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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #42

January 2005

Effective Date: July 2004 and January 2005

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.

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).

This manual letter contains new and revised information for the Health Care Programs Manual. Following is a list of the new and revised sections and a brief description of each change. The information added for the MA-EPD program was effective July, 2004. Otherwise, except for minor clarifications and corrections of existing policy or otherwise noted effective dates, all new and revised instructions are EFFECTIVE JANUARY 1, 2005.

HIGHLIGHTED CHANGE #1: This manual letter incorporates the changes to MA-EPD that were relayed in Bulletin #04-21-07. These changes were effective July 1, 2004. It

updates the employment definition for MA-EPD adding, that to be eligible a person has to have more than $65 in earned income and unless taxes are withheld or self-employment taxes paid, income received will not be counted as earnings from employment or self-employment. See below for a description of sections affected by these changes and effective dates.

HIGHLIGHTED CHANGE #2: This manual letter contains the following standard and deduction increases effective January 1, 2005:

> The Special Income Standard (SIS) for the SIS-EW program increases to $1,737. See §0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation--SIS-EW).

> The self-employment mileage rate increases to 40.5 cents per mile. Also use this amount for reimbursing medical transportation providers who are eligible for reimbursement at the IRS rate. See §0911.09.03.09 (Self-Employment Transportation) and §0914.11 (Access Services)

> The minimum spousal asset allowance increases to $26,898. The maximum spousal asset allowance increases to $95,100. See §0909.25 (Spousal Asset Assessments).

The percentage factor for calculating the Pickle disregard for the 1-1-2004 COLA increase is 1.027. See §0912.05.23 (Pickle Disregard).

> The maximum spousal income allowance increases to $2,378. See §0912.05.25.03 (Allocations--Community Spouse).

> The clothing and personal needs allowance increases to $76. The amount for certain veterans and surviving spouses of veterans who receive a monthly pension of $90 remains unchanged. See §0912.07.03 (Clothing and Personal Needs Allowance).

> The Blind and Disabled Student Child Disregard increases to $1,410 per month and $5,670 per year. See §0912.05.09.09 (Blind and Disabled Student Child Disregard).

HIGHLIGHTED CHANGE #3: This manual letter includes a change to most types of interest/dividend income. For community-MA (Method B) clients exclude most types of interest/dividend income. The change in interest/dividend income does not apply to those using LTC budgeting or to spousal impoverishment calculations. Interest/dividend income should continue to be counted for those using LTC budgeting. See §0911.09.19 (Interest and Dividends)

See below for a list of all the changes.

Submit questions through the HealthQuest system.

HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #42

REVISED AND DELETED SECTIONS

Revised Sections	Deleted Sections
0902.11	0902.11
0904.09	0904.09
0904.09.03	0904.09.03
0904.09.05	0904.09.05
0904.09.07	0904.09.07
0906.03	0906.03
0906.03.05	0906.03.05
0906.03.11.23	0906.03.11.23
0906.03.13	0906.03.13
0907.03	0907.03
0907.05	0907.05
0907.13	0907.13
0907.19.05.05	0907.19.05.05
0907.19.11	0907.19.11
0907.21.07	0907.21.07
0907.21.07.05	0907.21.07.05
0907.21.07.06	0907.21.07.05
0907.21.09.03	0907.21.09.03
0907.23.09.03	0907.23.09.03
0907.23.11	0907.23.11
0907.25.05	0907.25.05
0907.27	0907.27
0908.07	0908.07
0909.11	0909.11
0909.11.01	0909.11.01
0909.17.03	0909.17.03
0909.25	0909.25
0909.27.11	0909.27.11
0910.03.03	0910.03.03
0911.03	0911.03
0911.05.03	0911.05.03

0911.09.03.09	0911.09.03.09
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0914.03.09	0914.03.09
0914.03.13	0914.03.13
0914.03.15	0914.03.15
0914.03.17	0914.03.17
0914.11	0914.11
0915	0915
0915.03.01	0915.03.01
0915.05	0915.05
0915.15	0915.15
0918.13	0918.13

§0902.11 (Glossary: Effective…) corrected a manual reference under Emergency.

§0904.09 (Shared and Transferred Applications) deletes references to DHS-3279 Inter Program Transfer Form. Replaces it with DHS-3195 the Inter Agency Case Transfer form.

§0906.03 (Citizenship and Immigration Status) deletes references to the Bureau of Citizenship and Immigration Status (BCIS) and replaces it with the U.S. Citizenship and Immigration Services (USCIS).

§0906.03.05 (Non-Citizens Ineligible for Federal Funding) corrects a typing error.

§0906.03.11.23 (Other Lawfully Residing) adds the group: people with pending immigration status to the list of people who are lawfully residing in the U.S. on a temporary basis. Under certain circumstances a person may be considered to be lawfully residing in the United States while his of her application is still being processed. The specific people are listed in the manual section.

§0906.03.13 (MinnesotaCare Major Programs) deletes references to Program XX which was eliminated for adults with children whose income was over 275% FPG or $50,000. Adds the group listed above to Major Program JJ.

§0907.03 (MinnesotaCare Eligibility Group 1) adds Adults without Children whose income is at or below 75 % FPG to Group 1.

§0907.05 (MinnesotaCare Eligibility Group 2) deletes references to the exception of parents, relative caretakers, legal guardians and foster parents whose income exceeds $50,000.

§0907.13 (MinnesotaCare Parents/Guardians/Caretakers) deletes references to having income over 275% FPG, Major Program XX, and dependent siblings.

§0907.19.05.05 (Adding/Removing Auto Newborns) adds effective 10/1/04, newborns born on or after 10/1/04 should be retroactively enrolled in the same health plan the mother was enrolled in during the birth month.

§0907.19.11 (Transitional/Transition Year MA) updates the examples to the decreased income standard of 150% FPG that was effective 7/1/04.

§0907.21.07 (MA/Medicare Savings Basis: Disability) deletes references under GAMC to undocumented non-citizens who are disabled being eligible for GAMC.

§0907.21.07.05 (MA for Employed People with Disabilities) see Highlighted Change #1.

§0907.21.07.06 (MA-EPD: Employment Definition) see Highlighted Change #1.

§0907.21.09.03 (Medicare Savings Programs: QMB) updated the examples with the 7/04 income standard changes.

§0907.23.09.03 (TEFRA – SMRT Procedures) updated the documentation requirements that were previously relayed in Bulletin #04-21-02.

§0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation SIS EW) updated the SIS for 2005 to $1,737. See Highlighted Change #2.

§0907.25.05 (GAMC Hospital Only (GHO)) added the title GAMC/GHO.

§0907.27 (MA/GAMC Basis: IMD Residents) updated the asset limit in the MA example.

§0908.07 (Household Composition: Deeming) updated several areas in this section that were missed in previous manual letters and updated the examples.

§0909.11 (Excluded Assets) deleted from the "exclude as an asset" section, payments for disaster relief made by state and local governments and disaster relief organizations such as Red Cross and Salvation Army. These payments are in the "count income retained into the next month as an asset" section.

§0909.11.01 (Excluded Assets – Program Provisions) for Method A, added to exclude Earned Income Credit (EIC) income as an asset in the month of receipt and the next month. For Method B, added to exclude as an asset for 9 months any retroactive SSI or RSDI lump sum payments received on or after 3/2/04. Also to exclude as an asset for 9 months any Earned Income Tax Credit (EITC) or Child Tax Credit (CTC) refunds or payments received on or after 3/2/04 if retained after the month of receipt.

§0909.17.03 (Determining the Burial Fund Exclusion) added a clarification in the life insurance section regarding the CSV of a policy with an irrevocable designation. Do not count the CSV towards the asset limit for a policy with an irrevocable designation.

§0909.25 (Spousal Asset Assessments) updated the minimum ($26,898) and maximum ($95,100) spousal asset allowances for 2005. See Highlighted Change #2.

§0909.27.11 (Improper Transfer Ineligibility) clarified that a cause of action may exist if the applicant or the applicant's authorized representative failed to report a transfer of assets at any time not just at application time.

§0910.03.03 (Other Coverage – Prescription Drug) added CHAMPUS/TRICARE to the types of coverage that are considered to be prescription drug coverage for PDP. CHAMPUS/TRICARE was deleted from the list of other coverage types that are not considered to be prescription drug coverage for PDP.

§0911.03 (Availability of Income) clarified for Method B when a deduction from income is not allowed.

§0911.05.03 (Excluded Income – Program Provisions) added a reference to 0911.09.05 (Dependent Child Income) to the first bullet under MinnesotaCare. For Method B, the exclusion of irregular or infrequent earned income was increased to the first $30 per calendar quarter. Also, the exclusion of irregular or infrequent unearned income was increased to the first $60 per calendar quarter.

§0911.09.03.09 (Self-Employment Transportation) and §0914.11 (Access Services) updated the standard mileage amount for 2005 to 40.5 cents. See Highlighted Change #2.

§0911.09.07 (Student Financial Aid Income) clarified that MinnesotaCare and MA Method A should treat veterans' benefits the same way MA Method B does.

§0911.09.15 (Income from RSDI and SSI) updated an example with correct Medicare Part B premium for 2005.

§0911.09.15.01 (Income from RSDI and SSI – MA/GAMC) aligned Method A with Method B for when SSI benefits are suspended for reasons other than disability.

§0911.09.15.05 (Lump Sum RSDI and SSI Payments) exclude as an asset for 9 months any retroactive SSI or RSDI lump sum payments received on or after 3/2/04, if retained after the month of receipt.

§0911.09.19 (Interest and Dividends) for community-MA Method B only, added to exclude as income some types of interest and dividends received from counted or excluded assets. See Highlighted Change #3.

§0912.05.09.09 (Blind and Disabled Student Disregard) updated the maximum amounts for 2005, $1,410 per month up to the maximum of $5,670 in a calendar year. See Highlighted Change #2.

§0912.05.23 (Pickle Disregard) updated the percentage (1.027) for the 2005 RSDI increase. See Highlighted Change #2.

§0912.05.25.03 (Allocations – Community Spouse) increased the maximum monthly income allowance to the community spouse to $2,378 for 2005. See Highlighted Change #2.

§0912.07.03 (Clothing and Personal Need Allowance) increased the allowance to $76 for 2005. See Highlighted Change #2.

§0913.13.03 (LTC Spenddown – EW with Community Spouse) deleted reference to §0912.07.05 (133 + 1/3 Percent of AFDC).

§0913.13.05 (Waiver Obligation – SIS EW) increased the SIS for 2005 to $1,737. See Highlighted Change #2.

§0914.03.03 (Managed Care Exclusions) deleted the wording "…and for whom the state or county is paying the premium" from the last bullet under the MA exclusion list in regards to cost effective insurance. GAMC recipients in the GAMC Hospital Only (GHO) program were added to the list of managed care exclusion reasons.

§0914.03.05 (Managed Care Enrollment Process) updated what forms need to be included in the health plan enrollment packet sent out by DHS for MinnesotaCare.

§0914.03.05.01 (Managed Care Enrollment Process – MA/GAMC) the following information was effective 6/1/04: second bullet changed from 12 to 2 full calendar months, fourth and eighth bullet changed to; all household members will need to choose the same health plan when adding a managed care eligible person to a case. The information regarding the quarterly report for managed care was deleted.

§0914.03.05.03 (Managed Care Enrollment Presentations) updated the thirteenth through fifteenth bullets under what to include in managed care presentations. Also, updated what forms need to be included in the managed care enrollment presentation packets.

§0914.03.09 (Managed Care Re-Enrollments and Reinstatements) deleted the reference to §0914.03.19 (Managed Care: 1 Month Rolling Eligibility) and added a reference to §0914.03.07 (Health Plan Changes).

§0914.03.13 (Adding/Removing People from Managed Care) added that, effective 10/1/04 newborns born after 10/1/04 to a mother who was enrolled in a health plan at the time of birth will be retroactively enrolled in the same health plan back to the birth month, unless the newborn meets an exclusion.

§0914.03.15 (Managed Care Adjustments) deleted the first bullet under the subheading; request adjustments in the following situations.

§0914.03.17 (Managed Care County Transfers) corrects wording in fifth paragraph for MA/GAMC.

§0914.11 (Access Services) and §0911.09.03.09 (Self-Employment Transportation) updated the standard mileage amount for 2005 to 40.5 cents. See Highlighted Change #2.

§0915 (Changes in Circumstances) deleted the reference to dependent siblings.

§0915.03.01 (Adding a Person to the Household – MA/GAMC) deleted reference to retroactive GAMC.

§0915.05 (Removing a Person from the Household) deleted reference to MinnesotaCare major program XX.

§0915.15 (Change in MinnesotaCare Eligibility Group) deleted references to dependent siblings.

§0918.13 (Minnesota Children with Special Health Needs) Minnesota Children with Special Health Needs (MCSHN) is administered by the Minnesota Department of Health and it lost most of its funding in 2003. Its main function now is as an information and referral telephone line that helps identify resources and services for children with special health needs.

EFFECTIVE DATE:

The date a specific action such as an approval, DENIAL, TERMINATION, or other change in eligibility or coverage begins.

EIGHTEEN-MONTH RULE:

MINNESOTACARE:

One of the INSURANCE BARRIERS. The 18-month rule requires that some people not have current coverage or access to ESI. It also restricts eligibility for some people who have had access to ESI in the past 18 months if the employer chose to drop coverage. See §0910.11.03 (18-Month Rule).

ELDERLY:

MA:

Age 65 or older. Used interchangeably with AGED.

ELDERLY WAIVER (EW):

MA waivered services for a person over age 65 who would otherwise need care in a LONG TERM CARE FACILITY. See §0907.23.11 (MA Waiver Programs: EW).

ELIGIBILITY BEGIN DATE:

The date an ENROLLEE is eligible for coverage under one of the HEALTH CARE PROGRAMS.

ELIGIBILITY GROUP:

MINNESOTACARE:

One of 3 groups to which MINNESOTACARE ENROLLEES are assigned based on certain characteristics. See §0907 (Eligibility Groups and Bases of Eligibility).

ELIGIBILITY VERIFICATION SYSTEM (EVS):

DHS's system to verify ENROLLEES' coverage and eligibility dates under the HEALTH CARE PROGRAMS. Providers contact EVS by phone to confirm eligibility.

EMANCIPATED MINOR:

A person under the age of 18 who is or was married, is on active duty in the uniformed services, or has been declared emancipated by a court.

EMERGENCY:

MA:

A sudden onset of a physical or mental condition OR a chronic medical condition which, if left untreated, could reasonably be expected to place the person's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. This includes labor and delivery. See §0907.29 (Emergency Medical Assistance - EMA).

EMPLOYER SUBSIDIZED INSURANCE (ESI):

Insurance coverage offered to employees for which the employer pays at least 50% of the cost of coverage. See §0910.11 (Employer Subsidized Insurance).

ENCUMBRANCE:

A legal claim against REAL PROPERTY or PERSONAL PROPERTY payable when the property is sold.

ENROLLEE:

1. A person receiving coverage through MA, GAMC, or MINNESOTACARE.
2. A person enrolled in a HEALTH PLAN.

ENROLLMENT REPRESENTATIVE :

Term used by MINNESOTACARE OPERATIONS at DHS and on MINNESOTACARE notices to refer to an employee who determines initial and continued eligibility for MINNESOTACARE. Also see WORKER in §0902.41 (Glossary: Underinsured...)

EQUITY:

The FAIR MARKET VALUE of property minus any ENCUMBRANCE.

ESCROW:

A DEED, bond, money, or piece of property held in TRUST by a 3rd party to be turned over to the grantee only on fulfillment of a condition.

ESTATE CLAIMS:

A method of recovering MEDICAL ASSISTANCE from the estate of a deceased person.

ESTIMATED MARKET VALUE (EMV):

The value assigned to real estate by the county assessor for the purpose of levying property taxes. EMV is found on the annual property tax assessment statement.

EW:

See ELDERLY WAIVER above.

EXCESS ASSETS:

The amount of ASSETS which exceeds the client's ASSET LIMIT.

EXCLUDED INCOME :

Income not used to determine eligibility or MINNESOTACARE premium amount.

EXCLUDED TIME:

Any time a person spends in any of the following places or situations: hospitals, sanitariums, nursing homes, shelters (other than emergency shelters), HALFWAY HOUSES, FOSTER HOMES, board and care homes, maternity homes, battered women's shelters, correctional facilities, supervised board and lodging facilities, REGIONAL TREATMENT CENTERS, facilities based on an emergency hold, placements in training and habilitation programs (including a rehabilitation facility or work or employment program), day training and habilitation programs, assisted living services, placements with an indeterminate commitment, including independent living.

EXCLUDED TIME RESIDENCE/FACILITY:

A type of living arrangement which affects determining financial responsibility. See §0906.07.05 (Excluded Time).

EXCLUDED TIME SERVICES:

1. Participation in a rehabilitation facility which meets the definition of a long term sheltered workshop.
2. Receiving Personal Care Assistant (PCA) services.
3. Services from a SEMI-INDEPENDENT LIVING SERVICES (SILS) PROGRAM.

EXPENSES COVERED BY GAMC OR MA:

See the Minnesota Health Care Programs Provider Manual for detailed information on services covered by GAMC or MA.

EXTENDED MEDICAL ASSISTANCE:

See TRANSITIONAL MEDICAL ASSISTANCE (TMA) and TRANSITION YEAR MEDICAL ASSISTANCE (TYMA) in §0902.39 (Glossary: Tennessen...)

FACE-TO-FACE INTERVIEW:

A face-to-face meeting arranged to determine initial or ongoing eligibility for MA,

GAMC or MINNESOTACARE. Face-to-face interviews are at the option of the CLIENT for people who are requesting only health care coverage.

FAIR MARKET VALUE:

The price an item would sell for on the open market in a local geographic area. See individual property sections in §0909 (Assets) for exceptions and provisions.

The HCAPP allows people to apply for MA/GAMC and MinnesotaCare on the same form. Applications may be transferred or shared between county agencies and MinnesotaCare Operations when:

> People apply for MinnesotaCare through MinnesotaCare Operations and ask to have the application transferred to MA/GAMC if they are ineligible for MinnesotaCare. See §0904.09.03 (Transfers From MinnesotaCare to MA/GAMC).

> People request health care through a county agency that is not a MinnesotaCare enrollment site and are determined ineligible for MA/GAMC. See §0904.09.05 (Transfers From MA/GAMC to MinnesotaCare).

> People submit an application to MinnesotaCare Operations or to a county agency that is not a MinnesotaCare enrollment site requesting MinnesotaCare with retroactive MA or GAMC. See §0904.09.07 (MinnesotaCare With Retroactive MA/GAMC).

> Disabled adults without children who are required to apply for MA submit an application to MinnesotaCare Operations and ask to have the application transferred. See §0907.15 (MinnesotaCare Adults Without Children).

> GAMC applicants and enrollees who are mandatory MinnesotaCare referrals apply for or renew GAMC eligibility at a county agency that is not a MinnesotaCare enrollment site, or who apply at a county enrollment site but request to have MinnesotaCare eligibility determined at MinnesotaCare Operations. See §0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals).

The HCAPP does not provide a place for applicants to designate which health care programs they are requesting. If counties that are not MinnesotaCare enrollment sites receive a HCAPP, determine eligibility for MA/GAMC. Transfer the application to MinnesotaCare Operations if the applicant is ineligible for MA/GAMC. Use the Inter Agency Case Transfer Form (DHS 3195).

In most cases, do not transfer the application from MA/GAMC to MinnesotaCare or from MinnesotaCare Operations to county agencies if the reason for denial is the applicant's failure to provide verification or to respond to attempts to contact them to follow up on the application.

EXCEPTION:

Transfer the application when the reason for denial is the client's failure to provide information in the following circumstances:

> The applicant contacts you after receiving the denial notice and specifically asks to have the application transferred. Explain that they will need to provide appropriate verifications to the other program before eligibility can be determined.

> You know that the other program will not need the missing information.

EXAMPLE:

Household requests MinnesotaCare through MinnesotaCare Operations and asks that the application be transferred if they do not qualify. They provide all required information except information about past insurance. MinnesotaCare cannot determine eligibility without this information and has been unsuccessful in obtaining it for the applicant. Because MA/GAMC needs information on current insurance only, and the household has no current insurance, transfer the application.

County agencies that are Type 1 or Type 2 MinnesotaCare enrollment sites do not transfer applications to MinnesotaCare Operations unless a mandatory GAMC referral requests to have eligibility determined at MinnesotaCare Operations. The county agency determines eligibility for both programs. If applicants want to apply for MinnesotaCare only at a Type 1 or Type 2 enrollment site, they must notify the county agency verbally or in writing that they do not want eligibility determined for MA/GAMC. County agencies that are Type 3 MinnesotaCare enrollment sites transfer applications for MinnesotaCare only to MinnesotaCare Operations if the household does not meet the definition of current contact. See §0904.03.03 (MinnesotaCare Enrollment Sites) and §0906.07.03.01 (MinnesotaCare Enrollment Site Transfers) for information on case transfers in these situations.

If counties that administer multiple health care programs receive an application requesting all programs, determine eligibility for MA/GAMC first unless the applicant has requested a determination for MinnesotaCare only. If the applicant is ineligible for MA/GAMC or has a spenddown, determine eligibility for MinnesotaCare. If the applicant is eligible for MA/GAMC with a spenddown and MinnesotaCare, consult with the client to determine program choice.

In most cases, people who are terminated from MA or GAMC due to excess income or assets do not need to submit a new application to have MinnesotaCare eligibility determined. See §0904.05.05 (When Not to Require an Application).

MinnesotaCare:

If you deny coverage for someone who has requested transfer to MA/GAMC, forward the original HCAPP and all other forms and information obtained during the application process to the applicant's county of residence with the Inter-Agency Case Transfer Form (DHS 3195). Retain copies of all information except medical bills. Add an insert to the client's denial notice explaining that the application has been transferred.

When a disabled adult without children who receives SSI , RSDI, or other disability-based benefits applies for MinnesotaCare, determine if the person must be referred to apply for MA. See §0907.15 (MinnesotaCare Adults Without Children). If yes:

> If the HCAPP indicates a request to transfer the application to the county if there is no MinnesotaCare eligibility, send the original application and other available information to the applicant's county of residence. Send a notice advising the applicant that you have transferred the application and that the applicant must cooperate in the MA determination. Determine MinnesotaCare eligibility for up to 60 days while the MA application is pending.

> If the HCAPP indicates a request for MinnesotaCare only, send a notice advising the applicant of the requirement to apply for MA. Give the applicant a choice between having the HCAPP transferred or contacting the county directly. The notice will inform applicants that they must cooperate with the MA determination and that they will have to complete a new HCAPP if they choose to contact the county directly. The notice will advise them to contact MinnesotaCare if they want the application transferred. If they request transfer, send the original application and other available information to the county of residence.

MA/GAMC:

Review the application to determine if the applicant needs to complete additional questions that are not required for MinnesotaCare. Send MAXIS SPEC/LETR, HCAPP Referred from MinnesotaCare. If the applicant needs to answer additional questions on the HCAPP, obtain the answer by phone or send copies or the original missing pages to the applicant to complete. Do not return the entire application.

The application date is the date MinnesotaCare received the application. See §0904.07.03 (Date of Application).

Pend the application on PND2. The processing period begins the date your agency receives the application. If the application processing period is already over or it is within 10 days of the end of the processing period, MAXIS will generate a pending

notice. Add worker comments explaining that you have just received the application. SPEC/LETR, HCAPP Referred from MinnesotaCare, also explains the processing period.

The date MinnesotaCare received the HCAPP cannot be entered on MAXIS in the following situations:

> There is an existing MAXIS case for cash or Food Stamps with a more recent application date.

EXAMPLE:

John applied for MinnesotaCare on October 5. MinnesotaCare denied coverage on November 15 due to other health insurance and transferred the application to the county for GAMC. John has a pending application for Food Stamps on MAXIS with an application date of November 10. Enter a GAMC application date as follows:

- If Food Stamps is pending or active, enter November 10 as the GAMC application date. This is the earliest date MAXIS will accept.

- If Food Stamps was denied and the MAXIS case is inactive, use reapplication procedures to enter the GAMC application date. Enter an application date of November 11 (1 day after the Food Stamp application date).

> There is an existing MAXIS case with an MA/GAMC application date earlier than the HCAPP date.

EXAMPLE:

Mark applied for MinnesotaCare on October 5. MinnesotaCare denied coverage on November 11 due to other health coverage and transferred the application to the county for MA. When the county worker attempted to enter the application date on MAXIS, she discovered that Mark had submitted a separate MA application to the county on November 10. MAXIS will not allow entry of the October 5 date.

Leave the existing November 10 MA application date. If Mark is requesting retroactive MA for July, you will receive a warning edit when you enter a budget period beginning more than 3 months before the November application date. Transmit past the warning edit and enter the

correct application date in MAXIS case notes and on the RELG screen in MMIS.

> The application date is earlier than the date previously active MA or GAMC was closed on MAXIS.

EXAMPLE:

Mary's MA was closed on MAXIS effective November 11. She submitted an application to MinnesotaCare on October 28. MinnesotaCare denied coverage on November 15 and transferred the application to the county for MA. MAXIS will not allow entry of the October 28 application date because MA was still active. If Mary is eligible for MA, use the REIN function to approve the application. FIAT a new eligibility version for November.

If Mary is not eligible for MA, the MAXIS case will remain closed. Generate a manual notice denying the new application. Enter the correct application date in MAXIS case notes and on the MMIS RELG screen.

MinnesotaCare:

When a county transfers an application to MinnesotaCare, the county agency will forward the complete original application with the Inter-Agency Case Transfer Form (DHS 3195) and appropriate forms and verifications. The application will be assigned for processing based on the original date of application. See §0904.07.03 (Date of Application).

When you receive the application to process, review the application and the accompanying forms and verifications. Determine if the client needs to answer additional questions or provide more verifications. Contact the client by phone or mail to get the additional information. If the applicant needs to answer additional questions, obtain the answers by phone or mail the necessary pages of the application to the applicant for completion. Do not return the entire application.

Process the application following §0904.07.05 (Application Follow Up) and §0904.07.07 (Pending the Application).

M.S. 256L.05 subd. 2, subd. 4
Minnesota Rule 9506.0030 subp. 2a

MA/GAMC:

If you deny MA or GAMC, forward the complete original application with the Inter-Agency Case Transfer Form (DHS 3195) to MinnesotaCare Operations if your county is not a MinnesotaCare enrollment site. Include the following if applicable:

> Tax forms and related schedules for self-employed applicants.

> Wage verification including pay stubs or employer statements.

> Pregnancy verification.

> Notes or letters from the client.

> Original Health Insurance Information Form (HIIF, DHS 1922b) if this information is not on the HCAPP.

> Third party liability information.

> Original child support forms including good cause documentation, if applicable. See §0906.13 (Assigning Rights to Medical Support).

Do not transfer the case file. Do not include old applications or items you know are not required for MinnesotaCare eligibility. Follow your agency's procedures for retaining copies of the transferred information.

Add worker comments to the denial notice stating that you have transferred the application to MinnesotaCare.

Transfer applications and renewals from GAMC applicants and enrollees who meet mandatory MinnesotaCare referral criteria if your agency is not a MinnesotaCare enrollment site, or your agency is a MinnesotaCare enrollment site but the client requests to have eligibility determined at MinnesotaCare Operations. See §0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals).

Determine MinnesotaCare eligibility when people become ineligible for MA or GAMC due to income or assets. This can occur at the time of renewal, income review or when an enrollee reports a change. If your county is not a MinnesotaCare enrollment site, refer the case to MinnesotaCare Operations within 5 working days. Include the complete most recent application and renewal form as well as current case information listed above.

Applicants who request ongoing MinnesotaCare with retroactive MA may submit the HCAPP to MinnesotaCare or their county of residence. If MinnesotaCare Operations receives an application requesting retroactive coverage, immediately send the original HCAPP with the Inter-Agency Case Transfer Form (DHS 3195) and any verifications included with the HCAPP to the applicant's county of residence. Work with the county agency to process the applications simultaneously.

Follow policies governing program overlap. In most cases people cannot be covered by more than 1 program in the same month.

MinnesotaCare:

Notify the county worker when you are ready to pend awaiting payment. The county worker will coordinate the MA closing date to avoid a lapse in coverage to the extent possible.

M.S. 256L.04 subd. 9

MA:

When county agencies receive an application requesting retroactive coverage, determine eligibility for both retroactive and ongoing MA. County agencies that are not MinnesotaCare enrollment sites should transfer the HCAPP if the applicant is ineligible for MA. County agencies that are MinnesotaCare enrollment sites will determine MA eligibility first. Determine MinnesotaCare eligibility if the applicant is ineligible for MA.

GAMC:

No provisions.

U.S. citizens meet the citizenship/immigration requirements for all of the health care programs. Do not require verification of U.S. citizenship.

Eligibility for non-citizens depends on the immigration status granted by the U.S. Citizenship and Immigration Services (USCIS). For some statuses, such as LPRs, eligibility also depends on when the immigrant entered the U.S. Require verification of immigration status and date of entry for all applicants who report they are non-citizens. Do not request verification of immigration status for people listed on the application who are not requesting coverage.

Once an immigrant has provided verification of immigration status and date of entry, do not request additional verification unless the immigrant reports a change in status. Accept verification obtained by another program unless there is a change in status.

Do not contact USCIS without the applicant or enrollee's signed consent.

See §0906.03.11 (Verification of Immigration Status) for more information on verification requirements and sources of verification.

Some immigrants are eligible for federally funded MA or MinnesotaCare if they meet all other program requirements. These immigrants are called qualified non-citizens. See §0906.03.03 (Qualified Non-Citizens). Immigrants who have lawful permanent resident status and some immigrants with lawful temporary status who are not qualified non-citizens are eligible for state-funded MA or MinnesotaCare if they meet all other program requirements. See §0906.03.05 (Non-Citizens Ineligible for Federal Funding). Also see §0906.03.13 (MinnesotaCare Major Programs).

Undocumented non-citizens and non-immigrants are ineligible for federal and state-funded MA and MinnesotaCare but may be eligible for EMA. Pregnant women who are non-citizens and people receiving services from the Center for Victims of Torture (CVT) who are undocumented or non-immigrants are eligible for state-funded MA (program NM). See §0906.03.09 (Undocumented and Non-Immigrant People).

Consider the income, and assets if applicable, of the sponsor when determining eligibility for most sponsored non-citizens. See §0906.03.07 (Lawful Permanent Residents with Sponsors).

Non-citizens who do not meet the criteria in §0906.03.03 (Qualified Non-Citizens) and §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) are ineligible for the federally funded health care programs (MinnesotaCare programs LL and FF and program MA). They may be eligible for one of the state-funded programs: MinnesotaCare programs KK, BB, JJ, or XX, NM or GAMC. See the program-specific provisions below. See §0906.03.09 (Undocumented and Non-Immigrant People).

MinnesotaCare:

Non-qualified non-citizens are ineligible to receive MinnesotaCare with FFP. Non-qualified non-citizens who can obtain an SSN and have permission to remain in the U.S. permanently may be eligible for state-funded MinnesotaCare (program KK, BB, JJ, or XX). See §0906.05.03 (State Residence--MinnesotaCare Families, MA), §0906.05.05 (State Residence--MinnesotaCare Adults), and §0906.11 (Social Security Number--MinnesotaCare).

In addition to citizenship and immigration status, the correct MinnesotaCare program depends on the person's age, whether or not the person is pregnant, and household income. See §0906.03.13 (MinnesotaCare Major Programs) to determine the correct program.

MA:

Qualified non-citizens who do not qualify for program MA because of date of entry or length of time in the U.S. may qualify for state-funded program NM if they meet an MA basis of eligibility. They must meet all other MA eligibility requirements including income and assets. Program NM provides the same benefits as program MA.

Non-citizens with the following immigration statuses may be eligible for program NM if their date of entry into the U.S. is on or after 8-22-96:

> Lawful Permanent Residents. See §0906.03.11.03.

NOTE:

LPRs who were originally admitted as refugees, conditional entrants, or asylees may continue to be eligible under their original status for 5 years after the date of adjustment to LPR. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment).

> Immigrants granted parole for at least 1 year. See §0906.03.11.11.

> Conditional entrants. See §0906.03.11.09.

> Battered non-citizens and their children. See §0906.03.11.13.

The following groups of non-citizens may be eligible for program NM regardless of their date of entry into the U.S.:

> Pregnant women who are undocumented or non-immigrant. See §0906.03.09 (Undocumented and Non-Immigrant People).

> People who receive services from the Center for Victims of Torture who are not otherwise eligible for federal or state-funded MA, including those who are undocumented or non-immigrant.

See §0906.03.11.23 (Other Lawfully Residing) for more information on the following groups who are eligible for program NM regardless of date of entry:

> Deferred Enforced Departure.

> Entered U.S. before 1-1-72 and has lived here continuously since then under Section 249 of the INA.

> Family Unity Beneficiary.

> Lawful Temporary Resident (LTR).

> Temporary Protected Status.

> Applicant for Asylum.

> Paroled into U.S. for less than 1 year.

Non-citizens who are lawfully residing in the U.S. but do not have a qualified status must cooperate with the INS in efforts to obtain a qualified status or pursue citizenship. The INS application process and type of documentation required will vary according to the person's status. Terminate adults who fail to cooperate.

GAMC:

People who meet the citizenship and immigration status requirements for MA (program MA or program NM) but who do not meet a basis of eligibility for MA may be eligible for GAMC. Undocumented and non-immigrant people are not eligible.

The following groups of people are lawfully residing in the U.S. on a temporary basis. They are eligible for state funding (program NM and MinnesotaCare programs KK, JJ, and BB) if they meet other program requirements.

> Deferred Enforced Departure status was granted to some Salvadorans by executive authorization of the President. People with this status are authorized to remain in the U.S. with employment authorization. Acceptable forms of verification include form I-688B and I-94 indicating Deferred Enforced Departure status.

> Family Unity Beneficiary status provides protection from deportation and employment authorization to the spouses and children of non-citizens who obtained legal status under the Immigration Reform and Control Act of 1986 (IRCA). Acceptable forms of verification include form I-797, I-688B, and I-94 indicating Family Unity status.

> Lawful Temporary Residents (LTRs) are people who had resided in the U.S. unlawfully since before 1-1-82 who were allowed to legalize their status. Acceptable forms of verification include form I-688B and I-94 indicating LTR status.

> Temporary Protected Status (TPS) are people living in the U.S. who are from certain designated countries where unsafe conditions would make it a hardship for them to return. They are authorized to remain in the U.S. for a specified period of time. Acceptable forms of verification include form I-688B or I-94 indicating Temporary Protected status.

> Applicants for Asylum or Withholding of Deportation are allowed to remain in the U.S. with employment authorized while their applications for asylee status are pending with the INS. Acceptable forms of verification include form I-688B and I-94 indicating the person is an applicant for asylum.

> Individuals paroled for less than 1 year have been granted authorization to remain in the U.S. for emergency reasons such as to received medical care or other reasons in the public interest. This status is granted by the U.S. Attorney General.

< People with pending immigration status: The following groups are considered to be lawfully residing in the United States while their applications are still being processed.

- The spouse or child of a United States citizen whose visa petition has been approved and who has a pending application for adjustment of status to LPR.

Acceptable forms of documentation include:

- Form I-94 with a stamp displaying a grant of parole under Section 212(d)(5) of the INA. The I-94 may be stamped PIP or HP.

- Form I-688B.

- Form I-512 Parole Authorization annotated with the reason parole was granted under section 8 CFR.

MinnesotaCare:

The MMIS system uses 6 major program codes for MinnesotaCare enrollees. These codes are used to determine the correct benefit set for the enrollee and whether DHS can collect FFP.

The major program depends on age, pregnancy, income, and immigration status.

Use program LL (full MA benefits with FFP) for people who are under age 21 or pregnant and who are:

> U.S. citizens.

> Qualified non-citizens with the following immigration statuses, regardless of date of entry into the U.S.:

- U.S. veterans or on active duty with the U.S. forces. See §0906.03.11.19.
- American Indian born in Canada. See §0906.03.11.21.
- Refugee. See §0906.03.11.05.
- Asylee. See §0906.03.11.07.
- Deportation withheld under section 243(h) of the INA. See §0906.03.11.07.
- Cuban or Haitian entrant. See §0906.03.11.15.
- Amerasian. See §0906.03.11.17.

> Qualified non-citizens who entered the U.S. before 8-22-96 with the following immigration statuses:

- Lawful permanent resident (LPR). See §0906.03.11.03.
- Paroled for more than 1 year. See §0906.03.11.11.
- Conditional entrant. See §0906.03.11.09. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment) if conditional entrants adjust to LPR status on or after 8-22-96.
- Battered non-citizen or child of battered non-citizen. See §0906.03.11.13.

Use Program KK (full MA benefits without FFP) for people who are under age 21 or pregnant and who entered the U.S. on or after 8-22-96 with the following immigration statuses:

> Lawful permanent resident (LPR). See §0906.03.11.03.

> Paroled for more than 1 year. See §0906.03.11.11.

> Conditional entrant. See §0906.03.11.09. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment) if conditional entrants adjust to LPR status on or after 8-22-96.

> Battered non-citizen or child of battered non-citizen. See §0906.03.11.13.

Use Program KK (full MA benefits without FFP) for people who are under age 21 or pregnant and who have the following immigration statuses regardless of date of entry:

> Deferred Enforced Departure.

> Entered the U.S. before 1-1-72 and has maintained continuous residence under Section 249 of the INA.

> Family Unity Beneficiary.

> Lawful Temporary Resident (LTR).

> Temporary Protected.

> Applicant for asylum.

> Paroled for less than 1 year.

See §0906.03.11.23 (Other Lawfully Residing) for more information.

Use Program BB for all adults who are not parents and who have family income equal to or less than 175% FPG. Some people may be ineligible due to citizenship or residency. See §0906.03.09 (Undocumented and Non-Immigrant People) and §0906.05 (State Residence). Use program BB with eligibility type M1 and a G indicator on the RIMG screen for adults without children with incomes equal to or less than 75% FPG. Use program BB with eligibility type M3 and 1" or 2" income indicator on the RIMG screen for adults without children with incomes greater than 75% FPG but no more than 175% FPG. These enrollees are eligible for the MinnesotaCare Limited Benefit (MLB) set.

Use program FF (with FFP) for parents and relative caretakers who are not pregnant, have

income at or under 275% FPG, and who:

> Are U.S. citizens.

> Have one of the following immigration statuses regardless of date of entry:

- U.S. veterans or on active duty with the U.S. forces. See §0906.03.11.19.
- American Indian born in Canada. See §0906.03.11.21.
- Refugee. See §0906.03.11.05.
- Asylee. See §0906.03.11.07.
- Deportation withheld under section 243(h) of the INA. See §0906.03.11.07.
- Cuban or Haitian entrant. See §0906.03.11.15.
- Amerasian. See §0906.03.11.17.

> Have one of the following immigration statuses with date of entry before 8-22-96:

- Lawful permanent resident (LPR). See §0906.03.11.03.
- Paroled for more than 1 year. See §0906.03.11.11.
- Conditional entrant. See §0906.03.11.09. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment) if conditional entrants adjust to LPR status on or after 8-22-96.
- Battered non-citizen or child of battered non-citizen. See §0906.03.11.13.

Program FF adults with incomes less than or equal to 175% FPG have restorative dental with a 50% copay and no inpatient hospital co-payment or cap. Program FF adults with incomes over 175% FPG but equal to or less than 275% FPG have restorative dental with no co-pay and a $10,000 inpatient hospital cap. They do not have an inpatient hospital co-payment.

Use program JJ (no FFP) for the following adults with incomes equal to or less than 275% FPG:

> All legal guardians and foster parents.

> Non-citizen parents and relative caretakers with 1 of the following immigration statuses and date of entry on or after 8/22/96:

- Lawful permanent resident (LPR). See §0906.03.11.03.
- Paroled for more than 1 year. See §0906.03.11.11.
- Conditional entrant. See §0906.03.11.09. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment) if conditional entrants adjust to LPR status on or after 8-22-96.
- Battered non-citizen or child of battered non-citizen. See §0906.03.11.13.

> Non-citizen parents and relative caretakers with 1 of the following immigration statuses regardless of date of entry. See §0906.03.11.23 (Other Lawfully Residing) for more information on the following statuses:

- Deferred enforced departure.
- Continuously present since before 1/1/72 under Section 249 of the INA.
- Family Unity Beneficiary.
- Lawful Temporary Resident.
- Temporary Protected.
- Applicant for Asylum.
- Paroled for less than 1 year.
- People with pending immigration status.

Program JJ adults with incomes less than or equal to 175% FPG have restorative dental with a 50% co-pay and no inpatient hospital co-payment or cap. Program JJ adults with incomes over 175% FPG but equal to or less than 275% FPG have restorative dental with no co-pay and a $10,000 inpatient hospital cap. They do not have an inpatient hospital co-payment.

MinnesotaCare:

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

Group 1 includes:

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

> Children who have been continuously enrolled in Group 1. This includes children who were originally enrolled in the Children's Health Plan who have maintained continuous enrollment. Continuous enrollment means enrollment in MinnesotaCare or MA/GAMC without a break in coverage of one month or more. See CONTINUOUS ENROLLMENT in §0902.07 (Glossary: Client...)

Reevaluate the group status of 21-year-olds currently assigned to Group 1 for the first available month following the 21st birthday. Assign them to the appropriate group depending on their current circumstances. See §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4).

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

In 1995, Betty enrolled in MinnesotaCare with her parents. Based on the household income at the time of enrollment, Betty was assigned to Group 1. In 1996, Betty and her parents ended their MinnesotaCare coverage. They reapply in 1998. Determine Betty's group status based on the household income at the time of reapplication.

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

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

> Adults without children whose income is at or below 75% FPG.

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

MA/GAMC:

No provisions.

MinnesotaCare:

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

Group 2 includes:

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

EXCEPTION:

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

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

NOTE:

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

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

> Legal guardians and foster parents.

Redetermine eligibility for the next available month or at the time they apply for MinnesotaCare coverage on their own case when people enrolled in Group 2:

> Reach age 21.

OR

> Are no longer part of a family with children.

If people who originally enrolled in Group 2 reapply after losing coverage for one

month or more, redetermine eligibility based on current circumstances.

EXAMPLE:

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

EXAMPLE:

Emily Brown has reached age 21 and moved out of her parents' household. She requests to end coverage on her parents' case and begin her own MinnesotaCare case. Reevaluate her eligibility and group status when her application is processed. Since she is now an adult in a household with no dependent children, her income must be equal to or less than 175% FPG. Bruce is now age 20 and remains in his parents' household. Joe, Susan and Bruce retain Group 2 status.

EXAMPLE:

Bruce moves out of his parents' household. Assign his parents to a non-parent major program (BB and the appropriate group status) for the next available month with 10-day notice. If their income exceeds 175% FPG, terminate coverage the end of the month following the month in which excess income is determined. When Bruce submits an application for coverage on his own MinnesotaCare case, reevaluate his group status.

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

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

The income limit at application for Group 2 children, pregnant women and minor parents is 275% FPG. The income limit for other parents, relative caretakers, legal guardians and foster parents is 275% FPG or $50,000, whichever is less. Children under 21 in Group 2 who meet the MCHA exemption and maintain continuous enrollment can have income over the limit and remain enrolled. Pregnant women in Group 2 who maintain continuous enrollment can have income over the

limit and remain enrolled until the end of the 60-day post partum period. See §0912.03.03 (MinnesotaCare Excess Income).

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

MA/GAMC:

No provisions.

MinnesotaCare:

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

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

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

> Funding. Parents and relative caretakers qualify for federally funded MinnesotaCare if they:

-Have children under age 21 in the household.
AND
-Are U.S. citizens or have a qualified immigration status.
AND
-Have incomes equal to or less than 275% FPG. Those with incomes over 100% FPG but no more than 200% FPG qualify for enhanced federal funding.

Parents and relative caretakers qualify for state-funded MinnesotaCare if they:

- Have a non-qualified immigration status.
OR
-Are legal guardians or foster parents.
OR
-Legal guardians and foster parents are eligible for state–funded MinnesotaCare only.

For a person who is both a parent/relative caretaker AND a legal guardian or foster parent, use the federally funded basis of parent or relative caretaker.

EXAMPLE:
An aunt who is her nieces' legal guardian. Use the relative caretaker status based on her relationship to her niece.

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

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

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

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

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

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

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

When adults lose parent or caretaker status, change eligibility to major program BB and either Group 1 or Group 3 depending on their income level effective the first available month after the change.

M. S. 256L.04 subd. 13

MA:

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

GAMC:

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

MinnesotaCare:

No provisions.

MA:

Also see §0907.19.05.03 (MA Basis: Auto Newborn).

If the mother legally relinquishes control of the child before the child leaves the hospital, consider the child to be out of the mother's household starting with the first full calendar month for which you can give 10-day notice after papers are signed giving custody and control of the child to an agency or person other than the mother. This could be a pre-adoptive placement or foster home placement of any duration. The most common forms of documentation are the Voluntary Foster Care Placement Agreement, the Agreement Conferring Authority to Place Child for Adoption, or a court order. Redetermine eligibility using only the child's income. Continue basing eligibility on only the child's income until either:

> The child is legally adopted. Begin deeming the adoptive parents' income starting with the first full calendar month after the adoption is finalized, unless the child receives adoption assistance. See §0907.19.03.05 (MA Basis: Adoption Assistance).

OR

> Legal custody and control of the child is returned to the mother. At that time, the child would again become automatically eligible through the end of the auto newborn period.

EXAMPLE:

Anne has a baby on June 2 and voluntarily places the child in foster care. Add the child to Anne's MA effective June 1 and remove the child effective June 30. The child returns to Anne's care and custody on September 5. The child regains auto newborn status.

All children born to women enrolled in MA are eligible on the mother's case as auto newborns for the month of birth, including children who are placed for adoption immediately. Enroll newborns born on or after 10/1/04 retroactively in the same health plan the mother was enrolled in during the birth month. See §0914.03.13 (Adding/Removing People From Managed Care).

Obtain the newborn child's name and birth date. For MA-only cases, do not require an addendum. Document the information in the case record. Also do not require a

name as a condition of adding a child for whom the mother has relinquished care or control.

EXAMPLE:

Sheila receives MA and gives birth to a son on March 23. She signs papers relinquishing control of the child to an adoption agency on March 24. She does not name the child. The health plan provides verification of the birth date. Add the child to Sheila's case as an auto newborn effective March 1. Remove the child effective April 1, the first full month in which he lives apart from Sheila. If the child requires continued MA, a representative of the adoption agency, foster parent, or other responsible person may apply on his behalf. See §0904.11 (Authorized Representatives). The adoption agency is not responsible for the cost of the baby's medical care.

If you are unable to contact the mother to determine if she wants continued MA for a newborn, add the child for the birth month only. Send a notice to add the child for the birth month and a notice to remove the child the following month. If the mother contacts the county later requesting continued coverage for the child, reinstate MA for the child back to the date of removal if the child has continued to live with the mother.

EXAMPLE:

Rhonda receives GAMC. The worker receives notification that she had a pregnancy-related medical claim. The worker confirms and verifies the pregnancy and opens MA-PW. On August 10, the health plan notifies the county agency that Rhonda had a baby boy on August 2. The worker attempts to contact Rhonda by phone on August 12 and leaves a message asking Rhonda to call by August 22. Rhonda does not respond and the worker makes a 2nd attempt asking Rhonda to call by September 3. Rhonda has not contacted the worker by September 20.

Add the newborn to Rhonda's MA for the month of August only. Send a notice to Rhonda's last known address advising her that the newborn has been added to MA effective August 1 and removed effective September 1. If Rhonda calls asking for continued coverage for the baby, reinstate MA effective September 1 if the baby continues to live with Rhonda.

Terminate MA if the child and mother move out of Minnesota. If the mother and child return to live together in Minnesota before the end of the auto newborn period, the child regains auto newborn status as of the date the mother and child regain Minnesota residency.

EXAMPLE:

Tonya receives MA and gives birth to Amanda on August 4. Tonya and Amanda move to Indiana on October 10. Terminate MA effective November 1.

Tonya and Amanda move back to Minnesota the following June 16 when Amanda is 10 months old. Amanda regains auto newborn status from June 16 through the month of her 1st birthday. See §0906.05.03 (State Residence--MinnesotaCare Families, MA) for procedures if Amanda is on MA in Indiana.

Assess continued MA eligibility before terminating the child's coverage at the end of the auto newborn period. Require a renewal if no one in the household has completed a renewal within the past 12 months. See §0905 (Reviews and Renewals).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Some members of families with children who lose eligibility for regular MA may be eligible for additional coverage under Transitional MA (TMA) or Transition Year MA (TYMA). TMA provides 4 months of additional coverage to people who meet the criteria described in this section who become ineligible for MA Method A under the 100% FPG standard due to increased child or spousal support. TYMA provides up to 12 months of additional coverage to people who meet the criteria described in this section who become ineligible for MA Method A under the 100% FPG standard due to increased earned income.

Determine potential eligibility for TMA or TYMA separately for each family member who:

> Has a Method A (families with children) basis of eligibility, even if they choose a Method B (elderly/disabled) basis for MA eligibility

AND

> Is one of the following:

-A parent or relative caretaker with a dependent child in the household.
OR
-A dependent child with a parent or relative caretaker in the household.
OR
-A pregnant woman in her 3rd trimester.

It is not necessary that all household members be on MA, although only those on MA will be potentially eligible for TMA/TYMA

AND

> Has net countable income equal to or less than 100% FPG using Method A deeming and income computation rules. See §0912.100 (100 Percent of FPG Standard).

Flag each person meeting the criteria, including those who use Method B for ongoing eligibility. If the person later loses eligibility for MA Method A under the 100% FPG standard due to increased child/spousal support, increased earned income or loss of the earned income disregard, determine actual eligibility for TMA or TYMA.

EXAMPLE:

Ron and Cathy apply for MA with their daughter, Christina, age 5. Ron is

disabled. Cathy is working. Ron, Cathy and Christina all meet an MA Method A basis. Ron meets an MA Method A basis even if he chooses to use his disabled basis for actual eligibility. Each household member is a parent or dependent child. If each person's countable income using Method A deeming, disregards and deductions is at or below 100% FPG, flag all 3 for potential TMA/TYMA.

EXAMPLE:

Anthony and Karen apply for MA with Karen's daughter Melissa, age 2. Anthony is Melissa's stepfather. Anthony does not meet a basis for MA Method A. Karen and Melissa both meet an MA Method A basis. Karen is a parent and Melissa is a dependent child. If Karen and Melissa have income at or below 100% FPG using Method A deeming, disregards and deductions, MAXIS will flag both for potential TMA/TYMA. Anthony is not potentially eligible for TMA/TYMA.

Determine actual TMA or TYMA eligibility at the time each person's countable income for Method A increases beyond 100% FPG. To be eligible, the person must:

> Have received MA and been flagged as potentially eligible for TMA/TYMA in at least 3 of the 6 months preceding the income increase.

AND

> Remain in a household that includes a dependent child.

AND

> Lose eligibility for MA Method A under the 100% FPG standard because of increased child/spousal support (TMA), or a parent/caretaker's increased earned income or loss of an earned income disregard (TYMA). Increased income also includes the employment of a returning parent. It does not include marriage of the caretaker to a stepparent.

EXAMPLE:

Mary has received MA for herself and her 2 children since January. In June, her husband Perry returns to the home. He is the children's father and his income is deemed to the rest of the household. He is employed and his earnings cause the rest of the family's income to exceed 100% FPG. Mary, Perry and the children are eligible for up to 12 months of TYMA if Mary and the children were flagged in at least 3 of the last 6 months.

See §0907.19.11.03 (TMA/TYMA: Changes and Reporting Requirements) for information on when returning household members can be added to TMA or TYMA.

If a person becomes ineligible for MA Method A under the 100% FPG standard for more than one reason, determine if increased earnings would have caused ineligibility without regard to the other change. If yes, the person is eligible for TYMA.

EXAMPLE:

Jeanine has received MA for herself and 3 children for 6 months. They have been flagged as potential TMA/TYMA eligibles. One child leaves the home, resulting in a smaller household size. Jeanine gets a job the same month which would have resulted in income exceeding 100% FPG for each member of the original household size of 4, as well as for the current household size of 3. Jeanine and her 2 children are eligible for up to 12 months of TYMA because the increased earnings would have caused ineligibility for regular MA without regard to the household composition change.

If the household becomes ineligible due to a combination of a parent/caretaker's increased earnings and increased child or spousal support, they are eligible for up to 12 months of TYMA.

Because children under age 19 and pregnant women have a higher MA income standard, they may be eligible for regular MA and TMA/TYMA concurrently. Different household members may begin TMA/TYMA eligibility at different times.

EXAMPLE:

Nancy and her son Ray, age 3, have received MA for 6 months and have been flagged as potential TMA/TYMA eligibles for all 6 months. Nancy begins receiving child support for Ray that causes his income to exceed 100% FPG. His income remains below his standard of 150% FPG. Since the child support is not counted for Nancy, her income remains below 100% FPG.

Because Ray's income now exceeds 100% FPG, his 4-month TMA eligibility begins even though he remains eligible for regular MA. If his income increases beyond 150% FPG during the 4-month TMA period, he is eligible for TMA for any remaining months.

In the third month of Ray's TMA eligibility, Nancy reports increased earnings. Her income now exceeds 100% FPG. Ray's total income, including child support and Nancy's deemed earnings, exceeds 150% FPG. Nancy and Ray are now eligible for up to 12 months of TYMA. MAXIS will close Ray's TMA and open TYMA.

People with fluctuating income may move between regular MA and TMA/TYMA. If

TMA/TYMA enrollees have an income reduction resulting in renewed eligibility for regular MA under the 100% of FPG standard, stop counting the TMA/TYMA months. Determine how many remaining TMA/TYMA months are available when income again increases beyond 100% FPG. Also determine if the person meets the criteria for a new TMA/TYMA period.

EXAMPLE:

Carlos, Michelle and their son Lorenzo, age 3, have been enrolled in MA since August. They all have net income below 100% FPG and have been flagged for potential TMA/TYMA since August. On November 15, Michelle reports that Carlos got a raise from his employer. Their income is now above 100% FPG, but below 150% FPG. Since all three have been flagged in three of the last six months and there was an increase in earned income, TYMA eligibility begins December 1. Lorenzo remains eligible for regular MA, with TYMA eligibility running concurrently.

On January 9, Michelle calls to report that Carlos has been laid off. Their income is now below 100% FPG. They are now eligible for regular MA. MAXIS does not count the regular MA months toward the TYMA eligibility period. On February 13, Michelle calls to report that Carlos has found another job. Their income is now again over 100% FPG but below 150% FPG. TYMA begins again on March 1 with 10 remaining months available. TYMA and regular MA run concurrently for Lorenzo.

If regular MA eligibility had continued for 3 months with countable income equal to or less than 100% FPG, the household would again be eligible for a full 12 months of TYMA when regular MA ends.

People who were flagged for TMA/TYMA under Method A but use Method B for ongoing eligibility may also become eligible for regular TMA/TYMA and MA Method B concurrently.

EXAMPLE:

Melissa and George apply for MA for themselves and their son Ryan. Melissa works part time and earns less than 100% of FPG. George recently became disabled and has applied for RSDI. He is certified disabled by SMRT and found eligible for the CADI waiver. He must use Method B. Melissa's income is not deemed to him. All three are flagged for TMA/TYMA.

Melissa's income increases above 100% FPG when her disregard cycle ends. She and Ryan become eligible for TYMA. George remains on CADI Method

B with no income deemed to him. TYMA runs concurrently. Four months later, George is approved for RSDI and will now have a spenddown. If he continues to receive CADI services, he must remain on Method B with the spenddown. If he discontinues CADI, he can receive TYMA for the remaining months of the family's TYMA eligibility.

People must meet ALL the following conditions throughout the period of TMA/TYMA eligibility:

> The household must contain a dependent child. See the MA definition of DEPENDENT CHILD in §0902.09 (Glossary: Denial...).

Send the Transition Year Medical Assistance First Quarterly Report (DHS 2975a) at the end of the third month of TYMA. If the enrollee returns the form indicating there is no longer a dependent child in the home, close TYMA for the 1st month for which you can give 10-day notice. Determine if MA eligibility continues under another basis. If the enrollee does not return the form, assume the household still contains a dependent child. It is not necessary to monitor the return of the first quarterly report form.

> They must remain Minnesota residents. People who lose state residency but return to Minnesota within 12 months of beginning TYMA eligibility (4 months for TMA) may qualify for any remaining months in the original period if they meet all other TMA/TYMA requirements.

EXAMPLE:

Gene and Barbara and their children are found eligible for TYMA beginning February 1. In May they move to North Dakota to accept a new job. They move back to Minnesota in October. Reopen TYMA from the date they regain Minnesota residency through January 31 for all family members who meet all other TYMA requirements.

> The caretaker must enroll in the employer's cost effective health care plan if available. Terminate TMA/TYMA for caretakers who refuse to enroll. The children remain eligible.

> The caretaker must cooperate with medical support requirements. Terminate TMA/TYMA for caretakers who fail to cooperate without good cause. The children remain eligible.

TMA/TYMA are not available to any household member who is convicted of MA

fraud for any of the 6 months before termination of regular MA or for any month of TMA/TYMA medical. Remove caretakers who are convicted of fraud. The children may remain on TMA/TYMA.

Also see §0907.19.11.03 (TMA/TYMA: Changes and Reporting Requirements).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People who are certified as disabled have a basis of eligibility for MA and may also qualify for the Medicare Savings Programs. See §0907.21.09 (MA Basis: Medicare Savings Programs) for a description of these programs and the eligibility requirements. People whose basis of eligibility is disability may be eligible for a waiver of spousal or parental deeming requirements and/or expanded MA services. See §0907.23 (MA Waiver Programs).

Either the SSA or the SMRT must certify disability. See §0906.15 (Disability Determinations). There is no age limit.

Disabled children may qualify under more than one basis. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility).

Use Method B to determine countable income and assets.

The asset limit for MA for people with a disabled basis of eligibility is:

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

See §0909.05 (Asset Limits).

Effective 7-1-01, the income limit is 100% of FPG. See §0912.07.100 (100% of FPG).

People with incomes over 100% of FPG may be eligible by spending down to 75% of FPG effective 7-1-02 (70% of FPG through 6-30-02). See §0912.07.075 (75% of FPG).

The spenddown type depends on the person's living arrangement. See §0913.05 (Which Spenddown Type to Use).

People with a disabled basis of eligibility who qualify for MA are eligible for all MA covered services.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

The following groups are not eligible for MA-EPD:

> People age 65 and older.

> People under age 16.

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

> SSI recipients.

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

> People ineligible for GRH who reside in a GRH facility and whose MA spenddown is fully met with remedial care costs.

> People who reside in a long term care facility and are expected to remain for at least 30 consecutive days.

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

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

> The EW and AC waivers. These waivers are limited to people age 65 and over. See §0907.23.11 (MA Waiver Programs: EW) and §0918.05 (Alternative Care - AC).

> QI. See §0907.21.09.09 (Medicare Supplement Programs: QI). QI and MA-

EPD may overlap only when a QI enrollee requests retroactive coverage for MA-EPD. If MA-EPD eligibility will continue, close QI for the first month for which you can give 10-day notice.

> GAMC.

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

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

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

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

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

MA-EPD may not be the right choice for all employed people with disabilities. Determine eligibility for regular MA first. People with net countable incomes equal to or less than 100% FPG for their household size qualify for MA without a spenddown if they meet other MA eligibility requirements, including asset limits. All MA-EPD enrollees must pay premiums. The initial premium must be paid to the county prior to approving MA-EPD eligibility. See §0913.01.03 (MA-EPD Premiums). Allow people who qualify for both regular MA and MA-EPD to choose between them.

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

> Are certified disabled by SSA or SMRT or who have been certified by the county case manager as eligible to receive services through the MR/RC waiver. See §0907.23.05 (MA Waiver Programs: MR/RC). Refer people whose SSI, RSDI, 1619(A) or 1619 (b) benefits are terminated, and people with no current disability certification from either SSA or SMRT for a SMRT

review.

For MA-EPD, SMRT will determine disability without regard to the person's earnings level. See §0906.15 (Disability Determinations).

-People who are in non-pay status for RSDI continue to be certified disabled by SSA during the period of non-pay status. Do not refer these people to SMRT.

-Some people may remain disabled but lose RSDI because they earn more than the Substantial Gainful Activity (SGA) level. If they are enrolled in Medicare, these people are eligible for a Medicare extension. Because SSA considers them to remain disabled during the Medicare extension, they continue to meet a disabled basis for MA. Do not refer them to SMRT.

People who are eligible for Medicare Part B must enroll as a condition of MA-EPD eligibility, regardless of their income level and the amount of the Part B premium. Approve MA-EPD for Part B eligible people who failed to enroll. Require them to enroll during the next general enrollment period (January-March of each year) as a condition of continued eligibility. Reimburse Part B premiums for MA-EPD enrollees with incomes no greater than 200% FPG who are not eligible for QMB or SLMB. See §0910.05.05 (Medicare Premium Payments). People may be eligible for MA-EPD concurrently with QMB and SLMB. To be eligible for QMB or SLMB, MA-EPD enrollees must meet all the eligibility requirements of those programs, including deeming of spousal income and assets. See §0907.21.09.03 (Medicare Savings Programs: QMB) and §0907.21.09.05 (Medicare Savings Programs: SLMB).

> Receive an average of more than $65 per month in earned income from employment or self-employment. The earnings must have Medicare and Social Security taxes withheld or paid by the self-employed applicant or enrollee. State and federal income taxes need only be paid or withheld if the person earns enough to be required to pay those taxes. See §0907.21.07.06 (MA-EPD: Employment Definition) for a definition of earned income for MA-EPD.

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

policies in §0909 (Assets), including verification, availability, asset reduction, and treatment of specific types of assets.

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

> Pay required premiums and unearned income obligations.

All MA-EPD enrollees have monthly premiums based on a sliding scale or a minimum of $35, whichever is greater. Premiums are calculated in MAXIS on the EBUD panel. Count only the MA-EPD applicant or enrollee's income when determining the premium, unless the applicant or enrollee is age 16 or 17 and lives with one or both biological or adoptive parents. Count parental income in those cases. Follow §0908.05 (Determining MA/GAMC Household Size) to determine the household size, except for married couples who both apply for MA-EPD. In this case, use a household size of 1, plus children, for each spouse. See §0913 (Premiums and Spenddowns) and §0913.01.03 (MA-EPD Premiums).

MA-EPD enrollees with unearned income also have an unearned income obligation of one-half of 1 percent of the unearned income, in addition to the monthly premium.

MinnesotaCare:

No provisions.

MA:

See §0907.21.07.05 (MA for Employed Persons With Disabilities) for a description and general eligibility requirements for the MA-EPD program.

Consider the following types of payments as earned income for MA-EPD:

> Wages, including salaries, commissions, tips, bonuses, vacation pay, sick pay, and severance pay (if based on accrued leave time), if all of the following conditions are met:

-Average gross monthly earnings for the 6-month certification period are over $65 (at least $65.01)

AND

-Social Security and Medicare taxes are withheld. State and federal income taxes need only be paid or withheld if the person earns enough to be required to pay those taxes.

> Earnings from self-employment, if all of the following conditions are met:

-Average gross monthly earnings is over $65 (at least $65.01).

AND

- The person pays Medicare and Social Security taxes from self-employment income at least annually. Quarterly estimated tax payments and state and federal income taxes need only be paid if the person earns enough to be required to pay those taxes.

> Royalties earned in connection with publication of a person's work if all of the following conditions are met:

-Average gross monthly earnings for the 6-month certification period are over $65 (at least $65.01)

AND

-Social Security and Medicare taxes are withheld or paid if the person is filing self-employment taxes. State and federal income taxes need only be paid or withheld if the person earns enough to be required to pay those taxes.

> Honoraria or stipends received for services rendered if all of the following conditions are met:

-Average gross monthly earnings for the 6-month certification period are over $65 (at least $65.01)

AND

-Social Security and Medicare taxes are withheld or paid if the person is filing self-employment taxes. State and federal income taxes need only be paid or withheld if the person earns enough to be required to pay those taxes.

The enrollee must receive wages, royalties, honoraria or stipends, or must engage in self-employment activities each month unless:

-The enrollee changes jobs and receives no pay checks for 1 month because of different pay periods in each job

OR

-The enrollee is on a temporary medical leave. Allow up to 4 calendar months' leave from work without earned income. Require a physician's statement to verify the need for medical leave. If the physician's statement indicates the enrollee is expected to be unable to work for more than 4 calendar months, send 10-day notice to terminate MA-EPD eligibility effective the first day of the month following the first 4 full calendar months the enrollee was unable to work. Determine eligibility for MA under another basis before terminating MA-EPD.

EXAMPLE:

Maria, an MA-EPD enrollee, works 20 hours per week at a discount store. Her employer withholds Medicare and Social Security taxes. On July 17, her physician advises her to take 15 weeks off work due to a worsening medical condition. She anticipates returning to work November 15. Maria remains eligible for MA-EPD through November.

On November 5, Maria submits a new physician's statement extending her recommended medical leave through December 16. Terminate eligibility for MA-EPD effective December 1 since Maria's medical leave will exceed 4 calendar months. Determine eligibility for regular MA for December. Advise Maria that she may again qualify for MA-EPD when she returns to work if she continues to meet all other eligibility criteria.

OR

-The enrollee is without earnings for up to 4 months due to job loss that was not caused by or attributed to the enrollee. Situations which would allow a 4-month extension include, but are not limited to, layoffs due to lack or work, business closing or plant shutdown.

EXAMPLE:

Colleen is enrolled in MA-EPD and is employed part time at a local business. Her employer withholds Medicare and Social Security taxes. She is laid off in January due to staffing cuts. She receives her last paycheck on January 9. Consider January to be her last month of employment. She may remain enrolled in MA-EPD without earnings through May.

Employees who become unemployed while on medical leave from their jobs may remain enrolled for 4 additional months following the month in which they are terminated or laid off.

EXAMPLE:

Yanni has been on medical leave from his job since mid-August. His MA-EPD enrollment continues through December under the medical leave provision. In November, he is laid off. He may remain enrolled in MA-EPD for 4 additional months, December through March, without earnings.

Enrollees who remain eligible for MA-EPD due to the 4-month job loss extension may not further extend eligibility with a medical leave.

EXAMPLE:

Joanna is enrolled in MA-EPD. She loses her job and receives her last pay check in January because the company goes out of business. She may remain enrolled in MA-EPD through May under the job-loss provision. In March, Joanna is injured and is not recovered sufficiently to find a new job by the end of May. She is not eligible for any further extension. End MA-EPD and determine eligibility for regular MA beginning June 1.

MA-EPD enrollees who become unemployed for reasons attributable to them, such as poor work performance, discharge for misconduct, or resignation for reasons other than medical leave, are not eligible for the 4-month extension.

Enrollees who are employed in seasonal or temporary jobs are not eligible for the extension when laid off at the end of the work season. Allow the extension only if the job ends before the expected date due to reasons not caused by the employee. Extend MA-EPD eligibility only through the

month in which the job was expected to end.

EXAMPLE:

Joe works for a landscaping company which withholds Medicare and Social Security taxes from his wages. He is normally employed from May through November and is eligible for MA-EPD during those months. The business closes early, in October due to unseasonable weather. Joe's MA-EPD eligibility may be extended through November. He is not eligible for a job loss or medical leave in December through March since he is not normally employed during those months.

Do not consider the following payments to be earned income for MA-EPD:

-Gratuitous money allowances
-Honoraria or stipends to the extent that these payments only reimburse expenses or do not have Medicare and Social Security taxes withheld.
-Payments for participation in a clinical trial
-Payments for the sale of blood or blood plasma
-Work study

Require verification of earnings (with Medicare and Social Security taxes withheld) and employment status at application and 6-month and annual renewals.

Do not require monthly reports of income. MA-EPD enrollees must report changes in income and employment status within 10 days.

Do not interrupt the 6-month certification period if eligibility changes from MA-EPD to regular MA. See §0913.19.05 (When Not to Interrupt 6-Month Cert. Period).

Individuals with two sources of earned income, one source that has taxes withheld, and one source that does not may remain eligible for MA-EPD. To remain eligible, the gross earnings from which taxes are withheld must exceed $65 per month. Only the income from which taxes are withheld or paid may be considered employment for purposes of MA-EPD.

EXAMPLE:

Roman works two hours per week at Home Depot earning $60 per month. Home Depot withholds Medicare and, Social Security taxes. He also receives earnings of $90 per month from a DT&H that is not required to withhold taxes. He has no

other earned income. Roman is not eligible for MA-EPD because his gross monthly taxed earnings are not more than $65 per month.

All earned income (whether taxed or not) will continue to be counted for the premium determination.

Accept only the following forms of verification, in order of preference, for MA-EPD:

WAGES

> Pay stubs showing the employee's name or SSN, hours worked, gross pay, Social Security and Medicare taxes withheld, applicable state and federal income taxes withheld, net pay, period covered by earnings, and employer's name.

Social Security and Medicare taxes must be withheld from wages. If these taxes are not withheld, do not consider the payment as a wage for MA-EPD. These taxes must also be withheld from payment for services performed in a Day Training and Habilitation (DT&H) facility, sometimes referred to as a sheltered workshop or work activities center.

> A completed Consent for Release of Employment Information (DHS 3451). Require this form only if the employee does not provide pay stubs containing the required information.

SELF-EMPLOYMENT

> Federal tax forms if the person was required to file Federal income taxes for the previous year. For 2003, people with net earnings of $400 or more were required to file.

To be acceptable as verification of self-employment status for MA-EPD, tax forms must include:

-Quarterly Schedule ES (Form 1040) Estimated Tax for Individuals or Schedule SE (Form 1040) Self-Employment Tax

OR

-Form 1040 U.S. Individual Income Tax Return with line 55, self-employment tax, completed.

OR

-Schedule SE, Self-employment Tax, with Section A, line 5 or

Section B, line 12, completed.

> Business records if the person has not been in business long enough to file a Federal income tax return or quarterly estimated taxes. Advise the person to maintain records and to submit a copy of the federal tax return when it becomes available.

See §0911.09.03 (Self-Employment Income) for acceptable forms of business records. Count seasonal self-employment income only in the months in which it is received. This is an exception to the policy of annualizing seasonal self-employment for regular MA in §0911.09.09 (Seasonal Income).

An individual cannot retain MA-EPD eligibility or become eligible for MA-EPD simply by filing self-employment taxes. The individual must also be engaged in a trade or business, and have average gross self-employment earnings minus business expenses, or countable self-employment income of more than $65.

ROYALTIES, HONORARIA AND STIPENDS

If royalties, honoraria or stipends are the person's only source of earned income, payments of more than $65 must be received each month to qualify for MA-EPD. Accept the following forms of documentation which show the nature and amount of payments, the date received, the frequency of payments, and Medicare and Social Security taxes:

> Tax forms for the previous year showing evidence of royalties, honoraria or stipends with Medicare and Social Security taxes paid, such as entries on Form 1040, Schedule C, Schedule SE or Form 1099-Misc.

> Pay stubs or written statement from the source of payment showing Social Security and Medicare taxes withheld, the person's name or SSN, amount of the payment, period covered, and name of the issuer.

> Quarterly Schedule ES (Form 1040) Estimated Tax for Individuals or Schedule SE (Form 1040) Self-Employment Tax

NOTE:

Royalties from oil, gas or mineral properties are not considered earned income for MA-EPD.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People who are enrolled or are eligible to enroll in Medicare Part A may qualify for Qualified Medicare Beneficiary benefits (QMB). People who meet QMB requirements may receive QMB only or in addition to MA. Although most Medicare eligibles are age 65 and over, blind or have disabilities, some people without a current disability certification may be enrolled in Medicare and potentially eligible for QMB. See §0907.21.09 (Medicare Savings Programs) for more information on these situations.

QMB provides the following benefits:

> Payment of Medicare Part A and Part B premiums.

> Payment of Medicare cost-sharing (co-payments and deductibles) for Medicare services provided by Medicare-eligible providers.

The asset limit and income standard for QMB are higher than for MA only.

Asset limit effective 10-1-00:

> $10,000 for a household of 1.
> $18,000 for a household of 2 or more.

See §0909.05 (Asset Limits).

Income standard:
> 100% of FPG.

See §0912.07.100 (100 Percent of FPG Standards).

Follow MA household size and deeming rules for QMB. See §0908.05 (Determining MA/GAMC Household Size).

Disregard RSDI cost of living adjustments (COLA) at the beginning of each year. See §0912.05.15 (RSDI COLA Disregard).

QMB has no spenddown provisions. People with income in excess of the standard are not eligible for QMB.

EXAMPLE:

Bud's income is 125% FPG. He is ineligible for QMB even if he has covered expenses that would allow him to spend down to 100% FPG.

People may qualify for MA and QMB concurrently.

People with incomes at or under 100% of FPG qualify for MA without a spenddown if their assets are within MA limits. They also qualify for QMB. Because QMB allows a $20 income deduction and MA does not, people with incomes over 100% FPG but no more than 100% FPG + $20 are within the QMB income limit but must meet a spenddown to qualify for MA. People with incomes at or under 100% of FPG, but assets between the MA and the QMB limits, qualify for QMB only.

EXAMPLE:

Blanche has monthly income of $770 per month and countable assets of $2,000. Her MA income standard is $776. She qualifies for MA and QMB.

EXAMPLE:

Clara has monthly income of $790 and countable assets of $2,000. Her income is within QMB limits after deducting $20 but exceeds MA limits since the $20 is not allowed. She qualifies for QMB but must spend down to 75% of FPG to qualify for MA.

Do NOT use an LTC spenddown for people who are open as QMB-only in an LTCF. See §0913.13 (Long Term Care Spenddown Calculation). However, you must enter an LTCF living arrangement on the STAT/FACI screens in MAXIS and on the RLVA screens in MMIS.

Medicare Part A covers very limited skilled nursing care. Payment may not be confirmed until several months after the care is received. This makes it rarely advantageous for people in LTC to be QMB-only. However, if you know Medicare Part A is covering any of the LTCF costs, it is advantageous for people to be QMB-only because there wouldn't be an LTC spenddown. If Medicare retroactively covers any of the LTCF costs of people who are open on both QMB and MA while in an LTCF, the LTCF must reimburse the person for any amounts overpaid to the facility.

Determine eligibility for QMB promptly. Eligibility begins the first day of the month after the month in which the county agency makes an eligibility determination. Eligibility is not possible before or for the month of application. QMB-eligibles may

be eligible for SLMB for payment of Part B premiums for up to 3 months before the month of application until the first month of QMB eligibility. See §0907.21.09.05 (Medicare Savings Programs: SLMB). People who are eligible for QMB may not receive SLMB once they are approved for QMB.

EXAMPLE:

Melba's income and assets are within QMB limits. She requests to receive only SLMB benefits on an ongoing basis because she only wants payment of her Part B premium and does not wish to receive any other QMB benefits. Because she is eligible for QMB, she cannot choose SLMB. Advise her that she does not need to use her QMB for Medicare co-payments and deductibles if she does not wish to.

People residing in Institutions for Mental Diseases (IMDs) are not eligible for QMB unless they meet one of the conditions in §0907.27 (MA/GAMC Basis: IMD Residents) that allows MA eligibility in an IMD. People who would be eligible for QMB if they did not reside in an IMD may be eligible to have their Medicare premiums reimbursed as cost-effective coverage. See §0910.05.05 (Medicare Premium Payment).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Also see §0907.23.09 (MA Waiver Programs: TEFRA).

SMRT makes a disability and level of care determination for each TEFRA Option child. See §0906.15 (Disability Determinations). Only SMRT has the authority to evaluate disabilities for TEFRA certification.

Complete a Determination of Disability (DHS 1467A) for every submission to SMRT and attach documentation to support the client's physical, psychological and/or MR/DD condition. TEFRA Option referrals require physical and/or psychological evidence specific to the child's condition. The specific requirements for the three disability types, physical, developmental and mental health are listed on DHS 3854, DHS 3855, and DHS 3856, respectively. Referrals must include:

> A recent (within the past 3 months) routine physical examination performed by a licensed physician.

> A Children's Activities of Daily Living (CADL) Form (DHS 2904A) completed by the child's parent(s) or guardian(s).

Referrals must also include the following items depending on the child's disability:

> The current Individual Educational Plan (IEP) with the Team Assessment Summary. If the child is not of school age, submit an Early Childhood Assessment. If the child receives other special services, provide reports of these activities. These reports can be obtained from the local school district as part of an Individual Family Service Plan (IFSP).

> A Full Scale Intelligence Quotient (IQ) test or any other psychological evaluation that describes the mental functioning if there are problems related to Mental Retardation/Developmental Delay and the client is unable to be tested.

> Results of a complete psychiatric/psychological examination performed by a licensed psychiatrist or psychologist within the last 12 months. Include an updated progress note if the evaluation is over 3 months old or the child's condition has changed. See the Guide for Parents Applying for TEFRA (DHS 3368) for more information on what the evaluation must include.

SMRT may approve a TEFRA certification for up to a maximum of 4 years. SMRT's decision on the frequency of review of disability and level of care is not subject to administrative appeal. See §0917 (Appeals).

Retain a copy of the materials submitted to SMRT in the county case file pending the outcome of the determination by SMRT. SMRT will return the original documentation to the county agency once the review has been completed along with the State Medical Review Team Determination of Disability (DHS 1467B).

Assist the client in gathering medical information and completing forms as needed. If an active client who would not qualify for MA without TEFRA certification fails to cooperate in submitting medical information by the due date, send a timely closing notice for failure to cooperate with the TEFRA certification process. If the client is cooperating but is unable to supply all medical documentation by the recertification due date, leave the case open until the information is received and SMRT has made a decision. You may use health care access funds to pay for testing required by SMRT to determine disability.

For current TEFRA cases, SMRT will send the documentation requirements forms (DHS 3854, DHS 3855 or DHS 3856) to county agencies 90 days prior to the end of a TEFRA recipient's disability determination end date for recertification.

Parents of TEFRA-eligible children may be responsible to pay parental fees as partial reimbursement of the child's MA costs. After approving eligibility for the child under the TEFRA Option, complete the County Parental Fee Referral (DHS 2982) to DHS. See §0906.13.09 (Parental Fees).

GAMC:

No provisions.

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 1-1-05 through 12-31-05 is $1,737 for all EW applicants or enrollees, regardless of marital status. The SIS for 1-1-04 through 12-31-04 is $1,692. The maintenance needs allowance for 7-1-04 through 6-30-05 is $766 regardless of marital status. 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.

MinnesotaCare:

No Provisions.

MA:

No provisions.

GAMC:

People who do not have a basis of eligibility for MA and who meet the technical eligibility requirements for GAMC, but who have income or assets in excess of the limit for full GAMC benefits, may qualify for GAMC for inpatient hospitalization. Benefits are limited to inpatient hospital charges and physician's services received during the inpatient hospitalization. Eligibility begins the date of application or the date of inpatient hospital admission, whichever is later, and ends effective the date of discharge from inpatient hospitalization. There are no reviews or renewals for GHO.

Asset limit:

- $10,000 for a household of 1 and $20,000 for a household of 2 or more. Follow MinnesotaCare to determine what assets to exclude and how to evaluate counted assets. There are no improper transfer provisions for GHO.

See §0909.05 (Asset Limits).

Income standard:

- More than 75% FPG but no more than 175% FPG for a 6-month budget period. See §0912.07.075 (75 Percent of FPG Standards) and §0912..07.175 (175 Percent of FPG Standards). Use gross income. Follow MA Method B to determine what income to exclude.

There are no spenddown provisions. GHO enrollees have a $1,000 co-payment for each inpatient admission, regardless of income. The co-payment may be applied against the spenddown for household members who receive or are applying for MA. No other medical expenses may be applied to reduce the GHO enrollee's co-payment. MMIS will apply the co-payment to the claim automatically.

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

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

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

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

MA-EPD:

- $20,000

No asset limit for children under 21.

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

100% of FPG. See §0912.07.100 (100 Percent of FPG Standards).
People with incomes greater than 100% FPG may be eligible by spending down to

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

MA-EPD:

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

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

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

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

People who meet an MA basis of eligibility but are ineligible for MA solely because they live in an IMD are eligible for state-funded MA benefits, except for coverage of nursing homes that are IMDs. Use major program I/IM on MAXIS and MMIS. Determine eligibility using MA income and asset limits. Determine the MA basis of eligibility and apply the appropriate income standard, asset limit, and method. See §0907.19 (MA Families and Children Bases), §0907.21 (MA Basis: Age 65 and Over/Blind/Disabled), and §0909.05 (Asset Limits).

EXAMPLE:

Mary, age 35, receives MA for herself and 2 children. She is placed in an IMD for an estimated stay of 3-4 months. She is ineligible for MA solely due to IMD residence. Determine eligibility for program IM eligibility using the MA Parent/Caretaker asset limit ($20,000 for Mary and 2 children) and income limit (100% of FPG). Use Method A.

People who are eligible for program IM are eligible for MA if they have been discharged from the IMD or are on convalescent or conditional leave. See §0906.09.01 (Institutional Residence --MA/GAMC).
People who are enrolled in program IM solely due to IMD residence are also ineligible for the Medicare Supplement Programs. Reimburse cost-effective

Medicare premiums for this group. See §0910.05.05 (Medicare Premium Payment).

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

GAMC:

People who reside in an IMD and do not have a basis of eligibility for MA are eligible for GAMC. Use gross income. Follow MA Method B to determine what income to exclude.

Asset limit:

- $1,000 per household.

See §0909.05 (Asset Limits).

Income standard:

75% FPG See §0912.07.075 (75 Percent of FPG Standards).

EXAMPLE:

Peter, age 40, resides in an IMD. He is single with no children and is not blind or disabled. Determine GAMC eligibility.

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

Deeming means counting the income, and assets if applicable, of one person as available in determining the eligibility of another person.

MinnesotaCare:

No provisions. Consider the countable income of all household members. See §0911.05 (Excluded Income) for information on what types of income to exclude.

MA:

Deeming requirements are not the same as household composition rules. People may be included in another person's household without having their income and assets counted toward the other person's eligibility. Determine household size and countable income and assets separately for each person.

The information about counting income and assets in this section may not apply to people on an MA waiver program. See §0907.23 (MA Waiver Programs).

When the following people live with an MA applicant or enrollee, consider their income and assets available:

> The person's spouse unless it is the month the client has entered a long term care facility or begins receiving home care services covered through elderly waiver (EW). When a client is NOT divorced but is legally separated from his/her spouse and continues to live in the same household, consider the spouse's income and assets available to the client.

> The client's natural or adoptive parent, if the client is under 21 and not emancipated. When the father or alleged father of a child is not married to the child's mother, deem the father's income to the child only if paternity has been established AND the father lives with the child. Paternity has been established when adjudicated by a court or when the father has signed a Declaration of Parentage or Recognition of Parentage form (DHS 3159). See DECLARATION OF PARENTAGE (DOP) in §0902.07 (Glossary: Client...) and RECOGNITION OF PARENTAGE (ROP) in §0902.33 (Glossary: Quality...).

Do not count:

> Parents' income or assets as available to children from birth through the end of the month of the child's first birthday if the child qualifies as an auto newborn. See §0907.19.05.03 (MA Basis: Auto Newborn).
> The income or assets of parents of blind or disabled children ages 18 to 21.

> Stepparents' income or assets as available to a stepchild.

> Parent's income as available to children of any age who receive SSI. Count the parent's assets if the child is under age 18.

> Parent's income or assets as available to children eligible under TEFRA.

> Children's income or assets as available to parents.

GAMC:

Count the income and assets of a person's spouse when the spouse lives with the client.

MA/GAMC HOUSEHOLD SIZE AND DEEMING EXAMPLES:

EXAMPLE:

Kelly, age 30, lives with her husband Jason, age 33, her daughter from a previous marriage, Allie, age 8, and Jason's son from a previous marriage, Garrett, age 10. Kelly is pregnant and expecting a medically verified single birth. Each household member has a household size of 5. Kelly and Jason both have employment income, and Kelly receives child support for Allie. Garrett has no income. Only Kelly and Jason have assets.

Deem income and assets as follows:

Kelly: Count her own and Jason's income.
Jason: Count his own and Kelly's income and assets.
Allie: Count Kelly's income and Allie's child support.
Garrett: Count Jason's income.
Unborn child: The child will be eligible as an auto newborn if Kelly is on MA at the time of the birth. If the family requests continued MA after the child turns 1, you would count Kelly and Jason's income.

EXAMPLE:

Megan, age 18, lives with her mother, Sue, her father, Larry, her 15-year-old sister Laura, and her 2-year-old son Trevor. Megan has a household size of 5: Megan, parents, sibling, and her own minor child. Megan's parents each have a household size of 4: Larry, Sue, Megan, and Laura. Laura has a household size of 4: Laura, Larry, Sue, and Megan. Trevor has a household size of 2: Trevor and Megan.

Deem income and assets as follows:

Megan: Count Sue, Larry, and Megan's income.
Sue: Count Sue and Larry's income and assets.
Larry: Count Larry and Sue's income and assets.
Laura: Count Sue, Larry, and Laura's income.
Trevor: Count Megan and Trevor's income.

Exclude the following assets for all health care programs:

> Household and personal goods, such as pets, furniture, clothing, jewelry, appliances, and other tools and equipment used in the home.

> Income during the month of receipt. See §0911.05 (Excluded Income) and §0911.05.03 (Excluded Income--Program Provisions) for information on which payments are excluded as income.

Count income retained into the next month as an asset with the specific exceptions listed below:

> Exclude payments made to people because of their status as victims of Nazi persecution. This includes reparation payments the Federal Republic of Germany makes to certain survivors of the Holocaust. They may be monthly payments or a lump sum payment. Exclude these payments as assets in the month received and thereafter.

> Exclude payments resulting from an appeal as assets for 3 months after the month of receipt.

> Exclude payments made under state or federal law for foster care and adoption assistance as assets in the month of receipt and thereafter.

> Exclude disaster relief funds paid by state and local governments and disaster relief organizations such as Red Cross and Salvation Army as assets in the month of receipt and thereafter.

> Exclude Netherlands' Act (WUV) payments as assets in the month of receipt and thereafter.

> Exclude state and federal tax rebates as assets in the month received and thereafter.

Exclude the following federal payments as assets. For Method A, applicants and enrollees must hold these funds in a separate account from non-excluded funds to maintain the exclusion. For Method B, applicants and enrollees may hold these funds in an account with non-excluded funds but must be able to identify them separately from non-excluded funds.

> Low Income Energy Assistance Program (LIHEAP) payments.

> Payments for tribal land claim settlements listed in §0911.09.21 (Tribal Land Settlements and Trusts).

> Benefits from the Women, Infant, and Children (WIC) nutrition program.

> Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970.

> Payments received from youth incentive entitlement projects and youth community conservation and improvement projects.

> Reparation payments to Aleut people and people of Japanese ancestry under Public Law 100-383.

> Agent Orange payments to veterans and their dependents.

> Payments made under the Radiation Exposure Compensation Act (Public Law 101-426).

> Payments made by federal agencies under a presidential declaration of disaster including, but not limited to, individual and family grants from the Federal Emergency Management Agency (FEMA).

> Title VII, Nutrition Program for the Elderly funds.

> VISTA payments made to volunteers (not permanent staff salaries).

> Accrued interest on assets if any excess is properly reduced at the eligibility recertification.

> Payments from the Vietnamese Commandos Compensation Act.

> Blood Product Litigation settlement payments.

> Settlements to hemophiliacs under the Ricky Ray Hemophilia Relief Act of 1998.

See §0909.11.01 (Excluded Assets - Program Provisions) for additional excluded

assets for MinnesotaCare/ MA Method A/GHO and MA Method B/GAMC.

See §0909.11 (Excluded Assets) for additional assets excluded for ALL programs.

MinnesotaCare/MA Method A/GHO:

In addition to the items excluded for all health care programs, exclude the following as assets for MinnesotaCare, MA Method A and GHO:

> Assets owned by children. Follow §0909.07 (Jointly Owned Assets) when an adult subject to the asset limit owns an asset jointly with a child.

> Court-ordered settlements up to $10,000. Exclude the first $10,000 indefinitely. It does not have to be held in a separate account or identifiable from other assets. Count any amount over $10,000 if it is legally available to the applicant or enrollee. See §0909.09 (Availability of Assets).

> Individually owned pension and retirement funds, including but not limited to IRAs, 401(k) plans, 403(b) plans, and Keogh plans. See §0909.19 (Pensions and Retirements Funds).

> Up to $200,000 in capital or operating assets of a trade or business. See §0909.11.03 (Excluded Assets for Self-Support).

> Money held by a homeowner in a separate account which is used to pay real estate taxes or insurance, if these expenses are paid at least twice a year.

> Funds the client receives to repair or replace assets if the payments can be identified and are made by public agencies, insurance companies, court order, or solicited through a public appeal. Exclude the funds for 3 months after the month of receipt and only if they are held in escrow.

> Exclude the following sources of student financial aid indefinitely:

- Pell Grants.
- SEOG.
- Perkins Loans.
- Student Educational Loan Funds.
- Guaranteed Student Loans.
- Minnesota State Student Loans.
- State Student Incentive Grants.
- Minnesota State Scholarships and Grants.
- Federal College Work Study funds.
- Any other financial aid funded in whole or in part by Title IV.

See §0911.09.07 (Student Financial Aid Income) for more information.

Exclude all other school loans, grants, or scholarships as assets for the period they are intended to cover or until the month following the last month the student is enrolled in classes.

> Proceeds from the sale of a homestead for 6 months after the month of receipt. The client must keep the proceeds in a separate account and intend to use them to buy another home.

> Home Improvement loans from the Minnesota Housing Finance Agency for 9 months after the month of receipt.

> Exclude Earned Income Credit income as an asset in the month of receipt and the next month.

MA Method B/GAMC:

In addition to the items excluded for all health care programs, exclude the following as assets for Method B:

> Payments made to volunteers under the Domestic Volunteer Service Act of 1973 as stipends or reimbursements of out-of-pocket expenses.

> Benefits other than wages paid under the Older Americans Act.

> Exclude the specific types of financial aids listed under Method A as assets until the month following the last month the student is enrolled in classes, as long as they are identifiable from non-excluded funds.

> Exclude other educational funds as assets for the month of receipt only. After the month of receipt, exclude the funds if the aid is identifiable from non-excluded funds. Count any funds remaining as assets beginning the month following the month in which the student is no longer enrolled in classes.

> Exclude payments to replace lost, damaged, or destroyed assets for 9 full months after the date the client receives the payment. If the client tries to replace the assets during that time, but cannot do so for good cause, continue

to exclude the payment for up to 9 more months.

> Exclude the accumulation of the clothing and personal needs allowance for people in long term care facilities if any excess is properly reduced at the eligibility recertification. See §0909.29.03 (Excess Assets--Enrollees).

> Exclude funds used to meet real estate tax, insurance, and upkeep expenses for real property when held in a separate account.

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

> Exclude as an asset for 9 months any retroactive SSI or RSDI lump sum payments received on or after 3/2/04. Exclude as an asset for 6 months any retroactive SSI or RSDI lump sum payments received before 3/2/04.

See §0911.09.15.05 (Lump Sum RSDI and SSI Payments) for information on treatment of retroactive RSDI payments as income in the month of receipt.

> Exclude as an asset for 9 months any Earned Income Tax Credit (EITC) refunds or payments, received on or after 3/2/04, retained after the month of receipt. EITC refunds or payments received before 3/2/04 are excluded as an asset for 1 month following the month of receipt.

> Exclude as an asset for 9 months any Child Tax Credit (CTC) refunds or payments received on or after 3/2/04, retained after the month of receipt. CTC refunds or payments received before 3/2/04 are excluded as an asset for 1 month following the month of receipt.

> Exclude proceeds from the sale of a homestead for 3 months if the enrollee applies the funds to the purchase of another home during that period.

> Payments made to crime victims to compensate them for losses resulting from the crime for 9 months after the month of receipt.

> Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

> Payments to volunteers under Corporation for National and Community

Service (CNCS) Programs. (The former ACTION programs) Examples of such programs include:

- AmeriCorps (VISTA)
- University Year for ACTION (UYA)
- Special and Demonstration Volunteer Programs
- Retired Senior Volunteer Program (RSVP)
- Foster Grandparent Program
- Senior Companion Program

> Individual Development Accounts (IDAs) – TANF funded. An IDA is a special bank account that helps an individual save for education, the purchase of a first home, or to start a business. Contributions to the IDA are matched with money from TANF. Individuals must be working and receiving TANF to be eligible for a TANF IDA.

> Individual Development Accounts (IDAs) -- Demonstruction Project. Same as for IDA—TANF Funded with the exception that contributions are matched with money from special funds called "Demonstration Project" money. Eligible individuals must be working and either receiving TANF or have low income/assets.

> Payments made by the Department of Defense (DOD) to certain individuals who were captured and interned by North Vietnam. Payments are made by DOD under section 657 of the National Defense Authorization Act. Payments may be received by surviving spouse or children.

> VA benefits paid to or on behalf of Vietnam or Korea service veterans' natural children suffering disability due to spina bifida or other certain birth defects. Payments are made under Public Law 104-204, Public Law 106-419 or Public Law 109-183.

Some types of assets are excluded in whole or in part depending on their value and/or use. Examples of this type of asset include but are not limited to real property, vehicles, and burial funds. See the sections dealing with specific types of assets for more information.

In addition to the assets excluded for Method B in this section and the assets excluded in §0909.11 (Excluded Assets), exclude the following for the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program:

> Retirement funds owned by the applicant or enrollee such as IRAs, 401(k) plans, 403(b) plans, Keogh plans, and other individually owned pension and retirement funds.

> Medical expense accounts set up through an employer, regardless of whether the account is funded by employee salary deduction, by the employer, or both. These accounts allow employees to set aside pre-tax dollars to be used to reimburse the employee for qualified medical expenses not covered by the employer's health plan. They are also known as unreimbursed medical accounts and flexible spending accounts.

When an MA-EPD enrollee stops working for any reason, continue to exclude these assets when determining eligibility for regular MA for up to 12 months after the person loses MA-EPD status.

Apply the following assets to the $1,500 burial fund exclusion in the order listed.

1. Life insurance. If the client owns one or more life insurance policies with total face value of $1,500 or less, apply the face value to the burial fund exclusion and proceed to step 2. Exclude term life policies from this calculation. Include insurance policies with an irrevocable designation to any funeral home.

   If the total face value of non-term life insurance is greater than $1,500, total the cash surrender value(s) (CSV) of all life insurance policies with available CSV and count it toward the asset limit. Do not include the CSV of any policy with an irrevocable designation towards the asset limit. If after completing step 2, a balance remains in the burial fund exclusion, any available CSV of the life insurance policies may be applied to the burial fund exclusion. See step 3.

2. Irrevocable burial agreements. Apply irrevocable burial accounts of up to $2,000 (or the amount allowed by state law if the agreement was set up in another state) as follows:

   a. If no life insurance face value was applied in step 1, apply the total amount of the burial account, up to $1,500, to the burial fund exclusion. Consider any remaining amount up to $2,000 as an unavailable asset.

      EXAMPLE:

      Bob has no life insurance and an irrevocable burial agreement of $1,000. Apply the entire $1,000 toward the burial exclusion. Bob may apply up to $500 in other assets to the remaining burial exclusion. See step 3.

   b. If life insurance face value of less than $1,500 was applied in step 1, subtract the face value applied from $1,500. Apply the difference to the burial exclusion. Consider any remaining amount in the burial account as an unavailable asset.

      EXAMPLE:

      Gladys has a life insurance policy with a face value of $800 and an irrevocable burial fund of $2,000. Apply the entire face value of the life insurance to the burial exclusion. Apply $700 of the burial fund to the burial exclusion for a total of $1,500.

Consider the remaining $1,300 of the burial fund as an unavailable asset.

c. If $1,500 of life insurance face value was applied in step 1, consider the entire $2,000 irrevocable burial account as an unavailable asset.

EXAMPLE:

George has a life insurance policy of $1,500 to which he attached an irrevocable designation. He also has a $2,000 irrevocable burial fund. The life insurance policy and the burial account fund different items. Apply the face value of the life insurance policy to the burial fund exclusion. Consider the $2,000 irrevocable burial fund as an unavailable asset.

Count any amount over $2,000 held in an irrevocable burial account set up in Minnesota as an available asset. Do not count itemized amounts for burial space items. See §0909.17.05 (Burial Space Items).

3. Other assets designated by the client. If a balance of the $1,500 burial fund exclusion remains after applying the face value(s) of life insurance and/or irrevocable burial agreement, the client can apply the assets listed in §0909.17 (Burial Funds/Life Insurance: Fund Types) toward the balance of the burial fund exclusion. Apply the difference between $1,500 and the amounts applied in steps 1 and 2.

EXAMPLE:

Helen owns two non-term life insurance policies with total face value of $2,500 and CSV of $1,200. She owns no burial funds and has not designated either policy to a funeral home. Because the life insurance face value exceeds $1,500, none of it can be applied toward the burial exclusion. Helen may designate the $1,200 CSV toward the burial exclusion. She may also designate up to $300 in other assets listed in §0909.17 (Burial Funds/Life Insurance: Fund Types) for a total of $1,500.

EXAMPLE:

Jackson owns a non-term life insurance policy with face value of $500, a revocable burial fund with face value of $750 and accrued interest of $150 for a total of $900, and a savings account with a balance of $2,500. After applying the face value of the life insurance, a balance of $1,000 remains to be applied to the burial fund exclusion.

Jackson may designate $1,000 from the revocable burial fund plus interest and the savings account to make up the balance. Count the remaining $2,400 ($900 + $2,500 = $3,400, less $1,000 leaves $2,400) toward the asset limit.

Burial-related assets must be kept separate from other assets to be excluded. Burial-related assets are burial funds and burial spaces.

Do not require clients to separate burial funds from other assets if there is a circumstance beyond their control which makes the separation of funds impractical or requires the consent of non-household members who refuse to cooperate.

EXAMPLE:

Marlys has a life insurance policy with a face value of $4,000 and available CSV of $3,000. She previously designated $1,500 of the $3,000 CSV as a burial fund. It would be impractical to separate burial assets from other assets because she would have to borrow from the policy and pay interest to separate the burial fund from other assets. Document in the case record the specific reason why the burial assets cannot be separated.

Exclude any interest which accumulates on the burial fund if the interest remains in the fund after the initial valuation. For applicants, begin excluding interest the month of application or the month the burial fund is designated in a separate account, whichever is later.

Do not exclude dividend accumulations of a life insurance policy. Dividend accumulations must be counted as assets. Dividends may be designated as a burial fund. See step 3 above.

If there is a full calendar month break in MA eligibility, and the client later reapplies for MA, exclude up to $1,500 as a burial fund but do not exclude any interest which had accumulated in the fund unless the interest had previously been designated as irrevocable.

EXAMPLE:

John applies for MA and designates his savings account of $1,500 as a burial fund. While he receives MA, $300 in interest accumulates on the burial fund. John's MA is terminated. He reapplies several months later. John again designates his $1,500 savings account as a burial exclusion. Count the $300 in interest toward the asset limit because John was off MA for more than one calendar month.

MinnesotaCare:

No provisions.

MA:

The following provisions apply to married people when 1 spouse:

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

OR

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

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

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

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

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

OR

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

EXAMPLE:

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

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

Provide the Asset Assessment Form (DHS 3340) for the client to complete. Record the results of the assessment on the DHS 3340a. The effective date of the assessment is the earliest of the first day of the first continuous period of:

> Admission to a medical hospital.

OR

> Admission to a nursing facility (NF).

OR

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

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

EXAMPLE:

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

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

Do not consider the availability of an asset when completing an assessment. Only consider availability at application when determining which assets count toward the

applicant's asset limit. Verify all assets included in the assessment at the time of the assessment, initial application, and the first annual renewal. If you discover previously unreported assets at the time of application, revise the asset assessment to include those assets if they were owned at the beginning of the first continuous period of institutionalization.

Estimate the community spouse asset allowance as follows:

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

   > The homestead.

   > Personal and household goods.

   > 1 vehicle. For purposes of an asset assessment, exclude 1 vehicle regardless of use or value. Do not apply the criteria in §0909.15 (Vehicles).

   > Capital assets necessary to operate a trade or business.

   > The cash surrender value of life insurance policies with total face value of $1,500 or less per person, OR the first $1,500 of an irrevocable burial agreement for people who do not have life insurance with total face value of $1,500 or less. Do not designate other assets as burial funds as part of the asset assessment. See §0909.17.03 (Determining the Burial Fund Exclusion).

   > Other excluded assets. See §0909.11 (Excluded Assets) and §0909.11.01 (Additional Excluded Assets for Method A/B).

2. Divide the total countable assets in half.

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

4. If half of the total countable assets are:
   > Less than the minimum asset allowance, the estimated allowance is the minimum asset allowance.

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

> More than the maximum asset allowance, the estimated asset allowance is the maximum asset allowance.

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

	Minimum	Maximum
1-1-05 – 12-31-05	$26,898	$95,100
1-1-04 - 12-31-04	$26,190	$92,760
1-1-03 - 12-31-03	$25,601	$90,660
1-1-02 - 12-31-02	$25,247	$89,280
1-1-01 - 12-31-01	$24,607	$87,000
1-1-00 - 12-31-00	$23,774	$84,120
1-1-99 - 12-31-99	$23,171	$81,960
1-1-98 - 12-31-98	$22,828	$80,760
1-1-97 - 12-31-97	$22,336	$79,020
1-1-96 - 12-31-96	$21,685	$76,740
1-1-95 - 12-31-95	$21,156	$74,820
7-1-94 - 12-31-94	$20,540	$72,660
1-1-94 - 06-30-94	$14,532	$72,660
1-1-93 - 12-31-93	$14,148	$70,740

GAMC:

No provisions.

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, 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 first 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.

MinnesotaCare:

No provisions.

MA:

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

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

> CHAMPUS/TRICARE

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

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

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

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

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

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

> Access to prescription drug discount cards. Examples include:

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

prescription services.
-Discount cards offered through prescription "clubs".
-Discount cards offered through senior organizations or other associations.

> Access to prescription drugs through pharmaceutical manufacturers' prescription drug patient assistance programs.

> Access to facilities which provide prescription drug coverage to people who qualify, such as veterans' medical centers, Indian Health Centers, and community clinics.

> Auto, homeowner's or other liability insurance that pays prescription drug costs resulting from an accident.

> Workers' Compensation coverage for prescription drug costs resulting from a work-related injury.

> Basic Medicare supplement plans required by law to provide 80 percent coverage for physician-prescribed diabetic equipment and supplies and injectable insulin.

> UCare for Seniors Classic Plan for people who were enrolled in both PDP and the UCare Classic Plan on March 1, 2001. This exception expires on June 30, 2003.

See §0907.21.09.11 (Medicare Supplement Programs: PDP).

GAMC:

No provisions.

Determine if income is available or unavailable. Count only available income to determine eligibility. Income is available when:

> Received by the client.

> Received by someone else on the client's behalf.

> Counted as available to the client, whether or not the client receives it.

> Withheld by the employer or other payer at the client's request.

Income is unavailable when the client cannot gain access to the income.

EXAMPLE:

Adult applicant is disabled and his mother, with whom he lives, receives his social security check for him as his representative payee. Count the social security check as income to him. Do not count it as income to the mother. See §0911.09.15 (Income From RSDI and SSI).

EXAMPLE:

Program rules require a 19-year-old who lives at home to be considered part of his parents' household. See §0908 (Household Composition). Count his parents' income toward his eligibility whether or not he receives any cash payments from them.

EXAMPLE:

Applicant has a court order requiring her ex-husband to pay $400 per month child support for their 2 children. He is paying only $300 per month and efforts to enforce the full order have been unsuccessful. Count $300 as income. The unpaid portion is unavailable.

EXAMPLE:

Enrollee asks his employer to withhold his last 2 pay checks of the year until the following tax year. The pay checks are available on the date they would normally be paid.

MinnesotaCare:

If applicants/enrollees claim no income from any source, count zero income. If you have conflicting information, ask if they receive any money that they may not consider income but that is counted for MinnesotaCare.

EXAMPLE:

Pete applies for MinnesotaCare and claims no income. He also reports he is making current child support payments. Contact Pete to resolve the conflicting information.

MA/GAMC:

Clients must try to gain access to unavailable income as a condition of eligibility, unless they can document that the income is permanently unavailable. Deny or terminate MA or GAMC if clients refuse to cooperate in trying to gain access to unavailable income.

METHOD A:

Do not allow a deduction from income when part of the income is being withheld to repay a debt or obligation, unless the income is being reduced to recover a prior overpayment from the same income source.

EXAMPLE:

Roger is entitled to a VA payment of $400 per month. $150 is withheld to repay a prior VA overpayment. Count $250 per month as available income.

EXAMPLE:

Penny has $50 per week withheld from her pay check due to a court-ordered garnishment for an unpaid credit debt. Consider the $50 as available income. Do not deduct it from her gross wages.

METHOD B:

Do not allow a deduction from income when part of the income is being withheld to repay a debt or obligation, unless the income is being reduced to recover a prior overpayment AND the overpaid amount had been previously counted as unearned income for MA or GAMC eligibility.

EXAMPLE:

Larry has received MA for 2 years. He reports that his $300 per month VA check has been reduced by $100 to recover an overpayment incurred 1 year ago while he was receiving MA. Allow a deduction of $100 until the overpayment is paid.

EXAMPLE:

Mildred applies for MA for the first time. Her RSDI benefit of $500 has been reduced by $30 to repay a prior overpayment. Count the full $500 RSDI

benefit as available because the overpayment occurred before Mildred received MA.

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

MinnesotaCare:

Also exclude income from the following sources:

> Earned income of full- or part-time students under age 19. See §0911.09.05 (Dependent Child Income).

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

EXAMPLE:

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

EXAMPLE:

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

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

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

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

Some lump sums, such as winnings over a given amount, may be taxable. If

an applicant or enrollee's tax forms include a lump sum, subtract the lump sum from the adjusted gross income unless the household anticipates receiving income from the same source in the next year. See §0911.11 (Computing Countable Income--MinnesotaCare).

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

M. S. 256.9354 subd. 4a

MA/GAMC:

METHOD A:

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

EXAMPLE:

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

EXAMPLE:

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

METHOD B:

Infrequent or irregular income is income that is received no more than once in a calendar quarter from a single source or could not reasonably be expected.

Exclude the first $30 per calendar quarter of irregular or infrequent earned income. This exclusion is applies to the combined total irregular/infrequent earned income of all people whose income is being considered.

EXAMPLE:

Betsy reports receiving $38 for babysitting a neighbor's child. She does not babysit regularly. Exclude the first $30 of this income because it is irregular and count the remaining $8.

Exclude the first $60 per calendar quarter of irregular or infrequent unearned income. Apply this exclusion to the total irregular/infrequent unearned income received in each calendar quarter. To be considered infrequent income, the same type of income may be received more than once in a calendar quarter as long as it is not from the same source. This exclusion is applied to the combined total irregular/infrequent unearned income of all people whose income is being considered.

EXAMPLE:

Herman and Sheila receive MA using a manual monthly spenddown. See §0913.11 (Manual Monthly Spenddown Calculation). They report on their monthly income report for April that they received $65 as an anniversary gift from friends. Herman received $20 for his birthday from his mother. They do not expect to receive additional gifts during the calendar quarter.

Total all the infrequent unearned income ($85) and exclude the first $60. The remaining $25 is counted an unearned income because it exceeds the first $60 in a calendar quarter.

Exclude as income gifts used by an individual to pay tuition or other education related expenses.

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

MinnesotaCare:

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

MA/GAMC:

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

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

Transportation expenses include:

> Gas and oil costs.

> Parking fees.

> Car insurance.

> Car repairs.

> Interest payments on a car loan.

METHOD A:

Allow the IRS mileage rate (also known as the flat rate) for self-employment transportation. Effective January 1, 2005, the rate is 40.5 cents per mile. The rate for 2004 was 37.5 cents per mile. Use the flat rate even if itemized self-employment transportation costs exceed the flat rate amount.

METHOD B:

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

MinnesotaCare:

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

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

For graduate students:

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

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

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

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

- Tuition.
- Mandatory fees.
- Course and lab fees.

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

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

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

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

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

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

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

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

MA/GAMC:

METHOD A:

Follow MinnesotaCare.

METHOD B:

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

> Financial aid loans, including loans from the Tribal Development Student

Assistance Revolving Loan Program.

> Title IV financial aid in the month the client receives it.
> Financial aid used to fulfill an approved Plan to Achieve Self-Support (PASS) for disabled or blind people. See §0912.05.11 (Plan to Achieve Self-Support).
> Training expenses paid through the Trade Adjustment Reform Act of 2002.
> Gifts used to pay tuition or education related expenses.

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

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

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

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

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

Although the Social Security Administration (SSA) issues both RSDI and SSI payments, the terms are not interchangeable. Both programs are funded and administered by the federal government but have different purposes and eligibility requirements.

RSDI payments are funded by payroll taxes. Payments are made to people who retire, become disabled for an extended period, or who are dependents of a wage earner who has died. The amount of the payment is based on the earnings and payroll taxes of the qualifying person. Most retired people also qualify for Medicare. Disabled people qualify for Medicare after they have been continuously disabled for at least 2 years. People under 65 who receive survivors' benefits do not qualify for Medicare.

EXAMPLE:

Herb retires at age 65. He and his employer made social security payments on his behalf for 40 years. His 66-year-old wife did not work outside the home. Both receive RSDI retirement benefits based on Herb's earnings and social security contributions. Both are eligible for Medicare. Herb and his wife are ineligible for MinnesotaCare because they are covered by Medicare. See §0910 (Other Health Coverage). They may qualify for MA.

EXAMPLE:

Laura became unable to work due to a disability 12 months ago. She and her employer made social security payments on her behalf for 15 years. Laura receives social security disability payments. If she is still disabled 24 months after her disability payments began, she will qualify for Medicare. Advise Laura to report Medicare benefits when she becomes eligible for them.

EXAMPLE:

Anna died after she and her employer made social security payments on her behalf for 10 years. Her surviving spouse, Ken, receives survivor's benefits for their 3 children. He is employed and does not receive benefits for himself. Neither Ken nor the children qualify for Medicare. For MinnesotaCare, count the full amount of RSDI benefits as unearned income to the household. For MA, count the full amount of RSDI benefits each child receives as unearned income for that child.

SSI payments are made to people who are:

> Over 65.

OR

> Disabled.

OR

> Blind.

AND

> Who do not qualify for RSDI payments because they have not made payments to the RSDI system.

OR

> Whose RSDI payments are less than the SSI income standard.

People must be within SSI income and asset limits to qualify for payment. Income and assets of responsible household members (spouses and parents of minor children) are counted in determining eligibility and payment amount. However, responsible household members are not included in the payment unless they are also elderly, disabled, or blind and meet SSI income and asset requirements.

SSI recipients do not automatically qualify for Medicare. However, DHS may purchase Medicare benefits for them through the Buy-In. See §0910.05.05 (Medicare Premium Payment).

Most SSI recipients qualify for MA without a spenddown.

If you are unsure what type of payment an applicant/enrollee receives, review the social security claim number. The first part of the claim number is the social security number (SSN) of the wage earner on whose account claims are being paid. If the person receiving benefits is a dependent of the wage earner, the claim number SSN will not be the same as the SSN of the person receiving benefits.

EXAMPLE:

Mildred receives survivor's benefits on the account of her deceased husband, Milton. The first part of the claim number is 444-33-2222. Mildred's SSN is 444-34-5555. The claim number is based on Milton's SSN, not Mildred's.

The suffix following the claim number SSN is usually a letter which may or may not be followed by a digit. The suffix indicates what type of benefits the claimant receives. The Social Security Administration publishes a reference guide which identifies claim types by suffix.

MinnesotaCare:

Count the gross amount of RSDI and SSI payments as unearned income to the household.

EXAMPLE:

Bob is disabled and did not work long enough to qualify for RSDI disability payments. He receives SSI of $470 per month based on his and his wife Agnes's assets and Agnes's earnings from part-time employment. Bob is not eligible for Medicare and receives MA. Agnes is not elderly, disabled, or blind. They apply for MinnesotaCare for Agnes. Count Agnes's earnings and Bob's SSI to determine eligibility.

Many RSDI beneficiaries have their Medicare Part B premiums deducted from the RSDI check. Count the amount before the Part B payment is deducted. See §0911.09.15.03 (Determining Gross RSDI).

EXAMPLE:

Mildred is retired and receives an RSDI check for $683. $78.20 is deducted for Medicare Part B. Mildred's countable RSDI benefit is $761, the amount to which she is entitled before deductions.

The Medicare premium amount changes annually. If someone reports that they receive RSDI, check to see if they are also covered by Medicare Part B. If so, add the current Medicare premium to the amount of the RSDI check the person actually receives. Consider the availability of Medicare in determining the person's MinnesotaCare eligibility. See §0910 (Other Health Coverage).

MA/GAMC:

See §0911.09.15.01 (Income From RSDI and SSI--MA/GAMC).

See §0911.09.15 (Income From RSDI and SSI) for general provisions that apply to all programs.

MinnesotaCare:

See §0911.09.15 (Income From RSDI and SSI).

MA:

METHOD A:

Exclude SSI. Also exclude all other income that SSA considered in determining SSI eligibility and benefit amount in determining the SSI recipient's eligibility only. If SSI excludes a particular type of income, exclude that income for MA.

EXAMPLE:

Greta applies for MA for herself and her son Robert. Robert is disabled and receives SSI. Greta is employed. Her earnings are considered in determining the amount of Robert's SSI payment. Count Greta's earnings when determining her own MA eligibility. Do not deem her earnings to Robert, regardless of which method he chooses.

EXAMPLE:

Andrew applies for MA for himself and his daughter. Andrew is disabled and receives RSDI and SSI. His daughter receives dependent RSDI benefits. Exclude Andrew's income in determining his eligibility regardless of which method he chooses. Count his RSDI payment and his daughter's RSDI payment in determining her eligibility.

If a person does not receive SSI but receives RSDI, count the gross RSDI amount as unearned income unless the client has a representative payee who does not live in the client's household. If the representative payee does not live in the same household as the beneficiary, presume the gross RSDI is available to the beneficiary unless the client can demonstrate that the payment is not available. If the client demonstrates that part of the payment is unavailable, count only that portion made available to the client in cash or spent on behalf of the client or household.

Notify SSA in writing to request a change in representative payee under either of the following circumstances:

> The representative payee is diverting the RSDI benefit for use by the representative payee or a 3rd party, not the client.

> It appears that the representative payee is not using the RSDI benefit

in an appropriate way to meet the needs of the beneficiary.

If SSI benefits are suspended for reasons other than lack of disability, consider the person to be an SSI recipient for purposes of meeting a disabled basis of eligibility. See §0907.21.07 (MA/Medicare Savings Basis: Disability). However, do not exclude other income received during the month(s) of suspension even if it is normally considered in determining the SSI payment.

METHOD B:

Exclude SSI and all other income considered by SSA in determining SSI eligibility and payment amount when determining eligibility for the SSI recipient.

EXAMPLE:

Marcus receives SSI and MA. The MA worker discovers that he received a one-time VA payment in February. This payment is an excluded form of income for SSI. Exclude the payment for MA also.

EXCEPTION:

Count SSI and MSA for people who use long term care budgeting, with the specific exceptions listed in §0913.13 (Long Term Care Spenddown Calculation), items 10 and 11.

If a spouse or child of an SSI recipient (who lives with the SSI recipient) requests MA, exclude the SSI payment but count all other non-excluded income of the SSI recipient in determining the spouse and/or child's eligibility.

EXAMPLE:

Herman and Helen, a married couple, apply for MA and GAMC. Herman is disabled and receives RSDI and SSI. Helen is employed part time and her earnings are considered in determining Herman's SSI eligibility. Exclude Herman's SSI and RSDI and Helen's earnings in determining his eligibility. Exclude Herman's SSI but count his RSDI and Helen's earnings in determining her eligibility.

Some clients are still considered SSI recipients after their SSI payments stop. They have special SSI status under sections 1619 (a) and (b) of the Social Security Act. See §0907.21.07.03 (MA Basis: 1619 A and B).

If SSI benefits are suspended for reasons other than lack of disability, consider the person to be an SSI recipient for purposes of meeting a disabled basis of eligibility.

See §0907.21.07 (MA/Medicare Supplement Basis: Disability). However, do not exclude other income received during the month(s) of suspension even if it is normally considered in determining the SSI payment.

EXAMPLE:

Gary applies for MA in February. Gary receives SSI and is employed part time. His SSI benefits are suspended for 3 months beginning in February because of an overpayment. Count his earnings in determining his eligibility for February, March, and April. Disregard the earnings beginning the month that SSI payments resume.

For people who receive RSDI but not SSI, count the gross amount of RSDI as unearned income unless all or part of the benefit is excluded under another provision. Exclude RSDI for people who qualify as disabled adult children or disabled widows or widowers. See §0912.05.19 (Disabled Adult Children Disregard) and §0912.05.21 (Disabled Widow/Widower's Deduction). Deduct cost of living increases (COLA) from the RSDI of clients who qualify for the Pickle disregard, the widow or widower disregard or the MA COLA disregard. See the following sections:

§0912.05.23 (Pickle Disregard)
§0912.05.17 (Widows and Widower's Disregard)
§0912.05.15 (RSDI COLA Disregard)

Disregard RSDI benefits paid to or on behalf of children who receive MA under the Special Category for Disabled Children (§0907.21.07.07), CAC (§0907.23.07), MR/RC (§0907.23.05), CADI (§0907.23.03), TEFRA (§0907.23.09), and TBI (§0907.23.13).

For all other clients, count the gross amount of RSDI received. A Medicare premium included in the gross RSDI amount may be allowed as a deduction from excess income to meet a spenddown. For more information, see:

§0913.13	Long Term Care Spenddown Calculation
§0913.13.03	LTC Spenddown--EW With Community Spouse
§0913.15	Combination LTC/Medical Spenddown
§0913.21	Allowable Medical Bills to Meet Spenddown

Count the gross RSDI when a representative payee receives the RSDI payment regardless of the representative payee's decision to distribute the funds.

Notify the Social Security Administration in writing to request a change in

representative payee under either of the following circumstances:

> The representative payee is diverting the RSDI benefit for use by the representative payee or a 3rd party, not the client.

> It appears that the representative payee is not using the RSDI benefit in an appropriate way to meet the needs of the beneficiary.

See §0911.03 (Availability of Income) for information on when to deduct an overpayment withheld from an SSI or RSDI benefit.

GAMC:

Follow MA Method B.

MinnesotaCare:

People may receive a one-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 one-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.

Exclude as an asset for 9 months any retroactive SSI or RSDI lump sum payments, received on or after 3/2/04, if retained after the month of receipt.

Exclude as an asset for 6 months any retroactive SSI or RSDI lump sum payments, received before 3/2/04, 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.

SSI, RSDI or Special Veterans Benefits for the Elderly may be reissued by the SSA when an individual rep payee of 15 or more beneficiaries or an organization rep payee has been found to misuse the benefits. Treat the reissuance of these benefits as follows:

> SSI - Exclude the reissuance as income and an asset in the month received. Exclude as an asset for 9 months if retained after the month of receipt.

> RSDI & Special Veterans Benefits – Count the reissuance as income in the month received, unless the original payment of the income was used in determining the individual's MA eligibility. Exclude as an asset for 9 months if retained after the month of receipt.

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).

MinnesotaCare:

Count interest and dividend payments if they are paid or credited directly to the household at least annually. See §0911.05 (Excluded Income).

Count interest and dividends earned on an asset and paid to the household or credited to the household's account as unearned income. See §0911.07.05 (Unearned Income). These payments are shown on the household's tax forms.

EXAMPLE:

The Jones family has a savings account with a balance of $5,000. Interest of $60 is credited to the account each quarter. It is not paid directly to the family. The bank reports the interest annually to the Internal Revenue Service and it is included on the family's tax forms. Count the interest as income.

EXAMPLE:

John owns stock in ABC corporation. He is not an employee of the corporation. He receives a dividend check every 3 months which is reported on his tax return. Count the dividend payment as unearned income.

EXAMPLE:

Susie is a minor child. A trust fund of $50,000 was set up on her behalf as a result of an auto accident. She and her parents cannot gain access to the trust principal without court approval. However, her parents receive a monthly check representing interest earned by the trust. Count the monthly payment as unearned income.

Count dividends earned as part of a self-employment operation, such as dividends from ownership interest in a C-corporation, as part of the earned self-employment income.

EXAMPLE:

George has ownership interest in a C-corporation. He is also an officer of the corporation and receives wages. His share of corporate dividends are reported yearly and included on his tax return. Count the dividends as part of his annual income.

Minnesota Rules 9506.0040 subp. 2 Item C

MA/GAMC:

METHOD A:

Exclude as income any interest or dividends from assets, including amounts accrued

on the asset, which when combined with other assets are within and counted toward the asset limit.

EXAMPLE:

Al receives MA. He has a savings account with $2,500, which is within the $3,000 asset limit. At the time of his annual recertification, he reports that $75 in interest has been credited to the account in the past year. Exclude the interest as income because the total account balance remains within the asset limit.

Count other interest or dividends as unearned income. This includes the interest portion of payments on contracts for deed and promissory notes. Count the principal portion as an asset conversion. See §0909.13.05 (Contracts for Deed).

METHOD B:

The following exclusion does not apply to people using Long Term Care (LTC) budgeting or the spousal allocation calculations. For LTC budgeting continue to count interest/dividend income.

Exclude as income, interest or dividends received from counted or excluded assets.

EXCEPTION:
Count as unearned income interest or dividends earned on:

> Unspent tax refunds related to an Earned Income Tax Credit (EITC) or Child Tax Credit (CTC)
> Unspent federal relocation assistance payments
> Payments to replace lost, damaged or destroyed assets which are no longer excluded as assets. See §0909.11.01 (Additional Excluded Assets for Method A/B)
> Gifts to children with life-threatening conditions under Section 1613(a)(13) of the Social Security Act.
> Payments to replace lost, damaged, or destroyed assets if the payment is no longer an excluded asset. See §0909.11.01 (Excluded Assets – Program Provisions)
> Victims' compensation payments
> Financial aid which is neither Title IV nor received under the Bureau of Indian Affairs (BIA) program. Such aid includes grant, scholarship, fellowship, or gifts used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education

> A life insurance policy which pays interest on dividends accumulations

> Proceeds from the sale of a home which are excluded as an asset. See §0909.11.01 (Excluded Assets – Program Provisions)

If interest or dividend is not excluded due to the provisions above, review to determine if the income meets the exclusions for infrequent income. See §0911.05 (Excluded Income). Interest or dividends that are within and counted toward the asset limit should be excluded (See §0909.29.03 (Excess Assets--Enrollees).

Contracts for deeds - this interest exclusion includes the interest portion of payments on contracts for deed and promissory notes. Count the principal portion as an asset conversion. See §0909.13.05 (Contracts for Deed).

Burial funds – exclude interest that accrues on an excluded burial fund. See §0909.17 (Burial Funds/Life Insurance: Fund Types) and §0909.17.03 (Determining the Burial Fund Exclusion). This exclusion applies to LTC as well.

MinnesotaCare:

No provisions.

MA:

Method A:

No provisions.

Method B:

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

> Is under age 22.

> Is certified as blind or disabled by the Social Security Administration or the State Medical Review Team.

> Is expecting to attend school at least one month in the next calendar quarter, or did attend school at least one month of the current calendar quarter.

Limit the disregard to a maximum of $1,410 per month up to a maximum of $5,670 in calendar year 2005 ($1,370 per month up to a maximum of $5,520 in calendar year 2004). Apply the disregard only to the blind or disabled student's earned income. Do not apply it to the income of other people whose income is deemed to the student.

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

METHOD A:

No provisions.

METHOD B:

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

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

> Currently receive or be entitled to receive RSDI benefits.

> Were eligible for 1619(b) or were eligible for and received SSI, MSA, or 1619(a) benefits while concurrently entitled to or receiving RSDI in any month since April 1977.

> Lost eligibility for SSI, MSA, 1619(a) or 1619(b) for any reason.

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

EXAMPLE:

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

When clients eligible for the Pickle disregard have a spouse or parent receiving RSDI, consider the parent or spouse's RSDI income available to the client. Allow the

Pickle disregard from the spouse's or parent's RSDI when determining the client's eligibility. Do not allow the Pickle disregard when determining the parent's or spouse's eligibility unless they also meet the Pickle eligibility conditions.

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

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

OR

> 7-1-82.

This is known as the Pickle threshold date.

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

Current Gross RSDI Amount		
1.027 (1-05 RSDI increase)	=	Benefit Before 1-05 COLA
1.021 (1-04 RSDI increase)	=	Benefit Before 1-04 COLA
1.014 (1-03 RSDI increase)	=	Benefit Before 1-03 COLA
Current Gross RSDI Amount 1.026 (1-02 RSDI increase)	=	Benefit Before 1-02 COLA
Current Gross RSDI Amount 1.035 (1-01 RSDI increase)	=	Benefit Before 1-01 COLA
Current Gross RSDI Amount 1.024 (1-00 RSDI increase)	=	Benefit Before 1-00 COLA
Benefit before 1-00 COLA 1.013 (1-99 RSDI increase)	=	Benefit Before 1-99 COLA
Benefit before 1-99 COLA	=	Benefit Before 1-98 COLA

1.021 (1-98 RSDI increase)

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

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

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

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

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

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

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

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

Benefit before1-90 COLA = Benefit before 1-89 COLA
1.04 (1-89 RSDI increase)

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

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

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

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

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

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

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

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

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

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

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

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

EXAMPLE:

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

is eligible for the Pickle disregard if he continues to meet an MA basis of eligibility and has assets within MA limits.

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

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

   > Rent or mortgage payments.

   > Real estate taxes.

   > Homeowner's or renter's insurance.

   > Required maintenance charges for a cooperative or condominium.

   > A utility allowance. Use $262 for residences billed for heating and/or cooling. For residences not billed for heating or cooling, allow $75 for electricity and $25 for phone service. Reduce the utility allowance by the amount of any utility expenses included in a required cooperative or condominium maintenance charge.

3. Subtract $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 $2,378 ($2,319 from 1-

1-04 through 12-31-04), is the maximum monthly income allowance to the community spouse.

If there is a court order for support in excess of $2,378 ($2,319 from 1-1-04 through 12-31-04), 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).

If the allocation amount causes significant financial hardship for the community spouse due to exceptional circumstances, you may increase the amount on a

temporary basis. Verify the spouse is making reasonable efforts to resolve the situation (for example, seeking more affordable housing). Also see §0909.25.05 (Transfer of Income Producing Asset to Spouse) for the possibility of transferring income producing assets to the community spouse.

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

> Meet a spenddown using the allocated income.

OR

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

An LTC spenddown or an LTC/Medical spenddown may include a clothing and personal need allowance. For 2004, the allowance is $74 for all clients except certain veterans and surviving spouses of veterans. For 2005, the allowance is $76 for all clients except certain veterans and surviving spouses of veterans. Veterans who have no spouse or dependent children and surviving spouses of veterans with no dependent children, and who receive a monthly veteran's pension of $90, have a personal need allowance of $90. See §0913.13 (Long Term Care Spenddown Calculation) and §0913.15 (Combination LTC/Medical Spenddown).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Follow the procedures in this section ONLY for people who:

> Receive home care services through the Elderly Waiver (EW)

AND

> Who are not eligible for SIS EW (those with income more than the Special Income Standard). See §0913.13.05 (Waiver Obligation--SIS EW) for people who are eligible under the SIS EW, whether or not they have a community spouse.

AND

> Who have community spouses. See COMMUNITY SPOUSE in §0902.07 (Glossary: Client...) for a definition.

For single clients receiving EW who are not eligible under SIS EW, use Method B budgeting with a household size of 1. For a married couple who both receive EW but are not eligible under SIS EW, use Method B budgeting. Determine eligibility separately for each spouse using each spouse's income and a household size of 1.

Non-SIS EW clients with no community spouse may use a monthly or 6-month spenddown. For people who choose a monthly spenddown, use an automated monthly spenddown if income and medical expenses are non-varying. See §0913.09 (Automated Monthly Spenddown Calculation). EW clients using an automated monthly spenddown may select the designated provider option. See §0913.09.05 (Designated Provider Option). Use a manual monthly spenddown if income or medical expenses vary. See §0913.11 (Manual Monthly Spenddown Calculation).

LTC SPENDDOWN CALCULATION FOR EW CLIENTS WITH COMMUNITY SPOUSES

Before doing a spenddown calculation for months in which clients begin or end EW services, 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).

Review non-varying income every 6 months. See §0905.09 (6-Month Reporting).

Review varying income monthly and make appropriate adjustments to the LTC

spenddown. Budget earned and unearned income in the month it is received. Do not average income for clients receiving EW services. Apply changes in income or deductions to LTC spenddowns in the month the change occurs. Retroactive changes to LTC spenddowns do not require timely notice. See §0916 (Notices).

To calculate the spenddown in a month the client is subject to LTC budgeting, begin with the total gross unearned and earned income received by the client in that month. Include all excluded and non-excluded types of income except for income tax refunds, homeowner/renter property tax refunds and earned income tax credits.

If the income is equal to or less than the SIS, the client is eligible for the SIS EW program. Use LTC budgeting to calculate a waiver obligation according to §0913.13.05 (Waiver Obligation--SIS EW).

If income exceeds the SIS, continue with the following calculations.

Calculate countable earned income as follows:

Count all gross earned income or net self-employment income of a client unless the client is disabled and receiving wages from employment under an individual plan of rehabilitation.

Allow disabled people who are receiving wages from employment under an individual plan of rehabilitation the following deductions from gross earned income in the order listed:

1. $80 special personal allowance. See §0912.05.09.07 (Special Personal Allowance Disregard).
2. Actual FICA withheld.
3. Actual transportation expenses.
4. Actual employment expenses such as tools and uniforms.
5. State and federal taxes (only when the person is not exempt from withholding).

Allow the following deductions from the total gross unearned and countable earned income in the order listed:

1. Exclusions from income of institutionalized people mandated under federal law. These exclusions include:
   - German Reparation payments
   - Japanese and Aleutian Restitution payments

- Agent Orange Settlement Fund payments
- Radiation Exposure payments
- payments under the Domestic Volunteer Services Act
- payments received under the White Earth Land Settlement Act (WELSA)
- Netherlands Act (WUV) payments to victims of Nazi persecution
- Vietnamese Commando Compensation Payments
- payments to children of Viet Nam veterans with spina bifida
- Austrian reparation payments
- Blood Product Settlement Payments
- payments by the Secretary of Defense to people captured and interned by North Vietnam.

VA pensions limited to $90 per month are also excluded as the person's clothing and personal needs allowance. See §0912.07.03 (Clothing and Personal Need Allowance).

If you are unsure whether a particular payment meets this exclusion, submit a policy interpretation. Include the applicable public law number if known.

2. Medicare premiums of clients who are not Qualified Medicare Beneficiaries (QMBs), Service Limited Medicare Beneficiaries (SLMBs), or Qualified Individuals (QIs). See §0907.21.09 (MA Basis: Medicare Supplement Programs).

3. Clothing and personal needs allowance. See §0912.07.03 (Clothing and Personal Need Allowance).

4. Guardianship fees to a legally appointed guardian or conservator, or representative payee fees to an appointed representative payee authorized by the Social Security Administration. Allow up to 5% of the client's gross monthly income to a maximum of $100 after totaling all guardianship, conservator, and SSA representative payee fees. Apply the 5%/$100 maximum even if SSA or a court allows a greater amount.

5. Allocation to a community spouse. See §0912.05.25.03 (Allocations--Community Spouse).

6. Court-ordered child support garnished from income up to a maximum of $250 per month per client. First apply part or all of the garnished amount as the allocation to the child(ren). See §0912.05.25.05 (Allocations--Other

Relatives). Enter the balance up to the $250 limit in the MAXIS long term care budget guardianship fee field along with any allowable guardianship fee. Apply both current support and arrearages up to the maximum allowed.

7. Allocation to a family member other than a community spouse. See §0912.05.25.05 (Allocations--Other Relatives).

8. Health insurance premiums the client actually incurs in any month.

9. Other reasonable and necessary medical expenses not covered by MA that the client actually incurs during the 6-month certification period.

The remaining amount is the LTC spenddown. If the LTC spenddown is more than the cost of monthly elderly waiver services, see §0913.15 (Combination LTC/Medical Spenddown).

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 1-1-05 through 12-31-05 is $1,737. The SIS for 1-1-04 through 12-31-04 is $1,692.

   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.
   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 $78.20 and maintenance needs allowance of $766, he has income of $355 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.

MinnesotaCare:

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

M.S. 256L.12 subd. 3

MA/GAMC:

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

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

> Residents of state institutions, including Regional Treatment Centers (RTC), Institutions for Mental Disease (IMD), and state-operated long term care facilities who reside in the institution at the time of initial enrollment. People already enrolled in managed care who enter state institutions will remain enrolled their health plans if the placement has been approved by the health plan. This includes court-ordered placements for which the health plan is responsible. See §0906.09.01 (Institutional Residence--MA/GAMC) and §0907.27 (MA/GAMC Basis: IMD Residents).

NOTE: Do not exclude residents of Ah Gwah Ching Nursing Facility and Woodhaven Senior Community under this basis.

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

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

UCare Minnesota

> People eligible with all spenddown types except institutional spenddowns. See §0914.03.25 (Minnesota Senior Health Option - MSHO) for information on people with spenddowns who may voluntarily enroll.

> People who receive EMA. See §0907.29 (Medical Emergency Programs).

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

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

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

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

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

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

medication or other health services.

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

Children receiving IV-E or state adoption assistance.

SED and adoption assistance children may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

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

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

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

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

> Enrollees receiving care and rehabilitation services from the Center for Victims of Torture (CVT). See §0907.25.07 (State-Funded MA Basis: Victims of Torture).

> People with cost-effective employer-sponsored health insurance or people enrolled in an individual health plan determined to be cost-effective.

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

> GAMC recipients eligible for Medicare benefits.

> GAMC recipients living in nursing facilities.

> GAMC recipients in the GAMC Hospital Only (GHO) Program.

MinnesotaCare:

The managed care enrollment process is done through the mail and is completely automated on MMIS. When MinnesotaCare coverage is approved as pending awaiting payment, MMIS automatically chooses a default health plan and generates a health plan enrollment form. The default plan is the plan the household will be enrolled in if they fail to choose a health plan. The default plan is determined by the following criteria:

> If anyone in the household is enrolled in managed care through MA or GAMC, the default plan is the plan the MA or GAMC person is enrolled in unless that plan is not available through MinnesotaCare.

  If more than 1 household member is enrolled on MA or GAMC in different health plans, the system will select the first plan that is available to MinnesotaCare as the default plan.

> If no one in the household is enrolled in managed care through MA or GAMC but anyone in the household has previously been enrolled in managed care through MinnesotaCare, the default plan is the plan in which they were previously enrolled if that plan is still available.

> If neither of the above circumstances applies, MMIS assigns a default plan based on the plans available in the household's county of residence.

DHS sends the household a health plan enrollment packet and a premium notice packet. The health plan enrollment packet includes:

> DM-0107: MinnesotaCare Enrollment Form and Letter (printed at IOC) DHS-4106A used for phone-ins (e-Docs only)

> DHS 3253: Return Envelope

> DHS 3320A: Window Envelope for MinnesotaCare mailing

> DHS 3303: MinnesotaCare Guide to Managed Care Enrollment

The household must choose the same health plan for all household members. However, the household may choose different primary care clinics within the health plan for different household members.

If the household returns the enrollment form before the date that capitation payments are made to the health plans for the next month, MMIS is updated to show the household's health plan choice. The capitation date is usually 6 business days before the end of the month. However, if the household returns the form after the 15th of the month, there may not be time to enter the enrollment information before capitation. Refer the household to their MinnesotaCare enrollment representative or financial worker to complete a manual enrollment form to ensure enrollment in the plan of their choice for the next month. If the household has been found eligible but there is no enrollment information entered as of the capitation date, either because the household has not returned the form or returned it after the 15th and did not use the manual enrollment process, MMIS will enroll the household in the default plan. If new enrollment information is entered before the next capitation date, MMIS will enroll the household in the plan of their choice beginning the following month..See §0914.03.07 (Health Plan Changes).

EXAMPLE:

John is approved for coverage awaiting payment on October 3. MMIS mails John a premium notice packet and a health plan enrollment packet on October 5. MMIS also selects UCare as John's default plan. John returns his premium payment and enrollment form on October 22 indicating HealthPartners as his choice of plan. There is not time to process his enrollment form before capitation on October 23, and John does not use the manual enrollment process. He will be enrolled in UCare for November and will be switched to HealthPartners beginning December 1.

If MinnesotaCare is approved after the capitation date but before reinstatement (usually the last business day of the month), the household must choose a health plan by the reinstatement date. Otherwise, MMIS will enroll the household in the default plan.

M.S. 256L.12 subd 3
Minnesota Rule 9506.0200 subp 3, 4, 5, 6

MA/GAMC:

See §0914.03.05.01 (Managed Care Enrollment Process--MA/GAMC).

MinnesotaCare:

See §0914.03.05 (Managed Care Enrollment Process).

MA/GAMC:

Follow your county's procedures for informing clients about managed care. Refer people to a managed care presentation or give them a managed care education packet in the following situations:

> During an initial intake interview for MA or GAMC.

> During an intake interview for an MA or GAMC reapplication when the period of MA or GAMC ineligibility is 2 full calendar months or more. See §0914.03.09 (Managed Care Re-Enrollments & Reinstatements).

People who are applying for MA or GAMC in conjunction with cash or Food Stamps are required to have a face-to-face interview. People who are requesting only MA or GAMC are not required to have a face-to-face interview but may request one. See §0904 (Applications). When people who apply or reapply for MA or GAMC do not have an interview, you may refer them to a managed care presentation or mail them an education packet. Do not require people to attend a managed care presentation.

> When adding a person to a case which has no other people in managed care, if the person being added is required to enroll or volunteers to enroll in managed care.

> When adding a managed care eligible person to a case which has at least one other person in managed care, add the recipient to the same health plan as the rest of the case. Effective 6/1/04, all household members will need to choose the same health plan. Current households with multiple health plans will be grandfathered in and will not be required to change.

> When an MA or GAMC enrollee from a non-managed care county moves to a managed care county.

> When an enrollee moves from a managed care county to another managed care county and the enrollee's health plan is not available in the new county.

> When a managed care enrollee requests a change in health plan when moving between managed care counties. See §0914.03.17 (Managed Care County Transfers) for more information on enrollees who move between counties.

> When an MA or GAMC enrollee is no longer in an excluded group. If there are other family members enrolled in managed care, add them to the same health plan.

> When an enrollee changes from one health care program to another program and the health plan is not available for the new program.

Allow applicants and enrollees 30 days after attending presentations or receiving education packets to return the enrollment forms.

All managed care counties must enter tracking information directly on the MMIS Recipient Tracking (RTRK) screen. Be sure to update tracking information for all case members at the same time to reduce enrollee confusion. The RTRK screen generates a case-based notice for each enrollee which lists the health plan options available in the enrollee's county of residence and the health plan the client will be enrolled in if a choice is not made. The system also generates a 10-day reminder letter. If the client does not choose a health plan within 30 working days, the tracking system automatically creates an enrollment span on the RPPH panel for the assigned health plan.

Also see §0914.03.05.03 (Managed Care Enrollment Presentations).

MinnesotaCare:

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

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

MA/GAMC:

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

Include the following information in managed care presentations:

> How a health plan works.
> The exclusion groups.
> The enrollment form.
> The requirement to choose a health plan and to return the enrollment form within 30 days of the presentation date.
> Random assignment.
> Each health plan and network available in the county.
> Covered and non-covered services.
> Enrollment effective dates.
> A description and instructions on use of the health plan ID card and the Minnesota Health Care Programs card.
> How to receive emergency care outside of the health plan service area.
> Benefit coordination with primary insurance, Medicare, or private HMO coverage.
> Transportation cost reimbursement procedures.
> Inform the recipient they may change for cause at any time including:
- Lack of access to services and providers
- Amount of travel to get primary care
- Poor quality of care.
> Or without cause at the following times:
- Within 90 days from the date they were initially enrolled in the Health plan
- At least once every 12 months during open enrollment
- If they were not eligible at the time of open enrollment
- If the health plan no longer provides services in their county. To change health plans call their county worker.

> Enrollee rights to services provided by health plan patient representatives, county advocates, and state ombudsmen.
> Enrollee right to file an appeal with the state agency.
> Multi-language notification.

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

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

Include the following information in managed care education packets:

> Guide to Health Plan Enrollment (DHS 3354)
> Pre-Enrollment Questionnaire (DHS 3354C) available through eDocs only
> Automated MA/GAMC Enrollment Form (DM-0084A eDocs version is DHS -4106A)
> Health plan primary care network listing (PCNL) for each available health plan in the county.
> The following county-specific information. Materials other than the return envelope must be approved by DHS:
  - A county contact sheet listing where to call with questions.
  - A prepaid return envelope.

For MSHO enrollees:

> DM-0084B: Automated MA Enrollment Form for MSHO (eDocs version is DHS-4106B)
> DHS-3214A: Rights & Responsibilities brochure
> DHS-3540: MSHO Information Sheet (eDocs only)
> DHS-4098: Health Plan Option Sheet (eDocs only)

Note: DM-0084B: This version of the enrollment form will print automatically if anyone in the household is potentially eligible for MSHO (eDocs version is DHS-4106B).

County-Based Purchasing (CBP) Packet:

> DM-0084A: Automated MA/GAMC Enrollment Form (eDocs version is DHS-4106A)
> DHS-3320: Window Envelope for County Mailing
> DHS-3354: Guide to Health Plan Enrollment
> DHS-3354C: Pre-Enrollment Questionnaire (eDocs only)
Postage paid return envelope

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

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

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

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

Managed care counties must complete the appropriate MMIS screens with either an exclusion span or an enrollment span. Contract numbers are the provider numbers of the health plans which serve the managed care counties. Each county will have a list of the health plan provider numbers for that county. See the MMIS User Manual, MMIS Screens, RPPH, and the Managed Care Manual, section 4.02.01, both listed under manuals in CountyLink on the DHS web site.

If a client has not chosen a health plan when MA or GAMC is approved, code RENR with exclusion reason YY (Delayed Decision). Complete the RTRK panel. Follow your county's procedures for entering enrollment information on MMIS when people choose a health plan.

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

If a client has not chosen a health plan before the counter on the RTRK panel reaches

30 days, MMIS will assign a default plan.

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

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

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

MinnesotaCare:

Reinstatements are enrollments or re-enrollments completed between capitation and the last business day of the month. Reinstatements occur when:

> A renewal is completed after capitation.

> A household is canceled from MinnesotaCare or disenrolled from a managed care plan and reinstated before the effective date of disenrollment.

EXAMPLE:

Bob calls on October 9 to request to have his MinnesotaCare canceled. He expects to have other insurance in November. On October 23 he calls to report that the other insurance is no longer available. He requests reinstatement. He mails his premium the same day and it is received on October 26. Bob is reinstated into his health plan for November.

When an initial enrollment is completed after capitation, it will be processed the same way as initial enrollments completed before capitation but will appear on the health plan's reinstatement record. See §0914.03.05 (Managed Care Enrollment Process).

Re-enrollments occur when a household is reopened on MinnesotaCare and re-enrolled in managed care after the effective date of cancellation. If the household has been terminated for 12 months or less, MMIS will re-enroll them in the same health plan unless they have moved to a county where the old plan is unavailable. If the case has been canceled for more than 12 months, MMIS will send a new health plan enrollment packet when the case is pended awaiting payment.

M.S. 256L.12

MA/GAMC:

Reinstatements for MA and GAMC occur when:

> An individual or household is reinstated between capitation and the last working day of the month. If you enter the GAMC or MA reinstatement on the MMIS RELG screen on or before the last working day of the month in which the case closed, the managed care enrollment will be active the first day of the next month. There will be no break in health plan coverage.

EXAMPLE:

Marcia's annual recertification is due for October. She has not

returned her recertification forms by the September cutoff date. MA is canceled. She submits a new application and all required verification on October 27. She remains eligible for MA and is reopened effective October 1. Reinstate MA with the same health plan effective November 1.

> An individual or household is reinstated after the effective date of closing with no break in MA or GAMC eligibility. If you enter the MA or GAMC reinstatement on the MMIS RELG screen after the last working day of the month in which the case was closed, reopen managed care the 1st day of the next available month. Create a new enrollment span on the MMIS RPPH screen with the new enrollment begin date and an exclusion span for the current month. Fee-for-service may cover medical needs during the interim month(s). See MAXIS/MMIS Calendar in the TEMP Manual index for managed care enrollment cutoff dates.

Follow MinnesotaCare for re-enrollments. Re-enroll MA and GAMC applicants who have been terminated from MA or GAMC with less than a 12 full calendar month break in eligibility in the same health plans they had before the termination. The effective date of the re-enrollment will be the next available month on MMIS. See MAXIS/MMIS Calendar in the TEMP Manual for enrollment cutoff dates. Also see §0914.03.07 Health Plan Changes. Fee-for-service may cover the interim month(s).

EXAMPLE:

Louis is canceled from GAMC effective March 1 because he has excess income and is unable to meet a spenddown. He reapplies on April 10 because his income has dropped. He is found eligible without a spenddown effective April 1. Re-enroll Louis in his previous health plan. If the required information is entered on MMIS before the cutoff date in April, his managed care enrollment will be effective May 1. If the information is entered after April cutoff but before May cutoff, managed care enrollment will be effective June 1. He will be eligible on a fee-for-service basis for the month(s) before managed care enrollment.

MinnesotaCare:

Newborns born on or after 10/1/04, to a mother who was enrolled in a health plan at the time of birth will be retroactively enrolled in the same health plan back to the birth month, unless the newborn meets an exclusion (see §0914.03.03 Managed Care Exclusions).

If eligibility for the newborn is added within 90 days from the birth, the newborn should be retroactively enrolled in the health plan for the birth month and all succeeding months unless a health plan change is requested.

If the newborn is added to the case more than 90 days from the birth, an adjustment to pay the health plan for birth month ONLY must be requested. Add the newborn to the same health plan for the next available month based on managed care cut-off, unless a health plan change is requested. There will be a break in health plan enrollment, covered by fee-for-service, between the birth month and the next available month.

Disenroll people who are removed from coverage in an active household effective the first day of the next available month. If a capitation has already been made, coverage cannot be canceled until the next available month and the enrollee will be responsible for the premium payment. See §0914.03.11 (Managed Care Disenrollment).

Terminate coverage when an enrollee dies effective the date of death. DHS identifies and recovers any capitation claims after the date of death.

Minnesota Rule 9506.0030 subp. 4

MA/GAMC:

Newborns born on or after 10/1/04, to a mother who was enrolled in a health plan at the time of birth will be retroactively enrolled in the same health plan back to the birth month, unless the newborn meets an exclusion (see §0914.03.03 Managed Care Exclusions).

If eligibility for the newborn is added within 90 days from the birth, the newborn should be retroactively enrolled in the health plan for the birth month and all succeeding months unless a health plan change is requested.

If the newborn is added to the case more than 90 days from the birth, an adjustment to pay the health plan for birth month ONLY must be requested. Add the newborn to the same health plan for the next available month based on managed care cut-off, unless a health plan change is requested. There will be a break in health plan

enrollment, covered by fee-for-service, between the birth month and the next available month.

When adding a non-excluded person, enroll the person in the same health plan as the rest of the household. See §0914.03.05 (Managed Care Enrollment Process).

When adding a person to a household in which no other members are receiving MA or GAMC or are excluded from managed care, refer the applicant for a managed care presentation or provide a managed care education packet. When you approve eligibility, code the RENR screen with either an exclusion reason or a health plan contract number. If the person fails to choose a health plan within 30 days, MMIS will assign a default plan. Review RPPH to verify that the exclusion or enrollment is correct.

See MAXIS/MMIS Calendar in the TEMP Manual index for managed care enrollment cutoff dates. MA fee-for-service may cover medical services the client receives in the initial months before the enrollment effective date.

MinnesotaCare:

An adjustment is either:

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

OR

> Recovering a capitation payment from a health plan.

Request adjustments in the following situations:

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

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

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

M.S. 256L.12

MA/GAMC:

Request adjustments from the DHS managed care unit when:

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

> People are disenrolled from health plans incorrectly.

> People are hospitalized on the effective date of an enrollment change.

> MA enrollees are incarcerated at the time of initial managed care enrollment.

NOTE: Incarcerated GAMC enrollees remain in the health plan.

If the change is for a future month and no erroneous capitation payment has been made, delete the incorrect span or change the incorrect information on the RPPH panel. See instructions for adding newborns under §0914.03.13 (Adding/Removing People From Managed Care).

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

MinnesotaCare:

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

MA/GAMC:

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

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

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

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

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

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

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

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

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

Access services plans must cover reimbursement for the following items:

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

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

- Mileage reimbursement at the current IRS rate to volunteer drivers registered with the county who use their vehicles to transport enrollees. Effective January 1, 2005, the IRS rate is 40.5 cents per mile. The rate for 2004 was 37.5 cents per mile.

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

- Actual cost of parking.

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

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

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

Do not allow the following transportation costs in access plans:

- Special transportation. Special transportation providers are enrolled in Minnesota Health Care Programs. DHS will reimburse the providers directly

unless the cost is included in a per diem payment to an ICF-MR facility.

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

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

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

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

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

  EXAMPLE:

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

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

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

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

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

written treatment plan.

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

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

Access plans must require prior authorization for:

> Lodging and meal expenses for people accompanying the enrollee.

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

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

Access plans may not require prior authorization for emergency services.

MinnesotaCare:

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

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

MA and GAMC:

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

> Sign language and foreign language interpreters if needed to receive medical services.

> Reimbursement for transportation and child care if needed for a state appeal hearing related to the health plan's denial, reduction or termination of a health service.

> Common carrier transportation to receive medical services.

Health plans are not required to provide:

> Reimbursement to enrollees for personal mileage or parking unrelated to an appeal.

> Lodging, meals or out-of-state airfare related to obtaining medical services.

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

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

Most changes will be reported by enrollees. Enrollees must report required changes within 10 days after the date of the change. They may report by phone, mail, in person, or on a required scheduled reporting form. Clients must report the following changes for all health care programs:

> Changes in household composition, including household members moving in or out, births, and marriages. MinnesotaCare enrollees may add new household members for the first available month or at the time of the next scheduled renewal. See §0915.03 (Adding a Person to the Household).

> Changes in insurance or other health coverage.

> Pregnancy.

> Change of address.

You may also become aware of changes through other sources, such as:

> Changes reported by another person or agency.

> Changes reported by an enrollee to another program. For example, an enrollee may report a change to Food Stamp staff that also affects MinnesotaCare.

> Information reported by computer matches.

> Upcoming or potential changes that the agency has been tracking.

When you become aware of a change in circumstances, take the following steps:

1. Determine if you need more information. If yes, request the information. See the program specific sections of this chapter for what information to request.

2. Determine if the change affects eligibility for any household member. If eligibility continues, determine if the change affects spenddown or premium amount.

3. Determine what action program rules require as a result of the change. Most changes require you to take action as soon as possible after learning of a change. However, some changes will not affect the case immediately, such as changes in income that result in an increase in the MinnesotaCare premium. See the program specific sections of this chapter.

4. Apply the change according to program rules. If no action is taken, document the circumstances in the case record. Track the change if it will require action in the future.

Some types of changes are covered in detail in other chapters of this manual.

For changes in county of residence for MA and GAMC, see §0906.07 (County Residence).

For changes in certification periods and spenddowns, see §0913.19 (Shortened Spenddown).

For changes when people enter long term care or begin receiving Elderly Waiver (EW) services, 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).

For changes in managed care, see §0914.03.07 (Health Plan Changes) and §0914.03.17 (Managed Care County Transfers).

MinnesotaCare:

In addition to the changes listed in the general provisions, MinnesotaCare enrollees must report the following changes no later than the next scheduled renewal:

> Initial receipt of unearned income.

> Change in employment, including stopping, starting or changing employment; starting or stopping a business; and changes in hours or earnings.

See §0915.07 (Change in Income) for information on income changes reported between renewals.

If you determine that eligibility was determined erroneously on an active case, correct the error for the 1st available month with 10-day notice, regardless of the type of error. This includes changes that result in increased premiums. Do not wait until the next renewal. Do not allow an additional 12 months of coverage for children under 21 that should have been denied for excess income. See §0912.03.03 (MinnesotaCare Excess Income).

If the correction results in increased eligibility, such as a lower premium, eligibility on a denied case, or eligibility for additional household member(s), correct the error back to the month of the last renewal or application or the time the error occurred, whichever is most recent.

MA/GAMC:

In addition to the changes listed in the general provisions, MA/GAMC enrollees must report the following changes within 10 days or by the due date of the next scheduled income report or renewal, whichever is earlier:

> Change in unearned income.

> Change in employment, including stopping, starting or changing employment; starting or stopping a business; and changes in hours or earnings.

> Receipt of a lump sum.

> Changes in assets, if any household member has an asset limit and the change results in assets exceeding the applicable limit. See §0909.03 (Exemptions From Asset Limits) and §0909.05 (Asset Limits).

MinnesotaCare:

See §0915.03 (Adding a Person to the Household).

MA/GAMC:

See §0907.19.05.03 (MA Basis: Auto Newborn) for instructions on adding children born to women receiving or eligible for MA.

Take the following steps when you become aware of new household members other than auto newborns:

1. If the new household member is requesting MA or GAMC, request all information needed to determine the new household member's eligibility, such as SSN, assets if applicable, income, and information on other health coverage. Do not require an application or addendum.

   EXCEPTION: Require an application if the only active household member is an auto newborn and there is no application or renewal on file in the previous 12 months. See §0904.05.03 (When to Require an Application).

   If the new household member is not requesting MA or GAMC, determine if the new member's income and/or assets must be deemed to members of the existing household. If so, request a Household Report Form (DHS 2120) and verification of the new member's income, assets if applicable, and any other health coverage the new member has that covers any members of the existing household.

2. Determine the new member's effect on the household size and basis of eligibility. See §0908.05 (Determining MA/GAMC Household Size), §0908.07 (Household Composition: Deeming), and §0907.17 (MA/GAMC Bases of Eligibility).

3. Determine the new member's eligibility and the effect of adding the new member on eligibility, certification period, and spenddown for the existing household members. People who move into an existing household are eligible to be added effective the first full month that they live with the existing household. If the new member is not requesting MA or GAMC, begin deeming the new member's income effective the first full month they live with the existing household.

   If the new member requests coverage for the month of entry into the household or any retroactive months, determine eligibility for those months

separately.

If the new member was included in the household size but did not request MA or GAMC when the rest of the household was approved, the new member may be added for the first full month or up to 3 months retroactive for MA or the date that he/she requests GAMC. The new member is subject to the same spenddown type as the rest of the household. See §0913.05 (Which Spenddown Type to Use) and §0913.19 (Shortened Spenddown).

See §0913.19 (Shortened Spenddown) for instructions and examples covering when to interrupt the certification period and recompute the spenddown when adding a household member.

4. Determine if the new member must be enrolled or disenrolled from a health plan. See §0914.03.13 (Adding/Removing People From Managed Care).

MinnesotaCare:

There are several circumstances when one or more household members must be removed from an existing case, including:

> A minor child gets married.

> A person moves out of the household.

> A child turns age 21.

> A household member dies.

> A person remains in the household but no longer has a parental or marital bond with another household member.

When a household reports a change that requires one or more members to be removed from the household, take the following steps:

1. Ask whether the household member being removed wishes to be considered for eligibility on a separate case. Send a HCAPP for the household member being removed to complete and request any information needed to determine eligibility for the new case.

   When people move out of a MinnesotaCare household, attempt to contact them to find out if they want continued coverage. Remove them from the existing case effective the end of the month following the month in which the change is reported regardless of whether they respond to attempts to contact them. Do not open a separate case unless the person who left completes a HCAPP and is determined eligible for coverage as a separate household.

   EXAMPLE:

   Julie, age 16, is enrolled in MinnesotaCare with her parents. She reports that she got married and her husband Brad moved in with her and her parents. She would like to continue MinnesotaCare coverage. Because Julie is an emancipated minor, she must have her own case. She may choose to add Brad and apply on her own case now or wait until the next scheduled renewal for her parents' case. Brad is required to be a member of her household no later than the next renewal and to be covered if he is eligible. If Julie chooses to add Brad before her parents' next renewal, send a HCAPP for Brad and Julie to complete and sign. Determine Brad's eligibility. Set up a

separate case for Julie and include Brad if he is eligible for coverage. Remove Julie from her parents' case effective the end of the month following the month in which the change is reported, or the month of renewal if Julie chooses not to add Brad until renewal.

EXAMPLE:

Marianne reports that her husband, Jerome, has moved out of the household. She would like continued coverage for herself and her children. If Marianne is able to supply a new address and/or phone number for Jerome, contact him to ask if he would like continued MinnesotaCare coverage for himself. Also, ask him to send a written request to be removed from Marianne's case. If he responds and requests coverage, send him a HCAPP to complete and request all information needed to determine eligibility for Jerome as a separate case. Remove him from Marianne's household effective the end of the month after the month in which the change is reported.

2. If people being removed from an existing case are eligible as a separate case, establish a new case. The effective date of coverage for the new case is the first day after the month in which the initial premium payment is received. Deny coverage for people being removed who submit a HCAPP but are not eligible.

3. Remove people who are no longer eligible to be included on an existing case effective the end of the month after the month in which the change is reported. Review income, major program and group status for the remaining members of the original case. Enter the new income and household size information on MMIS. If the removal of a person results in the loss of parental status for anyone in the existing case, change them to the appropriate non-parent major program (BB) and group status of 3 for the next available month with 10-day notice. If removing a person results in a decreased premium, MMIS will rebill. Do not request manual adjustments.

   If the existing household requests to have the person removed before the end of the month following the month in which the change is reported, require a written request from the person being removed. To receive a premium refund, people who wish to end their MinnesotaCare at the end of the current month must submit the written request for cancellation prior to capitation. If the request is received after capitation, coverage cannot be closed until the next available month and the enrollee will be responsible for any premiums due for months for which a health plan capitation has been paid.

EXAMPLE:

Marianne calls on December 5 to report her husband, Jerome, left the home on November 30. Advise Marianne that Jerome will be removed from her case at the end of January, the month following the month in which the change is reported. Marianne asks to have Jerome removed at the end of December so her January premium can be reduced. Require a written statement from Jerome. If Jerome submits a written request before the January capitation is paid, remove him and reduce the premium effective January 1. If the household has already paid the January premium, refund Jerome's portion. If he submits the written request after capitation, he cannot be removed until February 1.

EXAMPLE:

George calls on December 28 to report his wife Suzanne left the home on December 26. Advise George that Suzanne will be removed from his case at the end of January, the month following the month in which the change is reported. Because January's capitation payment has been paid, it is not possible to remove Suzanne for January, even if she submits a written request.

People who become incarcerated while enrolled in MinnesotaCare may remain enrolled until the time of the next scheduled renewal. If the existing household requests to have the incarcerated member removed before the renewal, allow the incarcerated member to request MinnesotaCare on a separate case. Send the incarcerated person the Notice to MinnesotaCare Enrollees who are Residing in a Correctional Facility and a HCAPP. Obtain the address of the penal institution if there is no forwarding address. Allow the person 10 days to return the application. If eligibility exists, send a request to the MMIS Help Desk to set the renewal date for the new case to coincide with the existing household's scheduled renewal. See §0905 (Reviews and Renewals).

M. S. 256L.04 subd. 1
M. S. 256L.01 subd. 3a

MA/GAMC:

See §0915.05.01 (Removing a Person From Household--MA/GAMC).

MinnesotaCare:

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

> Their MinnesotaCare enrollment ends for 1 month or more.

OR

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

OR

> A parent loses parental status.

OR

> A person turns age 21.

EXCEPTION:

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

All changes must be made at renewal. Change group status between renewals when:

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

Reevaluate group status when children turn age 21.

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

> Group 3 and Group 4 Women who become pregnant gain Group 2 status effective with the month the pregnancy is diagnosed. Their husbands gain either Group 2 or Group 4 status. They retain this status as long as the woman is pregnant or they have a child under 21 in the home. If the woman is no longer pregnant and there is no child under 21 in the home, review group status for the woman the month after the postpartum period ends and for the spouse the first available month following the end of the pregnancy with 10-day notice.

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

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

EXAMPLE:

Mary is a single adult enrolled in Group 3. She reports and verifies that she is pregnant. Her income is 225% FPG. She now has Group 2 status and will retain this status as long as she is pregnant or has a child under 21 living with her.

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

Mai is enrolled as a Group 2 child. She turns 21 in June. Mai becomes Group 3 and will be on her own MinnesotaCare case effective in July.

M.S. 256.9354 subd. 1.

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

Minnesota Children with Special Health Needs (MCSHN) is administered by the Minnesota Department of Health.

MCSHN provides an information and referral telephone line for families, teachers, social workers, and others to help identify and locate resources and services for children with special health needs and their families.

Refer interested families to MCSHN at 651-215-8956 or 1-800-728-5420.