each Additional Person	\$ 5

If income after the work expense deduction is equal to or less than 275% FPG for pregnant women or 280% FPG, stop. There is no spenddown.

2. If income exceeds the applicable standard after allowing the work expense deduction, the pregnant woman or infant must spend down to 100% FPG. Do not allow the work expense deduction for this step. Allow the dependent care deduction, the 17% earned income disregard and the deduction for child support paid if applicable. See §0912.05.07 (Dependent Care Deduction), §0912.05.09 (Earned Income Disregards--Method A) and §0912.05.27 (Child Support Deduction).

EXAMPLE:

Jamal and Sheila, a married couple, apply for MA for their 1-year-old son Alex. Both Jamal and Sheila are employed and have day care expenses. Neither pays child support to non-household members. No one in the household has received MA before.

First deduct \$145 from the combined gross earnings. If income after the deduction is equal to or less than 280% FPG, Alex is eligible for MA without a spenddown.

If income remains above 280% FPG after the deduction, Alex must spend down to the 100% of FPG standard. See §0912.07.100 (100 Percent of FPG). Recompute Jamal and Sheila's income without the \$145 work expense deduction. Allow the dependent care deduction and the 17% earned income disregard.

METHOD B:

Clients who use Method B because of age:

- ▶ Do not allow a deduction for work expenses.

Clients who use Method B because of disability:

- ▶ Allow **IMPAIRMENT RELATED** work expenses as a deduction. The client must reasonably show the expenses relate directly to the disability and are necessary to produce the earned income. (For instance, do not allow expenses for a

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transportation method also used by non-disabled people such as a bus or unmodified vehicle.) If transportation expenses are allowed, use the same rate allowed as a flat rate deduction for self-employed people. See §0911.09.03.09 (Self-Employment Transportation).

Clients who use Method B because of blindness:

- ▶ Allow any work expense as a deduction when a client can reasonably show it relates directly to producing earned income. If transportation expenses are allowed, use the same rate allowed as a flat rate deduction for self-employed people. See §0911.09.03.09 (Self-Employment Transportation).

Do not allow a deduction for income or FICA taxes withheld from earnings.

See §0912.05.03 (Determining Net Income--Order of Deductions) for the order in which to apply the disregards and deductions.

Do not allow work expense deductions for items reimbursable or paid for by another source. When an expense qualifies both as a work expense and a PASS deduction, the client must choose whether to allow the expense as a PASS deduction or a work expense deduction. See §0912.05.11 (Plan to Achieve Self-Support).

GAMC:

No provisions.

This version of the manual is no longer in effect as of December 1, 2006.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

No provisions.

MA:

METHOD A:

Subtract 17% of the gross earned income for up to 4 months of the following people if their income is considered in determining eligibility. See §0908.07 (Household Composition: Deeming).

- ▶ Children ages 19 and 20
- ▶ Parents and caretakers
- ▶ Children under age 19 who have spenddowns

There is no earned income disregard for children ages 2-18 using the 150% FPG standard.

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

EXAMPLE:

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

Pregnant women and infants through the month of their 2nd birthday and children ages 2 through 18 whose income is equal to or below the applicable standard (275% FPG for pregnant women; 280% FPG for children through the month of their 2nd birthday; 150% FPG for children ages 2 through 18) do not receive an earned income disregard because the disregard is included in the standard. See §0912.05.05 (Work Expense Deductions).

If a pregnant woman has earned income while receiving MA using the 275% FPG standard, the disregard cycle continues to run. This also applies to a spouse or parent whose income is deemed to a pregnant woman, infant under age 2 or child ages 2 through 18. This does NOT apply to infants who are eligible as auto newborns, because no income is deemed to these infants. See §0907.19.05.03 (MA Basis: Auto Newborn).

If a pregnant woman's gross income exceeds 275% FPG, or an infant's income exceeds

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280% FPG after applying the work expense deduction in §0912.05.05 (Work Expense Deduction), the 17% disregard may be used to spend down to 100% of the FPG standard. See §0912.07.100 (100 Percent of FPG Standard).

EXAMPLE:

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

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

EXAMPLE:

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

If a child ages 2 through 18 has income that exceeds **150%** FPG, the 17% disregard may be used to spend down to 100% FPG. See §0912.07.100 (100 Percent of FPG Standard).

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

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

GAMC:

No provisions.

This version of the manual is no longer in effect as of December 1, 2006.

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 \$469 beginning 7-1-04 (\$455 from 7-1-03 through 6-30-04) from the total of expenses in step 3. The result is the excess shelter allowance.
4. Add \$1,562 beginning 7-1-04 (\$1,515 from 7-1-03 through 6-30-04) to the

excess shelter allowance. The result, up to a limit of \$2,319 (\$2,267 from 1-1-03 through 12-31-03), is the maximum monthly income allowance to the community spouse.

If there is a court order for support in excess of \$2,319 (\$2,267 from 1-1-03 through 12-31-03), 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 \$469 from \$687. The result, \$218, is the excess shelter amount.
4. Add \$218 to \$1,562. The result, \$1,780, is the maximum monthly allocation amount.
5. Subtract Leo's monthly income of \$1,050 from \$1,780. The result, \$730, is the actual allocation amount. Allow this amount in Norma's LTC budget. See §0913.13 (Long Term Care Spenddown Calculation).

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MDHS HEALTH CARE PROGRAMS MANUAL

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ALLOCATIONS--COMMUNITY SPOUSE

0912.05.25.03

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.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

No provisions.

MA:

Also see §0912.05.25 (Allocations) and §0912.05.25.03 (Allocations--Community Spouse).

To calculate the amount of a client's allocation deduction for a child under 18 not living with the community spouse (which includes a child under 18 living with the LTC client's former spouse), follow the steps below.

1. Determine the child's gross earned and unearned income. If two or more children live together, but apart from the community spouse, determine their incomes separately. Add all income received less often than monthly during a calendar year and divide by 12 to determine a monthly income figure. Consider interest earned to be income.

Allow deductions from income if the child has no access to the income or control over the deduction. Do not allow MA disregards and exclusions.

2. If calculations were done for two or more children, combine the individual net incomes.
3. Subtract the total countable income from the appropriate standard in the 100% of FPG table in §0912.07.100 (100 Percent of FPG) based on the household size. The household size is the number of children living together. This is the amount of the client's allocation deduction.

EXAMPLE:

Ronald resides in an LTCF. He has two children, Jeremy, age 17, and Anne, age 15, who live with his former wife. Jeremy is employed part-time earning \$400 per month. FICA taxes of \$31 are deducted. Anne has no income.

Determine an allocation from Ronald's income as follows:

1. Determine Jeremy's countable income by deducting the \$31 FICA tax. He has no control over this deduction.
2. Determine combined income for Jeremy (\$369) and Anne (\$0) for a total of \$369.

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3. Subtract \$369 from the standard for a household size of 2 in §0912.07.100 (100 Percent of FPG), or **\$1,041**. The result, **\$672**, is the maximum allocation amount. Allow this amount in Ronald's LTC budget.

NOTE:

If Ronald has court-ordered child support in excess of **\$672** garnished from his income, allow the excess up to a maximum of \$250. See §0913.13 (Long Term Care Spenddown Calculation).

Use the steps below to calculate the amount of a client's allocation deduction for any of the following people who live with the community spouse:

- ▶ Children under 21.
 - ▶ Children over 21 claimed as a dependent for tax purposes.
 - ▶ Parents claimed as dependents.
 - ▶ Siblings of the client or the community spouse claimed as dependents.
1. Determine the total of each family member's gross earned and unearned income separately. Do not deem the income of one family member to another. Add all income received less often than monthly during a calendar year and divide by 12 to determine a monthly income figure. Consider interest earned to be income. Do not allow MA disregards and exclusions.
 2. Subtract the amount of gross income from **\$1,562** beginning **7-1-04** (**\$1,515** from **7-1-03** through **6-30-04**).
 3. Divide the result by 3 and round up to the nearest dollar. This is the amount of the client's allocation deduction.

EXAMPLE:

Sandra resides in an LTCF. Her 18-year-old daughter Marcy lives with Sandra's husband Steve. Marcy receives RSDI of \$250 monthly because of Sandra's disability. She is employed part time, earning \$300 per month.

Calculate an allocation for Steve as the community spouse following the steps in §0912.05.25.03 (Allocations--Community Spouse). Calculate an

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allocation for Marcy as follows:

1. Determine Marcy's gross monthly income by adding the \$250 RSDI payment to her gross earnings of \$300 for a total of \$550.
2. Subtract \$550 from **\$1,562** for a result of **\$1,012**. |
3. Divide **\$1,012** by 3. The result, **\$338**, is the maximum allocation amount. Allow this amount as a deduction in Sandra's LTC budget. |
See §0913.13 (Long Term Care Spenddown Calculation).

Verify family members' income and expenses needed to determine allocations at the time of the initial eligibility determination. After the initial eligibility determination, only verify changes, including changes reported on 6-month or annual review forms. Inform clients and family members to report changes.

GAMC:

No provisions.

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MinnesotaCare:

Compare the total countable gross income of applicant households to the applicable standard.

For families with children, see §0912.07.275 (275 Percent of FPG Standards).

For adults without children, see §0912.07.175 (175 Percent of FPG Standards).

To determine children's group status and eligibility for the fixed premium, see §0912.07.150 (150 Percent of FPG Standards).

M.S. 256L.04 subd. 1, 7

MA:

Compare the total countable net income to the applicable standard for each person.

For pregnant women, see §0912.07.275 (275 Percent of FPG Standards). For information on eligibility requirements, see §0907.19.05 (MA Basis: Pregnant Women).

For infants through the month of their 2nd birthdays who are not eligible as auto newborns, see §0912.07.280 (280 Percent of FPG Standards).

For QWD, see §0912.07.200 (200 Percent of FPG Standards). For information on QWD eligibility, see §0907.21.09.07 (Medicare Supplement Programs: QWD).

For eligibility during the 2nd 6 months of TYMA, see §0912.07.185 (185 Percent of FPG Standards). For information on eligibility for TYMA, see §0907.19.11 (TMA/TYMA: 1st 6 Months).

For QI-2, see §0912.07.175 (175 Percent of FPG Standards) and §0912.07.135 (135 Percent of FPG Standards). To be eligible for QI-2 benefits, income must fall between these levels. See §0907.21.09.09 (Medicare Supplement Programs: QI).

For children age 2 through age 18, see §0912.07.150 (150 Percent of FPG Standards) and §0907.19.03 (Families and Children Basis: Child under 21). Children with incomes in excess of this standard may be eligible by spending down to 100% of FPG. See §0912.07.100 (100 Percent of FPG standard).

For SLMB, see §0912.07.120 (120 Percent of FPG Standards). For QI-1, see §0912.07.120 (120 Percent of FPG Standards) and §0912.07.135 (135 Percent of FPG

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Standards). Income must fall between these levels for QI-1 eligibility. For information on eligibility for SLMB and QI-1, see §0907.21.09.05 (Medicare Supplement Programs: SLMB) and §0907.21.09.09 (Medicare Supplement Programs: QI).

For children ages 19-20, parents/caretakers of dependent children, QMB and MA for people with blindness or disabilities or who are age 65 and over, see §0912.07.100 (100 Percent of FPG Standards). For information on eligibility for these groups, see 0907.19.03 (MA Basis: Child Under 21), 0907.19.07 (MA Basis: Parent/Caretaker), §0907.21 (MA Basis: Age 65 and Over/Blind/Disabled) and 0907.21.09.03 (Medicare Supplement Programs: QMB).

For MA for people who are age 65 and over or who have blindness or disabilities AND have incomes over 100% of FPG, see §0912.07.75 (75 percent of FPG). People in these groups may be eligible for MA by spending down to 75% of FPG. |

GAMC:

Use 75% FPG for all GAMC applicants and enrollees. See 0912.07.75 (75 Percent of FPG).

For GAMC Hospital Only (GHO), income must be between 75% of FPG and 175% of FPG. See §0912.175 (175 Percent of FPG). |

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

75 PERCENT OF FPG STANDARDS

0912.07.075

GAMC Standard for Full Benefits

MinnesotaCare Adults Without Children Standard for Basic Plus One Benefits

MA Method B Spenddown Standard (MAXIS Standard H)

75% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	6-Month Standard	Annual Standard
1	\$ 582	\$ 3,492	\$ 6,984
2	\$ 781	\$ 4,686	\$ 9,372
3	\$ 980	\$ 5,880	\$11,760
4	\$ 1,179	\$ 7,074	\$14,148
5	\$ 1,378	\$ 8,268	\$16,536
6	\$ 1,577	\$ 9,462	\$18,924
7	\$ 1,776	\$10,656	\$21,312
8	\$ 1,975	\$11,850	\$23,700
9	\$ 2,174	\$13,044	\$26,088
10	\$ 2,373	\$14,238	\$28,476
Additional People	\$ 199	\$ 1,194	\$ 2,388

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

100 PERCENT OF FPG STANDARDS

0912.07.100

MA Income Standard for Method A children ages 19-20 and parents/caretakers.
Income Standard for QMB and MA eligibility without spenddown for elderly/blind/disabled
(MAXIS Standard E)

100% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	6-Month Standard
1	\$ 776	\$ 4,656
2	\$ 1,041	\$ 6,246
3	\$ 1,306	\$ 7,836
4	\$ 1,571	\$ 9,426
5	\$ 1,836	\$ 11,016
6	\$ 2,101	\$ 12,606
7	\$ 2,366	\$ 14,196
8	\$ 2,631	\$ 15,786
9	\$ 2,896	\$ 17,376
10	\$ 3,161	\$ 18,966
Additional People	\$ 265	\$ 1,590

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MA Income Standard for SLMB and Prescription Drug
(MAXIS Standard S)

120% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard
1	\$ 931
2	\$ 1,249
3	\$ 1,567
4	\$ 1,885
5	\$ 2,203
6	\$ 2,521
7	\$ 2,839
8	\$ 3,157
9	\$ 3,475
10	\$ 3,793
Additional People	\$ 318

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

135 PERCENT OF FPG STANDARDS

0912.07.135

Upper Income Standard for QI-1 . (MAXIS Standard U)

135% of Federal Poverty Guidelines (FPG) effective 7-1-04.

Household Size	Monthly Standard
1	\$ 1,048
2	\$ 1,406
3	\$ 1,764
4	\$ 2,122
5	\$ 2,480
6	\$ 2,838
7	\$ 3,196
8	\$ 3,554
9	\$ 3,912
10	\$ 4,270
Additional People	\$ 358

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

150 PERCENT OF FPG STANDARDS

0912.07.150

MinnesotaCare \$48 Annual Premium

MA Method A Standard for Children Ages 2-18 (MAXIS Standard G)

150% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	Annual Standard
1	\$ 1,164	\$13,968
2	\$ 1,562	\$18,744
3	\$ 1,960	\$23,520
4	\$ 2,358	\$28,296
5	\$ 2,756	\$33,072
6	\$ 3,154	\$37,848
7	\$ 3,552	\$42,624
8	\$ 3,950	\$47,400
9	\$ 4,348	\$52,176
10	\$ 4,746	\$56,952
Additional People	\$ 398	\$ 4,776

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Income Limits for MinnesotaCare Adults Without Children Over 75% FPG–Limited Benefit
Income Limits for GAMC over 75% FPG–Hospital Only

175% of Federal Poverty Guidelines effective 7-1-04.

Household Size	Monthly Standard	6-month Standard	Annual Standard
1	\$ 1,358	\$ 8,148	\$16,296
2	\$ 1,822	\$10,932	\$21,864
3	\$ 2,286	\$13,716	\$27,432
4	\$ 2,750	\$16,500	\$33,000
5	\$ 3,214	\$19,284	\$38,568
6	\$ 3,678	\$22,068	\$44,136
7	\$ 4,142	\$24,852	\$49,704
8	\$ 4,606	\$27,636	\$55,272
9	\$ 5,070	\$30,420	\$60,840
10	\$ 5,534	\$33,204	\$66,408
Additional People	\$ 464	\$ 2,784	\$ 5,568

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

185 PERCENT OF FPG STANDARDS

0912.07.185

MA Income Standards for eligibility during the 2nd 6 months of TYMA (MAXIS Standard F)

185% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	6-Month Standard
1	\$ 1,436	\$ 8,616
2	\$ 1,927	\$ 11,562
3	\$ 2,418	\$ 14,508
4	\$ 2,909	\$ 17,454
5	\$ 3,400	\$ 20,400
6	\$ 3,891	\$ 23,346
7	\$ 4,382	\$ 26,292
8	\$ 4,873	\$ 29,238
9	\$ 5,364	\$ 32,184
10	\$ 5,855	\$ 35,130
Additional People	\$ 491	\$ 2,946

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

200 PERCENT OF FPG STANDARDS

0912.07.200

MA Income Standards for QWD (MAXIS Standard W).

200% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard
1	\$ 1,552
2	\$ 2,082
3	\$ 2,612
4	\$ 3,142
5	\$ 3,672
6	\$ 4,202
7	\$ 4,732
8	\$ 5,262
9	\$ 5,792
10	\$ 6,322
Additional People	\$ 530

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2003

275 PERCENT OF FPG STANDARDS

0912.07.275

MinnesotaCare Maximum Income Standards for Applicant Families and Children.

MA Maximum Income Standards for Pregnant Women. (MAXIS Standard C)

275% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	6-Month Standard	Annual Standard
1	\$ 2,134	\$ 12,804	\$ 25,608
2	\$ 2,863	\$ 17,178	\$ 34,356
3	\$ 3,592	\$ 21,552	\$ 43,104
4	\$ 4,321	\$ 25,926	\$ 51,852
5	\$ 5,050	\$ 30,300	\$ 60,600
6	\$ 5,779	\$ 34,674	\$ 69,348
7	\$ 6,508	\$ 39,048	\$ 78,096
8	\$ 7,237	\$ 43,422	\$ 86,844
9	\$ 7,966	\$ 47,796	\$ 95,592
10	\$ 8,695	\$ 52,170	\$104,340
Additional People	\$ 729	\$ 4,374	\$ 8,748

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MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

280 PERCENT FPG STANDARDS

0912.07.280

MA Income Standard for infants through their 2nd birthday who are not eligible as auto newborns. (MAXIS Standard K)

280% of Federal Poverty Guidelines (FPG) effective 7-1-04:

Household Size	Monthly Standard	6-Month Standard	Annual Standard
1	\$ 2,173	\$ 13,038	\$ 26,076
2	\$ 2,915	\$ 17,490	\$ 34,980
3	\$ 3,657	\$ 21,942	\$ 43,884
4	\$ 4,399	\$ 26,394	\$ 52,788
5	\$ 5,141	\$ 30,846	\$ 61,692
6	\$ 5,883	\$ 35,298	\$ 70,596
7	\$ 6,625	\$ 39,750	\$ 79,500
8	\$ 7,367	\$ 44,202	\$ 88,404
9	\$ 8,109	\$ 48,654	\$ 97,308
10	\$ 8,851	\$ 53,106	\$106,212
Additional People	\$ 742	\$ 4,452	\$ 8,904

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MinnesotaCare:

See §0913 (Premiums and Spenddowns).

MA:

People whose income is equal to or less than the applicable income standard are eligible without a spenddown. See §0912.07 (Income Standards).

People with income in excess of the applicable standard may be eligible by spending down to the standard. Spending down means incurring medical expenses equal to or greater than the difference between countable income and the income standard.

First compare household income to the appropriate Federal Poverty Guidelines (FPG) income standard to determine if there is eligibility without a spenddown.

See the income standards in the following sections:

§0912.07.275	275 Percent of FPG Standards.
§0912.07.280	280 Percent of FPG Standards.
§0912.07.150	150 Percent of FPG Standards
§0912.07.100	100 Percent of FPG Standards.
§0912.07.075	75 Percent of FPG Standards.

People whose income is equal to or less than the FPG standard applicable to their program and basis of eligibility are eligible without a spenddown. For people whose income exceeds the FPG standard, determine if they can meet a spenddown. The spenddown standard for Method A is 100% of FPG regardless of age or pregnancy. See §0912.07.05 (100 Percent of FPG). The spenddown standard for MA Method B is 75% of FPG. See §0912.07.075 (75 Percent of FPG).

EXAMPLE:

Beth applies for MA for her 16-year-old son Thomas. Countable income exceeds 150% of FPG (the appropriate standard for a child under age 18 on Method A) for a household of 2.

Because income exceeds the 150% FPG standard, Thomas is not eligible without a spenddown. You must determine if he can meet a spenddown using the 100% of FPG standard.

There are no spenddown provisions for:

-
- ▶ Transitional/Transition Year MA (TMA/TYMA). See §0907.19.11 (Transitional/Transition Year MA). There is no income limit for the 1st 6 months of eligibility. The income limit for the 2nd 6 months is 185% FPG. See §0912.07.185 (185 Percent of FPG Standards). People whose income exceeds the limit for the 2nd 6 months are no longer eligible for TYMA. Redetermine eligibility under another basis.
 - ▶ QMB, SLMB, QWD and QI. See §0907.21.09 (MA Basis: Medicare Supplement Programs). Income must be within the applicable standards for QMB, SLMB, QWD, or QI benefits. People with income in excess of these standards are not eligible for these programs. They may be eligible for MA if they meet a spenddown based on the 75% of FPG standard. See §0912.07.075 (75 Percent of FPG).
 - ▶ Pregnant women from the month they are found eligible under the 275% of FPG standard through the 60-day postpartum period. See §0907.19.05 (MA Basis: Pregnant Women).
 - ▶ Infants eligible as auto newborns through the month of their 1st birthdays. See §0907.19.05.03 (MA Basis: Auto Newborn).

Determine eligibility for a 6-month income certification period. See §0905.09 (6-Month Reporting). The client does not have to meet the spenddown in all 6 months. The certification period does not have to include the month of application.

EXAMPLE:

Joel applies for MA for himself and his family in May. He was laid off and received his final pay checks in May. He will begin receiving Unemployment Insurance in June. His income for May would result in a spenddown on both a monthly and 6-month basis. The family has no bills to meet the spenddown. Anticipated income for June-November results in no spenddown. Approve the May application for the certification period June-November if the family meets all other eligibility factors.

EXAMPLE:

Midge applies for MA for her husband, Ike, on November 21. Ike is entering an LTC on November 22 and will need MA effective December 1. If all eligibility factors are met, verify Ike's entry into the LTC and approve MA effective December 1. The 6-month certification period is December-May.

See the following sections for instructions on calculating the spenddown:

- §0913.07 6-Month Spenddown Calculation.
- §0913.09 Automated Monthly Spenddown Calculation.
- §0913.11 Manual Monthly Spenddown Calculation.
- §0913.13 Long Term Care Spenddown Calculation.
- §0913.15 Combination LTC/Medical Spenddown.

In some cases people have a choice of spenddown type. See §0913.05 (Which Spenddown Type to Use), §0913.05.03 (Use of MA Monthly Spenddown), and §0913.05.05 (Use of 6-Month and LTC Spenddowns). People must use the same spenddown type throughout a certification period unless they become subject to a long term care spenddown. For information about LTC spenddowns, see:

- §0913.17 Begin/End Use of LTC Spenddown - Part 1.
- §0913.17.01 Begin/End Use of LTC Spenddown - Part 2.
- §0913.17.03 Begin/End Use of LTC Spenddown - Part 3.
- §0913.19 Shortened Spenddown.

For deceased clients, use a shortened income certification period beginning with the month of application or the first retroactive month and ending with the month of death. See §0913.19 (Shortened Spenddown).

Deduct allowable health care expenses from excess income following the order in §0913.21 (Allowable Medical Bills to Meet Spenddown). On the date medical bills equal the client's excess income, the client has met the spenddown and is income eligible. If clients must use medical bills for an asset reduction as well as a spenddown, complete the asset reduction first. See §0909.29 (Excess Assets--Applicants) and §0909.29.03 (Excess Assets--Enrollees).

GAMC:

No provisions.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

No provisions.

MA:

Most clients who do not live in an LTCF or get LTC home-based services may choose which spenddown method to use. Some people may be eligible for more than 1 spenddown type. Help clients who could meet both a 1-month and a 6-month spenddown determine which method would result in the lower client obligation for the 6-month income certification period. You may need to determine what the spenddown amount would be on both a monthly and a 6-month basis to help the client make the best choice. Some clients may have a monthly spenddown but be eligible without a 6-month spenddown or vice versa because of changes in age, household size, income, or income deductions anticipated during the certification period.

EXAMPLE:

Mark, age 20, and his wife Melissa, age 19, apply for MA for themselves in October. They are not requesting retroactive coverage. Melissa has no income. Mark is receiving Reemployment Insurance which will end in mid-December. Anticipated income for October and November exceeds the income standard. Anticipated income for December-March is less than the income standard. Total anticipated income for October-March is less than the 6-month income standard. Advise Mark and Melissa that they are eligible without a 6-month spenddown.

EXAMPLE:

Fred applies for MA for his son Ben, age 14, in . October. He requests MA retroactive to .July. Fred is employed and had net income of \$1,500 per month in . July, August, September and October. His net income is anticipated to increase to \$1,600 per month in . November and December. Ben has no income. Ben's income standard is 150% FPG (\$1,562 per month effective July 1, 2004). His monthly income is less than the standard for July-October but exceeds the standard for November and December. Anticipated income for the 6-month certification period totals , \$9,200, which is less than the 6-month standard of . \$9,372. Ben is eligible without a spenddown for .July-December. If anticipated income continues to exceed the standard at the time of the 6-month review, Ben will have a spenddown for the next certification period (January-June).

This version of the manual is no longer in effect as of December 1, 2006.

Clients do not have to meet both a 6-month and a 1-month spenddown to be eligible for MA. However, they must use the same spenddown type for the entire 6-month income certification period.

Apply the following guidelines to people who live in the community and do not get home care services through Elderly Waiver:

- ▶ Spouses who live together or parents and children who live together must use the same type of spenddown. If some household members have no spenddown for the 6-month certification period, other household members may choose either a 6-month or a monthly spenddown. All household members who have spenddowns must choose the same spenddown type.

EXAMPLE:

Merrilee and Don apply for MA for themselves and their 2 children, ages 3 and 4. All household members meet an MA basis of eligibility. See §0907.17 (MA/GAMC Bases of Eligibility). The children have an income standard of 150% FPG. See §0912.07.150 (150 Percent of FPG Standards). Merrilee and Don have an income standard of 100% of FPG. See §0912.07.100 (100 Percent of FPG). Countable income for the 6-month certification period is less than the children's standard but exceeds the standard for Merrilee and Don. The children have no spenddown. Merrilee and Don may choose either a 6-month or a 1-month spenddown. Both must use the same spenddown type.

- ▶ For clients who choose a monthly spenddown, determine whether they must use an automated monthly or manual monthly spenddown.

Also see §0913.05.03 (Use of MA Monthly Spenddown), §0913.05.05 (Use of 6-Month and LTC Spenddowns).

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 1-1-04 through 12-31-04 is \$1,692. The SIS for 1-1-03 through 12-31-03 is \$1,656.

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 7-1-04 through 6-30-05 is \$766. The maintenance needs allowance for 7-1-03 through 6-30-04 is \$752.

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.

This version of the manual is no longer in effect as of December 1, 2006.

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 \$66.00 and maintenance needs allowance of \$766, he has income of \$368 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 one 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.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

No provisions.

MA:

The following is continued from §0913.17 (Begin/End Use of LTC Spenddown - Part 1) and §0913.17.01 (Begin/End Use of LTC Spenddown - Part 2).

LTC SPENDDOWN BEGIN DATE: APPLICANT ENTERS PERMANENT LTC PLACEMENT

When an applicant who enters permanent LTC placement requests retroactive MA for the months before the LTC spenddown begins, use either a 6-month certification period with a shortened spenddown or a 1-month medical spenddown to determine eligibility for the months before placement. See §0913.11 (Manual Monthly Spenddown Calculation), §0913.09 (Automated Monthly Spenddown Calculation), and §0913.07 (6-Month Spenddown Calculation). Begin using an LTC spenddown starting the first month the client is required to use an LTC spenddown. For a client with no community spouse, the LTC spenddown begins the month following the month of LTC placement. For a client with a community spouse, the LTC spenddown begins the month of placement. See §0913.05 (Which Spenddown Type to Use), §0913.13 (Long Term Care Spenddown Calculation), and §0913.15 (Combination LTC/Medical Spenddown).

For a 6-month spenddown, use the community assistance standard for any months before the month the LTC spenddown begins. Use the income deductions for long term care spenddowns in §0913.13 (Long Term Care Spenddown Calculation) beginning with the month the client becomes subject to an LTC spenddown.

Apply excess income in the months before LTCF placement toward medical expenses incurred in those months. Start with the oldest expense.

EXAMPLE:

Catherine applies for MA on April 25. She entered an LTCF for a permanent stay on April 10. She has no community spouse. She is requesting retroactive MA for February and March. She was hospitalized for 2 weeks in February and again from March 25 until she entered the LTCF. Use either a shortened 6-month spenddown or a monthly spenddown for February and March. Begin the LTC spenddown in April. April is considered the first full month of institutionalization since Catherine entered the LTCF directly from the hospital.

This version of the manual is no longer in effect as of December 1, 2006.

LTC SPENDDOWN END DATE: CLIENT WITH NO COMMUNITY SPOUSE
LEAVES LTC

When a client with no community spouse leaves LTC placement, end the LTC spenddown **the end of the month prior to** the month of discharge. Redetermine eligibility for the remainder of the certification period using a monthly spenddown. If the client cannot meet the spenddown, terminate MA for the first month for which you can give 10-day notice.

EXAMPLE:

Bertha has resided in an LTC for 9 months. Her current income certification period is June-November. She has no community spouse. She is discharged from the LTC to her home on August 9. Redetermine eligibility for August-November using a monthly medical spenddown. Terminate MA if Bertha cannot meet the spenddown.

LTC SPENDDOWN END DATE: CLIENT WITH COMMUNITY SPOUSE
LEAVES LTC OR ENDS EW SERVICES

When a client with a community spouse leaves LTC placement or stops receiving EW services, continue the LTC spenddown through the end of the month of discharge or end of EW services. Redetermine eligibility using a monthly medical spenddown for the remainder of the certification period. Terminate MA for the first month for which you can give 10-day notice if the client cannot meet a spenddown.

EXAMPLE:

Tobias has received EW services for 8 months. He lives with his wife Rachel, who is not receiving MA. Tobias's current income certification period is February-July. EW services end effective May 31, because he is no longer at risk of placement. Redetermine eligibility for June and July using a monthly spenddown. Terminate MA if Tobias cannot meet the spenddown.

Continue to use LTC budgeting through the month of discharge when the discharge is due to death.

For clients eligible under the SIS EW program, see §0913.17.05 (Begin/End Use of SIS EW Waiver Obligation).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

Do not interrupt an income certification period:

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

EXAMPLE:

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

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

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

EXAMPLE:

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

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

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

- ▶ When a client enters or leaves an LTCF. See §0913.17 (Begin/End Use of LTC Spenddown - Part 1), §0913.17.01 (Begin/End Use of LTC Spenddown - Part 2), and §0913.17.03 (Begin/End Use of LTC Spenddown - Part 3).
- ▶ When QMB, SLMB or QI eligibility is added to MA. Do not change the certification period or recalculate the spenddown when someone who is active on MA becomes eligible for QMB, SLMB or QI during the certification period. Begin QMB, SLMB or QI in the 1st eligible month.
- ▶ When a household size decreases because a person dies or leaves a current MA household. Recalculate the current 6-month income certification period.

EXAMPLE:

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

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

-
- ▶ When a client's income changes. Redetermine eligibility for the current 6-month certification period.
 - ▶ When a person who was included in the existing household size but did not request MA now requests MA within the same income certification period. The added member is subject to the spenddown type selected by the household at the time the last certification period was approved. The added member may request to be added up to 3 months before the month they make the request for MA

EXAMPLE:

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

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

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

EXAMPLE:

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

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

This version of the manual is no longer in effect as of December 1, 2006.

GAMC:

Do not interrupt the certification period when:

- ▶ People on GHO become eligible for full GAMC for the same time period.
- ▶ A person who was included in the existing household size but did not request GAMC now requests GAMC within the same income certification period. The new member can be added effective the date of request.
- ▶ A GAMC-only enrollee becomes eligible for GA during the income certification period. Since GAMC no longer has spenddown provisions, do not recompute eligibility for the period before GA began. Continue to compare income for the entire 6-month budget period to the 6-month standard.

EXAMPLE:

Roy becomes temporarily unable to work in February and applies for GAMC in February. He receives his last income from employment in February and begins receiving GA in March. His projected return to work date is unknown. His February earnings exceed the monthly GAMC standard, but projected income for the 6-month budget period (0 income projected for March-July) is less than the 6-month standard. He is eligible for GAMC in February as well as for the ongoing GA months.

MinnesotaCare:

No provisions.

MA:

The county agency may file an estate claim with a court of appropriate jurisdiction if the estate is opened, regardless of the estate's value, when a person who received MA, QMB, SLMB, or QI after turning age 55 dies. If there is a surviving spouse, the county agency may file the claim after the surviving spouse dies.

People who received MA, QMB, SLMB or QI after age 55 are always subject to estate recovery. They are NOT automatically subject to a lien on their real property. See §0914.09.03 (Liens).

The maximum amount of an estate claim is:

- ▶ The total amount of MA, QMB, SLMB and QI paid, without interest, for a person who received MA after turning age 55, regardless of whether the person received hospital or long term care services. The age for estate recovery was lowered from age 65 to age 55 on July 1, 1995. For people who were between ages 55 and 64 on July 1, 1995, the estate claim recovery is limited to MA/QMB/SLMB/QI services received on or after July 1, 1995.
- ▶ The total amount of MA, QMB, SLMB and QI paid, without interest, during institutionalization for a person who resided permanently in an LTCF or hospital before age 55, OR who resided in an LTCF or institution for 6 months or less before age 55 without reasonable expectation of discharge to the home. People in this category may be subject to real property liens as well as estate claims. See §0914.09.03 (Liens).

Do not file estate claims against MinnesotaCare or Prescription Drug program expenses, even if the person also received MA, QMB, SLMB or QI.

EXAMPLE:

Myrtle received QMB and Prescription Drug for 2 years until her death. Do not include any expenses paid by the Prescription Drug program in the estate claim.

Do not file a claim against the estate of a person who received MA while there is a surviving spouse, or if there is a surviving child who is under age 21, blind, or totally disabled.

Limit the claim against the estate of a surviving spouse who did not receive MA to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage.

Limit the claim to the value of non-homestead property if 1 or more of the following people survives the client. Do not include the value of the homestead.

- ▶ A child or grandchild who resided in the home, provided care which permitted the client to live at home for at least 2 years immediately before the client's LTCF admission, and has resided in the homestead continuously since the date of the deceased client's institutionalization.

OR

- ▶ A sibling who resided in the homestead at least 1 year before the client's institutionalization and continuously since the date of the deceased client's institutionalization.

Counties may use an Affidavit of Collection of Personal Property instead of filing an estate claim if all of the following conditions are met:

- ▶ The person has been dead for at least 30 days.
- ▶ The estate has not been opened.
- ▶ The assets consist entirely of personal property.
- ▶ The value of the estate, less liens and encumbrances, is \$20,000 or less.

Serve the affidavit on the financial institution, person, or other entity holding the client's money or property. This includes the contents of safe deposit boxes. For funds held in a joint or pay on death account, the affidavit must contain the amount of the county's claim and a good faith estimate of the extent to which the deceased enrollee was a contributor or beneficiary of the funds in the account. The institution or other entity receiving the affidavit is only obligated to turn over the deceased person's money or other property still in its possession when the affidavit is served. The institution is not obligated to turn over funds or property that have already been distributed to the joint owner or payable on death beneficiary.

This version of the manual is no longer in effect as of December 1, 2006.

MDHS HEALTH CARE PROGRAMS MANUAL

ML 41 JULY 2004

ESTATE CLAIMS

0914.09

GAMC:

When a person who received GAMC, or the surviving spouse who also received GAMC dies, the county agency may file an estate claim with a court of appropriate jurisdiction. The amount of the claim is the total amount of GAMC paid without interest. Do not file a claim while there is a surviving spouse, or if there is a surviving child who is under age 21, or blind, or totally disabled. ■

Limit the claim against the estate of a surviving spouse who did not receive GAMC to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage.

The county may use an Affidavit of Collection of Personal Property instead of filing an estate claim under the same conditions as for MA.

This version of the manual is no longer in effect as of December 1, 2006.

MinnesotaCare:

If an enrollee reports a change in income at a time other than the scheduled renewal, **act on the change if it results in ineligibility due to excess income. Terminate coverage for adults whose income exceeds the applicable limit. Terminate coverage for children whose income exceeds 275% FPG and who do not meet the MCHA exemption. See §0912.03 (MinnesotaCare Income Limits) and §0912.03.03 (MinnesotaCare Excess Income).**

If a reported change in income does not cause ineligibility, compare the new income to the income before the change to determine if the change would result in an increased premium, a decreased premium, or no change. Do not require verification of the change until the next renewal.

If the reported change would result in an increased premium, enter information on MMIS to calculate the increase if:

- ▶ The change is reported at the time of the scheduled renewal. See §0905 (Reviews and Renewals).
- ▶ The change results from the income of a person being added for coverage. See §0915.03 (Adding a Person to the Household). If other household members have increased income from a source other than the new member, do not act on that increase until the time of the next renewal.
- ▶ The change is reported when the household has been disenrolled from MinnesotaCare for at least 1 month. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).
- ▶ You discover an income increase or new source of income that should have been reported at the last scheduled renewal.

EXAMPLE:

Susan calls in November to report that she began receiving child support payments of \$125 per month in June. She did not include this information on her September renewal form. Recalculate household income including the child support payment and record the new amount in MMIS. Do not wait until the next renewal.

If a change that would result in an increased premium is reported at any other time, record the information. Do not take action until the time of the next scheduled

This version of the manual is no longer in effect as of December 1, 2006.

renewal. Compare income information reported on the renewal application to the reported change. Contact the household as needed to resolve any discrepancies.

If the reported change would result in a decreased premium, record the new income information in MMIS. Do not require verification unless the change is reported at the time of the annual renewal.

MMIS will adjust the premium for the first available month when income decreases on an active case. Do not request manual adjustments.

EXAMPLE:

On May 21, Rita calls to report her husband, Karl, left the household. Karl did not have coverage, but his income was counted to determine the household's premium. Remove Karl's income and decrease the household size. MMIS will adjust the premium automatically.

If a household reports 2 income changes at the same time, determine if the combined changes would result in an increased or a decreased premium. If the combined changes would increase the premium, do not act on either change until the next renewal. If the combined changes would decrease the premium, act on both changes as soon as possible to allow MMIS to decrease the premium for the first available month.

EXAMPLE:

Anthony calls his worker to report that his Unemployment Insurance (UI) stopped and he began a job. The wages he reports from the job are higher than the UI and would result in an increased premium. Do not act on either change until Anthony's next scheduled renewal.

EXAMPLE:

Jackson reports changes in his household's employment. He received a raise, but his wife started a new job at a lower hourly rate. The combined effect of the 2 changes is decreased household income that would result in a lower premium. Enter both changes in MMIS. Do not wait until the next renewal.

M.S. 256L.07 subd. 1

Minnesota Rule 9506.0040 subp. 2c

MA/GAMC:

See §0915.03 (Adding a Person to the Household) when adding the income of a person who moves into an existing household.

Households are required to report changes in income within 10 days of the date the change becomes known. Households who use a monthly manual spenddown must submit monthly income reports. See §0913.11 (Manual Monthly Spenddown Calculation) and §0905.07 (Monthly Reporting). All other households must submit income reports every 6 months. See §0913.07 (6-Month Spenddown Calculation), §0913.09 (Automated Monthly Spenddown Calculation), and §0905.09 (6-Month Reporting).

When you become aware of a change in household income, determine the effect of the change on the household's eligibility. If the change is reported during a certification period, recalculate eligibility for the current certification period. Do not require verification of the change if it is reported at a time other than a scheduled 6-month or annual review.

EXAMPLE:

Bridget receives MA for herself and her 2 children. Their current certification period is June-November. The household's only income is child support for the children. All household members are eligible without a spenddown. On September 5, Bridget reports that she began a job on September 1.

Redetermine eligibility for each household member for the current certification period. Count zero income for Bridget for June-August, since the children's child support is not deemed to her. Project anticipated earnings for September-November. Count child support for the children for the entire 6-month certification period. Add Bridget's projected net earnings for September-November. If any household member has a spenddown as a result of the new calculation, determine whether the spenddown can be met with bills incurred before the current certification period or with bills incurred during the certification period that were not covered by MA.

If a household member with a spenddown cannot meet a 6-month spenddown with existing bills, determine if the person could meet a monthly spenddown based on anticipated income and bills for the remaining months in the certification period. Terminate MA effective the first month for which you can give 10-day notice for any household member who cannot meet a 6-month or monthly spenddown.

When you become aware of a decrease in income during a certification period, determine the effect on eligibility. If no one in the household has a spenddown, no action is required.

This version of the manual is no longer in effect as of December 1, 2006.

If the household has an automated or monthly manual spenddown, recompute the spenddown beginning with the month the change occurred. See §0913.09 (Automated Monthly Spenddown Calculation) and §0913.11 (Manual Monthly Spenddown Calculation).

If any household member has a 6-month spenddown, recompute eligibility for the existing certification period. If the decreased income results in an earlier satisfaction date, change the spenddown amount and satisfaction date on MAXIS and MMIS. Send a notice to the household to notify appropriate providers to bill MA or GAMC. See §0913.07 (6-Month Spenddown Calculation) and §0913.19 (Shortened Spenddown).

EXAMPLE:

Delbert receives GAMC with a 6-month spenddown. His current certification period is January-June. He was hospitalized from January 13-16 and met his spenddown on January 14. On April 9, he reports his hours have been cut from 30 to 20 per week. The worker determines that Delbert would meet his spenddown on January 13 based on the reduction in income. Change the spenddown satisfaction date and recipient amount on MAXIS and MMIS. Notify Delbert of the change and advise him to have the hospital rebill the January 13-14 charges to GAMC. When the hospital receives payment, they will refund the difference between the old and new spenddown amounts to Delbert.

Premiums for people enrolled in Medical Assistance for Employed Persons with Disabilities (MA-EPD) are established for the full 6-month certification period. If a MA-EPD enrollee reports a change in income during the certification period, change the premium only if the income change results in a decreased premium or no premium. If the change results in an increased premium, do not take action to increase the premium until the next 6-month income review or annual recertification.