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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #43

May 2005

Effective Date: May 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 651-296-7675, toll-free at 1-800-657-3739, 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. Otherwise, except for minor clarifications and corrections of existing policy or otherwise noted effective dates, all new and revised instructions are EFFECTIVE MAY 1, 2005.

HIGHLIGHTED CHANGE #1: This manual letter describes the changes to the vehicle exclusion for people on MA/GAMC using Method B budgeting. Apply this change to

applications received on and after May 1, 2005, and at the time of renewal for people currently on MA/GAMC using Method B budgeting. See §0909.15 (Vehicles).

HIGHLIGHTED CHANGE #2: This manual letter clarifies policy regarding allowable deductions from rental income for Method B. Examples of what is considered an allowable deduction and how to apply the deduction were added to §0911.09.03.13 (Rental Income).

HIGHLIGHTED CHANGE #3: This manual letter clarifies that all people applying for MinnesotaCare are required to provide or apply for Social Security Numbers (SSN). Under the All or Nothing Rule, if a required household member fails to provide an SSN do not approve coverage for all household members that required to apply with that household member. Coverage cannot be approved until the person either supplies the SSN or applies for an SSN. See §0908.11 (All or Nothing Rule)

HIGHLIGHTED CHANGE #4: This manual letter updates §0907.23.09.03 (TEFRA – SMRT Procedures) with changes to submitting documentation for the SMRT Certification Process previously relayed in Bulletin 04-21-16 (Changes in Procedures When Submitting Requests for SMRT Certifications issued December 28, 2004).

See below for a list of all the changes.

Submit questions through the HealthQuest system.

HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #43

REVISED AND DELETED SECTIONS

Revised Sections	Deleted Sections
0902.09	0902.09
0902.17	0902.17
0902.27	0902.27
0902.41	0902.41
0903.05.05	0903.05.05
0904.11	0904.11
0906.03.05	0906.03.05
0906.03.11	0906.03.11
0906.03.11.01	0906.03.11.01
0906.03.11.03	0906.03.11.03
0906.03.11.05	0906.03.11.05
0906.03.11.07	0906.03.11.07
0906.03.11.09	0906.03.11.09
0906.03.11.11	0906.03.11.11
0906.03.11.13	0906.03.11.13
0906.03.11.15	0906.03.11.15
0906.03.11.17	0906.03.11.17
0906.03.11.23	0906.03.11.23
0906.03.11.25	0906.03.11.25
0906.03.11.27	0906.03.11.27
0906.05.07	0906.05.07
0906.13.03	0906.13.03
0907.21.03	0907.21.03
0907.21.05	0907.21.05
0907.23.09.03	0907.23.09.03
0908.07	0908.07
0908.11	0908.11
0909.03	0909.03
0909.15	0909.15
0909.17	0909.17
0911.09.03.13	0911.09.03.13

0911.11.05	0911.11.05
0912.05.09.05	0912.05.09.05
0912.05.09.07	0912.05.09.07
0913.07	0913.07
0913.09	0913.09
0913.11	0913.11
0914.05	0914.05
0914.07	0914.07
0915.11	0915.11
0916.23	0916.23

§0902.09 (Glossary: Denial…) clarifies the definition of DEPENDENT CHILD for MA by adding that the child must live with parent, legal guardian, relative caretaker or foster parent

§0902.17 (Glossary: Health Care…) changes the name of the INS to USCIS under IMMIGRATION AND NATURALIZATION SERVICE (INS).

§0902.27 (Glossary: Non-Citizen…) and §0902.41 (Glossary: Underinsured…) deletes references to INS and replaces it with the U.S. Citizenship and Immigration Services (USCIS) under NON-IMMIGRANT and UNDOCUMENTED PEOPLE.

§0904.11 (Authorized Representatives) clarifies that DHS-3417B (Request to Apply for MN Health Care Programs) is part of the application process. Authorized representatives can sign this form to set the date of application for a person who is unable to sign a request for health care.

§0906.03.05 (Non-Citizens Ineligible for Federal Funding) changes references from INS to USCIS.

§0906.03.11 (Verification of Immigration Status) changes references from INS to USCIS.

§0906.03.11.01 (Systematic Alien Verification Entitlements - SAVE) changes references from BCIS to USCIS.

§0906.03.11.03 (Lawful Permanent Residents) changes references from INS to USCIS and deletes a reference to MinnesotaCare program XX.

§0906.03.11.05 (Refugees) changes references from INS to USCIS.

§0906.03.11.07 (Asylees/Deportation Withheld) changes references from INS to USCIS.

§0906.03.11.09 (Conditional Entrants) changes references from INS to USCIS.

§0906.03.11.11 (Paroled for at Least One Year) changes references from INS to USCIS and deletes a reference to MinnesotaCare program XX.

§0906.03.11.13 (Battered Immigrants) deletes reference to MinnesotaCare program XX.

§0906.03.11.15 (Cuban/Haitian Entrants) changes references from INS to USCIS.

§0906.03.11.17 (Amerasian Immigrants) changes references from INS to USCIS.

§0906.03.11.23 (Other Lawfully Residing) changes references from INS to USCIS.

§0906.03.11.25 (Trafficking Victims) changes references from INS to USCIS.

§0906.03.11.27 (Micronesians/Marshall Islanders) changes references from INS to USCIS and deleted reference to MinnesotaCare program XX.

§0906.05.07 (State Residence -- GAMC) updates the cross reference to the manual section that defines medical emergency.

§0906.13.03 (Medical Support: When to Refer) clarifies that the legal custody that a county agency has when placing a child in foster care does not factor into the determination of non-custodial parent.

§0907.21.03 (MA/Medicare Savings Basis: Age 65 & Over) for GAMC, deletes the reference to undocumented non-citizens. There are no provisions for GAMC.

§0907.21.05 MA/Medicare Savings Basis: Blindness) for GAMC, deletes the reference to undocumented non-citizens. There are no provisions for GAMC.

§0907.23.09.03 (TEFRA – SMRT Procedures) see HIGHLIGHTED CHANGE #4.

§0908.07 (Household Composition Deeming) updates examples to reflect that assets are not counted for children under the age of 21 and that auto-newborn eligibility has changed to age 1.

§0908.11 (All or Nothing Rule) see HIGHLIGHTED CHANGE #3.

§0909.03 (Exemptions From Asset Limits) deletes reference to dependent sibling.

§0909.15 (Vehicles) see HIGHLIGHTED CHANGE #1.

§0909.17 (Burial Funds/Life Insurance: Fund Types) clarifies that the statement of goods and services needs to be for an amount that is equal to or greater than the purchase price of the life insurance policy or annuity.

§0911.09.03.13 (Rental Income) see HIGHLIGHTED CHANGE #2.

§0911.11.05 (MA/GAMC Varying Income) deletes a reference to delayed verification.

§0912.05.09.05 (Earned Income Disregards – Method B) under GAMC, deletes reference to Method A disregard section.

§0912.05.09.07 (Special Personal Allowance Disregard) under GAMC, adds there are no provisions and deletes reference to any deductions.

§0913.07 (6-Month Spenddown Calculation), §0913.09 (Automated Monthly Spenddown Calculation) and §0913.11 (Manual Monthly Spenddown Calculation) updates the MAXIS panel references to reflect the health care rewrite changes.

§0914.05 (Fee-For-Service) updates the date for the list of managed care counties and clarified the last example.

§0914.07 (Minnesota Health Care Programs Card) updates the description of the Health Care Programs card.

§0903.05.05 (Client Responsibilities – Premium Payment) and §0915.11 (Fail to Pay Premium/Voluntary Cancellation) under MA clarifies that all people receiving MA-EPD pay a premium.

§0916.23 (Certificates of Creditable Coverage) deletes reference to EGAMC.

DENIAL:

The act of disapproving an APPLICATION, a request to add a person to coverage, or a request for specific medical services.

DEPENDENT CARE DEDUCTION:

An income DEDUCTION based on the cost of caring for a CHILD or adult. See §0912.05.07 (Dependent Care Deduction).

DEPENDENT CHILD:

MINNESOTACARE:

A person less than 21 years old who lives with a PARENT, LEGAL GUARDIAN, RELATIVE CARETAKER, or foster parent.

MA:

A person who lives with a parent, legal guardian, relative caretaker or foster parent and is less than 18 years old, or an 18-year-old FULL-TIME STUDENT expected to graduate by age 19.

DEPENDENT HEALTH INSURANCE:

Health insurance coverage offered or provided to the insured's specified dependents. EMPLOYER SUBSIDIZED INSURANCE may be available only to the employee or to the employee and dependents.

DHS:

The Minnesota Department of Human Services.

DISABILITY:

MA:

A BASIS OF ELIGIBILITY based on the disability standards of the SOCIAL SECURITY ADMINISTRATION (SSA). Disability may be determined by the SSA or the STATE MEDICAL REVIEW TEAM (SMRT). See §0906.15 (Disability Determinations).

DISABILITY INSURANCE:

A policy which pays a fixed amount of income to a person who becomes disabled under the terms of the policy. DISABILITY insurance is intended as an income replacement and is not health insurance.

DISREGARD:

An amount of income which is excluded in determining NET INCOME.

DIVIDEND:

The amount of the profit distribution a shareholder receives or the amount of the surplus distribution a policyholder of a participating insurance policy receives.

DOMESTIC VOLUNTEER SERVICE ACT:

Federal law authorizing the Foster Grandparents Program, Retired Senior Volunteer Program, Service Corps of Retired Executives, Active Corps of Executives, Action Cooperative Volunteer Program, Senior Companion Program, VISTA, and University Year for Action.

EARNED INCOME :

Money received from employment or SELF-EMPLOYMENT. This includes but is not limited to salaries, wages, tips, commissions, vacation, and sick pay. See §0911.07 (Determining if Income Is Earned or Unearned) and §0911.07.03 (Earned Income).

EARNED INCOME DISREGARD:

MA :

An amount deducted from earned income as an employment incentive. See §0912.05.09 (Earned Income Disregards--Method A) and §0912.05.09.05 (Earned Income Disregards--Method B).

EARNED INCOME DISREGARD CYCLE:

MA :

The time period in which you apply the EARNED INCOME DISREGARD for Method A. See §0912.05.09.03 (Earned Income Disregard Cycle--Method A).

EARNED INCOME CREDIT (EIC):

A federal tax credit given to low income people. Household members may receive an EIC once a year as a refund or as an advance payment or tax reduction with each paycheck.

HEALTH CARE APPLICATION (HCAPP):

A form which people can use to apply for GAMC, MA, or MINNESOTACARE.

HEALTH CARE PROGRAMS:

MINNESOTACARE, MEDICAL ASSISTANCE (MA), and GENERAL ASSISTANCE MEDICAL CARE (GAMC). MA includes QMB, SLMB, QWD, QI, MA-EPD and the federally funded waivers. The MA references in this manual apply to these programs unless otherwise stated. References to the state-funded PRESCRIPTION DRUG PROGRAM are included under MA and identified as applying to Prescription Drug.

HEALTH INSURANCE INFORMATION FORM (HIIF):

A form (DHS 1922 or 1922b) used to supply information on ENROLLEES' other health coverage to the BENEFIT RECOVERY SECTION. See §0910 (Other Health Coverage).

HEALTH MAINTENANCE ORGANIZATION:

An organization licensed by the Department of Health to provide all defined health care benefits to people in return for a capitated payment.

HEALTH PLAN:

An organization contracting with the State to provide health services to ENROLLEES covered by MA, GAMC, or MINNESOTACARE in exchange for a monthly CAPITATION payment. A health plan may be a HEALTH MAINTENANCE ORGANIZATION or other defined group of medical providers. See MANAGED CARE in §0902.23 (Glossary: Managed Care...).

HILL-BURTON ACT:

A federal act that gives hospitals and other health facilities money to build and remodel in return for providing a limited volume of services to people living in their area who cannot pay for health care.

HOME AND COMMUNITY BASED SERVICES:

Services not normally covered by MA which are covered under a WAIVER, including CASE MANAGEMENT, homemaker services, home health aide, personal care, adult day health treatment, habilitation, respite care, and day treatment for individuals with chronic mental illness. See §0907.23 (MA Waiver Programs) for detailed information on the services covered under each waiver. Also see EXCLUDED TIME SERVICES in §0902.11 (Glossary: Effective...). Except for personal care attendant services, home and community based services are not considered excluded time services.

HOSPITAL LEAVE DAY:

MA:

Each day an LTCF is eligible for MA payment even though the client has been transferred to an INPATIENT hospital for medically necessary health care. See §0908.15 (Nursing Facilities and ICF-MR Leave Days).

HOUSEHOLD REPORT FORM (HRF):

MA and GAMC:

A form (DHS-2120) used by ENROLLEES to report income and circumstance changes.

HOUSEHOLD SIZE:

MINNESOTACARE:

The number of people used to determine the premium amount for the number of individuals covered. The household size is also used to determine income eligibility.

MA/GAMC:

The number of people used to determine each person's income standard. See §0908.05 (Determining MA/GAMC Household Size).

IEVS (INCOME AND ELIGIBILITY VERIFICATION SYSTEM):

A set of data exchanges with other state and federal sources that is used to verify income and assets of MA APPLICANTS and ENROLLEES.

IMD (INSTITUTION FOR MENTAL DISEASES):

An INSTITUTION for the treatment of mental diseases. See §0907.27 (MA/GAMC Basis: IMD Residents) for information on eligibility for IMD residents.

IMMIGRANT:

A person who leaves another country to settle permanently in the U.S.

IMMIGRANT SPONSOR:

1. A person, church, organization, or group agreeing to help receive and place refugees in the U.S.
2. A person who agrees to provide financial support to an IMMIGRANT as a condition of entry into the U.S.

See SPONSOR in §0902.37 (Glossary: Sole...).

IMMIGRATION AND NATURALIZATION SERVICE (INS):

The former name of the federal agency responsible for immigration and citizenship. See U.S. CITIZENSHIP and IMMIGRATION SERVICES (USCIS) in §0902.41 (Glossary: UNDERINSURED).

IMPROPER TRANSFER:

When an ASSET is sold, given away, or otherwise disposed of for less than FAIR MARKET VALUE for the purpose of obtaining or maintaining MA or GAMC eligibility.

NON-CITIZEN:
A person who is not a U.S. citizen.

NON-CUSTODIAL PARENT:
A PARENT who does not have physical custody of a CHILD.

NON-IMMIGRANT:
A person from another country who is admitted to the U.S. on a temporary basis and does not have USCIS permission to settle permanently. See UNDOCUMENTED PEOPLE in §0902.41 (Glossary: Underinsured...).

NON-REIMBURSABLE MEDICAL EXPENSE:
MA and GAMC:
An expense that is not eligible for payment under MA or GAMC but that is

> Prescribed or recommended in writing by the enrollee's physician or dentist

AND

> Of direct benefit to the enrollee

AND

> Available but not necessarily obtained through a licensed medical provider.

MEDICALLY NECESSARY non-reimbursable expenses may be allowed as spenddown deductibles. See MEDICALLY NECESSARY in §0902.23 (Glossary: Managed Care...) and §0913.21 (Allowable Medical Bills to Meet Spenddown).

EXAMPLE:
Jim's dentist, a licensed provider, refers him to a specialist who is not a licensed provider. Although the expense is not reimbursable through MA, it can be allowed as a non-reimbursable spenddown deductible.

EXAMPLE:
Glenda purchased vitamins through a mail-order company. Her physician advised her to take the vitamins for a 12-month period. Although the mail order company is not a licensed provider and cannot be reimbursed, the vitamins could have been obtained through a licensed pharmacy and can be allowed as a non-reimbursable

spenddown deductible.

EXAMPLE:

Matt purchased a prescription drug while enrolled in MA, and incurred a $3 co-payment. The co-payment amount can be allowed as a non-reimbursable spenddown expense.

Do not allow expenses for food or utilities as a spenddown deductible, even if the cost is related to a special diet or medical equipment recommended by a physician. Do not allow items that do not directly benefit the enrollee, such as special equipment requested by the enrollee's personal care attendant or other caretaker.

OPEN ENROLLMENT:

The annual period during which MANAGED CARE ENROLLEES may change HEALTH PLANs.

OVERPAYMENT:

MA and GAMC:

Benefits households receive that exceed the amount for which they are eligible.

PARENT:

MINNESOTACARE:

A CHILD's biological or adoptive mother or father whose parental rights have not been terminated or STEPPARENT.

MA:

A CHILD's legal biological or adoptive mother or father whose parental rights have not been terminated.

PARENTAL FEE:

MA:

An amount assessed to the PARENTs of a MINOR CHILD as reimbursement for the cost of care of a CHILD under 18 who receives MA without consideration of parental income and ASSETS. See §0906.13.09 (Parental Fees).

PARENTAL RELATIONSHIP:

MINNESOTACARE:

The relationship that exists between a PARENT and his or her biological or

adoptive CHILD.

PARTNERSHIP:

A SELF-EMPLOYMENT enterprise in which 2 or more people share in the profits and losses of the business according to their individual shares of ownership.

PATERNITY:

Legal fatherhood, either adjudicated or acknowledged by the father.

PEND:

1. To enter an APPLICATION that has not yet been approved or denied on MAXIS or MMIS.
2. To delay approving or denying an application until more information is received.

PEND AWAITING PAYMENT:

MINNESOTACARE:

To approve an APPLICATION conditioned on the receipt of the INITIAL PREMIUM PAYMENT. When an application is pending awaiting payment, the household has been found eligible for MINNESOTACARE but will not have coverage until the month after DHS receives the initial payment.

UNDERINSURED:

MINNESOTACARE:

A person whose health insurance lacks coverage in 2 or more of the following areas:

> Basic hospital insurance, medical-surgical insurance, prescription drug coverage, PREVENTIVE and COMPREHENSIVE dental, coverage (with or without co-pays), or PREVENTIVE and COMPREHENSIVE vision coverage (with or without co-pays).

OR

> Has an annual DEDUCTIBLE of $100 or more per person.

OR

> Excludes coverage for some diagnoses.

Children under 21 are also considered underinsured if their only coverage is through MEDICARE. See §0910.09 (Determining if Someone Is Underinsured).

UNDOCUMENTED PEOPLE:

People living in the U.S. without the knowledge or approval of the U.S. CITIZENSHIP and IMMIGRATION SERVICES (USCIS). See §0906.03.09 (Undocumented and Non-Immigrant People).

UNEARNED INCOME:

Income a person receives without being required to perform any labor or service. See §0911.07 (Determining if Income Is Earned or Unearned) and §0911.07.05 (Unearned Income).

UNEMPLOYMENT INSURANCE:

A state cash payment made to some people who have lost their jobs. This program was formerly known as REEMPLOYMENT INSURANCE in Minnesota.

UNSALABLE REAL PROPERTY:

Property which 2 sources who are knowledgeable about the value of the property and the local area agree cannot be sold due to a specified condition, or property which has been for sale at least 90 days at a price no more than the highest current FAIR MARKET VALUE without an offer received. Current market value means a value established within 6 months of application or since the last RECERTIFICATION.

UNVI:

Unverified Unearned Income. An IEVS tape exchange completed annually for recipients and monthly for applicants of federal programs. The source is the Internal

Revenue Service (IRS). It reports information such as DIVIDENDS, INTEREST, and lottery winnings.

U.S. CITIZENSHIP and IMMIGRATION SERVICES (USCIS):
A bureau of the U.S. Department of Homeland Security; the USCIS is responsible for the administration of immigration and naturalization.

VARYING INCOME:
MA:
For purposes of determining whether a CLIENT will use an automated or a manual monthly SPENDDOWN, varying income is any income that cannot reasonably be anticipated to be the same amount every month. For example, most earned income for non-salaried employees is varying income. Most monthly benefit payments such as Social Security are non-varying income.

VERIFICATION:
The process and evidence used to establish accuracy or completeness of information from an APPLICANT, ENROLLEE, third party, or AUTHORIZED REPRESENTATIVE. Require the CLIENT's written consent to obtain verification from a third party.

VETERANS' BENEFITS:
Benefits and services provided by the U.S. Veterans Administration (VA) to people who have served in the U.S. armed forces and their dependents.

WAGE MATCH:
MA:
An IEVS tape exchange with the Minnesota Department of Economic Security completed quarterly for recipients and monthly for applicants of federal programs. It provides information on wages earned in Minnesota.

WAIVER:
A suspension or change of a federal regulation, service limitation, or eligibility requirement.

WAIVER OBLIGATION:
The amount of income in excess of the MAINTENANCE NEEDS ALLOWANCE that people eligible for SIS EW must contribute toward the monthly cost of waivered services. See §0913.13.05 (Waiver Obligation--SIS EW).

WIC:
See WOMEN, INFANTS, AND CHILDREN NUTRITION PROGRAM (WIC).

WIDOW'S AND WIDOWER'S DISREGARD:

MA:

A DISREGARD of UNEARNED INCOME available to some MA clients who are widows or widowers with a DISABILITY. See §0912.05.17 (Widow and Widower's Disregard).

WOMEN, INFANTS, AND CHILDREN NUTRITION PROGRAM (WIC):

A federal program authorized by the Child Nutrition Act of 1966 to provide nutritious food and nutrition education to low-income pregnant and postpartum women and their children. (In this instance, postpartum means up to 6 months after termination of pregnancy.)

WORKER:

An employee of a COUNTY AGENCY or MINNESOTACARE OPERATIONS who determines initial and continued eligibility for the HEALTH CARE PROGRAMS.

WORKERS' COMPENSATION:

A state program providing payments and reimbursement of medical expenses for people injured on the job.

MinnesotaCare:

Applicants must make an initial premium payment before coverage begins. Enrollees must continue to pay premiums to maintain coverage. Except for pregnant women and children under 2, failure to pay premiums results in cancellation. It also results in a 4-month ineligibility period unless the household shows good cause for failure to make a timely payment.

See §0913 (Premiums and Spenddowns) and §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

M.S. 256L.05 subd. 3
M.S. 256L.06 subd. 3c
Minnesota Rule 9506.0030 subp. 4A1, 4B1
Minnesota Rule 9506.0040 subp. 1

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

MA:

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

GAMC:

No provisions.

People may authorize a representative to help with contacts with the county agency or MinnesotaCare. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. Authorized representatives may contact the agency, attend interviews, complete forms, provide documentation, appeal agency decisions, and receive forms, notices, and pay premiums if the applicant or enrollee wishes them to do so.

Authorized representatives must be at least 18 years old and have sufficient knowledge of the applicant or enrollee's circumstances to provide necessary information. County or MinnesotaCare employees who determine eligibility cannot be authorized representatives.

People may designate an authorized representative by filling in the person's name, address, phone number, and relationship in the appropriate place on the application. The authorized representative designation remains in place until revoked by the household or the authorized representative. The authorized representative and the applicant must both sign the application unless the applicant is unable to sign. Once the authorized representative has been designated, applicants/enrollees age 18 and over who have signed a previous application or renewal are not required to sign renewals. The authorized representative's signature is sufficient. The authorized representative may respond to requests for information on the applicant's behalf and may discuss the case with the enrollment representative. The designation on the application authorizes the exchange of information. Do not request a Consent Form in addition.

NOTE: Accept a written request, which could include but is not limited to, the DHS-3417B (Request to Apply for MN Health Care Programs). The written request might only be signed by the authorized representative. This written request does set the date of application even if the client later completes and signs a Minnesota Health Care Programs application.

If the client is unable to designate an authorized representative, the agency may allow a person who can act responsibly for the client to act as an authorized representative. This applies to people who are incapacitated or incompetent, including children who are unable to act on their own behalf.

If an active household wishes to designate an authorized representative after the initial application, provide the form Giving Permission for Someone to Act on My Behalf (DHS 3437). County agencies and MinnesotaCare must also accept the appropriate signed pages of the application or externally created statements that designate an authorized representative. External statements must be in plain language and include the following:

< The name of the authorized representative.

< The agencies information may be shared with, and who the authorized representative

will work with to provide information

< The purpose of the information provided by the authorized representative

Accept a designation of Power of Attorney in place of another authorized representative designation if the person holding the Power of Attorney will serve as the authorized representative. A Power of Attorney is a legal document granting specified authorities to a person. If the client wishes to designate someone other than the person holding the Power of Attorney as their authorized representative for the health care programs, require a designation on the application or another written statement meeting the requirements of this section.

Potential authorized representatives for children in foster care or pre-adoptive placements include but are not limited to, social workers or other representatives of the agency that has legal custody and control of the child.

County agencies or MinnesotaCare may disqualify authorized representatives who knowingly provide false information or who are unable or refuse to provide required information. If you disqualify an authorized representative, allow the applicant or enrollee to designate a new one.

MinnesotaCare:

Any household member who is at least 18 years old may complete the household's application. Households may also designate family members who do not reside with the household or others who meet the criteria in the general provisions to act as authorized representatives.

If the applicant answers YES to the question on the HCAPP which asks if the applicant wants the person acting on his/her behalf to receive forms, notices, and premium notices, enter the authorized representative's name, address and indicators on the AREP screen on MMIS.

M.S. 256L.05 subd.1a

MA/GAMC:

Regional Treatment Center (RTC) reimbursement officers cannot act as authorized representatives.

MAXIS automatically sends all notices of action to the authorized representative. If clients indicate on the HCAPP or by another means that they want the authorized representative to receive other forms such as report forms and explanations of

medical benefits, enter a Y on STAT/AREP in the "Forms to AREP" field.

If you disqualify an authorized representative based on the criteria in the general provisions, determine whether to make a vulnerable adult referral to social services.

Providers may assist applicants in submitting requests for health care. The provider does not have to serve as the applicant's authorized representative. See §0904.07.03 (Date of Application).

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, or JJ, 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, or JJ). 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 USCIS in efforts to obtain a qualified status or pursue citizenship. The USCIS 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.

Require verification of immigration status for all applicants who are requesting coverage EXCEPT undocumented people who are requesting:

> EMA

OR

> Program NM for pregnant women or for people eligible solely due to receipt of services from the Center for Victims of Torture (CVT).

If applicants or enrollees claim a status under which they would qualify for federal or state-funded MA or MinnesotaCare but are unable to submit documentation or submit expired USCIS documents, request further verification and refer the applicant or enrollee to the USCIS district office to secure proper documentation. Approve the appropriate health care program while documentation is pending. However, if MinnesotaCare or MA has previously requested verification of immigration status and the applicant failed to submit it, do not approve health care coverage until you receive the verification.

If verification of immigration status is not received within two months of the request for the verification, send a letter to remind the applicant to provide the information. If verification of immigration status is not received within 30 days of the date of the reminder letter, terminate health care coverage for the next available month.

See §0906.03.11.03 through §0906.03.11.23 for information on acceptable sources of verification. See §0906.03.11.01 (Systematic Alien Verification for Entitlements (SAVE) for information on when to use the automated SAVE system to validate immigration status.

Assist people in obtaining documentation if they request help. Do not contact the USCIS without the person's written consent. Do not contact USCIS for undocumented people unless the person specifically requests the contact and gives signed permission.

MinnesotaCare:

Follow general provisions.

M.S. 256L.04 subd. 10

MA:

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

GAMC:

Follow general provisions.

The Systematic Alien Verification for Entitlements (SAVE) system is used to validate the immigration status of eligible non-citizen applicants for certain programs, and for enrollees who report a change in immigration status.

SAVE is an information-sharing initiative that allows authorized staff to validate a non-citizen's immigration status by accessing USCIS data. The USCIS will protect people's privacy to the maximum degree possible, in accordance with the Immigration and Nationality Act and other applicable statutes. No consent for release of information is required to use SAVE.

Use SAVE to validate the non-citizen status of eligible non-citizen applicants and of enrollees who report a status change for the following health care programs:

> MA. This includes state-funded MA (program NM), except for undocumented and non-immigrant people receiving services from the Center for Victims of Torture (CVT) or undocumented/non-immigrant pregnant women.

> Refugee Medical Assistance (RMA).

> GAMC.

> MinnesotaCare for families with children.

Do NOT use SAVE for the following programs:

> EMA.

> State-funded MA (program NM) for people whose eligibility is based solely on receipt of services from the Center for Victims of Torture (CVT) or who are undocumented/non-immigrant pregnant women.

> MinnesotaCare for adults without children.

SAVE does not determine eligibility for health care programs or provide information unrelated to a person's immigration status. It does not replace the requirement for non-citizens to provide verification of their immigration status. It is not a reporting mechanism. The USCIS cannot use information provided to workers by SAVE for the purpose of administrative (non-criminal) enforcement of immigration laws.

To use SAVE for applicants:

1. Request verification of immigration status if required for the programs(s) for

which the person is applying. See §0906.03.11 (Verification of Immigration Status).

2. Determine eligibility for the appropriate program(s).

3. If the non-citizen applicant submits required documentation of immigration status and has verified eligibility for the program, submit to SAVE through the Automated Status Verification System (ASVS). Do not delay or deny approval pending SAVE primary or secondary verification if the applicant is eligible based on the documentation provided.

To use SAVE for enrollees who report a change in immigration status:

1. Request verification of the new status.

2. Redetermine eligibility based on the new status.

3. If the non-citizen submits verification and remains eligible, submit through ASVS. Do not reduce or terminate coverage pending SAVE verification.

4. If the non-citizen is no longer eligible based on verification provided, do not submit to SAVE. Consider eligibility for other programs.

Do NOT use SAVE:

> When the immigration status claimed and the USCIS documentation provided by the applicant/enrollee cause ineligibility for the programs applied for, and the applicant/enrollee does not claim a different status.

> When the applicant or enrollee is ineligible for other reasons, such as income, assets or other coverage.

> For people who are not requesting coverage for themselves.

> When people withdraw their applications before SAVE validation has occurred.

See TEMP Manual TE02.12.19 (SAVE System) and TE02.12.20 (SAVE Secondary Responses).

MinnesotaCare:

Follow general provisions for families with children. Do not use SAVE for adults without children.

MA:

Follow general provisions. Do not use SAVE for EMA.

GAMC:

Follow general provisions.

Lawful Permanent Residents (LPRs) are people admitted to the U.S. as permanent residents under the Immigration and Naturalization Act (INA). They have permission to work in the U.S. and may travel abroad and return if they do not abandon their U.S. residence. They may apply for citizenship after living in the U.S. for 5 years.

Determine eligibility for LPRs according to the date of entry. LPRs who entered the U.S. before 8-22-96 are eligible for federal funding (MA program MA or MinnesotaCare program LL or FF) if they meet the other requirements of those programs. See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs). This includes people who were lawfully present in the U.S. before 8-22-96 who adjusted to LPR status on or after 8-22-96. See §0906.03.03.05 (Qualified Non-citizens/Status Adjustment).

LPRs who entered the U.S. on or after 8-22-96 are ineligible for federal funding for 5 years after the date of entry. They may be eligible for state-funded MA (program NM) or state-funded MinnesotaCare (programs KK, BB, or JJ depending on income and family status). See §0906.03.05 (Non-Citizens Ineligible for Federal Funding) and §0906.13 (MinnesotaCare Major Programs). They are eligible for federal funding after residing in the U. S. for 5 years.

Require one of the following forms of verification of LPR status:

> USCIS form I-151 or I-551 (green card).

> Reentry permit (Form I-327).

> Foreign passport showing evidence of LPR status (temporary I-551 stamp).

> USCIS Form I-94.

Refugees have permission to enter and live in the U.S. because of a well-founded fear of persecution in their home countries due to race, religion, membership in a particular social group, or due to political opinion. Refugee status is granted before the person enters the U.S.

Refugees are eligible for federal funding (MA program MA or MinnesotaCare program LL or FF). See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs). Consider people originally admitted as refugees who later adjust to LPR status to be refugees for 7 years from the date of entry. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment).

Require one of the following forms of verification of refugee status:

> USCIS Form I-94 showing entry as a refugee and date of entry.
> USCIS Form I-688B annotated 274a.12(a)(3).
> USCIS Form I-766 annotated A3.
> USCIS Form I-571.

Consider eligibility for Refugee Medical Assistance (RMA) for refugees in their first 8 months in the U.S. who do not meet an MA basis of eligibility. RMA is also available to asylees, trafficking victims, Cuban/Haitian entrants and Amerasian immigrants who do not meet an MA basis. See §0907.21.13 (MA Basis--RMA).

Asylees are granted permission to remain in the U.S. because of fear of persecution in the home country due to race, religion, nationality, membership in a particular social group, or political opinion. Asylee status is granted to people already present in the U.S.

People who have been granted asylum are eligible for federal funding (MA program M or MinnesotaCare program L or F) regardless of date of entry. See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs). Consider people originally admitted as asylees who later adjust to LPR status to be asylees for 7 years from the date asylum is granted. See §0906.03.03.05 (Qualified Non-Citizens/Status Adjustment.

Require one of the following forms of verification of asylee status:

> USCIS Form I-94 annotated with a stamp showing a grant of asylum.
> Grant letter from the Asylum Office of the USCIS.
> USCIS Form I-688B annotated 274a.12(a)(5).
> USCIS Form I-766 annotated A5.
> Order from an Immigration Judge granting asylum.

People whose deportation has been withheld have a similar status to asylees. The USCIS withholds deportation because of a threat to life or freedom in the person's home country due to race, religion, nationality, membership in a particular social group, or political opinion.

People whose deportation has been withheld have the same eligibility status as asylees. Consider people whose deportation was withheld who later adjust to LPR status to have deportation withheld status for 7 years from the date that status was granted

Require one of the following forms of verification for people whose deportation is withheld:

> Order from an Immigration Judge showing the date of a grant of deportation withheld under section 243(h) of the Immigration and Naturalization Act.
> USCIS Form I-688B annotated 274a.12(a)(10).
> USCIS Form I-766 annotated A10.
> I-94 stamped Withholding of Deportation.

Conditional entrants are granted conditional entry into the U.S. because of fear of persecution in the home country due to race, religion, political opinion, or because of a natural catastrophe.

Conditional entrants are eligible for federal funding (MA program MA, MinnesotaCare program LL, or MinnesotaCare program FF.) See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs).

All conditional entrants entered the U.S. before 1981, when the federal government stopped using this status. While many conditional entrants have adjusted to LPR status, some retain their original status.

Require one of the following forms of verification of conditional entrant status:

> USCIS Form I-94 with stamp showing admission under section 203(a)(7) of the INA or refugee-conditional entry.
> USCIS Form I-688B annotated 274a.12(a)(3).
> USCIS Form I-766 annotated A3.

PAROLED FOR AT LEAST ONE YEAR 0906.03.11.11

People who have been paroled into the U.S. for at least 1 year have authorization to remain in the U.S. for an indefinite temporary period of at least 1 year at the discretion of the Attorney General. Parole is granted for emergency reasons, such as to receive medical care or for other reasons deemed to be in the public interest.

People paroled for at least 1 year who entered the U.S. before 8-22-96 are eligible for federal funding (MA program MA or MinnesotaCare programs LL or FF). People paroled for at least 1 year who entered on or after 8-22-96 and have resided in the U.S. for less than 5 years are eligible for state funding (MA program NM, MinnesotaCare programs BB, JJ, or KK, or GAMC) if they meet all other program requirements. They are eligible for federal funding after residing in the U.S. for 5 years.

See §0906.03.11.23 (Other Lawfully Residing) for information on people granted parole for less than 1 year.

Acceptable verification includes form I-94 with a stamp showing parole granted for at least 1 year under Section 212(d)(5) of the USCIS. The I-94 may be stamped PIP or HP.

Battered immigrants are defined as immigrants or their spouses or children who have been battered or subjected to extreme cruelty in the U.S. by a family member residing in the same household.

Battered immigrants and their spouses and children who entered the U.S. before 8-22-96 are eligible for federal funding (MA program MA, MinnesotaCare program LL, or program FF). See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs).

Battered immigrants and their spouses and children who entered the U.S. on or after 8-22-96 are eligible for state funding for the first 5 years of U. S. residence if they meet all other program requirements (MA program NM or MinnesotaCare programs KK, JJ, and BB). They are eligible for federal funding after residing in the U.S. for 5 years.

See §0906.03.07.05 (Substantial Connection--Battery) for information on verifying battered status.

Certain immigrants from Cuba and Haiti have special status as Cuban or Haitian entrants. Not all people from Cuba or Haiti have this status. Some are admitted under other statuses, such as refugee or LPR. Cuban and Haitian entrants are those who are paroled, who are the subject of exclusion or removal proceedings, or who have an application for asylum pending.

Cuban and Haitian entrants are eligible for federal funding (MA program MA, MinnesotaCare programs LL, or FF) regardless of date of entry. See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs).

Require one of the following forms of documentation of Cuban/Haitian entrant status:

> USCIS Form 551 with codes CU6, CU7, or CH6.
> Unexpired temporary I-551 stamp in foreign passport or USCIS Form I-94 with codes CU6 or CU7.
> USCIS Form I-94 with stamp showing paroled as Cuban/Haitian Entrant under Section 212 (d) (5) of the INA.

Amerasians born in Vietnam between 1-1-62 and 1-1-76 are eligible for immigrant visas if the father was a U.S. citizen. Amerasians are eligible for federal funding (MA program M, MinnesotaCare program L, or MinnesotaCare program F) regardless of date of entry. See §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) and §0906.03.13 (MinnesotaCare Major Programs).

Require one of the following forms of verification of Amerasian status:

> USCIS Form 551 with codes AM6, AM7, or AM8.

> Unexpired temporary I-551 stamp in foreign passport or on USCIS Form I-94 with the code AM1, AM2, or AM3.

The following groups of people are lawfully residing in the U.S. on a temporary basis. They are eligible for state funding (MA 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 USCIS. 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.

A non-citizen who is forced into the international sex trade, prostitution, slavery and forced labor through coercion, threats of physical violence, psychological abuse, torture and imprisonment is a victim of severe forms of trafficking. People who are certified as trafficking victims are eligible for federal funding if they meet all other program requirements. Trafficking victims who do not meet an MA basis may be eligible for RMA for their first 8 months in the U.S. See §0907.21.13 (MA Basis: Refugee Medical Assistance-RMA).

The Office of Refugee Resettlement (ORR) of the U.S. Department of Health and Human Services (HHS) issues certification letters for adults who meet the requirements for certification as trafficking victims. The ORR issues similar confirmation letters for children under age 18. The letters include an initial eligibility date and an expiration date 8 months later. ORR will issue follow up certification letters for people who continue to meet the requirements for certification as victims of trafficking after the initial 8 month period.

Require the ORR letter as verification of trafficking victim status. Also call the trafficking verification line at 202-401-5510 to confirm the validity of the claim as shown on the letter. Do not require any other USCIS documentation.

If an applicant appears to meet the criteria for certification as a trafficking victim but does not have a letter from ORR, call the following numbers:

Adults:	202-401-4561 202-401-5702
Children under age 18:	202-420-4732

Or contact the DHS Refugee Services Section at 651-282-9817.

See the Combined Manual and TEMP TE02.05.88 (Trafficking Victims Q&A) for additional background.

The U.S. Government has agreements with the trust territories of Micronesia and the Marshall Islands which grant special status to citizens of those territories. Citizens of Micronesia and the Marshall Islands may live and work permanently in the U.S. They are considered non-immigrants and are not eligible for federal funding. They are eligible for the state-funded health care programs if they meet all other eligibility requirements.

Do not require citizens of Micronesia or the Marshall Islands to work with the USCIS to adjust their status. Status adjustment is not possible.

Require verification of Micronesian or Marshall Islands citizenship, such as:

< Micronesian or Marshall Islands passport

< I-94 or other USCIS documents indicating the person was admitted as a citizen of Micronesia or the Marshall Islands.

MinnesotaCare:

Citizens of Micronesia or the Marshall Islands are eligible for the state-funded programs (MMIS codes KK, BB or JJ) if they meet all other eligibility requirements.

MA:

Citizens of Micronesia or the Marshall Islands are eligible for state-funded MA (MMIS code NM) if they meet all other eligibility requirements.

GAMC:

Citizens of Micronesia or the Marshall Islands who do not meet an MA basis of eligibility are eligible for GAMC if they meet all other eligibility requirements.

MinnesotaCare:

See §0906.05.03 (State Residence--MinnesotaCare Families, MA) and §0906.05.05 (State Residence--MinnesotaCare Adults).

MA:

See §0906.05.03 (State Residence--MinnesotaCare Families, MA).

GAMC:

To establish state residency for GAMC, a person must have lived in Minnesota for at least 30 days with the intent of establishing a home. A stay in a battered woman's shelter counts toward the 30 days if the person intends to establish a home in Minnesota after leaving the shelter.

Do not apply the 30-day residency requirement if:

> A household member has a medical emergency meeting the definition in §0907.29 (Emergency Medical Assistance-EMA). Although there is no emergency program under GAMC, people who are eligible for regular GAMC and have an emergency may be approved before the 30-day period is up.

> The county waives the 30-day residency requirement for GA. Waive the GAMC requirement as well.

> A household member is a migrant worker who verifies that the household worked and earned at least $1,000 in Minnesota within 12 months preceding the month of application. The $1,000 may have been earned from sources other than migrant work.

Do not deny GAMC solely because the client has not yet resided in Minnesota for 30 days. Pend the individual until residency is established or until you can establish eligibility or ineligibility.

Except for residents of battered women's shelters, an applicant who indicates an out-of-state residence or who lives in an excluded time facility is not a state resident if she/he indicates intent to leave Minnesota within 30 days from the date of application. See §0906.07.05 (Excluded Time).

Verify state residency for GAMC. Verify intent to establish a home ONLY if questionable.

See §0906.13 (Assignment and Referral: Medical Support) for additional information.

Medical support referrals are not required for all children on MA or MinnesotaCare. Determine whether a referral is required for each child. In all cases, do not refer if the caretaker has shown good cause.

Do not make a medical support referral if a court order to provide health insurance exists and the parent is in compliance with the order.

Do not make a medical support referral if the caretaker is not receiving or requesting MA or MinnesotaCare and paternity has not been established for the child.

Make medical support referrals in all other situations. In cases where the child lives with the caretaker but only the child is receiving MA or MinnesotaCare, make a referral to IV-D if:

< The child was born when the parents were married

OR

< Paternity has been established by court order or signing of a Recognition of Parentage (ROP)

AND at least one of the following conditions exist:

- < There is no court order.
- < A court order for medical support health insurance exists, but the non-custodial parent is not meeting the obligation.
- < An existing court order does not include a provision for medical support or indicates that medical support has been reserved.
- < There are court-ordered medical support cash payments, whether or not the non-custodial parent is currently making the payments.
- < The caretaker of a child enrolled in MA or MinnesotaCare notifies you that the non-custodial parent is no longer complying with the medical support order. When a caretaker notifies you of a change in circumstances that requires a referral, take action within 2 working days after you learn of the change. Require the caretaker to complete referral forms. Send the forms to IV-D within 2 working days after you receive them from the client.

< The applicant requests child support services.

EXAMPLE:

Maia applies for MA for her two children, Seng and Lou. She is not requesting MA or MinnesotaCare for herself. She is separated from her husband, who is Lou's father. There is no court order. She was not married to Seng's father and there is no court order or ROP establishing paternity. Make a IV-D referral for Lou because her parents were married when she was born and there is no court order. Do not make a referral for Seng because paternity has not been established and Maia is not receiving MA or MinnesotaCare for herself.

EXAMPLE:

Marina applies for MA for her son, Ryan. She is divorced from Ryan's father. He is court ordered to carry health insurance for Ryan but is not complying. Make a referral to IV-D.

EXAMPLE:

Karla applies for MinnesotaCare for her children, Per and Kari. She was not married to Per's father, but they signed an ROP when Per was born. There is no court order for medical support. Karla is divorced from Kari's father and he is complying with an order to make monthly cash medical support. Make a IV-D referral for both children.

In cases where the caretaker and child are both receiving MA or MinnesotaCare, make a medical support referral in all cases unless the non-custodial parent is complying with an order to provider medical support health insurance. This includes making paternity referrals as described below.

Paternity can be established either through a court order or by both parents signing an ROP. The ROP has been accepted as a legal showing of paternity since 8-1-95. Before 8-1-95, the Declaration of Parentage (DOP) served as an acknowledgement of paternity but does not serve as a legal establishment. Make a paternity referral when:

< There is no ROP or court order.

< There is an ROP, but the non-custodial parent is not living with the child.

< There is a court order establishing paternity, but the non-custodial parent does not live with the child, and there is no order for medical support or the non-custodial parent is not complying with the order.

< The alleged father lives with the mother and child(ren), but only a DOP has been signed. Make the referral even if the alleged father is part of the household and his income is counted toward the child(ren)'s eligibility. Note on the referral form that the father's income is being counted.

The parents may choose to sign an ROP and submit a copy to MinnesotaCare instead of being referred to IV-D.

EXAMPLE:

Tyesha applies for MinnesotaCare for herself and her son Dante. She was not married to Dante's father and has not talked to him for several years. There is no ROP or paternity order. Make a referral to IV-D.

EXAMPLE:

Rhonda applies for MA for herself and her daughter, Selena. She and Selena's father recently separated after living together for several years. They signed an ROP when Selena was born, but there is no court order for medical support. Make a referral to IV-D.

When a minor child lives apart from both parents, a IV-D referral may be required. One or both parents may be subject to payment of a parental fee. DHS collects parental fees in certain situations. See §0906.13.09 (Parental Fees). County procedures for parental fee collections vary. In some counties, the IV-D unit may pursue parental fees along with child and medical support orders. Other counties may have separate staff handling parental fees. Follow your county's procedures using the guidelines below:

< If a child is in a foster care placement funded through Title IV-E, do not make a separate referral for medical support or MA parental fees. Follow your agency's procedures for Title IV-E referrals.

< If the child is in foster care placement that is not funded through Title IV-E, OR the child is not in a placement but lives apart from both parents:

-Determine if there is a non-custodial parent.

-If the child previously lived with both parents, there is no non-custodial parent.

-If legal custody of the child was transferred to a person other than a parent, both parents are non-custodial.

Note: This does not apply when the county agency is given custody of a child for purposes of out-of-home placement. When the agency has custody, determine whether there is a non-custodial parent based on who the child lived with before entering placement.

-If the child previously lived with one parent, consider that parent to be the custodial parent. The other parent is the non-custodial parent.

Refer the non-custodial parent(s) to IV-D following the rules for child-only cases. Do not refer the custodial parent(s). Follow your agency's procedures for pursuing parental fees from the custodial parent.

EXAMPLE:

John, age 9, is placed in a foster home. He does not have a disability that would result in DHS pursuing parental fees. He was removed from the home of his parents, who are married. He is not eligible for Title IV-E reimbursement for the placement but is eligible for MA. Do not make a referral for IV-D medical support enforcement because there is no non-custodial parent. Refer for parental fees according to your agency's procedures.

EXAMPLE:

Alyssa, age 10, is removed from her mother's home and placed in foster care. She does not have a disability that would result in DHS pursuing parental fees. She is not eligible for Title IV-E reimbursement for the placement but is eligible for MA. Her parents are divorced and her father is court-ordered to provide health insurance for Alyssa. If he is not complying with the order, make a IV-D referral for him and pursue parental fees according to your agency's procedures. If he is complying with the order, no IV-D referral is required. Pursue parental fees for both parents according to your agency's procedures.

EXAMPLE:

Lynn, age 17, lived with her mother. Her parents are divorced and there is a court order for medical support from her father. He is not complying with the order. Lynn moved out of her mother's home into her own apartment and applies for MinnesotaCare for herself. Make a medical support referral for Lynn's father based on the existence of the medical support order. Do not refer Lynn's mother, the custodial parent, to IV-D. Although Lynn cannot legally assign rights to her medical support, she must provide as much information about her father as possible as a condition of eligibility. The IV-D worker will determine what action can be taken.

If Lynn applies for MA instead of MinnesotaCare, make a medical support referral for her father. Pursue a parental fee for her mother according to your agency's procedures.

EXAMPLE:

Tina was removed from her parents' home and placed with her aunt, who was given legal custody. Since both parents are now considered non-custodial, make a medical support referral to IV-D.

< If the applicant is a minor with dependent children, determine whether a IV-D referral is required for both the minor parent and the dependent child(ren). If the minor has a non-custodial parent, treat this as two child support cases. If appropriate, make a referral for the minor's non-custodial parent. Make another referral for the non-custodial parent of the applicant's child(ren).

EXAMPLE:

Lori applies for MinnesotaCare for herself, her 12-year-old son Michael, her 15-year-old daughter Amber, and Amber's 3-month-old son Peter. Lori is divorced from Michael and Amber's father. There is a court order for medical support, but the non-custodial parent is not complying. Lori has access to insurance for herself only through her employer and is ineligible for MinnesotaCare. Michael, Amber, and Peter are eligible. Paternity has not been established for Peter.

Make a IV-D referral for Michael and Amber. Make a separate referral for Peter, since paternity has not been established and Amber is receiving MinnesotaCare. Amber must provide information about Peter's father and cooperate with establishing an order for medical support for him as a condition of her own eligibility.

EXAMPLE:

Corinne, age 16, and her 1-year-old daughter Megan live with Corinne's aunt. Corinne's parents are married and live together. She is covered by their health insurance and does not want MA for herself. She applies for MA for Megan only. Paternity has not been established for Megan. No IV-D or parental fee referrals are required.

If Corinne received MA for herself, a IV-D referral would be required for Megan. No referral would be required for Corinne because there is not a non-custodial parent. Refer her parents for parental fees according to your agency's procedures.

MinnesotaCare:

No provisions.

MA:

People who are age 65 and over have a basis of eligibility for MA. They may 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.

Do not require verification of age.

Use Method B to determine countable income and assets.

The asset limit for MA for people age 65 and over 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 from 7-1-01 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 age 65 and over who qualify for MA are eligible for all MA covered services.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People who are certified as blind have a basis of eligibility for MA. They may 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 blindness 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 blindness. See §0906.15 (Disability Determinations). There is no age limit.

Blind 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 blindness 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 from 7-1-01 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 blindness basis of eligibility who qualify for MA are eligible for all MA covered services.

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).

Fax or mail the documentation to SMRT. If the county agency chooses to mail the documentation, send only one-sided copies to SMRT retaining the originals with the case file. SMRT will shred the documentation after it is stored electronically. Once the review is complete, SMRT will fax the decision to the county. The fax number to submit SMRT documentation is (651) 296-7694.

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.

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...).

NOTE:

Although parents' assets are considered available to children, there is no asset limit for children under 21. See §0909.03 (Exemptions from Asset Limits).

Do not count:

< Parents' income 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 of parents of blind or disabled children ages 18 to 21.

< Stepparents' income as available to a stepchild.

< Parent's income as available to children of any age who receive SSI.

< Parent's income 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.

MinnesotaCare:

Unlike MA and GAMC, which allow people to choose which eligible household members want coverage, MinnesotaCare requires certain eligible family members to enroll. This provision is known as the All or Nothing Rule. The All or Nothing Rule requires that:

< All eligible children in a household who do not have other health insurance enroll if one child enrolls.

< All eligible spouses or parents in a household who do not have other health insurance enroll if one spouse or parent enrolls.

< Parents may enroll only if the eligible children in the household who do not have other health insurance enroll. Parents may choose not to enroll. Eligible children may enroll regardless of whether the parents enroll.

NOTE: If a child who is required to provide or apply for a SSN fails to do so, they are still considered an eligible child and all children are ineligible. If an adult who is required to provide or apply for a SSN fails to do so, they are still considered an eligible adult and all adults are ineligible. Eligible children or adults refer to the bullets above. See §0906.11 (Social Security Number--MinnesotaCare).

EXAMPLE:

Bob, Mary and their two children, Sam (10) and Anna (3) apply for MinnesotaCare. They do not have any other health insurance. The HCAPP lists SSNs for everyone but Anna. Bob, Mary and Sam meet all eligibility requirements; Anna does not meet the SSN requirement. Do not approve coverage for Bob, Mary and Sam until a SSN is either applied for or obtained for Anna.

EXAMPLE:

Troy, Denesha and their two children ages 15 and 13 apply for MinnesotaCare. They do not have any other health insurance. The HCAPP lists SSNs for everyone but Denesha. Do not approve coverage for Denesha or Troy until Denesha supplies her SSN. Coverage for the children can be approved under the All or Nothing Rule because parents are not required to enroll with their children.

Do not enroll people who have other health coverage that prevents enrollment in MinnesotaCare. See §0910 (Other Health Coverage).

EXAMPLE:

Bud and Mabel, a married couple with no children in the home, apply for MinnesotaCare. They are both U.S. citizens and permanent Minnesota residents. Bud is disabled and covered by Medicare Parts A and B. Mabel has no health care coverage. Both would be required to enroll under the All or Nothing Rule. However, Bud cannot enroll because he has Medicare. Mabel can enroll separately. Base eligibility and premium amount on a household of 2 with 1 person covered.

EXAMPLE:

Judy and Greg apply for MinnesotaCare for their 2 children. Judy and Greg each have health insurance through work. Neither employer offers dependent coverage. The children have no insurance. Both children must enroll if they meet all other eligibility requirements. Base eligibility and premium amount on a household of 4 with 2 people covered.

EXAMPLE:

Alice applies for MinnesotaCare for her son Troy, who requires regular care for chronic ear infections. She does not want coverage for herself and her daughter Mavis, because they have no ongoing medical needs and Alice feels she can't afford the premium for 3 people. All 3 household members meet MinnesotaCare eligibility requirements. No one in the household has other health care coverage available. Both Troy and Mavis must enroll under the all or nothing rule. Alice is not required to enroll. Base eligibility and premium amount on a household of 3 with 2 people covered.

EXAMPLE:

Abe and Mary apply for MinnesotaCare for themselves and their 2 children, Kevin and Kyle. Mary is pregnant and covered by MA. Kevin is also on MA. Abe and Kyle are not covered on MA or GAMC because of excess income. They have no other coverage available. Mary and Kevin want to stay on MA. Kevin and Kyle would be required to enroll together because of the all or nothing rule, as would Abe and Mary. However, since Mary and Kevin have other health coverage through MA, they are not required to enroll. Kyle can enroll separately from Kevin. Abe is not required to enroll but may enroll separately from Mary as long as Kyle enrolls. Base eligibility and premium amount on a household of 4 with 2 people enrolled.

Do not apply the All or Nothing Rule to non-insurance eligibility factors that apply only to individual household members. Ineligibility of household members due to

technical factors does not affect the eligibility of other members who meet eligibility requirements. These factors include but are not limited to:

< Cooperating with obtaining medical support. Caretakers who fail to cooperate without good cause are ineligible. Spouses and children may be eligible. See §0906.13 (Assigning Rights to Medical Support) and §0906.13.05 (Good Cause Exemptions--Medical Support).

< Cooperating with applying for MA. Certain people with disabilities are required to apply for MA and become ineligible for MinnesotaCare if they fail to do so. Their spouses may remain eligible. See §0907.15 (MinnesotaCare Adults Without Children).

< Meeting citizenship and immigration requirements. People who do not have a status that qualifies for MinnesotaCare are ineligible. Other household members with a qualifying status may be eligible. See §0906.03 (Citizenship and Immigration Status).

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MA/GAMC:

No provisions.

MinnesotaCare:

Exclude the value of assets for:

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

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

Apply the asset limits to all other people age 21 and over.

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MA:

Exclude the value of assets for:

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

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

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

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

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

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

GAMC:

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

MinnesotaCare/ MA Method A/ GHO:

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

EXAMPLE:

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

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

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

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

MA Method B/GAMC:

If a vehicle is used as a place of residence or it is essential for self-support, exclude the vehicle under those provisions. See §0909.13 (Real Property: Homestead) and §0909. 11.03 (Excluded Assets for Self-Support). If a vehicle can not be excluded under the provisions above follow the policy below.

Exclude one vehicle per household regardless of the value if it is used for transportation of the client or a member of the client's household. Assume the vehicle is used for transportation, unless there is evidence to the contrary. A vehicle may be any conveyance used on air, land, or water. It need not be licensed.

Only one vehicle can be used for transportation. If the household owns more than

one vehicle that is used for transportation, exclude the vehicle with the highest equity value. Use the NADA trade-in value to determine the fair market value (FMV) of all non-excluded vehicles. To determine the equity value, subtract the balance owed on secured loans from the FMV. A secured loan is any loan for which the vehicle is held as collateral and/or the lender holds title to the vehicle.

EXAMPLE

Yara and Thor are both disabled and applying for MA. They own two vehicles, both of which are used for transportation. One vehicle has a FMV of $3400. The other vehicle has a FMV of $12,000 with $9000 owed, leaving an equity value of $3000. Since both vehicles are used for transportation, exclude the vehicle with the highest equity value, which in this case is the first one with a FMV of $3400.

Do not exclude the equity value of the following vehicles:

< A vehicle that has been junked,

< A vehicle that is used only as a recreational vehicle (e.g. a boat used on weekends for pleasure).

Count the equity value of any vehicle that does not meet an exclusion reason towards the asset limit.

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

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

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

EXAMPLE:

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

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

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

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

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

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

- The statement of goods and services is for an amount equal to or greater than the purchase price of the life insurance policy or annuity.

AND

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

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

EXAMPLE:

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

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

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

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

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

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

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

MinnesotaCare/ MA Method A/ GHO:

Follow general provisions.

MA Method B/ GAMC:

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

MinnesotaCare:

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

MA/GAMC:

Rental property is property the client owns and rents to others, but where the client does not live. This may include separate living quarters in the same building, such as a duplex. For information on rental income from people living with the client, see §0911.09.03.17 (Roomer/Boarder Income).

Income from rental property may be earned or unearned. Follow the specific provisions for Method A and Method B to determine whether rental income is earned or unearned.

Deduct allowable self-employment expenses from both earned and unearned rental income. However, allow earned income disregards only for earned rental income. See §0912.05.09 (Earned Income Disregards--Method A) and §0912.05.09.05 (Earned Income Disregards--Method B).

When the client lives on the rental property, determine the rental property ratio. Divide the number of rooms or square footage that the client rents out by the total number of rooms or square footage in the building. To determine the portion of an expense that is an allowable deduction, multiply the expense by the ratio.

METHOD A:

Count income from rental property as earned income when the client spends an average of at least 20 hours per week maintaining or managing the property. Otherwise count it as unearned income.

Allowable expenses for rental property include:

> Real estate tax.
> Insurance.
> Utilities.
> Interest.
> Upkeep and repairs.

In addition to the expenses listed above, allow up to $103 per year or 2% of the estimated market value on the county tax assessment form, whichever is greater, for upkeep and repairs.

METHOD B:

Count income from rental property as earned income for each month the client spends an average of at least 10 hours per week maintaining or managing the property. Otherwise count rental income as unearned income.

Allowable expenses for rental property include:

> Real estate tax
> Insurance
> Utilities
> Interest
> Advertising expenses
> Lawn maintenance
> Snow removal costs
> Property management fees paid to a 3rd party

In addition to the expenses above, deduct expenses for upkeep and repairs made to maintain or repair existing structures or equipment. Only consider minor corrections to an existing structure as a repair. There is no limit to the amount of this deduction. Do not allow expenses for adding to or replacing existing structures or equipment to increase the value of the property.

EXAMPLE:

Tim owns rental property that has damage to the roof. Allow the expense to repair only the damaged area of the roof as a deduction from the rental income Tim receives for that month. If Tim decides to replace the entire roof do not allow this expense as a deduction from the rental income.

EXAMPLE:

Jill resides in an LTCF and has a life estate interest in a home. She is receiving rental income monthly. Jill's AREP determines that the house is very drafty and expensive to heat in the winter due to the homes' very old windows. The AREP has all of the windows in the house replaced and requests that this expense be deducted from the rental income. This is a capital expenditure and cannot be allowed as a deduction from Jill's rental income.

If it is uncertain whether an expense is for repair or replacement, submit a policy

interpretation question to HealthQuest.

If the rental income is part of a self-employment enterprise, annualize gross rental income and expenses. Otherwise follow the instructions below.

> Subtract the allowable deductible expenses paid in a month from the gross rental income received in the same month.

> If the allowable deductible expenses paid in a month exceed the gross rental income in the same month, subtract the excess expenses from the next month's gross rental income. Continue to do this as necessary until the end of the tax year in which the expense is paid.

> If there is still excess expenses after applying the expenses to the future months rental income, subtract the remaining excess expenses from the gross rental income received in the month prior to the month the expenses were paid. Continue to do this as necessary to the beginning of the tax year involved.

EXAMPLE:

Alfred is living in an LTCF. He owns a life estate that is currently being rented for $600 a month. Half of his property tax of $900 is due in May. Alfred pays the $900 in May. Deduct $600 of the property tax payment from the rental income received in May. There is a balance of $300 that can be deducted from the rental income received in June.

Note: Do not carry excess expenses over to other tax years. Do not use excess expenses to offset other income.

MinnesotaCare:

No provisions.

MA/GAMC:

Also see §0911.11.03 (Computing Countable Income--MA/GAMC).
For MA-EPD, see §0913.01.03 (MA-EPD Premiums). MA-EPD rules for computing varying income differ slightly from regular MA in order to maintain consistent premiums.

When income from a single source varies but is expected to be received throughout the certification period, determine an average weekly or biweekly amount based on the available information. Compare the income information on the application, income review or renewal to the income verification. Follow up with the client if the verification does not reflect the reported information to determine the reason for the discrepancy. Examples of situations that may result in a discrepancy between reported ongoing income and verified income from the preceding 30 days include but are not limited to:

> Receipt of non-recurring overtime.

> Temporary or ongoing change in pay rate or hours worked.

> Job change.

> Short-term absence from employment without pay.

Do not require verification of income beyond the 30 days preceding application, income review or renewal unless an applicant requests retroactive coverage. If the client submits additional verifications, determine if verified income older than 30 days provides a more accurate reflection of expected income in the certification period.

EXAMPLE:

Bert applies for MA on July 10. He is not requesting retroactive coverage. He reports on the HCAPP that he works 10-20 hours per week and earns $6.50 per hour. He is paid weekly. He supplies the following pay stubs:

June 4 - $72
June 11 - $113.75
June 18 - $98.15
June 25 - $82

All pay stubs reflect between 10 and 20 hours weekly at $6.50 per hour. To anticipate income for the July-December certification period, determine average weekly income by averaging the checks submitted. This results in average weekly income of $91.48. Project income for the July-December certification period by either:

- Multiplying the weekly average of $91.48 by 4.3 to arrive at a monthly average of $393.64. Subtract applicable deductions and disregards. Multiply the average monthly amount (truncated) by 6 for projected income for the certification period.

OR

- Multiplying the average weekly amount by the number of weekly checks anticipated during the certification period. The result will depend on whether there are 26 anticipated pay dates ($91.48 x 26 = $2,378.48) or 27 anticipated pay dates (27 x $91.48 = $2,469.96) in the certification period.

EXAMPLE:

George applies for MA for himself and his family on October 9. He reports on the HCAPP that he works 40 hours per week at $8.00 per hour. He submits the following pay stubs:

September 3 $360
September 10 $450
September 17 $430
September 24 $260
October 1 $320

The worker contacts George to clarify the discrepancy between his regular reported wage and his recent check stubs. He explains that the company had a short-term project in late August and early September that resulted in overtime. In mid-September he took time off without pay because of a family emergency. He is now working his regularly scheduled 40 hours per week and does not expect any changes or further overtime. Anticipate income beginning in October based on a weekly wage of $320.

EXAMPLE:

Gerald and Suzanne receive MA for themselves and their 2 children. Both are employed. On their 6-month income review they report that Suzanne started a

new job during the previous month. She has received 2 weekly pay checks so far. They submit her pay stubs from the past 30 days, which include her final checks from the previous job. Use the pay checks from the new job to anticipate Suzanne's income for the next certification period. Average Gerald's income based on the 30 days of wages he submitted.

When income is received less often than monthly, count the full amount in the month it is received. Do not prorate the payment to convert it to a monthly amount.

EXAMPLE:

Rodney applies for MA in February. He is not requesting retroactive coverage. He lives in the community. He receives quarterly payments of $450 on a contract for deed. He receives the payments on January 1, April 1, July 1, and October 1 of each year. Anticipate $900 for the certification period of February-July (April and July payments). If Rodney has other income which results in a spenddown and chooses a manual monthly spenddown, count the payments only in the months in which they are received (April and July). See §0913.11 (Manual Monthly Spenddown Calculation).

If Rodney becomes subject to a long term care spenddown, count the payments in the month in which they are received. See §0913.13 (Long Term Care Spenddown Calculation).

MinnesotaCare:

No provisions.

MA:

For Method A, see §0912.05.09 (Earned Income Disregards--Method A) and §0912.05.09.03 (Earned Income Disregard Cycle--Method A).

Disregard the first $65 plus half the remaining earned income. If more than 1 person's income is used to determine eligibility (for example, income of the client's spouse), apply the disregard to the total combined earned income.

EXAMPLE:

Norm and his wife Marge apply for MA using Method B. Both are disabled and employed part time. Norm earns $200 per month. Marge earns $500 per month. To determine each person’s eligibility, subtract $65 plus one-half of the remaining income from the combined total gross income of $700.

If a person who uses Method B due to disability has impairment-related work expenses, deduct the impairment-related expenses after the $65 work incentive disregard but before deducting one-half of the remaining earned income. See §0912.05 (Determining Net Income) and §0912.05.05 (Work Expense Deductions).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

The special personal monthly allowance is an $80 earned income disregard for clients:

> With mental retardation or other certified disabilities.

AND

> Who are employed under a plan of rehabilitation.

AND

> Who live in a skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or a regional treatment center.

Deduct the 1st $80 of monthly earned income.

Do not reduce earned income to less than $0 or use the disregard to reduce unearned income. Allow actual work expense deductions in place of Method A or B work deductions.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Applicants can request eligibility for the month of application and the retroactive month(s). Retroactive coverage is available for 3 months before the month of application See §0904.07.09 (Eligibility Begin Date).

Eligibility begins on the day incurred medical expenses equal or exceed the 6-month spenddown amount. Eligibility continues through the last day of the 6-month certification period. Clients must meet the spenddown by the end of the application month OR the date you process the application, whichever is later.

EXAMPLE:

Brad applies for MA on February 23. He is requesting retroactive coverage for January. He submits all verifications on March 5. The worker completes the eligibility determination on March 10. Brad met his 6-month spenddown on March 3. Approve eligibility effective March 3 for the certification period January-June.

Do not anticipate medical bills the client has not yet incurred when determining whether the client meets the spenddown.

EXAMPLE:

Sherita applies for MA on July 15. She does not have enough bills to meet her spenddown in July, but plans to fill a monthly prescription on August 1. Because this is within the 45-day processing period, it is possible to approve the application with an August effective date. Do not approve eligibility until Sherita verifies the August 1 charge.

To calculate the spenddown for applicants:

1. Enter income information on the appropriate MAXIS STAT panel. Enter the anticipated income in the HC Income Estimate window in the current month plus one, benefit month. See §0911.11.03 (Computing Countable Income – MA/GAMC) for instructions on determining the anticipated income. If retroactive eligibility has been requested, update STAT/HCRE. The retroactive months will need to be FIATed in ELIG/HC using the actual income received during the retroactive months. See TEMP Manual TE09.17.02 (HCRW: FIAT).

2. Enter the gross and net amounts of verifiable medical expenses in MAXIS on the STAT/BILS panel. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determining Net Medical Expenses) and TEMP Manual TE09.07.02 (HCRW: STAT/BILS).

3. MAXIS will calculate the spenddown based on the information that is entered in STAT. After background has run, review the budget in ELIG/HC. From the BSUM panel select MOBL and SPDN to review the spenddown calculation. See TEMP Manual TE09.18 (HCRW: Retro Processing) if there is a need to FIAT due to retroactive eligibility.

4. Enter the appropriate information on MMIS. See MMIS User Manual (Spenddowns - Six-Month Spenddown).

To calculate the spenddown at the time of the 6-month income review or annual recertification:

1. Do not take a new application when the income certification period expires. Use the income review due in the 5th month to determine continued eligibility for the next 6-month certification period. Verify the amount of any health insurance premiums that are due on the first day of the next review period, even if they were paid during the last 3 months of the current review period. Also verify any non-MA reimbursable expenses incurred in the last 3 months of the current period and any unpaid medical expenses incurred before the current certification period that were not used to meet a previous spenddown. See §0913.21 (Allowable Medical Bills to Meet Spenddown).

   Clients must provide verification of current income and medical expenses to be applied to the next 6-month period by the last day of the current 6-month review period.

2. Enter income information on the appropriate MAXIS STAT panel. Enter the anticipated income in the HC Income Estimate window in the current month plus one, benefit month. See TEMP Manual TE09.26.01 (HCRW: Processing Health Care Renewals). See §0911.11.03 (Computing Countable Income – MA/GAMC) for instructions on determining the anticipated income. Enter the gross and net amounts of verifiable medical expenses in MAXIS on the STAT/BILS panel.

3. MAXIS will calculate the spenddown type and amount based on the information that is entered in STAT. See TEMP Manual TE09.13.06 (HCRW: Determining Community Spenddown Type). After background has run, review the budget in ELIG/HC. From the BSUM panel select MOBL and SPDN to review the spenddown calculation.

4. Enter the appropriate information on MMIS. See MMIS User Manual (Spenddowns - Six-Month Spenddown). If eligibility continues, schedule an income or eligibility review for the 5th month of the next review period. See §0905.09 (6-Month Reporting).

   If clients cannot meet the new spenddown, terminate the case at the end of the 6-month income review period. Advise clients to reapply if they incur new medical expenses or have a change in income. The MAXIS termination notice advises them of the availability of MinnesotaCare.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Clients can request eligibility for the month of application and the retroactive month(s). Retroactive coverage is available for 3 months before the month of application for MA. See §0904.07.09 (Eligibility Begin Date).

Determine eligibility separately for each month. If clients are eligible in the month of application or any of the retroactive months, the case remains open for the rest of the 6-month certification period, if the client meets all other eligibility factors.

To calculate the spenddown for applicants:

1. Enter income information on the appropriate MAXIS STAT panel. Enter the anticipated income in the HC Income Estimate window in the current month plus one, benefit month. See §0911.11.03 (Computing Countable Income – MA/GAMC) for instructions on determining the anticipated income. If retroactive eligibility has been requested, update STAT/HCRE. The retroactive months will need to be FIATed in ELIG/HC using the actual income received during the retroactive months. See TEMP Manual TE09.17.02 (HCRW: FIAT).

2. Enter the gross and net amounts of verifiable medical expenses in MAXIS on the STAT/BILS panel. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determining Net Medical Expenses) and TEMP Manual TE09.07.02 (HCRW: STAT/BILS). If the client expects to pay Medicare premiums each month and you are not using an LTC budget, enter the Medicare premium as an expense on the STAT/BILS panel for each month of the income certification period. Use actual dollars and cents (use the gross amount; do not round or truncate). Also enter health insurance premiums if they are paid on a monthly basis rather than on a quarterly basis or some other interval. If health insurance premiums are not paid monthly, do not enter them as an automated monthly spenddown expense.

   If a client using an LTC budget expects to pay Medicare premiums each month, indicate that on STAT/MEDI.

3. MAXIS will calculate the spenddown type and amount based on the information that is entered in STAT. See TEMP Manual TE09.13.06 (HCRW: Determining Community Spenddown Type). After background has

run, review the budget in ELIG/HC. From the BSUM panel select MOBL and SPDN to review the spenddown calculation.

4. Enter the appropriate information in MMIS. Do not enter a satisfaction date. See MMIS User Manual II-25 (Automated Monthly Spenddown).

5. MAXIS anticipates income for the remaining months of the review period from information entered in the HC Estimate window on the appropriate STAT income panel. Do not verify income and medical expenses monthly. Schedule an income review for completion during the 5th month of the review period. Tell the client to report any changes. See §0905.09 (6-Month Reporting). Unless income changes, MMIS continues the current spenddown amount for the remainder of the 6-month review period.

To calculate the spenddown at the time of the 6-month income review or annual recertification:

1. Do not take a new application when the 6-month certification review period expires. Use the income review in the 5th month as a guide to determine continued eligibility for the next period. Also request verification of medical expenses incurred in the 5th month or review the RSPD and RSLG screens in MMIS for the 5th month to determine if the spenddown was met

2. Enter the income and medical expenses in STAT using the information from the review and your best estimate of the client's income and expenses for the new certification period. See TEMP Manual TE09.13.08 (HCRW: Automated Monthly Spenddown Reviews). If the client wants to switch spenddown methods, see §0913.07 (6-Month Spenddown Calculation), §0913.11 (Manual Monthly Spenddown Calculation) and TEMP Manual TE09.13.10 (HCRW: How to Change Spenddown Type). Clients must use a manual monthly medical spenddown if they still want a monthly spenddown, but their income or medical expenses now vary.

3. If MAXIS determines that the client will continue to meet a spenddown in the next period, extend eligibility for another 6-month period. MAXIS will use the anticipated income entered in the HC Estimate window on the income panels in STAT for the next period. An income or eligibility review will be due for the 5th month of the next review period. See §0905.09 (6-Month Reporting).

   If MAXIS determines that the client is unlikely to meet a spenddown in the

next certification period using any spenddown method, close the case at the end of the 6-month income certification period. Advise clients to reapply if they incur new medical expenses or have a change in income. The MAXIS termination notice advises them of the availability of MinnesotaCare.

Clients eligible for an automated monthly spenddown may choose to pay their spenddown obligation to DHS or to a specific provider. See §0913.09.03 (Client Option Spenddown).

Clients who receive personal care attendant services, certain waivered services, or child welfare targeted case management services may choose to pay their spenddown to a designated provider. See §0913.09.05 (Designated Provider Option).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Clients can request eligibility for the month of application and the retroactive month(s). Retroactive coverage is available for 3 months before the month of application. See §0904.07.09 (Eligibility Begin Date).

Determine eligibility separately for each month of the 6-month certification period. Eligibility may be intermittent during the certification period. If clients are eligible in the month of application or any of the retroactive months, approve the case on a 6-month certification period beginning with the first month of eligibility. Determine eligibility for every month in the 6-month period. Do not terminate MA before the end of the 6-month period even if available information indicates the client will not meet a spenddown in the remaining months.

EXAMPLE:

Bill applies for MA on November 28. His income exceeds the standard for both a 6-month and a monthly spenddown. He incurred a large hospital bill and related charges earlier in November. The total expenses exceed the monthly spenddown amount for November. Bill selects a monthly spenddown. Leave the case open for the entire 6-month period regardless of whether Bill meets the spenddown in subsequent months.

To calculate the spenddown for applicants:

1. Enter income information on the appropriate MAXIS STAT panel. Enter the anticipated income in the HC Income Estimate window in the current month plus one, benefit month. See §0911.11.03 (Computing Countable Income – MA/GAMC) for instructions on determining the anticipated income. If retroactive eligibility has been requested, update STAT/HCRE. The retroactive months will need to be FIATed in ELIG/HC using the actual income received during the retroactive months. See TEMP Manual TE09.17.02 (HCRW: FIAT).

2. Enter the gross and net amounts of verifiable medical expenses in MAXIS on the STAT/BILS panel. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determining Net Medical Expenses) and TEMP Manual TE09.07.02 (HCRW: STAT/BILS).

3. MAXIS will calculate the spenddown type and amount based on the

information that is entered in STAT. See TEMP Manual TE09.13.06 (HCRW: Determining Community Spenddown Type). After background has run, review the budget in ELIG/HC. From the BSUM panel select MOBL and SPDN to review the spenddown calculation. See TEMP Manual TE09.13.11 (HCRW: Manual Monthly Spenddown: Applicants).

4. Enter the appropriate information on MMIS. See MMIS User Manual (Spenddowns - Manual Monthly Spenddown).

To calculate the spenddown at the time of the 6-month income review or the annual recertification:

1. The client must provide the HRF with income and medical expense verification by the last day of the month after the budget month. See §0905.07 (Monthly Reporting). Clients may meet the spenddown in some months and not in others. Enter the information from the monthly Household Report Form (HRF) on the appropriate STAT panels.

2. Follow steps listed in TEMP Manual TE09.13.13 (HCRW: Manual Monthly Spenddown: Renewal/HRF).

3. Do not take a new application when the income certification period expires. During the 6th month, use the information reported on the HRFs for months 1-5 to determine if the client is likely to be able to meet a spenddown in 1 or more months of the next income certification period. Base this decision on your best estimate of the client's income and medical expenses for the next 6 months. Leave the case open with a manual monthly spenddown if you determine that the client is likely to meet a spenddown in at least 1 month of the next certification period.

GAMC:

No provisions.

People obtain medical care through fee-for-service by presenting their Minnesota Health Care Programs Card to the provider. See §0914.07 (Minnesota Health Care Programs Card). DHS pays claims directly to the provider. Enrollees receive an Explanation of Medical Benefits (EOMB) each month showing what claims DHS has paid on their behalf.

To receive payment through fee-for-service, providers must be enrolled to receive payment from the Minnesota health care programs. Refer providers who request information about enrollment to the DHS Provider Help Desk at 651-282-5545 or 1-800-366-5411. The service must be covered by the program in which the person is enrolled. Providers receive detailed information about covered services in the Minnesota Health Care Programs Provider Manual. Information is also available through the Eligibility Verification System (EVS) or the Provider Help Desk.

MinnesotaCare:

DHS provides medical care to MinnesotaCare enrollees on a fee-for-service basis in the following instances:

- When adding a newborn or newly adopted child whose mother is not enrolled in a health plan. The child is covered on fee-for-service for the month of birth or adoption and any subsequent months pending health plan enrollment.

  EXAMPLE:

  Julie has 2 children enrolled in MinnesotaCare. She is not enrolled in MinnesotaCare. On October 2, she reports she had a baby on September 25. Enroll the baby in MinnesotaCare fee-for-service for September and October. Enroll the baby in the same health plan as the other children beginning in November.

- When an enrollee requests continued benefits pending the outcome of an appeal after cancellation. Re-enroll the person in the health plan for the next available month.

  EXAMPLE:

  Joan's MinnesotaCare is canceled effective March 1. On March 3 she appeals the action and requests continued benefits. No payment was made to the health plan for March because her coverage had been terminated before capitation. If Joan pays her premium, reinstate coverage on fee-for-service for March. Re-enroll Joan in the health plan for April if the appeal is still pending.

- When a case is reopened after the reinstatement date if the enrollee took all

required action before the effective date of termination. Reopen the case on fee-for-service for the 1st month. Re-enroll the household in the health plan beginning the 2nd month.

EXAMPLE:

Andrew received a termination notice for October for failing to provide information. MinnesotaCare received the necessary information at the end of the month and determined that Andrew remains eligible. However, MinnesotaCare was not able to process the change before reinstatement ran on the last working day of September. Reopen the case on fee-for-service for October. Re-enroll Andrew in his health plan beginning in November.

- When enrollees canceled for nonpayment pay all billed premiums by the due date in the month following disenrollment and are reinstated back to the date of closing. These enrollees receive coverage through fee-for-service for the reinstatement month. They are reenrolled in their former health plans for the following month. See §0915.11.05 (Fail to Pay Premium/Reinstatement).

M.S. 256L.12

MA/GAMC:

DHS provides medical care to MA and GAMC enrollees on a fee-for-service basis for:

- People who do not live in managed care counties. See §0914 (Service Delivery) for a list of managed care counties as of September 2003.

- People who live in managed care counties but are in excluded groups, and:

  - Are not in a group that may voluntarily enroll in managed care.

  OR

  - Are in a group that may voluntarily enroll in managed care but choose not to enroll. See §0914.03.03 (Managed Care Exclusions) and §0914.03.03.03 (Managed Care Voluntary Enrollment).

- People who live in managed care counties and are required to enroll in managed care but who are not enrolled for a particular month because enrollment could not be completed in time for a capitation payment to be made for that month. Examples include:

- People who are approved for MA or GAMC for any months before the first month they can be enrolled in managed care. See §0914.03.05 (Managed Care Enrollment Process) and §0914.03.05.03 (Managed Care Enrollment Presentations).

EXAMPLE:

Sheila applies for MA on November 12. She requests coverage retroactive to August. She attends a managed care presentation on November 15 and selects a health plan on December 7. MA is approved effective August 1. Sheila will be covered through fee-for-service for August through December. Enroll Sheila in the health plan she selects effective January 1.

- People who move from a managed care county to a non-managed care county. These people may continue to receive coverage through fee-for-service for one or more months after the move. See §0914.03.17 (Managed Care County Transfers).

- People who were in an excluded group who become mandatory managed care enrollees. These people will continue to receive coverage through fee-for-service until the first available month they can be enrolled in managed care.

EXAMPLE:

Doug lives in a managed care county. He is eligible for MA with a spenddown and is excluded from managed care. He submits his 6-month income report, due on March 8, on March 20. The worker determines that he no longer has a spenddown and he is required to enroll in managed care. Doug will continue to receive coverage through fee-for-service until he can attend a managed care presentation or receive an education packet and be enrolled in a health plan.

- People who are reinstated or re-enrolled after being terminated from MA or GAMC and disenrolled from their health plans. These people may be eligible under fee-for-service for the any month(s) in which they are eligible for MA or GAMC but have not been reinstated or re-enrolled in a health plan. See §0914.03.09 (Managed Care Re-Enrollments & Reinstatements).

- Certain people, including newborns, who are added to a managed care

household for one or more months before they can be enrolled in managed care. See §0914.03.13 (Adding/Removing People From Managed Care).

DHS issues a Minnesota Health Care Programs Card for each eligible person in the household. The card does not specify the program of coverage and does not verify eligibility. The card gives information the medical service provider needs to call the Eligibility Verification System (EVS) to verify eligibility dates. EVS also provides health plan enrollment information for managed care enrollees. For ID cards issued before January 2003, the front of the ID card has the metro and 1-800 telephone numbers for provider access into EVS. The back of the ID card has the metro and out-state telephone numbers for enrollees to call with questions about medical services they have received. For ID cards issued after January 2003, the front of the ID card has the metro and out-state telephone numbers for enrollees to call with questions about medical services they have received. The back of the ID card has the metro and 1-800 telephone numbers for provider access into EVS.

MMIS generates a Minnesota Health Care Programs Card. See MMIS User Manual, Health Care Identification Cards. If enrollees need medical services before they receive their cards, providers can use the PMI number for each approved person to verify eligibility through EVS. The PMI numbers are shown on initial notices. Also provide PMI numbers to enrollees over the phone on request.

Issue replacement identification cards at no charge to the enrollee for:

- Lost, destroyed, damaged, or stolen cards.

OR

- Corrections to name, gender, or date of birth.

There is no limit on the number of replacements.

Managed care enrollees receive both a Minnesota Health Care Programs Membership Card and an identification card from the health plan. Medical providers use the Minnesota Health Care Programs Cards to access EVS medical eligibility information.

Enrollees must present the Minnesota Health Care Programs Card along with other health care coverage information to all health care providers. Clients must be eligible during the time of services for the provider to be paid. Providers should contact EVS or the provider help desk to verify medical eligibility. You may verify the PMI number and eligibility dates without the client's written consent.

DHS may restrict clients' use of the medical identification card to certain providers of health care services for the following reasons:

- To prevent duplication or abuse of services.

- To prevent violation of prior authorization requirements.
- To ensure continuity of care.

Because managed care enrollees' choice of providers is limited to providers enrolled in the health plan, DHS does not restrict cards for people enrolled in managed care. The health plan is responsible for prior authorization, monitoring use of medical services, and ensuring continuity of care.

MinnesotaCare:

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

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

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

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

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

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

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

EXAMPLE:

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

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

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

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

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

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

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

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

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

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

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

EXAMPLE:

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

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

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

MA:

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

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

DHS Special Recovery Unit

444 Lafayette Road
St. Paul, MN 55155-3863

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

GAMC:

No provisions.

People who have received coverage under MA (with or without cash assistance), GAMC (with or without cash assistance), EMA, or MinnesotaCare are entitled to a Certificate of Creditable Coverage (COCC) when coverage ends. The COCC verifies receipt of health care coverage through the Minnesota Health Care Programs. It provides evidence of past coverage that may be used for the purpose of reducing the exclusion period that a new health plan imposes because of a pre-existing condition or to permit special enrollment in a health plan outside of an employer's open enrollment period.

See §0910.11.03 (18-Month Rule) for more information on special enrollment allowed under the Health Insurance Portability and Accountability Act (HIPAA).

COCCs are available any time within 24 months after coverage ends, or before coverage ends if requested. MMIS issues COCCs automatically 2 months after eligibility ends. Enrollees may request COCCs before eligibility ends and up to 24 months after the end date. If you receive a request for a COCC, submit the enrollee's full name, current mailing address, names of any dependents needing certificates and PMI numbers for each person requesting a certificate to:

SRU-COCC DHS
444 Lafayette Road
St. Paul, Minnesota
55155-3863
Interoffice mail code 3863
FAX: (651) 282-6744
MAXIS E-Mail: MADE
Voice Mail: (651) 296-5551