

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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #40

March 2004

Effective Date: April 1, 2004

TO: MinnesotaCare Operations
County Agencies
and Other Manual Holders

SUBJECT: Revised Material for the MDHS Health Care Programs Manual

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

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

New material in this manual letter is effective April 1, 2004, unless otherwise noted.

HIGHLIGHTED CHANGE #1: This manual letter updates references to the Bureau of U.S. Citizenship and Immigration Services (USCIS) in several sections. Previous references were to the INS or the BCIS, both previous names of the agency. References to INS or BCIS in other sections will be updated as the sections are revised for other reasons. This manual letter also clarifies provisions for deeming sponsor income when the sponsor is a household member and provides new procedures for verifying sponsorship when the applicant does not have a copy of the affidavit. See Attachment A.

See Attachment A for a list of other changes. NOTE: The changes in Bulletin #04-21-01, 2003. Legislative Changes Effective February 1, 2004, Affecting MinnesotaCare, dated March 8, 2004, are NOT included in the manual letter. These updates will be in the next manual letter.

Submit questions through the HealthQuest system.

Sincerely,

BRIAN OSBERG
Assistant Commissioner, Health Care

**HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #40
ATTACHMENT A
REVISED AND DELETED SECTIONS**

Revised Sections

Deleted Sections

0904.11	0904.11
0905.03.01	0905.03.01
0905.05	0905.05
0906.03.07	0906.03.07
0906.03.07.03	0906.03.07.03
0906.03.09	0906.03.09
0906.05.03	0906.05.03
0906.11	0906.11
0907.19.11	0907.19.11
0907.19.13	0907.19.13
0907.21.09	0907.21.09
0907.21.09.11	0907.21.09.11
0907.25	0907.25
0907.25.09	0907.25.09
0909.19	0909.19
0910	0910
0910.05	0910.05
0910.05.01	0910.05.01
0910.05.03	0910.05.03
0910.05.03.03	None (new)
0910.07	0910.07
0910.09	0910.09
0910.13	0910.13

§0904.11 (Authorized Representatives), §0905.03.01 (Annual Renewal Timelines--MA/GAMC) and §0905.05 (Annual Renewal--Eligibility) clarify that in cases with authorized representatives, only the authorized representative is required to sign the renewal form.

§0906.03.07 (Lawful Permanent Residents with Sponsors) deletes an obsolete reference to EGAMC and changes references from INS to USCIS. It clarifies provisions for deeming when the sponsor is a household member. If the sponsor is a member of the household, apply the applicable disregards and deductions to the sponsor's income. This is not a policy change but was not previously stated. This section also contains new procedures for verifying sponsorship when the applicant does not have a copy of the affidavit. See Highlighted Change #1.

§0906.03.07.03 (Sponsored Immigrants--Program Provisions) clarifies provisions for deeming when the sponsor is a household member.

§0906.03.09 (Undocumented and Non-immigrant People) changes several references to INS and BCIS to USCIS. See Highlighted Change #1. It corrects a cross reference under MA.

§0906.05.03 (State Residence--MinnesotaCare Families) moves information on migrant families

and a general sentence on non-institutionalized people who enter the state to work or seek work from MA to the general provisions. These provisions apply to MinnesotaCare as well.

§0906.11 (Social Security Number–MinnesotaCare) removes obsolete information related to delayed verification.

§0907.19.11 (Transitional/Transition Year MA) revises references to MAXIS functionality. Not all TYMA processes are fully automated.

§0907.19.13 (MA for Breast/Cervical Cancer-MA/BC) changes references to the Minnesota Breast and Cervical Cancer Control Screening Program (MBCCCP) to its new name, Sage Screening Program.

§0907.21.09 (MA Basis: Medicare Savings Programs) removes a misleading sentence about MA status from the first paragraph.

§0907.21.09.11 (Prescription Drug Program: PDP) changes the bullet on other prescription drug coverage from the 4 months preceding the month of application to 3 months. It removes MSHO as a barrier to PDP. People enrolled in MSHO, MnDHO or AC may also receive PDP.

§0907.25 (GAMC Program Types) clarifies that when a GAMC enrollee is certified disabled for MA, MA can be approved back to the month GAMC was approved OR the month the disability certification began, if later.

§0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals) removes an obsolete reference to shortened spenddown.

§0909.19 (Pension and Retirement Funds) revises the material under MinnesotaCare/Method A/GHO to clarify that all pension and retirement funds are excluded, including funds held by a current or former employer as well as funds held in an individual retirement instrument. Under Method B, it moves the MA-EPD exception to the beginning.

§0910 (Other Health Coverage) under MinnesotaCare revises the text for clarity. There are no policy changes.

§0910.05 (Current Health Insurance) under MinnesotaCare reorganizes the text and adds examples. There are no policy changes.

§0910.05.01 (Current Health Insurance--MA/GAMC) clarifies procedures for reimbursing cost-effective premiums for pregnant women when the policy also covers other household members.

§0910.05.03 (Health Insurance Premium Payment) updates obsolete references to GAMC work expense deductions and retroactive coverage.

§0910.05.03.03 (Mail Order Prescription Drug Reimbursement) is a new section with instructions for requesting reimbursement through Benefit Recovery for mail order drug co-payments. These instructions apply only to fee-for-service cases. They do not apply to managed care.

§0910.07 (4-Month Rule) rewords the text and adds an example. There are no policy changes.

§0910.09 (Determining if a Child is Underinsured) changes the title and text to clarify that only children can be considered underinsured.

§0910.13 (Third Party Liability) revises the instructions for sending out second requests for MSQs.

0901	Table of Contents
0902	Glossary
0903	Client Rights and Responsibilities
0904	Applications
0905	Reviews and Renewals
0906	Technical/Procedural Eligibility
0907	Eligibility Groups and Bases of Eligibility
0908	Household Composition
0909	Assets
0910	Other Health Coverage
0911	Income
0912	Income Eligibility
0913	Premiums and Spenddowns
0914	Service Delivery
0915	Changes in Circumstances
0916	Notices
0917	Appeals
0918	Other Related Programs

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TABLE OF CONTENTS

0901

0901	Table of Contents
0902	Glossary
0902.01	Glossary: 10-Day . . .
0902.03	Glossary: Assignment. . .
0902.05	Glossary: Capital. . .
0902.07	Glossary: Client. . .
0902.09	Glossary: Denial. . .
0902.11	Glossary: Effective. . .
0902.13	Glossary: Family. . .
0902.15	Glossary: FPG. . .
0902.17	Glossary: Health Care. . .
0902.19	Glossary: In-Kind. . .
0902.21	Glossary: Insurance. . .
0902.23	Glossary: Managed Care. . .
0902.25	Glossary: MFIP. . .
0902.27	Glossary: Non-Citizen. . .
0902.29	Glossary: Pension. . .
0902.31	Glossary: Procedural. . .
0902.33	Glossary: Quality...
0902.35	Glossary: Renewal...
0902.37	Glossary: Sole...
0902.39	Glossary: Tennessean...
	0902.39.01 Trust Definitions
0902.41	Glossary: Underinsured...
0903	Client Rights and Responsibilities
0903.03	Client Rights
	0903.03.03 Client Rights--Civil Rights
	0903.03.05 Client Rights--Privacy Rights
0903.05	Client Responsibilities
	0903.05.03 Client Responsibilities--Quality Assurance
	0903.05.05 Client Responsibilities--Premium Payment
0904	Applications
0904.03	Initial Requests
	0904.03.03 MinnesotaCare Enrollment Sites
0904.05	Health Care Application Forms
	0904.05.03 When to Require an Application
	0904.05.03.03 Who May Apply
	0904.05.05 When Not to Require an Application

TABLE OF CONTENTS

0901

	0904.05.07	Forms for New Applicants
	0904.05.09	Updating the Application
0904.07	Accepting and Processing Applications	
	0904.07.01	Applications in Advance of Inmate's Release
	0904.07.03	Date of Application
	0904.07.05	Application Follow Up
	0904.07.07	Pending the Application
	0904.07.09	Eligibility Begin Date
	0904.07.09.03	Retroactive MinnesotaCare
0904.09	Shared and Transferred Applications	
	0904.09.03	Transfers From MinnesotaCare to MA/GAMC
	0904.09.05	Transfers From MA/GAMC to MinnesotaCare
	0904.09.07	MinnesotaCare With Retroactive MA/GAMC
	0904.09.09	Mixed Households
	0904.09.11	MinnesotaCare/MA Overlap
0904.11	Authorized Representatives	
0904.13	Verification	
	0904.13.01	Verification - MA/GAMC
	0904.13.03	Case Notes
0905	Reviews and Renewals	
	0905.03	Renewal Timelines
	0905.03.01	Annual Renewal Timelines--MA/GAMC
	0905.05	Annual Renewal--Eligibility
	0905.07	Monthly Reporting
	0905.09	6-Month Reporting
0906	Technical/Procedural Eligibility	
	0906.03	Citizenship and Immigration Status
	0906.03.03	Qualified Non-Citizens
	0906.03.03.03	Qualified Non-Citizens--Program Provisions
	0906.03.03.05	Qualified Non-Citizens/Status Adjustment
	0906.03.05	Non-Citizens Ineligible for Federal Funding
	0906.03.07	Lawful Permanent Residents With Sponsors
	0906.03.07.03	Sponsored Immigrants--Program Provisions
	0906.03.07.05	Substantial Connection--Battery
	0906.03.07.07	Family/Employment Based Immigration Codes

TABLE OF CONTENTS

0901

	0906.03.09	Undocumented and Non-Immigrant People
	0906.03.11	Verification of Immigration Status
	0906.03.11.01	Systematic Verification for Alien Entitlements (SAVE)
	0906.03.11.03	Lawful Permanent Residents
	0906.03.11.05	Refugees
	0906.03.11.07	Asylees/Deportation Withheld
	0906.03.11.09	Conditional Entrants
	0906.03.11.11	Paroled for at Least One Year
	0906.03.11.13	Battered Immigrants
	0906.03.11.15	Cuban/Haitian Entrants
	0906.03.11.17	Amerasian Immigrants
	0906.03.11.19	Veterans and Active Duty Status
	0906.03.11.21	American Indians Born in Canada
	0906.03.11.23	Other Lawfully Residing
	0906.03.11.25	Trafficking Victims
	0906.03.11.26	Micronesians/ Marshall Islanders
	0906.03.13	MinnesotaCare Major Programs
0906.05	State Residence	
	0906.05.03	State Residence--MinnesotaCare Families, MA
	0906.05.03.03	State Residence--Prescription Drug
	0906.05.05	State Residence--MinnesotaCare Adults
	0906.05.07	State Residence--GAMC
0906.07	County Residence	
	0906.07.03	County Residence--Transfers
	0906.07.03.01	MinnesotaCare Enrollment Site Transfers
	0906.07.05	Excluded Time
0906.09	Institutional Residence--MinnesotaCare	
	0906.09.01	Institutional Residence--MA/GAMC
0906.11	Social Security Number--MinnesotaCare	
	0906.11.01	Social Security Number--MA/GAMC
0906.13	Assignment and Referral: Medical Support	
	0906.13.03	Medical Support: When to Refer
	0906.13.03.03	Medical Support Referral--Newborns
	0906.13.03.05	Medical Support--No Referral
	0906.13.05	Good Cause Exemptions--Medical Support
	0906.13.07	Good Cause Determination
	0906.13.09	Parental Fees
0906.15	Disability Determinations	
	0906.15.03	Disability Determination/SMRT Referral

- 0906.17 Technical Factors--GAMC

- 0907 Eligibility Groups and Bases of Eligibility
 - 0907.03 MinnesotaCare Eligibility Group 1
 - 0907.05 MinnesotaCare Eligibility Group 2
 - 0907.07 MinnesotaCare Eligibility Group 3
 - 0907.08 MinnesotaCare Eligibility Group 4
 - 0907.09 MinnesotaCare Pregnant Women
 - 0907.09.03 MinnesotaCare Auto Newborns
 - 0907.11 MinnesotaCare Children Under 21
 - 0907.13 MinnesotaCare Parents/Guardians/Caretakers
 - 0907.15 MinnesotaCare Adults Without Children
 - 0907.17 MA/GAMC Bases of Eligibility
 - 0907.17.03 MA Basis: Multiple Bases of Eligibility
 - 0907.19 MA Families and Children Bases
 - 0907.19.03 Families and Children Basis: Child Under 21
 - 0907.19.03.03 MA Basis: Children in Foster Care
 - 0907.19.03.05 MA Basis: Adoption Assistance
 - 0907.19.05 MA Basis: Pregnant Women
 - 0907.19.05.03 MA Basis: Auto Newborn
 - 0907.19.05.05 Adding/Removing Auto Newborns
 - 0907.19.07 Families & Children: Parents/Caretakers
 - 0907.19.07.01 MA: AFDC-Related Adults--UP/IP Bases
 - 0907.19.09 MA Determination for MFIP
 - 0907.19.11 Transitional/Transition Year MA
 - 0907.19.11.03 TMA/TYMA: 2nd 6 Months
 - 0907.19.13 MA for Breast/Cervical Cancer (MA-BC)
 - 0907.21 MA Basis: Age 65 and Over/Blind/Disabled
 - 0907.21.03 MA/Medicare Savings Basis: Age 65 & Over
 - 0907.21.05 MA/Medicare Savings Basis: Blindness
 - 0907.21.07 MA/Medicare Savings Basis: Disability
 - 0907.21.07.03 MA Basis: 1619 A and B
 - 0907.21.07.05 MA for Employed Persons With Disabilities
 - 0907.21.07.06 MA-EPD: Employment Definition
 - 0907.21.07.07 Special Category: Disabled Children
 - 0907.21.09 MA Basis: Medicare Savings Programs
 - 0907.21.09.03 Medicare Savings Programs: QMB
 - 0907.21.09.05 Medicare Savings Programs: SLMB
 - 0907.21.09.07 Medicare Savings Programs: QWD

TABLE OF CONTENTS

0901

	0907.21.09.09	Medicare Savings Programs: QI
	0907.21.09.11	Prescription Drug Program: PDP
	0907.21.11	MA Basis: MSA Recipients
	0907.21.13	MA Basis: Refugee Medical Assistance - RMA
0907.23		MA Waiver Programs
	0907.23.03	MA Waiver Programs: CADI
	0907.23.05	MA Waiver Programs: MR/RC
	0907.23.07	MA Waiver Programs: CAC
	0907.23.09	MA Option: TEFRA
	0907.23.09.03	TEFRA--SMRT Procedures
	0907.23.11	MA Waiver Programs: EW
	0907.23.13	MA Waiver Programs: TBI
0907.25		Gamc Program Types
	0907.25.03	GAMC Basis: Families With Children
	0907.25.05	GAMC Basis: Adults Without Children
	0907.25.07	State-Funded MA Basis: Victims of Torture
	0907.25.09	GAMC: Mandatory MinnesotaCare Referrals
0907.27		MA/GAMC Basis: IMD Residents
0907.29		Emergency Medical Assistance-EMA
0908		Household Composition
	0908.03	Determining MinnesotaCare Household Size
	0908.03.05	MinnesotaCare HH Size/Non-Parent Caretakers
	0908.05	Determining MA/GAMC Household Size
	0908.07	Household Composition: Deeming
	0908.09	Who Must Be Excluded From the Household
	0908.11	All or Nothing Rule
	0908.13	Temporary Absence--MinnesotaCare - Part 1
	0908.13.01	Temporary Absence--MinnesotaCare - Part 2
	0908.13.03	Temporary Absence--MA/GAMC
	0908.15	Nursing Facilities and ICF-MR Leave Days
0909		Assets
	0909.03	Exemptions From Asset Limits
	0909.05	Asset Limits
	0909.05.03	Verification of Assets
	0909.07	Jointly Owned Assets
	0909.09	Availability of Assets
	0909.11	Excluded Assets
	0909.11.01	Additional Excluded Assets - Program Provisions
	0909.11.03	Excluded Assets for Self-Support

TABLE OF CONTENTS

0901

0909.13	Real Property: Homestead
0909.13.03	Real Property: Non-Homestead
0909.13.05	Contracts for Deed
0909.13.07	Life Estates
0909.13.07.03	Life Estate Mortality Table
0909.15	Vehicles
0909.17	Burial Funds/Life Insurance: Fund Types
0909.17.03	Determining the Burial Fund Exclusion
0909.17.05	Burial Space Items
0909.19	Pension and Retirement Funds
0909.21	Trusts
0909.21.03	Supplemental Needs Trusts
0909.21.05	Special Needs Trusts
0909.21.07	Trusts Established Before 8-11-93
0909.21.09	Trusts Established on or After 8-11-93
0909.23	Annuities
0909.23.03	Life Expectancy Table - Annuities
0909.25	Spousal Asset Assessments
0909.25.03	Spousal Asset Allowance
0909.25.05	Transfer of Income Producing Asset to Spouse
0909.25.07	Community Spouse Contribution
0909.27	Asset Transfers
0909.27.01	MA Transfers--Cont.
0909.27.03	Spousal Asset Transfers
0909.27.05	Asset Transfer Exceptions
0909.27.07	Transfer Lookback Period
0909.27.09	Determining Uncompensated Value
0909.27.11	Improper Transfer Ineligibility
0909.27.11.03	Transfers Before 8-11-93
0909.27.11.05	Transfers 8-11-93 Through 8-31-94
0909.27.11.07	Transfers 9-1-94 Through 4-13-96
0909.27.11.09	Transfers After 4-13-96
0909.27.13	Improper Transfers - Onset Of Ineligibility
0909.27.13.03	Multiple Asset Transfers
0909.29	Excess Assets--Applicants
0909.29.03	Excess Assets--Enrollees
0909.31	Waiver of Asset Rules
0910	Other Health Coverage
0910.03	Types of Other Coverage
0910.03.03	Other Coverage--Prescription Drug

TABLE OF CONTENTS

0901

0910.05	Current Health Insurance
0910.05.01	Current Health Insurance--MA/GAMC
0910.05.03	Health Insurance Premium Payment
0910.05.03.03	Mail Order Prescription Drug Reimbursement
0910.05.05	Medicare Premium Payment
0910.07	4-Month Rule
0910.09	Determining if a Child Is Underinsured
0910.11	Access to Employer Subsidized Insurance
0910.11.01	Verification of ESI
0910.11.03	Access to ESI in Past 18 Months
0910.11.04	Employer Terminates ESI
0910.11.05	Determining the Employer Contribution
0910.11.06	Open Enrollment and ESI
0910.13	Third Party Liability
0911	Income
0911.03	Availability of Income
0911.03.03	Applying for Other Benefits
0911.05	Excluded Income
0911.05.03	Excluded Income--Program Provisions
0911.07	Determining if Income Is Earned or Unearned
0911.07.03	Earned Income
0911.07.05	Unearned Income
0911.09	Specific Types of Income
0911.09.03	Self-Employment Income
0911.09.03.03	Self-Employment Income--MinnesotaCare
0911.09.03.05	Self-Employment Income--MA/GAMC
0911.09.03.07	Self-Employment Use of Home
0911.09.03.09	Self-Employment Transportation
0911.09.03.11	In-Home Day Care
0911.09.03.13	Rental Income
0911.09.03.15	Farm Income
0911.09.03.17	Roomer/Boarder Income
0911.09.05	Dependent Child Income
0911.09.07	Student Financial Aid Income
0911.09.09	Seasonal Income
0911.09.11	Child Support Income
0911.09.11.01	Child Support Income--MA/GAMC
0911.09.13	Assistance Payments Income

TABLE OF CONTENTS

	0911.09.15	Income From RSDI and SSI
	0911.09.15.01	Income From RSDI and SSI-- MA/GAMC
	0911.09.15.03	Determining Gross RSDI
	0911.09.15.05	Lump Sum RSDI and SSI Payments
	0911.09.17	In-Kind Income
	0911.09.19	Interest and Dividends
	0911.09.21	Tribal Land Settlements and Trusts
	0911.09.23	Lump Sum Income
0911.11		Computing Countable Income--MinnesotaCare
	0911.11.01	Computing Income--MinnesotaCare - Part 2
	0911.11.03	Computing Countable Income--MA/GAMC
	0911.11.05	MA/GAMC Varying Income
0912		Income Eligibility
	0912.03	MinnesotaCare Income Eligibility
	0912.03.03	MinnesotaCare Excess Income
	0912.03.05	Annual MCHA Premiums
	0912.05	Determining Net Income
	0912.05.03	Determining Net Income--Order of Deductions
	0912.05.05	Work Expense Deductions
	0912.05.07	Dependent Care Deduction
	0912.05.09	Earned Income Disregards--Method A
	0912.05.09.03	Earned Income Disregard Cycle-- Method A
	0912.05.09.05	Earned Income Disregards--Method B
	0912.05.09.07	Special Personal Allowance Disregard
	0912.05.09.09	Blind and Disabled Student Child Disregard
	0912.05.11	Plan to Achieve Self-Support
	0912.05.13	Standard Deduction
	0912.05.15	RSDI COLA Disregard
	0912.05.17	Widow and Widower's Disregard
	0912.05.19	Disabled Adult Children Disregard
	0912.05.21	Disabled Widow/Widower's Deduction
	0912.05.23	Pickle Disregard
	0912.05.25	Allocations
	0912.05.25.03	Allocations--Community Spouse
	0912.05.25.05	Allocations--Other Relatives
	0912.05.27	Child Support Deduction
0912.07		Income Standards

TABLE OF CONTENTS

0901

	0912.07.03	Clothing and Personal Need Allowance
	0912.07.075	75 Percent of FPG Standards
	0912.07.100	100 Percent of FPG Standards
	0912.07.120	120 Percent of FPG Standards
	0912.07.135	135 Percent of FPG Standards
	0912.07.150	150 Percent of FPG Standards
	0912.07.170	170 Percent of FPG Standards
	0912.07.175	175 Percent of FPG Standards
	0912.07.185	185 Percent of FPG Standards
	0912.07.200	200 Percent of FPG Standards
	0912.07.275	275 Percent of FPG Standards
	0912.07.280	280 Percent of FPG Standards
0913	Premiums and Spenddowns	
	0913.01	Computing the MinnesotaCare Premium
		0913.01.03 MA-EPD Premiums
		0913.01.03.03 MA-EP Premiums: Ongoing
	0913.02	Premium Payment Options
		0913.02.03 Premium Refunds
	0913.03	Spenddowns--MA/GAMC
	0913.05	Which Spenddown Type to Use
		0913.05.03 Use of MA Monthly Spenddown
		0913.05.05 Use of 6-Month and LTC Spenddowns
	0913.07	6-Month Spenddown Calculation
	0913.09	Automated Monthly Spenddown Calculation
		0913.09.03 Client Option Spenddown
		0913.09.05 Designated Provider Option
	0913.11	Manual Monthly Spenddown Calculation
	0913.13	Long Term Care Spenddown Calculation
		0913.13.03 LTC Spenddown--EW With Community Spouse
		0913.13.05 Waiver Obligation--SIS EW
		0913.13.07 Relationship Between EW and AC
	0913.15	Combination LTC/Medical Spenddown
	0913.17	Begin/End Use of LTC Spenddown - Part 1
		0913.17.01 Begin/End Use of LTC Spenddown - Part 2
		0913.17.03 Begin/End Use of LTC Spenddown - Part 3
		0913.17.05 Begin/End Use of SIS EW Waiver Obligation
	0913.19	Shortened Spenddown
		0913.19.03 When to Interrupt 6-Month Cert. Period
		0913.19.05 When Not to Interrupt 6-Month Cert. Period
	0913.21	Allowable Medical Bills to Meet Spenddown

TABLE OF CONTENTS

0901

	0913.21.03	Determine Net Medical Expenses
	0913.21.05	MinnesotaCare Expenses to Meet Spenddown
	0913.21.07	MinnesotaCare Inpatient Hospitalization
	0913.21.09	Bills Reported After Approval
0913.23		Spenddown Notice Requirements
0914		Service Delivery
	0914.03	Service Delivery - People W/Other Coverage
		0914.03.03 Managed Care Exclusions
		0914.03.03.03 Managed Care Voluntary Enrollment
	0914.03.05	Managed Care Enrollment Process
		0914.03.05.01 Managed Care Enrollment Process-- MA/GAMC
		0914.03.05.03 Managed Care Enrollment Presentations
	0914.03.07	Health Plan Changes
	0914.03.09	Managed Care Re-Enrollments & Reinstatements
	0914.03.11	Managed Care Disenrollment
	0914.03.13	Adding/Removing People From Managed Care
	0914.03.15	Managed Care Adjustments
	0914.03.17	Managed Care County Transfers
	0914.03.21	Managed Care Covered Services
	0914.03.23	Managed Care Complaints and Appeals
	0914.03.25	Minnesota Senior Health Option - MSHO
	0914.03.27	Minnesota Disability Health Options - MnDHO
	0914.05	Fee-for-Service
	0914.07	Minnesota Health Care Programs Card
	0914.09	Estate Claims
		0914.09.03 Liens
	0914.11	Access Services
	0914.13	Out of State Services
0915		Changes in Circumstances
	0915.03	Adding a Person to the Household
		0915.03.01 Adding a Person to the Household--MA/GAMC
	0915.05	Removing a Person From the Household
		0915.05.01 Removing a Person From Household--MA/GAMC
	0915.07	Change in Income
	0915.09	Change in Other Health Coverage
	0915.11	Fail to Pay Premium/Voluntary Cancellation
		0915.11.03 Fail to Pay Premium/PW's and Infants
		0915.11.05 Fail to Pay Premium/Reinstatement
	0915.13	Enrollee Becomes Pregnant

TABLE OF CONTENTS

0901

0915.15	Change in MinnesotaCare Eligibility Group
0915.15.01	Change in MA/GAMC Basis of Eligibility
0916	Notices
0916.03	Content of Notices
0916.05	Notice of Approval
0916.07	Notice of Processing Delays
0916.09	Notice of Denial
0916.11	Timing of Notices of Adverse Action
0916.13	Notice of Termination or Cancellation
0916.15	Premium Notices
0916.17	Notice of Late or Incomplete HRF
0916.19	Homestead Exclusion Notice - LTCF Residents
0916.21	IEVS Notices
0916.23	Certificates of Creditable Coverage
0917	Appeals
0917.03	Appealable Issues
0917.05	Appeal Rights
0917.07	Appeal Requests
0917.09	Appeal Hearings
0917.09.03	Appeal Hearing Reimbursement
0917.11	Continuation of Benefits
0917.13	Effect of Appeal Decision
0918	Other Related Programs
0918.03	Long Term Care Consultation
0918.05	Alternative Care - AC
0918.07	Child & Teen Checkups - C&TC
0918.09	Hill-Burton Act
0918.11	Minnesota Comprehensive Health Association
0918.13	Minnesota Children with Special Health Needs
0918.15	HIV/AIDS Programs
0918.17	Food Stamps and Related Programs
0918.19	Women, Infant, and Child (WIC) and MAC
0918.21	School Lunch Program
0918.23	DHS Cash Assistance Programs
0918.25	Family Support Grant Program
0918.27	Consumer Support Grant Program
0918.29	Workers' Compensation
0918.31	Veterans' Benefits

0918.33	Unemployment Insurance
0918.35	Repatriation Program
0918.37	Telephone Assistance Plan - TAP
0918.39	Social Services
0918.41	Publicly Assisted Housing
0918.43	Low Income Home Energy Assistance Program
0918.45	Child Care Subsidy Funds
0918.47	Relative Custody Assistance Program

AUTHORIZED REPRESENTATIVES

0904.11

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 signed only by the authorized representative to set the date of application even if the client later completes and signs the 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

AUTHORIZED REPRESENTATIVES

0904.11

< 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).

MinnesotaCare:

See §0905.03 (Renewal Timelines).

MA/GAMC:

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

EXAMPLE:

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

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

- < For people residing in long term care facilities or receiving EW services, MAXIS sends the MA-LTC Eligibility Form (DHS 2128). This includes LTC residents who receive MSA for personal needs and EW enrollees residing in GRH facilities and receiving GRH payments.
- < For people who receive MA automatically with cash, MAXIS sends the Combined Application Form (CAF, DHS 3469). Follow the timelines and procedures for the appropriate cash program.

EXCEPTION:

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

- < For people receiving only MA or GAMC, MAXIS sends the Minnesota Health Care Programs Renewal Form (DHS 3418) and a return envelope.
- < For people who receive MA or GAMC separately from cash assistance but who are also receiving cash or Food Support, MAXIS sends the CAF if the recertifications and renewals for all programs are due at the same time.

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

EXCEPTION:

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

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

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

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

All enrollees age 18 and older who are requesting health care for themselves must sign the renewal form annually **unless there is an authorized representative. If there is an authorized representative, require only the authorized representative's signature as long as signatures are on file for all household members age 18 and over. Send a photocopy of the renewal form to enrollees age 18 and over or authorized representatives who did not sign the form.** Eligibility will end for enrollees who have not provided required signatures by the renewal due date. See §0905.05 (Annual Renewal–Eligibility).

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

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

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

EXAMPLE:

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

EXAMPLE:

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

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

MinnesotaCare:

When processing a renewal:

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

For households who were determined to have income over the limit at the last renewal but were found eligible for extended eligibility under §0912.03.03 (MinnesotaCare Excess Income), compare the household's current income to the appropriate standard as well as to the applicable MCHA premium. If income remains above 275% FPG for families with children AND 10% of the income remains greater than the MCHA premium for the family in §0912.03.05 (Annual MCHA Premiums), send the MinnesotaCare Over Income Disenrollment - 12-Month Reminder Letter (DHS 3388) to notify the household that they are still over income and the date coverage will end. Also send the form Private Health Insurance in Minnesota (DHS 3416).

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

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

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

EXAMPLE:

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

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

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

M.S. 256L.05 subd. 3a and 4
Minnesota Rules 9506.0020 subp. 6 and 7

MA/GAMC:

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

For other renewals:

- < Review the renewal form. Contact the household to complete missing items or request additional information. Obtain all required signatures. See §0905.03.01 (Annual Renewal Timelines–MA/GAMC).
- < Check to see if anyone has moved in or out of the household. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).
- < Check to see if anyone is pregnant. If yes, request verification of pregnancy. Once the pregnancy is verified, treat the pregnant household member as a pregnant woman. See §0907.19.05 (MA Basis: Pregnant Women).
- < Review the health insurance information. Obtain new health insurance information if the household has obtained other health coverage or the coverage has changed.
- < Review asset information. Request verification of liquid assets if total reported assets are within \$300 of the asset limit unless you have received verification as part of an application or review for another program within the

last 30 days. Advise people with excess assets of the need to reduce. See §0909.29.03 (Excess Assets--Enrollees). Follow up on reported transfers that may affect eligibility. See §0909.27 (Asset Transfers).

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

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

Terminate coverage for people who no longer qualify for MA or GAMC under any basis of eligibility. If the household completed a Minnesota Health Care Programs Renewal Form, county agencies that are MinnesotaCare enrollment sites will evaluate MinnesotaCare eligibility or transfer the application to MinnesotaCare Operations based on the household's choice of enrollment site. County agencies that are not MinnesotaCare enrollment sites will forward the renewal to MinnesotaCare Operations as an application. See §0904.09.05 (Transfers From MA/GAMC to MinnesotaCare).

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

LAWFUL PERMANENT RESIDENTS WITH SPONSORS

0906.03.07

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

Do not apply sponsor deeming provisions to the following groups:

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

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

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

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

If the sponsor is a household member whose income is deemed to the sponsored non-citizen under the rules of the health care program you are determining eligibility for, allow the applicable deductions, disregards and household size. See §0906.03.07.03 (Sponsor Deeming–Program Provisions).

If the sponsor is not a household member whose income is already deemed to the sponsored non-citizen, deem all of the gross income and assets of the sponsor and the sponsor's spouse to each immigrant covered by the affidavit regardless of whether the sponsor actually contributes income to the immigrant. Do not prorate income if there is more than 1 sponsored immigrant. Do not prorate or allow any deductions for the needs of the sponsor, spouse, or other household members. Do not count the sponsor or sponsor's family members in the immigrant's household size. See §0906.03.07.03 (Sponsored Immigrants-Program Provisions).

EXCEPTION:

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

- < They have Battered Status granted by the **USCIS**
OR
The county or MinnesotaCare operations determines the immigrant or children have been battered or subjected to extreme cruelty. For county and MinnesotaCare operations, require a statement of abuse from the client OR other documentation, such as:
 - Police, government agency, or court records.
 - Statement from a battered women's shelter staff or sexual assault or domestic violence advocate with knowledge of circumstances or credible evidence that supports a sworn statement.
 - Statement from a professional from whom the applicant or enrollee has sought assistance about the abuse.
 - A sworn (notarized) statement from any other person with knowledge of the circumstances or credible evidence that supports a sworn statement.

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

AND

LAWFUL PERMANENT RESIDENTS WITH SPONSORS

0906.03.07

< They are not living with the batterer.

AND

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

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

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

AND

< They have either an order for protection or a **USCIS** determination

AND

< The sponsor is the batterer.

EXCEPTION:

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

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

If the client and/or sponsor is unable to supply a copy of the affidavit, **or appears to be subject to sponsor deeming rules but claims not to have a sponsor:**

1. **Obtain a release of information to contact the U. S. Citizenship and Immigration Service (USCIS).**
2. **Complete a Document Verification Request, Form G-845, and a Document Verification Request Supplement, Form G-845 Supplement.**
 - < **Form G-845 can be downloaded as a fillable form from the USCIS Website. Form G-845 Supplement is not available online, but may be reproduced or requested from the USCIS Forms Request Line at 1-800-870-3676.**
 - < **Both forms must be completed and reproduced as 2-sided documents.**
3. **Send the completed forms with a readable copy of both sides of the document submitted as verification of immigration status to:**

U. S. Citizen and Immigration Services
St. Paul District
2901 Metro Drive, Suite 100
Bloomington, MN 55425
Attn. Immigration Status Verifier

The local USCIS office will respond with the following information:

- < Whether the immigrant was sponsored using Form I-864
- < The identity of the sponsor
- < The identity of joint sponsor(s), if any.

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

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

SPONSORED IMMIGRANTS--PROGRAM PROVISIONS

0906.03.07.03

See §0906.03.07 (Lawful Permanent Residents with Sponsors) for general provisions on sponsor deeming for the health care programs.

MinnesotaCare:

If the sponsor is part of the MinnesotaCare household, include the sponsor's gross countable income (and assets if an asset test applies) as part of the household's gross countable income and include the sponsor in the household size. Do not deem the income and assets a second time as part of sponsor deeming.

EXAMPLE:

Abdul signed an affidavit of sponsorship, Form I-864, for his wife and child who now live with him. They apply for MinnesotaCare. Since Abdul is part of the household, his income and assets are already counted. This meets the sponsor deeming requirement.

If the sponsor is not part of the MinnesotaCare household, add the total gross income of the sponsor and sponsor's spouse to the immigrant household's income. Do not prorate income or allow any deductions or exclusions for the sponsor's household. Do not count the sponsor or sponsor's family members in the immigrant's household size.

For applicants, deny MinnesotaCare if total income exceeds the applicable limit. For enrollees, follow §0912.03.03 (MinnesotaCare Excess Income).

If total income is within the limit and the household is otherwise eligible, count all of the sponsor's income in determining the premium amount.

EXAMPLE:

John entered the U.S. on February 4, 1998. He was sponsored by his sister, Janet. John applies for MinnesotaCare as an adult without children. He has earned income of \$600 per month. Janet has earned income of \$1,500 per month. John is ineligible for MinnesotaCare because his total countable income of \$2,100 (all of Janet's gross income plus John's gross income) exceeds the applicable income limit.

EXAMPLE:

Hans entered the U.S. on April 10, 1998. He was sponsored by his brother, Olaf. Hans applies for MinnesotaCare as an adult without children. He lives with his brother and has no income. Olaf has earned income of \$1,000 per month. Hans is found eligible for MinnesotaCare. Count all of Olaf's income (\$1000 per month) in determining Hans's premium amount.

EXAMPLE:

Rudolph and Olga entered the U.S. on February 15, 1998. They were sponsored by Rudolph's brother, Mikhail. Olga gave birth to Natasha on June 16, 1998. Rudolph and Olga apply for MinnesotaCare on November 12, 1998. Mikhail and Rudolph are both employed. Their combined income exceeds the MinnesotaCare limit for Rudolph, Olga, and Natasha. Deny MinnesotaCare for all family members.

MA and GAMC:

If the sponsor is included in the MA or GAMC household size, deem the sponsor's income to his/her spouse and children who are applying for MA or GAMC. Allow applicable MA disregards and deductions. Also deem the sponsor's assets if an asset test applies. Do not deem the income and assets a second time as part of sponsor deeming.

EXAMPLE:

Olga signed an affidavit of sponsorship, I-864, for her 2 children, ages 12 and 14, who now live with her. She applies for MA for the family. She is employed full time. Allow any applicable Method A disregards and deductions from Olga's income and use a household size of 3. Consider Olga's assets for her own eligibility only, since the children have no asset test.

If the sponsor is not a member of the MA or GAMC household or is a household member whose income is not deemed to other household members under MA policy, deem the income of the sponsor and the sponsor's spouse to each household member who is requesting or receiving coverage and who is covered by the affidavit. Do not deem sponsor income to other household members, such as children born in the U.S. who are citizens.

Deem the assets of the sponsor and the sponsor's spouse to each household member who is requesting or receiving coverage, is covered by the affidavit, and is subject to an asset limit. See §0909.03 (Exemptions from Asset Limits).

EXAMPLE:

Susan and her daughter Kathy, age 8, entered the U.S. on February 15, 1998, and were sponsored by Susan's brother, Paul. Susan gave birth to another child, Samantha, on October 2, 1998. Susan applies for MA for herself and the 2 children on January 3, 1999. Susan has earned income of \$800 per month. Paul and his wife have earned income of \$2,500 per month and assets of \$1,900. Susan and Kathy are ineligible for federally funded MA (program M) due to immigration status but are potentially eligible for coverage under

Program **NM**. Samantha is a U.S. citizen and potentially eligible for program **MA**.

Count Susan's net earned income to determine eligibility for her and Kathy. Allow all applicable Method A deductions. See §0912.05 (Determining Net Income). Add the result to the countable sponsor income of \$2,500. Do not allow earned income deductions from the sponsor's income. Apply the assets of Paul and his wife toward Susan's asset limit. Kathy has no asset limit.

Count only Susan's earned income to determine Samantha's eligibility. Do not deem sponsor income because Samantha is a U.S. citizen and is not covered by the Affidavit of Support. Use Susan's gross earned income because Samantha is an infant under age 2. See §0912.05.05 (Work Expense Deductions). Samantha has no asset limit.

EXAMPLE:

Frederick entered the U.S. on January 5, 1998, and was sponsored by his father, Arthur. Frederick applies for GAMC for himself. He lives with Arthur and has earned income of \$300 per month. Arthur has earned income of \$1,500 and countable assets of \$20,000. Count Frederick's **gross** earned income, Arthur's gross earnings, and Arthur's assets in determining Frederick's eligibility.

EXAMPLE:

Rodney signed an I-864 agreeing to sponsor his wife and his stepson Ivan. The family applies for MA for Ivan only. Rodney is included in Ivan's household size, but stepparent income is not deemed under regular MA rules. Because Rodney is the sponsor, deem all of his income to Ivan.

Non-immigrants include people admitted as visitors or on another temporary basis. Examples include but are not limited to:

- < Students and their dependents admitted on a student visa.

NOTE:

Dependents who are born in the U.S. will usually be U.S. citizens. Their status is not dependent on the parents' status.

- < Tourists.
- < Diplomats and their dependents.

Undocumented people are those who do not have and cannot obtain current **USCIS** documentation because they are present in the U.S. without **USCIS** authorization. This includes people who enter the country illegally as well as people whose authorization to remain has expired.

MinnesotaCare:

Most non-immigrants are ineligible for both federally funded and state-funded MinnesotaCare. They are in the U.S. legally and may be able to obtain SSNs. However, their temporary status prevents them from meeting the state residency requirements for families and children and adults without children because they do not have authorization to remain in Minnesota once their immigration documents expire. See §0906.05.03 (State Residence--MinnesotaCare Families, MA) and §0906.05.05 (State Residence--MinnesotaCare Adults).

Citizens of Micronesia and the Marshall Islands have a special status and may be eligible for state-funded MinnesotaCare. See §0906.03.11.27 (Micronesians/Marshall Islanders).

People with one of the Other Lawfully Residing statuses may be eligible for MinnesotaCare. See §0906.03.11.23 (Other Lawfully Residing) and §0906.03.13 (MinnesotaCare Major Programs).

Undocumented people are ineligible for MinnesotaCare because they are in the U.S. without **USCIS** authorization and cannot legally establish permanent residency.

MA:

Most non-immigrants are ineligible for MA program MA and program NM. Although they are legally present in the U.S., their temporary immigration status prevents them from having a qualified status and from meeting state residency requirements. People with one of the Other Lawfully Residing statuses may be eligible. See §0906.03.11.23 (Other Lawfully Residing). Most undocumented people are ineligible for MA program MA and program NM.

EXCEPTIONS:

Pregnant non-immigrants and undocumented non-citizens are eligible for Program NM through the 60-day postpartum period. MMIS will identify any emergency charges, including labor and delivery, and bill them to EMA.

Non-immigrants and undocumented people who receive services from the Center for Victims of Torture (CVT) are eligible for NM while receiving CVT services.

Citizens of Micronesia and the Marshall Islands have a special status and may be eligible for program NM. See §0906.03.11.27 (Micronesians/Marshall Islanders).

Non-immigrant and undocumented people who have a medical emergency may be eligible for emergency MA (EMA, program EH). They must meet an MA basis of eligibility and meet all other MA requirements except for citizenship and immigration status. See §0907.29 (Emergency **Medical Assistance--EMA**).

GAMC:

Citizens of Micronesia and the Marshall Islands have a special status and may be eligible for GAMC. See §0906.03.11.27 (Micronesians/Marshall Islanders).

People who are subject to the federal Medicaid residency rules must be Minnesota residents and intend to remain in Minnesota. This includes all MA applicants and enrollees and MinnesotaCare families, children and pregnant women. Except for Emergency MA, non-citizens must have a status that qualifies them for either state or federally funded MA (program MA or NM) or MinnesotaCare (program LL, KK or FF). See the following sections:

- §0906.03.03 (Qualified Non-Citizens)
- §0906.03.05 (Non-Citizens Ineligible for Federal Funding)
- §0906.03.09 (Undocumented and Non-Immigrant People)
- §0906.03.13 (MinnesotaCare Major Programs)
- §0907.29.03 (Emergency MA)

Do not require a fixed or permanent address. For citizens and non-citizens with eligible status, accept applicants' and enrollees' statements regarding their intent to remain. If residence is unclear, ask for additional information such as:

- < Whether the person continues to maintain a home outside of Minnesota.
- < Where the person receives mail.
- < Where the person keeps most personal possessions.
- < Where the person is registered to vote.
- < The address on the person's drivers license or ID card.

Evaluate the information to determine the person's residence. Do not require verification.

EXAMPLE:

Monica is pregnant. She recently moved to Minnesota from Iowa and is staying in a motel while she looks for an apartment. She states on the application that she plans to remain in Minnesota. She gave up her apartment in Iowa and has applied for a Minnesota drivers license. Monica meets the state residence requirement for MA and for MinnesotaCare for pregnant women and families and children.

EXAMPLE:

George, age 20, left his job in Wisconsin to stay with his mother in Minnesota, who is recovering from surgery. He is unsure how long he will stay at his mother's home. His mail is forwarded to her address. He plans to return to Wisconsin, where he rents a room from a friend, when his mother recovers. George does not meet the state residence requirement for MinnesotaCare because he maintains a home elsewhere and does not intend to remain in Minnesota.

The state of residence for non-institutionalized people who entered the state to work or seek employment (whether or not they are currently employed) is the state where they live when they apply. Consider agricultural workers and people traveling as part of a family who are in Minnesota as agricultural workers to be residents while they are working or intending to work in agriculturally-related jobs in Minnesota, regardless of whether they intend to remain. They may maintain a home in another state.

See §0906.05 (State Residence) for information on Minnesota residents temporarily residing outside the state.

MinnesotaCare:

Follow general provisions.

M.S. 256L.09 Subd. 2, 4, 5

MA:

Follow general provisions except for the following special circumstances:

- < Consider children receiving Title IV-E foster care or Title IV-E adoption assistance to be residents of the state in which they currently reside, even if placed by another state. Foster children placed in Minnesota by an agent of another state become Minnesota's responsibility if the placement is funded by Title IV-E. Minnesota foster children funded by Title IV-E and placed in another state become the new state's responsibility. See §0907.19.03.03 (MA Basis: Children in Foster Care).

Children receiving adoption assistance funded by Title IV-E are residents of the state where they reside. Title IV-E adoption assistance children who move from Minnesota to another state become the new state's responsibility. Title IV-E adoption assistance children who move to Minnesota from another state become Minnesota's responsibility.

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- < Consider children who live in Minnesota and receive non-Title IV-E adoption assistance to be residents of Minnesota even if the adoption assistance is funded by another state. Consider children who receive state funded adoption assistance from Minnesota who move to another state to remain Minnesota residents unless the new state accepts responsibility.

Under federal law, states have the option of accepting financial responsibility for state adoption assistance children from other states. Minnesota selected this option. State adoption assistance children who move to Minnesota from another state become the financial responsibility of Minnesota. State adoption assistance children who move from Minnesota to another state become the responsibility of the new state if that state has chosen the federal option. If the new state does not accept financial responsibility, the child remains Minnesota's responsibility. See §0907.19.03.05 (MA Basis: Adoption Assistance).

- < Consider children who receive non-Title IV-E foster care who are placed in **Minnesota** under the Interstate Compact to be residents of the placing state. These children are not eligible for MA in Minnesota. The placing state remains responsible for the cost of the child's medical care. Non-Title IV-E foster children placed in other states by Minnesota remain Minnesota's responsibility.

- < Consider the state of residence for institutionalized people under 21 or institutionalized people who became incapable of showing intent before age 21 to be:

- The current state of residence of the parent filing the application.

OR

- The current state of residence of the legal guardian filing the application if parental rights were terminated after the placement.

OR

- The state where the person is institutionalized if the person has been abandoned by his/her parents, does not have a legal guardian, and has not been placed by an agent of another state.

- < Consider the state of residence for institutionalized people who became incapable of showing intent at or after age 21 to be the state where they are physically present at the time they apply unless they were placed in the institution by another state.

In all other cases, Minnesota residents placed directly into out-of-state facilities by agents of the state remain Minnesota residents. People placed in Minnesota facilities by agents of other states remain residents of the placing state.

Making a placement includes any action that leads to placement EXCEPT:

- < Providing information about another state's assistance programs or the availability of services or facilities in another state.
- < Helping a person locate services or a facility in another state if that person is capable of showing intent and independently decides to move there.

See §0906.07.05 (Excluded Time) for special provisions for people who enter Minnesota nursing facilities from North Dakota or the reverse.

People do not meet state residency requirements until they enter the state. Eligibility does not begin until people meet state residency. People who do not meet state residency requirements on the 1st of the month of application are eligible on the date they become state residents. Eligibility is not retroactive to the beginning of the month. Enter the date of eligibility in both MAXIS and MMIS. ||

If an applicant wants MA to begin in Minnesota before the former state is able to close medical coverage, have the applicant provide a written statement asking the former state to close the case effective the date the applicant moved. Send a copy to the other state. Ask the applicant to turn over any MA cards from the other state for any period that MA will be open in Minnesota. Ask the other state to suppress payment beginning with the date you approve MA.

GAMC:

See §0906.05.07 (State Residence--GAMC).

MinnesotaCare:

Check the application to ensure that an SSN is provided for each person in the household who is requesting coverage. Do not require SSNs for the following:

- < Adults and children who are not requesting coverage (unless required to apply under the All or Nothing Rule) or who are found ineligible for another reason.
- < All children under age 2 through the month of their 2nd birthday.
- < Newly adopted children over age 2 until the next renewal.
- < People who provide convincing evidence that their refusal to obtain a SSN is based on well established religious objections. A person who claims this exemption must show membership in a recognized sect or division. A statement that the person objects to obtaining a SSN for religious reasons or other personal beliefs is not sufficient.

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

Do not require copies of the social security card or other documents to verify the number. Reported numbers entered on MAXIS are interfaced to MMIS.

If no SSN is provided for a household member who is required to provide one, contact the applicant to find out if the person has a number. If the person does not have an SSN, instruct the applicant to apply for a number by calling or going to the local Social Security Office for an application. Instruct the applicant to report the number when they receive it. **Until the number is assigned and reported, accept a receipt verifying the person has applied.** Use form DHS 3328 (MinnesotaCare Form to Obtain Social Security Number) to make requests by mail.

If the household reports that they need a letter from MinnesotaCare to Social Security in order to obtain a SSN, provide form DHS 3329 (Template-Form to Obtain Social Security Number) for the client to give to Social Security.

Do not approve coverage for any household member(s) required to apply under the All or Nothing Rule until all members have provided SSNs or proof of application. See §0908.11 (All or Nothing Rule).

EXAMPLE:

Application received for 2 parents and 2 children, ages 4 years and 2 years. The application reports SSNs for all but the 2-year-old. The family is requesting coverage for everyone. When contacted, the mother reports that the 2-year-old does not have an SSN. Instruct the mother to apply for an SSN for the child. **Do not approve coverage for any household members until the household verifies they have applied for the child's SSN.**

EXAMPLE:

Applicant family was recently admitted to the U.S. with refugee status. The application reports SSNs for all household members except the mother. They explain that they all applied for SSNs when they entered the country but the mother has not yet received her number. Accept a receipt to verify that the mother applied for a number. If the mother does not have a receipt, instruct her to contact Social Security to ask for a duplicate receipt. **Do not approve coverage for the other parent until the mother provides verification.**

M.S. 256L.05 subd. 2

Minnesota Rule 9506.0030 subp. 2a

MA/GAMC:

See §0906.11.01 (Social Security Number--MA/GAMC).

MinnesotaCare:

No provisions.

MA:

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

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

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

AND

< Is one of the following:

-A parent or relative caretaker with a dependent child in the household.

OR

-A dependent child with a parent or relative caretaker in the household.

OR

-A pregnant woman in her 3rd trimester.

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

AND

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

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

EXAMPLE:

Ron and Cathy apply for MA with their daughter, Christina, age 5. Ron is disabled. Cathy is working. Ron, Cathy and Christina all meet an MA Method A basis. Ron meets an MA Method A basis even if he chooses to use his disabled basis for actual eligibility. Each household member is a parent or dependent child. If each person's countable income using Method A deeming, disregards and deductions is at or below 100% FPG, flag all 3 for potential TMA/TYMA.

EXAMPLE:

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

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

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

AND

< Remain in a household that includes a dependent child.

AND

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

EXAMPLE:

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

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

If a person becomes ineligible for MA Method A under the 100% FPG standard for more than 1 reason, determine if increased earnings would have caused ineligibility without regard to the other change. If yes, the person is eligible for TYMA.

EXAMPLE:

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

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

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

EXAMPLE:

Nancy and her son Ray, age 3, have received MA for 6 months and have been flagged as potential TMA/TYMA eligibles for all 6 months. Nancy begins receiving child support for Ray that causes his income to exceed 100% FPG. His income remains below his standard of 170% FPG. Since the child support is not counted for Nancy, her income remains below 100% FPG.

Because Ray's income now exceeds 100% FPG, his 4-month TMA eligibility begins even though he remains eligible for regular MA. If his income increases beyond 170% FPG during the 4-month TMA period, he is eligible for TMA for any remaining months.

In the 3rd month of Ray's TMA eligibility, Nancy reports increased earnings. Her income now exceeds 100% FPG. Ray's total income, including child support and Nancy's deemed earnings, exceeds 170% FPG. Nancy and Ray are now eligible for up to 12 months of TYMA. MAXIS will close Ray's

TMA and open TYMA.

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

EXAMPLE:

Carlos, Michelle and their son Lorenzo, age 3, have been enrolled in MA since August. They all have net income below 100% FPG and have been flagged for potential TMA/TYMA since August. On November 15, Michelle reports that Carlos got a raise from his employer. Their income is now above 100% FPG, but below 170% FPG. Since all three have been flagged in three of the last six months and there was an increase in earned income, TYMA eligibility begins December 1. Lorenzo remains eligible for regular MA, with TYMA eligibility running concurrently.

On January 9, Michelle calls to report that Carlos has been laid off. Their income is now below 100% FPG. They are now eligible for regular MA. MAXIS does not count the regular MA months toward the TYMA eligibility period. On February 13, Michelle calls to report that Carlos has found another job. Their income is now again over 100% FPG but below 170% FPG. TYMA begins again on March 1 with 10 remaining months available. TYMA and regular MA run concurrently for Lorenzo.

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

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

EXAMPLE:

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

Melissa's income increases above 100% FPG when her disregard cycle ends. She and Ryan become eligible for TYMA. George remains on CADI Method B with no income deemed to him. TYMA runs concurrently. Four months later, George is approved for RSDI and will now have a spenddown. If he continues to receive CADI services, he must remain on Method B with the spenddown. If he discontinues CADI, he can receive TYMA for the remaining months of the family's TYMA eligibility.

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

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

Send the Transition Year Medical Assistance First Quarterly Report (DHS 2975a) at the end of the 3rd month of TYMA. If the enrollee returns the form indicating there is no longer a dependent child in the home, close TYMA for the 1st month for which you can give 10-day notice. Determine if MA eligibility continues under another basis. If the enrollee does not return the form, assume the household still contains a dependent child. It is not necessary to monitor the return of the 1st quarterly report form.

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

EXAMPLE:

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

- < The caretaker must enroll in the employer's cost effective health care plan if available. Terminate TMA/TYMA for caretakers who refuse to enroll. The children remain eligible.
- < The caretaker must cooperate with medical support requirements. Terminate TMA/TYMA for caretakers who fail to cooperate without good cause. The children remain eligible.

TMA/TYMA are not available to any household member who is convicted of MA fraud for any of the 6 months before termination of regular MA or for any month of TMA/TYMA. medical. Remove caretakers who are convicted of fraud. The children may remain on TMA/TYMA.

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

< Have been screened by the **Sage Screening** Program and used program funds to pay for the screening

AND

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

AND

< Are under age 65

AND

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

-Parents/Caretakers. See §0907.19.07 (MA Families and Children Basis: Parents/Caretakers).

-Children Under Age 19. See §0907.19.03 (MA Families and Children Basis: Child Under 21).

-Pregnant Women. See §0907.19.05 (MA Families and Children Basis: Pregnant Women).

-Blind or disabled receiving SSI, OR who have income at or below 100% FPG and are eligible for the Disabled Adult Children Disregard, Widow/Widowers' Disregard, or Pickle Disregard. See §0912.05.19 (Disabled Adult Children Disregard), §0912.05.17 (Widow and Widower's Disregard) and §0912.05.23 (Pickle Disregard).

-1619(a) or (b). See §0907.21.07.03 (MA Basis: 1619a and b).

-Blind or disabled and receiving MSA. See §0907.21.11 (MA Basis: MSA Recipients).

Women who are eligible for MA under a basis not listed above may choose to enroll in either regular MA or MA-BC.

AND

< Are not covered by any of the following other creditable health insurance plans:

-Group health plans, unless the plan does not cover the needed cancer treatment

-Individual health insurance coverage, unless the plan does not cover the needed cancer treatment.

-Medicare

-MA

-Armed forces insurance (CHAMPUS/TRICARE, CHAMPVA).

-MCHA. See §0918.11 (Minnesota Comprehensive Health Association).

AND

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

Women who meet all of these conditions are eligible for all MA-covered services for as long as they need treatment. There is no income or asset limit. **Women enrolled in MA-BC receive MA on a fee-for-service basis.**

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

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

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

AND

- < Have been screened through **the Sage Screening Program** and need treatment for breast or cervical cancer, including precancerous conditions and early stage cancer.

AND

- < Are under age 65

AND

- < Have no health coverage

After determining presumptive eligibility, the provider will:

- < Obtain the client's signed consent to share the **Sage Screening Program** form with the county agency.

-
- < Complete a Temporary Medical Assistance Authorization (DHS 3525B) and fax a copy to the county's designated MA-BC staff: along with the completed **Sage Screening Program** form.
 - < Give the applicant the Enrollee Copy of the DHS 3525B as temporary proof of eligibility until she receives a Minnesota Health Care Programs ID Card and a Minnesota Medical Assistance Breast and Cervical Cancer Coverage Group Application/Renewal (MA-BC Application/Renewal, DHS 3525) to complete and return to the county agency within 30 days. The date of application is the date the provider grants presumptive eligibility.

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

COUNTY ACTION: PRESUMPTIVE ELIGIBILITY

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

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

COUNTY ACTION: ONGOING MA-BC

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

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

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

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

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

MinnesotaCare:

No provisions.

MA:

Some people who are eligible for Medicare may qualify for a Medicare Savings Program with or in place of MA. The QWD program is limited to people with a blind or disabled basis of eligibility. The QMB, SLMB and QI programs are available to all Medicare eligibles who meet all other Medicare Savings Program requirements. While the majority of Medicare eligibles are over age 65, blind, or have disabilities, some people may become Medicare eligible while a disability certification is pending or be eligible for a Medicare extension after their eligibility for RSDI ends. These people may be eligible for QMB, SLMB or QI based on their receipt of Medicare. Use Method B and the income deductions that would apply under the applicable blind or disabled status to determine eligibility for the Medicare Savings Programs.

EXAMPLE:

Don, age 35, has End Stage Renal Disease (ESRD). He is found eligible for Medicare on an expedited basis designed for people with ESRD. He has also applied for RSDI and SSI, but his Medicare is approved before the RSDI/SSI disability certification. He applies for health care. Based on his income, assets and receipt of Medicare, he is eligible for QMB. Use Method B and appropriate deductions for people with disabilities. He is not eligible for MA until he is certified disabled by SSA or SMRT.

NOTE:

Some people may remain disabled but lose RSDI because they earn more than the Substantial Gainful Activity (SGA) level. These people are eligible for a Medicare extension. They are eligible for the Medicare Savings Programs during the extension if they meet income and asset limits. Because SSA considers them to remain disabled, they continue to meet a disabled basis for MA. Do not refer them to SMRT.

The savings programs have higher income and asset limits than MA.

See the following sections for a description of each program, the services it covers, and eligibility requirements:

§0907.21.09.03 Qualified Medicare Beneficiary (QMB).

§0907.21.09.05 Service Limited Medicare Beneficiary (SLMB).

§0907.21.09.07 Qualified Working Disabled (QWD).

§0907.21.09.09 Qualified Individuals (QI).

People who receive Medicare Part A or B simultaneously with MA or any of the Medicare savings programs are known as dual eligibles. This means they have coverage through both Medicare and Medicaid.

In addition to the federally funded savings programs, Minnesota funds the Prescription Drug Program (PDP) for certain QMB- or SLMB-eligibles. See §0907.21.09.11 (Prescription Drug Program: PDP). People who are eligible for MA without a spenddown are not eligible for PDP.

Seniors who are eligible for SIS-EW are not eligible for PDP because prescription bills do not apply to the waiver obligation. They are eligible for full MA, including drug costs, regardless of whether they meet a waiver obligation.

People can be eligible for the Medicare Savings Programs and PDP, and the Alternative Care (AC) program at the same time. See §0918.05 (Alternative Care - AC).

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

Use Method B to determine eligibility for the Medicare Savings Programs. If people who are eligible for both regular MA and a Medicare savings program meet more than one MA basis, they may choose the most advantageous basis for MA. They must use Method B for the Medicare savings programs.

EXAMPLE:

Duane applies for MA and QMB. He receives RSDI based on disability. He lives with Susan and their 2 children. He pays child support for a child outside the home. He may have MA eligibility determined under Method A if it is to his advantage. He must use Method B for QMB.

GAMC:

No provisions.

PRESCRIPTION DRUG PROGRAM: PDP

0907.21.09.11

MinnesotaCare:

No provisions.

MA:

Certain people who are eligible for QMB or SLMB are eligible for the Prescription Drug Program (PDP). See §0907.21.09.03 (Medicare Savings Programs: QMB) and §0907.21.09.05 (Medicare Savings Programs: SLMB) for eligibility requirements for QMB and SLMB.

PDP covers those prescription drugs that are covered by the MA program **if the** manufacturers have a Prescription Drug rebate agreement with the state.

To qualify for PDP, QMB and SLMB eligibles must:

- < Be age 65 and over
- OR
- Be under age 65 with a disability.

AND

- < Be eligible for QMB or SLMB
 - OR
 - Be dually eligible for MA with a spenddown and QMB or SLMB.
- Residents of long term care facilities can receive PDP unless they are eligible for MA without a spenddown or **have** a long term care spenddown.

EXAMPLE:

Pete enters a long term care facility for convalescent care for 2-3 months following surgery. He is enrolled in SLMB and PDP. His assets exceed \$3,000. Medicare and his supplemental policy will pay the majority of his nursing home costs. He does not want to reduce assets to qualify for MA with a spenddown. He may remain on PDP while in the facility.

AND

- < Be a permanent Minnesota resident for at least 180 days. See §0906.05.03.03 (State Residence--Prescription Drug).

AND

- < Not have prescription drug coverage (including Medigap) for the month of application and the preceding **3** months. See §0910.03.03 (Other Coverage--Prescription Drug) for information on what types of coverage are considered other prescription drug coverage when determining Prescription Drug Eligibility.

Asset limit:

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

See §0909.05 (Asset Limits).

Income standard:

- 120% of FPG.

See §0912.07.120 (120 Percent of FPG Standards). People are not eligible for PDP if they:

- < Are eligible for QMB or SLMB and MA without a spenddown, or are eligible for MA with a long term care spenddown.
- < Choose the client option or designated provider spenddown
- < **Are currently enrolled in MinnesotaCare.**
- < Are enrolled in SIS-EW.

People enrolled in MSHO, MnDHO or AC may also be enrolled in PDP.

PDP enrollees with spenddowns may use any spenddown type. However, only the automated monthly spenddown will automatically deduct prescriptions paid by PDP from the spenddown. Help clients determine which spenddown type or combination of programs best meets their needs. See §0913.05 (Which Spenddown Type to Use).

PDP enrollment begins the month following the month in which the PDP application is approved.

PDP enrollees have a \$35 monthly deductible. Most enrollees will pay the deductible directly to the pharmacy. If the pharmacy does not have point-of-sale billing, the deductible will be processed like a spenddown.

PDP deductibles and prescription costs paid by PDP may all be used toward the spenddown for the PDP enrollee and other family members. Bills used to meet a spenddown for 1 family member may not be applied to the PDP deductible for other

family members. See §0913.21 (Allowable Medical Bills to Meet Spenddown) for more information on using PDP expenses toward spenddowns.

Help clients with spenddowns determine whether they will benefit from the PDP by comparing expected out-of-pocket expenses with and without PDP coverage.

Clients who can meet their spenddowns with prescription drug costs and have few or no other regular medical expenses will have lower out-of-pocket expenses on PDP, since the \$35 deductible will be less than the monthly spenddown.

EXAMPLE:

Albert is determined to be eligible for MA with a \$220 monthly spenddown. He will meet the spenddown using only prescription drug costs. He would have out-of-pocket expenses of \$2,640 per year ($\220×12) on MA. If he enrolled in PDP, he would have out-of-pocket expenses of \$420 per year ($\35 monthly deductible $\times 12$). If he also incurs non-prescription costs, his \$35 deductible will be applied toward the spenddown, and MA will pay for covered services over the spenddown amount.

EXAMPLE:

Jack is determined to be eligible for MA with a \$225 monthly spenddown. He can meet the spenddown with a combination of prescription and non-prescription charges. He would have out-of-pocket expenses of \$2700 per year ($\225×12) on MA. If he enrolled in PDP, he would have a \$35 monthly deductible for prescriptions, which could be applied toward his monthly spenddown. He would benefit from PDP and MA with a spenddown.

People who regularly meet their spenddowns on the 1st of the month with non-prescription costs, such as services received through a home and community based waiver (CAC, CADI, MR/RC, TBI) or GRH remedial care, may not need PDP coverage but may choose to enroll.

Applicants may have different effective dates for QMB, SLMB, and PDP. Redetermine PDP eligibility at the time of the annual recertification for QMB or SLMB. Terminate PDP for enrollees who lose QMB or SLMB eligibility.

EXAMPLE:

Theola is enrolled in QMB. She is found eligible for PDP on January 21. PDP begins February 1. She loses QMB eligibility effective June 1 because of a quarterly payment that results in excess income for that month. PDP also ends June 1. She regains QMB eligibility effective July 1. She is again

eligible for PDP effective July.

EXAMPLE:

George applied for retroactive SLMB with ongoing QMB and PDP on February 10. On March 8, he was approved for SLMB for November 1-March 31 with QMB and PDP effective April 1. His recertification is due for November. If eligibility continues, George will remain eligible for PDP and QMB until the scheduled November annual review. If he is found ineligible for QMB or fails to submit his review, terminate QMB and PDP effective October 31.

GAMC PROGRAM TYPES

0907.25

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

People who do not have a basis of eligibility for MA may be eligible for GAMC. This includes people who:

- < Receive General Assistance (GA) and do not have an MA basis of eligibility. GA recipients who have an MA basis of eligibility receive MA instead of GAMC.

EXAMPLE:

Donald, age 19, receives GA. He has an MA basis as a child under 21. He is not eligible for GAMC because he is eligible for MA.

GA recipients with no MA basis do not have to accept automatic GAMC. They may decline health care coverage. They may apply for MinnesotaCare although they are not required to do so.

- < Receive GRH payments and do not have an MA basis of eligibility.
- < Are adults between age 21 and age 65 who do not live with children who meet the definition of a dependent child. See §0902.29 (Glossary: Denial...). This includes parents whose only child(ren) are between ages 18 and 21, as well as adults with no children in the home and stepparents with no biological or adoptive children in the home.

People who are waiting for a disability determination for MA may receive GAMC while the determination is pending. See §0906.15 (Disability Determinations). If the disability is approved, they are eligible for MA back to the first day of the month in which GAMC was approved **or the date the disability certification begins, whichever is later**. They may be eligible for retroactive MA for the 3 months before the month of application if the disability certification includes those months.

There are 2 benefit sets for GAMC with different income and asset limits. People with incomes equal to or less than 75% FPG and assets equal to or less than \$1,000 receive full GAMC benefits. People with incomes between 75% and 175% FPG and assets equal to or less than \$10,000 for a household of 1 and \$20,000 for a household of 2 or more may qualify for limited coverage while in the hospital through the GAMC Hospital Only (GHO) program.

See §0907.25.03 (Full GAMC) and §0907.25.05 (GAMC Hospital Only).

Except for income, assets, and inpatient hospitalization, the eligibility requirements for full GAMC and GHO are the same. See §0906 (Technical Requirements) for information on technical requirements including citizenship and immigration status, Social Security Number, state residence, and specific program barriers such as drug convictions. See §0910 (Other Health Insurance) for requirements related to cost-effective health insurance and 3rd party liability.

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

GAMC applicants and enrollees who do not meet an MA basis of eligibility must be referred to MinnesotaCare if they are:

- < Stepparents and spouses of non-parent caretakers with gross family incomes equal to or less than 75% FPG. See §0912.07.075 (75 Percent of FPG Standards).
- < Adult caretakers with gross family incomes equal to or less than 75% FPG if no child in the home meets the MA definition of a dependent child. See §0902.09 (Glossary: Denial...). This includes:
 - Caretakers of children age 18 who are not in high school or are not expected to graduate by the 19th birthday.
 - Caretakers of children ages 19 and 20.

Caretakers of children who meet the dependent child definition have an MA basis of eligibility and are not mandatory MinnesotaCare referrals.

Do not refer GAMC-eligible people to MinnesotaCare if they:

- < Receive GAMC automatically with GA.
- < Have a pending disability status from SSA or SMRT. If they are found disabled, they meet an MA basis. If they are determined not to be disabled, refer them to MinnesotaCare if they appear to meet all requirements.
- < Appear ineligible for MinnesotaCare due to:
 - Current health insurance.
 - Lack of state residence.
 - Immigration status.

-
- Residence in Group Residential Housing (GRH) or an Institution for Mental Diseases (IMD). ||
 - < Have incomes between 75% and 175% FPG and are eligible for GAMC Hospital Only (GHO). Determine MinnesotaCare eligibility when GHO ends. However, GHO enrollees are not required to accept MinnesotaCare as a condition of future GHO eligibility.

People who meet the mandatory referral criteria may receive GAMC if otherwise eligible while a MinnesotaCare determination is pending if they cooperate with the referral process.

NOTE: These instructions do not apply to people who are ineligible for GAMC. Refer people whose GAMC is denied or terminated for a MinnesotaCare determination. See §0904.09 (Shared and Transferred Applications) and §0904.09.05 (Transfers from MA/GAMC to MinnesotaCare).

When you determine that people who meet the mandatory referral criteria are eligible for GAMC, complete the Screening Tool and Transfer Document (STTD) (DHS 3392) to screen for potential MinnesotaCare eligibility. Do not refer people who do not meet MinnesotaCare criteria. Continue GAMC if otherwise eligible and rescreen for potential MinnesotaCare eligibility at each income review, annual renewal, and when people report changes that may result in MinnesotaCare eligibility.

When people meet MinnesotaCare criteria:

1. Determine MinnesotaCare eligibility if your county is a MinnesotaCare enrollment site unless the client asks to have MinnesotaCare eligibility determined at MinnesotaCare Operations. See §0904.03.03 (MinnesotaCare Enrollment Sites). If your county is not an enrollment site or the client requests service at MinnesotaCare Operations, transfer the complete application to MinnesotaCare Operations with the STTD (DHS 3392). Send or give the Mandatory Referral Form Letter (DHS 3398) to the client. Leave GAMC open during the MinnesotaCare determination.
2. Monitor for MinnesotaCare eligibility. If you are not processing the MinnesotaCare application, check the MMIS RELG screen monthly.
3. When MinnesotaCare is approved, terminate GAMC for the 1st month for which you can give 10-day notice.

Terminate people who fail to cooperate with the MinnesotaCare application process for the 1st month for which you can give 10-day notice. This includes people who fail to cooperate with pursuing the application or who fail to make the 1st premium payment.

Disqualify people who fail to cooperate with MinnesotaCare or who voluntarily request termination of MinnesotaCare once approved from receiving GAMC. These people remain ineligible for GAMC at all future applications unless they no longer meet MinnesotaCare eligibility criteria.

EXAMPLE:

Paul applies for GAMC and meets the mandatory MinnesotaCare referral criteria. He is approved for MinnesotaCare but fails to make his 1st premium payment. GAMC is terminated. He reapplies for GAMC 6 months later and now has private health insurance. Approve GAMC if he is otherwise eligible.

If Paul did not have private health coverage and continued to meet other MinnesotaCare mandatory referral criteria, he would be ineligible for GAMC.

MinnesotaCare/MA Method A/GHO:

Exclude pension and retirement funds. This includes individually owned retirement instruments and employer-based plans, including funds left in the employer's plan when the employee leaves employment. Examples of excluded funds include but are not limited to IRAs, 457 deferred compensation plans, and 401K plans. Other examples are employee retirement funds, such as PERA and other public and private employer plans. Exclude these plans for both current and former employees, if the funds remain in the plan. Do not exclude assets that are not held in a retirement instrument, even if the owner intends to use the funds for retirement.

EXAMPLE:

George has an IRA. He is also a former public employee. He chose to leave his contributions in his pension plan when he changed jobs. He has a 401K through his current employer. All three of these funds are excluded from his asset limit.

EXAMPLE:

Michele has a 401K plan from a former employer. She has a 457 deferred compensation plan through her current employer. She also has a savings certificate that she intends to use for retirement. Exclude the 401K and the deferred compensation plan from Michele's asset limit. Count the savings certificate. See §0909.11 (Excluded Assets).

MA Method B/GAMC:

MA-EPD only: Follow MinnesotaCare/MA Method A/GHO.

All other Method B and GAMC: Count the full amount of pension and retirement funds if available, whether owned individually or through an employer or union.

Consider pension funds held by an employer or union unavailable if the employee cannot gain access to them.

EXAMPLE:

Joe is a substitute teacher. He has a pension fund with the Teacher's Retirement Association. He cannot gain access to these funds. Exclude the balance from the asset limit. Do not require verification of the balance.

Count the full amount of pension and retirement funds held by an employer or union if they are available to a current employee. Circumstances under which funds are available will vary but may include disability, purchase of a home, or educational

needs.

EXAMPLE:

Fern has a deferred compensation plan through her employer. She is currently on medical leave for several months. The deferred compensation plan is available in cases of disability. Determine whether Fern's medical leave meets conditions for early withdrawal. Count the full amount that is currently available for withdrawal.

Count the full amount of pension and retirement funds held by an employer or union and available to a former employee.

EXAMPLE:

Mary is a former county employee. She has \$3,000 in a PERA account. Mary must apply for the available funds. Count the money as income in the month it is received and as an asset if retained the following month.

For IRAs, Keogh plans, and other retirement funds held by individuals, subtract the early withdrawal penalty from the amount in the plan to determine the countable value.

EXAMPLE:

Bernard has an IRA with a balance of \$3,500. If he cashes it in, he will have to pay \$300 as an early withdrawal penalty. Count \$3,200 toward the asset limit.

OTHER HEALTH COVERAGE

0910

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

MinnesotaCare:

MinnesotaCare has several insurance barriers that exist to prevent individuals and employers from dropping health coverage in favor of MinnesotaCare.

Generally, applicants and enrollees are ineligible for MinnesotaCare if they:

- < Had health coverage in the past 4 months. See §0910.07 (4-Month Rule).
- < Have current health coverage. See §0910.05 (Current Health Insurance).
- < Have access to employer subsidized insurance (ESI). See §0910.11 (Access to Employer-Subsidized Insurance).
- < Had access to ESI through a current employer in the past 18 months. See §0910.11.03 (Access to ESI in Past 18 Months).
- < Lost ESI because their employer terminated ESI as an employee benefit in the past 18 months. See §0910.11.04 (Employer Terminates ESI).

There are exceptions to each of these insurance barriers. See the specific manual sections for detailed information.

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

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

OTHER HEALTH COVERAGE**0910**

MA/GAMC:

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

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

EXAMPLE:

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

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

MinnesotaCare:

People who have other current health care coverage are not eligible for MinnesotaCare.

EXCEPTION:

Children under age 21 who have coverage that is considered underinsured may keep that coverage and enroll in MinnesotaCare. For a definition of Group 1, see §0907.03 (MinnesotaCare Eligibility Group 1). For information on how to determine if someone is underinsured, see §0910.09 (Determining if Someone Is Underinsured).

Children with Group 1 status with current coverage that does not meet the definition of underinsured in §0910.09 (Determining if Someone Is Underinsured) are not eligible for MinnesotaCare. Children with Group 2 status and all adults who have current coverage are not eligible regardless of whether the coverage is considered underinsured. See §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3), and §0907.09 (MinnesotaCare Eligibility Group 4).

EXAMPLE:

Jessica applies for MinnesotaCare for herself and her 3 children. Jessica has insurance through her employer, but it is not considered ESI because the employer pays less than 50% of the cost. The insurance meets the definition of underinsured. Jessica has Group 4 status. Her children have Group 1 status. Jessica is ineligible for MinnesotaCare because she has current insurance. If she drops the insurance, she is ineligible for MinnesotaCare for 4 months. Jessica's children are eligible for MinnesotaCare because they are underinsured. They are not required to drop the insurance.

EXAMPLE:

Arnold applies for MinnesotaCare. He has ESI through his employer. He is ineligible for MinnesotaCare because he has current health insurance. If Arnold drops the insurance and remains with the same employer, he continues to be ineligible for MinnesotaCare for 18 months because he had access to ESI through a current employer in the past 18 months. See §0910.11.03 (Access to ESI in the Past 18 Months).

If families with verified income equal to or less than 150% FPG choose not to request coverage for children with other insurance or access to ESI, deny the child for not wanting coverage. Send the child's caretaker the Request for Child Insurance Information (DHS 3448) or follow up by phone to explain that the child may qualify

for MinnesotaCare if the other insurance is considered underinsured. If the family would like MinnesotaCare for the child, request the insurance information on the DHS 3448 or a copy of the child's insurance card. If the family returns the information, contact the insurance company to determine if the coverage is underinsured according to §0910.09 (Determining if Someone is Underinsured). Add the child to MinnesotaCare if the other insurance meets the underinsured criteria.

When people qualify for MinnesotaCare with current health insurance or policies that are not considered other health care, complete a Health Insurance Information Form (HIIF, DHS 1922b) for each policy OR note the coverage types on the completed insurance page of the HCAPP. Forward the HIIF or copy of the HCAPP page to the Benefit Recovery Section, or for county enrollment sites, enter the information on the MMIS TPL screens. Benefit Recovery and the enrollee's managed care plan are responsible for coordinating benefits with the other health insurance.

EXCEPTION:

When people qualify for MinnesotaCare with CHAMPUS/TRICARE, submit a HIIF, appropriate HCAPP page or enter the information on MMIS for any household members with CHAMPUS/TRICARE for whom DHS receives FFP. Do not report CHAMPUS/TRICARE coverage to BRS for household members whose MinnesotaCare coverage is entirely state funded. If a state-funded enrollee with CHAMPUS/TRICARE becomes eligible for FFP, notify BRS by sending a HIIF or appropriate HCAPP page or by entering the information on MMIS.

M. S. 256L.04 Subd. 2

M. S. 256L.07 Subd. 3

Minnesota Rule 9506.0020 Subp. 1(d)

Minnesota Rule 9506.0020 Subp. 3

MA/GAMC:

See §0910.05.01 (Current Health Insurance--MA/GAMC).

MinnesotaCare:

See §0910.05 (Current Health Insurance).

MA/GAMC:

Require applicants or enrollees who are eligible to enroll on their own behalf in a cost effective group health plan to enroll as a condition of eligibility for MA or GAMC. Cost effective coverage is coverage which provides services at a lower premium than the costs DHS would incur if the client was not enrolled in the coverage.

Clients already enrolled in a cost effective group health plan must remain enrolled to be eligible. Adults who disenroll from a cost effective group health insurance plan are ineligible for MA or GAMC until the next open enrollment period for the cost effective group plan. They must re-enroll at that time to reestablish eligibility. Do not deny or terminate eligibility for children whose parents or other caretakers refuse or fail to maintain enrollment in cost effective plans.

Require applicants or enrollees who are eligible to continue group health plan coverage through COBRA to cooperate with cost effective insurance requirements. COBRA-eligible people include:

- < Employees who are terminated, laid off, or whose hours are reduced below 20 hours per week can continue coverage up to 18 months.
- < Widows, divorced spouses, spouses of Medicare-eligible employees, dependent children of any of these people, and dependent children who lose eligibility due to age can continue coverage up to 3 years.

Require applicants or enrollees who are eligible for Medicare Part B to enroll or remain enrolled in Medicare Part B unless an increased premium is assessed due to late enrollment, or the client would be terminated from a group health insurance plan if enrolled in Medicare Part B. If either circumstance applies, request a cost effective decision from the Benefit Recovery Section.

Clients must cooperate in determining the cost effectiveness of any health insurance they have or any group health plan they may be eligible for by providing information about the plan and completing the Health Insurance Premium Cost Effectiveness Review Form (DHS 2841). The following policies are considered cost-effective by BRS and do not require further review:

-
- < Policies where annual covered medical expenses exceed annual premium costs by a 2:1 ratio if the client's medical condition remains the same as in the period reviewed. Review insurance payment reports or the EOMB to determine benefit versus cost.
 - < Policies covering people who have AIDS or who are HIV positive when the premiums are not substantially increased due to the person's condition or policy conversion.
 - < Family coverage when the applicant's or enrollee's out-of-pocket premiums are \$100 or less per month, if all family members are on MA or GAMC.

EXAMPLE:

Paul applies for MA for himself, his wife, and their 2 children. He has group health coverage through his employer. The employer pays \$200 per month. Paul pays \$95. Consider the coverage to be cost effective.

Paul is laid off while receiving MA and has the option of continuing coverage through COBRA. He must pay the full \$295 premium. Redetermine cost effectiveness by determining if there is a 2:1 cost-benefit ratio. Submit a request to BRS if the policy is not cost effective based on the available information or there is not enough payment history to make the determination.

- < Policies covering a pregnant woman's maternity care **are cost-effective for the pregnant woman and any other MA-eligible household members covered by the same premium.** Request that the Benefit Recovery Section review the policy at the end of 60-day postpartum period or if coverage of maternity care is unclear. **If there are other family members covered by the policy, determine whether their portion of the premium is cost-effective under any of the other provisions in this section. If you cannot approve the other family members' portion as cost-effective, refer the policy to Benefit Recovery.**

EXAMPLE:

Paula applies for MA-PW. She has health insurance for herself, her husband and her daughter. The health insurance covers maternity care. Paula is the only family member who is eligible for MA. Refer the case to Benefit Recovery to determine whether it is cost effective to pay the premium for the entire family.

EXAMPLE:

Maia applies for MA for herself and her 2 children. Maia is pregnant and has health insurance for herself and the children that covers maternity care. Maia's cost for family coverage is under \$100 per month. The entire premium is cost effective: Maia's portion because it covers maternity care, and the children's portion because the cost is under \$100 per month and they both receive MA. If the children's portion did not meet any of the cost effective provisions in this section, refer to Benefit Recovery.

- < Children covered by policies when the child is:
 - Receiving MA under the TEFRA Option if the child's portion of the premium is \$50 or less per month.
 - Receiving MA as part of IV-E or state adoption assistance if the child's portion of the premium is \$50 or less per month.
 - Receiving MA while living in an ICF-MR or NF when medical coverage through the policy is accessible to the child. Consider coverage to be accessible if providers covered by the policy are available within 30 minutes or 30 miles of the facility where the child resides.
 - Receiving MA while hospitalized (request the Benefit Recovery Section to review the policy 6 months after discharge).

- < Medicare Part A premiums when the client is QMB or QWD eligible.

- < Medicare Part B when the client enrolls timely (paying the base rate for coverage) and is not enrolled in a group policy which terminates with enrollment in Medicare.

- < Medicare Supplement/Plus policies with drug coverage if the client's monthly drug expense exceeds the premium cost.

- < Policies covering LTCF residents when, at a minimum, coverage includes the Medicare co-insurance for the current nursing facility stay. Request the Benefit Recovery Section to review the policy at the end of 3 months.

The following policies are not cost effective and do not require BRS review:

- < Medicare supplement policies for clients with routine medical needs. The only exception is a policy with drug coverage if the client's prescription needs exceed the premium.

If an applicant or enrollee's Medicare supplement policy is not cost effective, the applicant or enrollee may request suspension of the policy for up to 24 months during a period of MA enrollment. The suspension allows the person to re-enroll in the policy without reapplying if MA ends during the suspension. The policyholder must request the suspension from the insurer within 90 days of the effective date of MA enrollment.

- < Hospital indemnity policies which provide cash payments for each day in a hospital or nursing facility if the client is not currently collecting benefits.

Do not submit Minnesota Comprehensive Health Association (MCHA) policies for cost effectiveness review. Minnesota statutes prohibit MA and GAMC from paying MCHA premiums. MA/GAMC enrollees may carry MCHA coverage at their own expense but are not required to do so as a condition of eligibility.

Send all other policies to the BRS for review of cost effectiveness. Include the following information:

- < 3 copies of a completed DHS 2841 (with particular attention to Section 4).
- < A copy of the health care policy.
- < The applicant or enrollee's prorated cost of the health care premium. Include the prorated amount for all family members who are applying for or receiving MA.
- < Available payment reports or Explanation of Medical Benefits (EOMB).

If a policy will lapse before the DHS 2841 can be reviewed, call the Benefit Recovery Section for an oral decision.

Notify the client if cost effective payments are approved. Use the appropriate MAXIS SPEC LETR.

If payment of health insurance premiums is denied, notify the client of the decision and the right to appeal the action. BRS will reconsider denials if the client provides additional information to support a finding of cost effectiveness within 30 days. Use the appropriate MAXIS SPEC LETR.

Clients are not required to maintain private or group coverage that is not determined to be cost effective. If they do maintain non-cost effective coverage, they must continue to assign their rights and to cooperate with the county agency and BRS in providing information about the coverage.

If MA or GAMC ends, notify the client that MA/GAMC will no longer pay premiums on the cost effective policy. Use the appropriate MAXIS SPEC LETR.

See TEMP manual TE02.13.48 (Cost Effective SPEC/LETR) for more information on using MAXIS SPEC LETR to notify clients of decisions on cost effective health insurance payments.

County agencies must reimburse clients or directly pay premiums for cost effective health insurance. When the policy holder and dependents are covered by the cost effective health care plan but are not all MA recipients, prorate the premium to determine what portion of the premium is reimbursable. See §0910.05.03 (Health Insurance Premium Payment).

MinnesotaCare:

No provisions.

MA and GAMC:

The county agency must pay health insurance premiums if DHS determines the premiums are cost effective according to the provisions in §0910.05 (Current Health Insurance) AND the premium was not used to meet a spenddown. See §0913.21 (Allowable Medical Bills to Meet Spenddown). Pay premiums directly to the insurance provider, or as a reimbursement to the client.

A client is eligible for reimbursement of cost effective health insurance premiums for the month of application and retroactive months if:

< The client was eligible for MA or GAMC during the retroactive month(s).

AND

< The client or a financially responsible relative other than a non-custodial parent who is court ordered to provide medical support paid the premium.

AND

< The premiums were not used to meet a spenddown or **asset reduction**. |||

If only part of a premium was used to meet a spenddown or asset reduction, the client is eligible for reimbursement of the difference between the total amount paid for premiums in the application and retroactive months and the amount used to meet the spenddown or asset reduction.

EXAMPLE:

Pete applies for MA in April requesting retroactive coverage for March. He has health insurance which is determined to be cost effective. He paid his health insurance premium of \$80 per month for March and April. \$60 of the March premium was used to meet his 6-month spenddown. Reimburse Pete for \$20 of the March premium and all of the April premium for total reimbursement of \$100. Pete must maintain the cost effective coverage as a condition of continued eligibility. After the month of application, the county may either reimburse Pete for the premium each month or pay it directly to the insurance company. |

For retroactive reimbursement, issue a check within 30 days of the decision to approve MA or GAMC. Verify the amount to be reimbursed. If the county elects to reimburse clients rather than pay premiums directly to the insurance company after the month of application, issue reimbursements in the same month clients pay the premiums.

When all people covered by the insurance policy are NOT receiving MA or GAMC, pay only the portion of the premium that covers family members enrolled in MA or GAMC. Consider paying premiums for other family members only if their enrollment is a condition of the MA or GAMC family members' eligibility for the health plan and it is cost effective.

EXAMPLE:

Sara is eligible for MA using the TEFRA waiver. She lives with her parents and her brother, none of whom receive MA or GAMC. Her father has health insurance through his employer at no charge for the employee. The cost of dependent coverage for Sara, her mother, and her brother is \$96 per month. Reimburse (or pay directly) \$32 of the premium (one-third of the cost of dependent coverage).

Note that this policy is considered cost effective without BRS review because Sara receives MA through TEFRA and her share of the premium is less than \$50 per month.

EXAMPLE:

Mary is eligible for MA for herself and her 2 daughters. Her husband John, the children's stepfather, does not receive MA or GAMC. Mary has health insurance through her employer at a cost of \$300 per month for Mary and all dependents. Mary would pay \$30 for employee-only coverage. Based on this information, consider \$30 of the \$300 premium to be Mary's share and \$270 to be the cost of dependent coverage for John and the children. Reimburse (or pay directly) \$210 of the premium (\$30 for Mary plus \$90 each prorated for the 2 children).

EXAMPLE:

Bill applies for MA for his 2 sons. He is not eligible for MA for himself. He has health coverage through his employer at a cost of \$50 for the employee and \$100 for dependent coverage. He cannot enroll his sons in the health plan unless he is enrolled.

Determine whether the premium is cost effective by comparing the full cost of the premium (\$150) to insurance payments made for the children. See §0910.05 (Current Health Insurance). If the policy is cost effective based on only the sons' medical expenses, reimburse (or pay directly) the full \$150 premium since the children cannot be enrolled in the health plan unless Bill is enrolled.

If the policy is not cost effective using only the sons' medical expenses, do not reimburse or pay any part of the premium. Do not require Bill to maintain dependent coverage as a condition of eligibility.

Do not reimburse or pay premiums for non-custodial parents who are court-ordered to provide medical support unless all the following conditions are met:

< The non-custodial parent leaves a job and has continued dependent coverage available through COBRA.

AND

< The Child Support Officer determines that the non-custodial parent is no longer financially able to keep the coverage in effect.

AND

< The coverage is cost effective. The Child Support Officer will refer the insurance policy to the MA worker for a cost effectiveness determination. Determine cost effectiveness following the provisions in §0910.05 (Current Health Insurance).

Do not reimburse the non-custodial parent directly for the cost of premiums. Make the payment directly to the employer or to the custodial parent if the custodial parent makes payments to the employer.

The Child Support Officer may pursue repayment of the premiums from the non-custodial parent at a later date.

EXAMPLE:

Brent receives MA for his son Jerod. Jerod's mother, Susan, is court-ordered to provide health insurance for Jerod. She has dependent coverage available through her employer at a cost of \$75 per month. Susan contacts the county and requests reimbursement of the \$75 premium because Jerod receives MA. Do not reimburse or pay the premium regardless of whether the policy is cost effective.

Several months later, Susan is laid off. She can continue coverage for Jerod for up to 18 months under COBRA at a cost of \$150 per month. The child support officer determines that Susan is unable to pay the premium and requests a cost effectiveness determination. The policy is determined to be cost effective. Pay the \$150 premium directly to the employer or insurance company.

MinnesotaCare:

No provisions.

MA and GAMC:

Some employer-sponsored and private health plans offer prescription drug benefits only through mail order companies such as CareMark, ExpressScripts, and Merck-MedCo. These mail order companies refuse to enroll as MA/GAMC providers and will not bill enrollee co-payments to Minnesota Health Care Programs. MA and GAMC can reimburse the enrollee directly for out-of-pocket payments to these mail order companies if:

- < They were not used to meet an MA spenddown
- AND
- < The enrollee receives MA or GAMC through fee-for-service
- AND
- < Benefit Recovery determines that it is cost-effective. In this instance, “cost-effective” means it is less costly to reimburse the client for the mail order co-payments using 100% state funding than to pay the full cost of the drug through MA at a retail pharmacy.

Contact Benefit Recovery if an enrollee who receives MA or GAMC on a fee-for-service basis has a mail-order only drug benefit with co-payments. Do not contact Benefit Recovery for enrollees who receive MA or GAMC from managed care plans. Refer the enrollee to the managed care plan for help with benefit coordination.

4-MONTH RULE

0910.07

MinnesotaCare:

People who had other health coverage in the past 4 months are not eligible for MinnesotaCare.

EXCEPTION:

Do not count the following types of insurance as other health coverage. Do not apply the 4-month insurance barrier to:

- < Any insurance held by children under age 21 with Group 1 status. See §0907.03 (MinnesotaCare Eligibility Group 1).
- < CHAMPUS/TRICARE
- < MA
- < GAMC
- < Cost-effective health insurance that was paid for by MA OR applied to the enrollee's spenddown. Do not consider the cost-effective health insurance to be exempt from the 4-month barrier if the enrollee kept the insurance after MA determined it was no longer cost-effective or after MA closed.

Do not consider MA or GAMC to be other coverage when determining whether applicants meet the 4-month rule. Do consider other coverage in effect while the applicant received GAMC, regardless of whether it was cost-effective.

EXAMPLE:

Marcia's MA is terminated effective May 1 because she cannot meet a spenddown. She had other cost effective health insurance in effect for which MA paid the premium. She dropped the other coverage effective April 30, because she felt the premium was not affordable. She applies for MinnesotaCare on May 10. She is exempt from the 4-month barrier because the cost-effective insurance that was paid for by MA does not count as other insurance for purposes of the 4-month insurance barrier. If she had received GAMC instead of MA, or the other coverage was not considered cost-effective under MA, she would be ineligible for MinnesotaCare until September 1.

Do not submit a HIIF to Benefit Recovery for people who had health insurance in the past 4 months but no longer have it.

M. S. 256.9357 subd. 3

MA/GAMC:

No provisions.

DETERMINING IF A CHILD IS UNDERINSURED

0910.09 |

MinnesotaCare:

Consider a **child** as underinsured if the other health care coverage:

- < 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).
 - Preventive and comprehensive vision coverage (with or without co-pays).

See §0902.07 (Glossary: Client...) and §0902.29 (Glossary: Pension...) for definitions of comprehensive and preventive coverage.

OR

- < Has a deductible of \$100 or more per person per year. If the policy has a per family rather than a per person deductible, divide the deductible by the number of family members covered by the policy to arrive at a per person amount.

OR

- < Excludes services for a pre-existing condition.

OR

- < Excludes coverage for a particular diagnosis.

OR

- < The applicant/enrollee is a child who is enrolled in Medicare Part A, Part B, or both.

DETERMINING IF A CHILD IS UNDERINSURED

0910.09 |

See §0910.05 (Current Health Insurance) and §0910.07 (4-Month Rule) to determine when someone who is underinsured can be eligible for MinnesotaCare.

M. S. 256L.07 subd. 3

Minnesota Rules 9506.0020 subp. 3 item B

MA/GAMC:

No provisions.

THIRD PARTY LIABILITY**0910.13**

In some situations people may have coverage for all or part of their medical expenses through a 3rd party payor that is not considered to be health insurance. Examples include:

- < Workers' Compensation may be liable for the cost of medical care related to on-the-job injuries.
- < Auto insurance policies may cover medical costs related to auto accidents within certain limits.
- < Homeowners or business liability policies may cover medical costs related to accidents on the home or business owner's property.
- < Tort claims may result in court-ordered awards for recovery of medical expenses caused by another party's negligence or malpractice.

If an applicant or enrollee currently has access to 3rd party liability payments, notify the Benefit Recovery Section (BRS). BRS will coordinate payments for which the 3rd party is liable with payments made by the health care programs. Also notify BRS if an applicant or enrollee has a claim, settlement, or lawsuit pending that could result in payment of medical expenses. BRS may be able to file a lien to allow the Department to be reimbursed for medical care paid by the health care programs while the claim, settlement or lawsuit was pending.

Do not require a HIIF for current or potential 3rd party liability payments reported on an application. See the program specific provisions.

MinnesotaCare:

Do not consider actual or potential 3rd party liability payments to be health insurance in determining whether people meet the insurance requirements for eligibility. See §0910.03 (Types of Other Coverage). If someone indicates at application or renewal that a household member has been injured on the job or in an accident, follow up to determine if there are current or potential 3rd party liability payments. Send the Accident/Injury Follow-Up Request for Information (MS 1261) if the application does not contain enough information. Do not pend the application or renewal for receipt of this information. Also follow up if you become aware of possible 3rd party liability payments between renewals.

Notify BRS by MAXIS email to AV. Include the following:

- < Enrollee's name and PMI number
- < Date of injury

THIRD PARTY LIABILITY

0910.13

-
- < Type of potential TPL (auto insurance, workers' compensation, homeowner's insurance, etc.)
 - < Whether a claim or settlement is pending and the name and address of the attorney if applicable

M. S. 256.9354 Subd. 1a

MA/GAMC:

When applicants or enrollees report accidents or injuries with possible 3rd party liability, enter the information on the STAT/ACCI screen on MAXIS. MAXIS will interface the information to MMIS. MMIS will generate a Medical Services Questionnaire (MSQ) (DHS 2337) to be returned to Benefit Recovery. Benefit Recovery will monitor the return of the **MSQs** and will generate 2nd notices **for the worker to send to the enrollee** if necessary. **If you receive a 2nd MSQ from BRS, send it to the applicant/enrollee and allow 10 days for its return. Deny or close with 10-day notice if the applicant or enrollee fails to respond to the 2nd request. Notify Benefit Recovery of the denial or termination.** Do not deny or terminate benefits for children.

Complete the STAT/ACCI screen if:

- < The applicant or enrollee is pursuing legal action on an old or recent injury.
- OR
- < Insurance is currently paying for medical costs related to the injury.
- OR
- < Potential insurance payments are available for costs associated with the injury.

Also complete the STAT/ACCI screen if the client has an active or pending Workers' Compensation claim. BRS will generate a Work Injury Report if they receive notice of possible Workers' Compensation eligibility through an interface with the Department of Labor and Industry.

EXAMPLE:

Mark applies for GAMC. He reports he was injured in a fall at a grocery store 2 years ago. He has not received any payments as a result of this injury but has retained an attorney and plans to file suit. Complete the STAT/ACCI screen. MMIS will generate an MSQ. Mark must supply the requested information to BRS. If the suit is successful, BRS may be able to recover amounts paid by GAMC for costs related to the injury.

EXAMPLE:

Jean applies for MA. She reports she was injured in an auto accident 2 months ago. Her auto insurance carrier is covering the costs of ongoing medical treatment related to the accident. Complete the STAT/ACCI screen. Jean must provide information on the auto insurance claim to BRS.

EXAMPLE:

Jolene applies for MA for herself and her children. She reports that her son was treated at the emergency room for cuts and bruises sustained in a sledding accident 2 months ago. There are no insurance claims active or pending. Jolene does not plan to file a suit. Do not complete the STAT/ACCI screen.

EXAMPLE:

Bob applies for MA for himself and his family. He was injured on the job 6 months ago and has been unable to return to work. He receives weekly payments from Workers' Compensation as well as coverage for medical costs related to the injury. Complete the STAT/ACCI screen. Count the weekly payments as income.