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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #39

January 2004

Effective Date: January 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 January 1, 2004, unless otherwise noted.

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HIGHLIGHTED CHANGE #1: This manual letter updates several sections of the Applications (chapter 4) and Reviews and Renewals (chapter 5) chapters to incorporate new forms and signature requirements, including the Minnesota Health Care Programs Application for People who have a Disability and Seniors age 65 and older (DHS-3531), HCAPP Signature Page (DHS-3417a), and Request to Apply for Minnesota Health Care Programs (DHS-3417b). These changes were previously introduced in Bulletin #03-21-13, HCAPP Undergoes Significant Revisions, dated October 30, 2003. See Attachment A for a list of sections affected by this change.
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HIGHLIGHTED CHANGE #2: This manual letter incorporates several changes to the MA-EPD program. These changes were previously introduced in Bulletin #03-21-05, County Agencies to Bill and Collect Initial MA-EPD Premiums, dated September 3, 2003, and Bulletin #03-21-11, 2003 Legislative Changes Affecting the Medical Assistance for Employed Persons with Disabilities (MA-EPD) Program, dated October 8, 2003. These changes were effective October 1, 2003, and November 1, 2003, with some changes affecting January 2004 premiums. See Attachment A for a description of sections affected by these changes and effective dates.

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HIGHLIGHTED CHANGE #3: This manual letter revises instructions for making medical support referrals on child-only cases. This change was previously relayed in Bulletin #03-21-14, DHS Announces Changes to the Child Support Referral Criteria for Child-Only Medical Assistance and MinnesotaCare Cases, dated October 30, 2003.
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HIGHLIGHTED CHANGE #4: This manual letter contains the following standard increases effective January 1, 2004:

< The Special Income Standard (SIS) for the SIS-EW program increases to $1,692. See §0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation--SIS-EW).

< The self-employment mileage rate increases to 37.5 cents per mile. Also use this amount for reimbursing medical transportation providers who are eligible for reimbursement at the IRS rate. See §0911.09.03.09 (Self-Employment Transportation) and §0914.11 (Access Services).

< The minimum spousal asset allowance increases to $26,190. The maximum spousal asset allowance increases to $92,760. See §0909.25 (Spousal Asset Assessments).

< The percentage factor for calculating the Pickle disregard for the 1-1-2004 COLA increase is 1.021. See §0912.05.23 (Pickle Disregard).

< The maximum spousal income allowance increases to $2,319. See §0912.05.25.03 (Allocations--Community Spouse).

< The clothing and personal needs allowance increases to $74. The amount for certain veterans and surviving spouses of veterans who receive a monthly pension of $90 remains unchanged. See §0912.07.03 (Clothing and Personal Needs Allowance).

< The Blind and Disabled Student Child Disregard increases to $1,370 per month and $5,520 per year. See §0912.05.09.09 (Blind and Disabled Student Child Disregard).

This manual letter also increases the boarder-only and roomer/boarder deductions for Method A to $141 and $212. These increases were effective October 1, 2003, but were not included in Manual Letter #38. See §0911.09.03.17 (Roomer/Boarder Deduction).
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HIGHLIGHTED CHANGE #5: This manual letter reorganizes the material on the MinnesotaCare Employer Subsidized Insurance (ESI) barrier. It creates new sections and adds policy on part-time employment and choice of compensation. See Attachment A for a list of revised and new sections.

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See Attachment A for a list of other changes.

Submit questions through the HealthQuest system.

Sincerely,

BRIAN OSBERG
Assistant Commissioner, Health Care

HEALTH CARE PROGRAMS MANUAL LETTER #39
ATTACHMENT A
REVISED AND DELETED SECTIONS

Sections Revised	Sections Deleted
0904	0904
0904.03	0904.03
0904.05	0904.05
0904.05.03	0904.05.03
0904.05.03.03	0904.05.03.03
0904.05.05	0904.05.05
0904.07	0904.07
0904.07.03	0904.07.03
0904.11	0904.11
0905	0905
0905.03.01	0905.03.01
0905.05	0905.05
0906.13	0906.13
None (deleted)	0906.13.01
0906.13.03	0906.13.03
0907.21.07.05	0907.21.07.05
0907.21.07.06	0907.21.07.06
0907.23.11	0907.23.11
0909.05.03	0909.05.03
0909.25	0909.25
0909.27.13.03	0909.27.13.03
0910.05.05	0910.05.05
0910.11	0910.11
0910.11.01	None (new)
0910.11.03	0910.11.03
0910.11.04	None (new)
0910.11.06	None (new)
0911.09.03.09	0911.09.03.09
0911.09.03.17	0911.09.03.17
0912.05.09.09	0912.05.09.09
0912.05.23	0912.05.23
0912.05.25.03	0912.05.25.03
0912.07.03	0912.07.03
0913	0913
0913.01.03	0913.01.03
0913.01.03.03	None (new)
0913.02	0913.02
0913.13.05	0913.13.05
0914.11	0914.11

§0904 (Applications) changes the form number of the HCAPP and the title of a cross-reference.

§0904.03 (Initial Requests) deletes references to the LTC application form and adds references to the new HCAPP for elderly and disabled (DHS 3531) and the Request to Apply for Minnesota Health Care Programs (DHS 3417b). See Highlighted Change #1.

§0904.05 (Health Care Application Forms), §0904.05.03 (When to Require an Application), §0904.05.05 (When Not to Require an Application), §0904.07 (Accepting and Processing Applications), §0904.07.03 (Date of Application), and §0904.11 (Authorized Representatives) delete references to the LTC application form and add references to the new HCAPP for elderly and disabled (DHS 3531). See Highlighted Change #1.

§0904.05.03.03 (Who May Apply) adds references to the HCAPP Signature Page (DHS-3417a) and instructions on obtaining signatures for adults age 18 and over who are applying for health care for themselves. See Highlighted Change #1.

§0905 (Reviews and Renewals), §0905.03.01 (Annual Renewals–MA/GAMC), and §0905.05 (Annual Renewals–Eligibility) add requirements for obtaining signatures of all enrollees age 18 and over who are requesting health care for themselves. See Highlighted Change #1.

§0906.13 (Assignment and Referral: Medical Support) revises the title, rearranges the text and combines information previously included in §0906.13.01 (Assigning Rights to Medical Support--MA), which is deleted, with material in this section. It updates instructions to reflect changes in referring child-only cases. See Highlighted Change #3.

§0906.13.03 (Medical Support: When to Refer) revises the title and updates the instructions to reflect changes in referring child-only cases. See Highlighted Change #3. It reorganizes the text to better specify referral requirements for child-only cases, cases where the caretaker receives MA or MinnesotaCare, and cases where a child lives apart from both parents.

§0907.21.07.05 (MA for Employed Persons With Disabilities) adds that there is a minimum premium of $35 for MA-EPD enrollees regardless of income. It adds that MA-EPD enrollees with incomes over 200% FPG are not eligible for reimbursement of Medicare Part B premiums, although they must apply for and accept Medicare Part B as a condition of eligibility. See Highlighted Change #2.

§0907.21.07.06 (MA-EPD Employment Definition) adds instructions on applying the 4-month extension for enrollees who lose employment for reasons not attributable to them. See Highlighted Change #2.

§0907.23.11 (MA Waiver Programs: EW) and §0913.13.05 (Waiver Obligation–SIS EW) update the SIS for 2004 to $1,692. See Highlighted Change #4.

§0909.05.03 (Verification of Assets) updates the instructions to reflect the new asset page of the HCAPP (DHS 3417) and the asset questions on the HCAPP for elderly and disabled populations (DHS 3531). See Highlighted Change #1.

§0909.25 (Spousal Asset Assessments) adds a reference to DHS form 3340a, which is used to record the results of an asset assessment. It updates the minimum and maximum spousal asset allowances for 2004. See Highlighted Change #4.

§0909.27.13.03 (Multiple Asset Transfers) updates the instructions to reflect that the penalty period begins the month after the month of the transfer. This change was inadvertently missed in Manual Letter #38.

§0910.05.05 (Medicare Premium Payment) adds that MA-EPD enrollees with incomes over 200% FPG are ineligible for reimbursement of their Medicare Part B premium, regardless of the amount of the premium or cost-effective status. However, all MA-EPD enrollees who are eligible for Part B must accept it as a condition of eligibility. See Highlighted Change #2.

§0910.11 (Access to Employer Subsidized Insurance) revises the title. It removes information now included in new sections and adds policy on employees who have a choice to receive pay in lieu of ESI or lower salary with ESI. See Highlighted Change #5.

§0910.11.01 (Verification of ESI) is a new section. The material in this section was previously found in §0910.11 (Access to Employer Subsidized Insurance).

§0910.11.03 (Access to ESI in Past 18 Months) revises the title. It removes information on open enrollment now included in new sections and adds information on part-time employment and access to ESI. See Highlighted Change #5.

§0910.11 (Employer Terminates ESI) is a new section covering situations when an employer chooses to terminate ESI as an employee benefit. This policy was previously found in other sections.

§0910.11.06 (Open Enrollment and ESI) is a new section on employer annual and special enrollment periods and their effect on access to ESI. The material was previously found in other sections.

§0911.09.03.09 (Self-Employment Transportation) updates the standard mileage amount for 2004 to 37.5 cents. See Highlighted Change #4.

§0911.09.03.17 (Roomer/Boarder Deduction) updates the boarder deduction to $141 and the roomer/deduction to $212 for MA Method A effective October 1, 2003. See Highlighted Change #4.

§0912.05.09.09 (Blind/Disabled Student Child Disregard) updates the maximum amounts for 2004 to $$1,370 per month and $5,520 per year. See Highlighted Change #4.

§0912.05.23 (Pickle Disregard) updates the COLA factor for 2004 to .0221. See Highlighted Change #4.

§0912.05.25.03 (Allocations: Community Spouse) updates the maximum community spouse income allowance for 2004 to $2,319. See Highlighted Change #4.

§0912.07.03 (Clothing and Personal Needs Allowance) updates the amount for 2004 to $74. See Highlighted Change #4.

§0913 (Premiums and Spenddowns) modifies MA to state that all MA-EPD enrollees now have premiums. See Highlighted Change #2. It adds that MinnesotaCare enrollees may now pay premiums through the DHS Web site.

§0913.01.03 (MA-EPD Premiums) and §0913.01.03.03 (MA-EPD Premiums: Ongoing) add that MA-EPD enrollees have minimum premiums of $35 per month and an unearned income obligation of one-half of one percent of unearned income. It adds instructions for county billing and collection of initial premiums. See Highlighted Change #2.

§0913.02 (Premium Payment Options) adds information on Web-based premium payments for MinnesotaCare enrollees. Under MA, it adds that MA-EPD credit card payments may be made with MasterCard as well as Visa.

§0914.11 (Access Services) updates the maximum mileage reimbursement for registered volunteers for 2004 to 37.5 cents per mile. See Highlighted Change #4.

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Everyone applying for 1 or more of the health care programs for the first time must submit a written application. All MinnesotaCare applicants must use the Health Care Application Form (HCAPP), DHS 3417. See §0904.05 (Health Care Application Forms).

People who are reapplying for health care may be required to complete a new HCAPP. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).

Workers must take certain actions and meet certain time frames when processing applications. See §0904.07 (Accepting and Processing Applications).

People can request MinnesotaCare and MA or GAMC on the same application form. See §0904.09 (Shared and Transferred Applications).

Applicants or enrollees may designate someone else to act on their behalf. See §0904.11 (Authorized Representatives).

People who are mentally competent but unable to sign the application due to physical or other limitations may sign by making a distinct mark, such as an “X”. Two witnesses must sign and date the application to verify that the person making the mark is indeed the person who is applying.

People may request health care by phone, in person, or in writing. Explain that they must complete an application and submit required information to find out if they qualify. There are several application forms depending on the applicant's circumstances. See §0904.05 (Application Forms). Provide the appropriate application form based on available information and encourage people to return it as soon as possible. See §0904.07.03 (Date of Application). Accept any DHS-approved application form.

Do not include informational brochures or supplemental forms with any version of the HCAPP (DHS 3417 or DHS 3531). Mail or give only the HCAPP. See the MA/GAMC provisions of this section for information on which application form to provide. See §0904.05.07 (Forms for New Applicants) for a list of items that may be requested after reviewing the application.

MinnesotaCare:

Explain that some people have a choice of enrolling in MinnesotaCare through MinnesotaCare Operations at DHS or through the county agency where they live. See §0904.03.03 (MinnesotaCare Enrollment Sites). Direct people who want to apply only for MA or GAMC to their county of residence.

People who want to apply only for MinnesotaCare may submit their applications to MinnesotaCare Operations or to their county of residence if it is a MinnesotaCare enrollment site. Because county enrollment sites normally determine MA/GAMC eligibility first, applicants must inform the county agency if they wish to be considered only for MinnesotaCare.

Direct people who want to apply for MinnesotaCare to mail, fax or bring a completed Health Care application to MinnesotaCare Operations or to their county of residence (if an enrollment site) as soon as possible. Explain that MinnesotaCare Operations processes applications in the order they are received. Explain that applications submitted by fax may be used to set the date of application and determine initial eligibility, but that the original application must be mailed to the enrollment site within 30 days of the date the application was faxed. See §0904.07.03 (Date of Application) and §0904.07.05 (Application Follow Up).

For clients who request an application by mail or phone, mail the application no later than the following work day. Give the application form to clients who inquire in person. Also, advise them that the HCAPP is available on the DHS web site at www.dhs.state.mn.us. See §0904.05.07 (Forms for New Applicants).

Besides advising people of their enrollment and case maintenance site options, enrollment sites must:

< Provide information about area outreach grantee locations who provide assistance with the application process.

< Provide one-to-one assistance in the application process to county residents.

< Assist applicants and enrollees who reside in counties that are not enrollment sites with completing the application and forwarding the application and verifications to MinnesotaCare Operations.

M.S. 256L.05 subd. 1
Minnesota Rule 9506.0030 subp. 1

MA/GAMC:

Ask people if they want to apply for cash or food stamps or if they have a non-medical emergency. People who want to apply for cash, food stamps, or emergency assistance (with or without health care) must complete a Combined Application Form (CAF) and have an interview. If people indicate they want cash, food stamps, or emergency assistance or are not sure which programs they want to apply for, provide a CAF.

Follow the procedures in chapter 5 of the Combined Manual for people who apply for MA or GAMC on a CAF.

If people want to apply only for health care programs, explain that some people may have a choice between MA or GAMC and MinnesotaCare. Direct people who want to apply for MinnesotaCare to apply through the state agency or through a county enrollment site if they live in a county that provides this service. Because county enrollment sites normally determine MA/GAMC eligibility first, applicants must inform the county agency if they wish to be considered only for MinnesotaCare.

Provide applicants who request MinnesotaCare only with a denial notice for MA/GAMC to confirm their choice.

Provide the appropriate version of the HCAPP to people who inquire in person. Offer to mail the application to people who inquire by phone. Also, advise them that both versions of the HCAPP are available on the DHS web site at www.dhs.state.mn.us/healthcare.

If people want to apply for MA or GAMC, explain that they may mail or fax the application to the county agency or request an in-person interview. See §0904.07 (Accepting and Processing Applications) and §0904.07.05 (Application Follow Up). Explain that applications submitted by fax may be used to set the date of application and determine initial eligibility, but that the original application must be mailed to the county agency within 30 days of the date the application was faxed. See §0904.07.03 (Date of Application).

Follow your agency's procedures if people request an interview. Schedule interviews for pregnant women who request interviews within 5 days of receiving the application. Schedule interviews for people with medical emergencies in time to meet the emergent need.

Mail the appropriate application form no later than the next working day to people who inquire by phone or mail. Offer the option of picking up the form in person or downloading the HCAPP from the DHS web site at www.dhs.state.mn.us/healthcare. | Give the application to people who inquire in person. Explain that the date of application is the date the agency receives a signed and dated application form or another signed, dated request for health care assistance including the applicant's name and address, including but not limited to the Request to Apply for Minnesota | Health Care Programs, DHS 3417B. Health care providers may assist in setting the | date of application for patients who are unable to do so at the time services are received. Explain that the date of application determines when MA or GAMC can begin. See §0904.07.03 (Date of Application) and §0904.07.09 (Eligibility Begin Date).

The Health Care Application (HCAPP, DHS 3417) allows people to apply for any or all of the health care programs on one form. It is available for downloading on the DHS web site at www.dhs.state.mn.us/healthcare. The HCAPP is designed for people under age 65 who do not have a disability and who want to apply only for MA, GAMC, and/or MinnesotaCare. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).

The HCAPP sets the date of application and requests information on eligibility factors. See §0904.07.03 (Date of Application).

The back cover includes the DHS address and a space for the county agency name and address. The post office will return undeliverable applications to DHS. DHS will forward the application to the appropriate site.

The Rights and Responsibilities page of the HCAPP is detachable. Applicants should retain this page.

The HCAPP contains questions needed to determine eligibility for all of the health care programs. Many questions apply to all 3 programs. Some apply only to 1 or 2 programs or to certain populations.

County agencies also use the HCAPP with the Title IV-E Foster Care Supplement to the Health Care Programs Application (DHS 3478) to determine eligibility for Title IV-E for children in placement. If the child is IV-E eligible, MA is automatic. If there is no IV-E eligibility, the agency uses the HCAPP to determine MA eligibility. See §0907.19.03.03 (MA Basis: Children in Foster Care).

The Minnesota Health Care Programs Application (HCAPP) for People Who Have a Disability and Seniors Age 65 and Older (DHS 3531) is designed for those specific populations. Provide the DHS 3531 to people who ask to apply for long term care services and other applicants who are known to have disabilities or be age 65 and over. However, do not require the DHS 3531. Accept a HCAPP or CAF. Accept the DHS 3351 from people who are requesting health care but are under age 65 and do not have disabilities if they submit one instead of a HCAPP or CAF. See §0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application).

The Minnesota Medical Assistance Breast and Cervical Cancer Coverage Group Application/Renewal, known as the MA-BC Application/Renewal Form (DHS 3525), is used for women who are screened and found to need treatment through the Minnesota Breast and Cervical Cancer Control Program (MBCCCP). See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC).

Accept all signed and dated applications. Follow up with the applicant to obtain any missing information. See §0904.07.05 (Application Follow Up).

MinnesotaCare:

Require a HCAPP in the following situations:

< A person or household applies for MinnesotaCare for the 1st time. EXCEPTION: Do not require a HCAPP (DHS 3417) for MinnesotaCare when people apply for health care programs on a CAF or HCAPP for People with Disabilities and Seniors Age 65 and Over (DHS 3531). Use the CAF or DHS 3531 to determine eligibility for all health care programs. Counties that are not enrollment sites will transfer the CAF or DHS 3531 to MinnesotaCare Operations if there is no MA/GAMC eligibility OR the applicant specifically requests MinnesotaCare only.

< A previously enrolled person or household reapplies 11 or more months after they last completed an application or renewal form. If the household reapplies 11 months or less after the date of the last application or renewal, update the information and determine eligibility without requiring a new application.

EXAMPLE:

Pam applies for MinnesotaCare on June 15, 1998, and is enrolled effective August 1. Her coverage is canceled effective March 1999. She calls on July 20, 1999, to request coverage. Require a new HCAPP since it has been 13 months since she last completed an application and there is no renewal form on file.

< A previously denied individual or household reapplies more than 11 months after they last submitted an application.

< A person or household who applied for MA or GAMC and was denied asks to have the application transferred to MinnesotaCare more than 11 months after the MA or GAMC application date.

< One or more people who request MinnesotaCare on a HCAPP are required to be in a separate household from the primary applicant if the original application is not signed by the second household and/or does not have sufficient information to determine eligibility. In that case, send an application to the second household. Instruct them to return it as soon as possible to the representative who is assigned the original application. For purposes of determining the order in which the application is processed, consider the date of application to be the date MinnesotaCare received the first application.

EXAMPLE:
Application is received for James, Judy, and their 3 sons, ages 16, 17, and 22, on March 5. The application is assigned to a worker for processing on March 20. The worker determines that the 22-year-old must be a separate household. See §0908 (Household Composition). The 22-year-old has not signed the application. Send him an application with instructions to return it as soon as possible. Do not delay processing the application for the rest of the household. Assign the returned application to the worker handling James and Judy's case as soon as it is received. The application date for the second application will be the same as for the first application.

< People leave an existing MinnesotaCare household and request MinnesotaCare for themselves. See §0915.05 (Removing a Person From the Household).

M.S. 256L.05 subd. 3a, 3b
Minnesota Rule 9506.0020 subp. 6

MA/GAMC:

Use the HCAPP (DHS 3417) as the application form for MA and GAMC unless: |

< The household contains people with disabilities or people who are age 65 and over. Use the HCAPP for People with Disabilities and Seniors Age 65 and Over (DHS 3531). However, if a disabled or elderly applicant submits a HCAPP or CAF, accept that application. See §0904.07.05 (Application Follow Up). | | |

< The household is requesting cash or food stamps. Use the CAF. The household must have a personal interview for cash and Food Stamps. If the applicant fails to attend the interview or uses the CAF to request only health care, do not require an interview as a condition of eligibility.

See §0904.05.05 (When Not to Require an Application).

Require an application in the following situations:

< An individual or household not requesting cash or food stamps applies for MA or GAMC for the 1st time.

< An individual or household previously denied MA or GAMC reapplies more

than 45 days after the date of the previous application. If the individual or household reapplies within 45 days, reinstate the denied application.

< A previously enrolled individual or household reapplies after the effective date of MA or GAMC termination.

EXCEPTION:
Do not require a new application if former GHO enrollees are rehospitalized within 6 months of the date of the most recent application.

< People active on a health care program request a different health care program unless they meet one of the exceptions in §0904.05.05 (When Not to Require an Application).

< People receiving cash or food stamps request MA or GAMC after the agency has acted on the CAF. If pending cash or food stamp applicants request MA or GAMC in addition to or instead of the program(s) they originally requested, allow them to amend the pending CAF to include MA or GAMC.

< People leave a household and request MA or GAMC for themselves and they are not person 01 on MAXIS. If the primary applicant leaves the household, request a new application signed by the primary applicant remaining in the household.

< The household asks to add members when the only household member on MA is an auto newborn and the household has not completed an application or renewal form within the past 12 months.

Require all applicants age 18 or over who are requesting health care coverage for themselves to sign the application unless the household consists only of people under 18 applying on their own behalf. In that case, require the signature of the primary applicant under 18. Also require the signature of the authorized representative if the household designates one. See §0904.11 (Authorized Representatives). Pend applications for applicants age 18 and over who do not sign the application. Send the HCAPP Signature Page (DHS 3417a) with the Request for Signatures Form Letter (DHS 3555, available only on edocs) to obtain the missing signatures. Deny eligibility for applicants age 18 and over who did not sign if they do not return the DHS 3417a by the end of the processing period.

When only one spouse of a married couple is requesting health care, do not require the other spouse's signature. If a health care application is for children under age 18 only, require the signature of only one parent, stepparent, guardian, or relative caretaker.

EXAMPLE:

> John and Barbara apply for coverage through either MA or MinnesotaCare for themselves and their 2 children. John completes and signs the application. Barbara must also sign the application. Send the DHS 3417a with the DHS 3555 to obtain Barbara's signature. She cannot be approved for MA for herself until she returns the signature form. Neither John nor Barbara can be approved for MinnesotaCare without her signature because of the All or Nothing Rule. The children are under age 18. John's signature is sufficient to approve either MA or MinnesotaCare for the children. If either child was age 18 or over, the child would also be required to sign.

Use the DHS 3417a to obtain the signatures of adults age 18 and over who move into an enrollee's household and request health care coverage for themselves if they are not required to complete a new application. Provide them with a copy of the Rights and Responsibilities. See §0905.04.03 (When to Require an Application) and §0905.04.05 (When Not to Require an Application).

People under 18 who do not live with a parent, relative caretaker, foster parent, or legal guardian may apply on their own behalf. This includes minor caretakers and minors without children. The minor's parents may be liable for medical support or parental fees. See §0906.13.03 (Medical Support Referrals) and §0906.13.09 (Parental Fees).

EXAMPLE:

> Abe, age 17, lives in an apartment with an unrelated 19-year-old friend. Abe may apply for MA or MinnesotaCare on his own behalf. If he is eligible, determine if either parent is liable for medical support or parental fees.

EXAMPLE:

Elizabeth, age 16, lives with her infant son Jeremy. Elizabeth may apply for MA or MinnesotaCare for herself and Jeremy. If they are eligible, determine if Elizabeth's parents are liable for medical support or parental fees. Also make a medical support referral for Jeremy's father if applicable.

When people under 18 without children live with parents, relative caretakers, or legal guardians, the adult parent, caretaker or guardian must apply on the minor's behalf. See §0908 (Household Composition) to determine whether the adult may or must be included in the household and whether to deem the adult's income to the minor.

EXAMPLE:

Desmond, age 15, has lived with his grandmother Shirley for several years. His father Ken moves in with the household. Shirley applies for MA for Desmond. Ken does not need to sign the application. However, the household must provide information on Ken's income since it must be deemed to Desmond.

EXAMPLE:

Kristin, age 15, lives with her grandmother, Lana. Lana may apply for MA or MinnesotaCare on Kristin's behalf. See §0908 (Household Composition) if Lana is also requesting coverage.

Foster parents may apply for MA or MinnesotaCare on behalf of foster children. However, in most cases the county social service agency will apply for MA on the child's behalf. See §0908.03.05 (MinnesotaCare HH Size/Non-Parent Caretakers) if the foster parents wish to include the child in their MinnesotaCare household.

If a minor does not live with parents, guardians, relative caretakers, or in a formal placement arrangement, the person or agency legally responsible for the child must apply.

EXAMPLE:

Talia, age 10, is living with a friend of her mother, Julia, while Julia attends school out of state. This is an informal arrangement. Julia remains the child's legal guardian and may apply for MA on Talia's behalf.

Make a referral to the social services department in the client's county of residence if a minor appears to be abused or neglected. Local agencies should develop their own procedures for social service referrals. The social service agency will determine what action, if any, is appropriate. Do not delay or deny eligibility pending social services action.

See the program-specific sections below when minor caretakers live with parents, guardians, or relative caretakers.

MinnesotaCare:

When a minor caretaker lives with 1 or both parents, require a parent to apply on behalf of the minor and the minor's child unless you have already determined that the parents' income causes ineligibility for the minor caretaker's child OR the parents refuse to apply. The minor may then apply on behalf of his or her child only. See §0908.03 (Determining MinnesotaCare Household Size).

EXAMPLE:

Lauren, age 17, and her 2-year-old daughter Sierra live with Lauren's mother, Joanne. Lauren would like MinnesotaCare for Sierra. Joanne must file an application for the entire household. If Joanne's income causes ineligibility for Sierra or Joanne refuses to provide the necessary information, Lauren may then apply for MinnesotaCare for Sierra only. Lauren may not receive MinnesotaCare for herself separately from Joanne.

When minor caretakers live with legal guardians or relative caretakers who choose to include the minor and minor's child in their own household, the guardian or caretaker must apply. Minor caretakers applying as separate households may apply on their own behalf.

MA:

Minor caretakers who live with 1 or more parents may apply on behalf of themselves and their children. If the minor is requesting MA, require verification of parental income. If the parent is also requesting MA, the parent must apply.

EXAMPLE:

Lauren, age 17, and her 2-year-old daughter Sierra live with Lauren's mother Joanne. Lauren is requesting MA for herself and Sierra. Lauren may apply on her own behalf. Require verification of Joanne's income since it must be deemed to Lauren. If Lauren requests MA for Sierra only, do not require verification of Joanne's income.

When minor caretakers live with legal guardians or relative caretakers, either the minor or the guardian or caretaker may apply on behalf of the minor and/or the minor's child.

MinnesotaCare:

Do not require a HCAPP in the following situations:

< A person is added to an existing MinnesotaCare household. Gather the necessary information to add the person. See §0915.03 (Adding a Person to the Household).

< People reapply for MinnesotaCare after a break in coverage if 11 months or less have elapsed since they last completed an application or renewal form. If more than 1 month has elapsed since the last application or renewal, contact the applicant to update the information on the last form completed. See §0904.05.09 (Updating the Application).

EXAMPLE:

Georgia applies for MinnesotaCare on January 3 and is enrolled effective February 1. Her coverage terminates effective June 1. She calls in August to reapply. Do not require a new HCAPP since it has been less than 11 months since she completed her application. Update the application since more than 1 month has elapsed since coverage ended.

< People who applied for MA or GAMC and were denied request MinnesotaCare within 11 months of the application date.

< People who were denied or pended awaiting payment but failed to make the initial premium payment reapply 11 months or less after the date of the last application. Contact the applicant to update the information on the last application. See §0904.05.09 (Updating the Application).

EXAMPLE:

Stuart applies for MinnesotaCare on April 10 and is pended awaiting payment on April 25. No payment has been received as of September 1. He calls in October requesting coverage. Do not require a new HCAPP since less than 11 months have elapsed since he completed his application. Update the previous application.

< People who live together but must be in separate MinnesotaCare households apply on the same HCAPP. Copy the HCAPP for the second household's case file if it contains sufficient information and signatures to determine eligibility for the second household. If it does not, send the second household a separate application to complete and sign. The application date for the second application will be the same as for the first application.

- A county agency or MinnesotaCare Operations determines MinnesotaCare eligibility for people who lose MA or GAMC eligibility. Determine eligibility based on information in the case record using any form completed by the enrollee, including a CAF or CAF renewal form completed within the previous 11 months. County agencies that are not MinnesotaCare enrollment sites must send the most recent application and current renewal form, if any, to MinnesotaCare Operations. If there is no renewal form on file, send the most recent application along with current case information. The date of application is the date of the most recent application or renewal form.

M.S. 256L.05 subd. 3a, 3b
Minnesota Rule 9506.0020 subp. 6

MA/GAMC:

Do not require an application in the following situations:

- There is a change in the basis of eligibility under a specific health care program.

  EXAMPLE:

  Susan receives MA as a parent/caretaker. She reports she is pregnant. Do not require an application to change the basis of eligibility to pregnant woman.

- A person on MA enters or leaves long term care, regardless of which application form they completed.

  EXAMPLE:

  Bertha, age 78, lives in the community. She applied for MA on the HCAPP (DHS 3417) and was approved effective May 1. In October, she enters a LTC facility. Do not require a CAF or a HCAPP for People with Disabilities and Seniors Age 65 and Over (DHS 3531). Use the Information for Long-Term Care (DHS 3543) to gather the additional information.

- An applicant submits a form designed for a different population. For example, do not require a person with a disability who submits a DHS 3417 HCAPP to complete a DHS 3531 HCAPP. Contact the applicant to gather any missing information.

- People are added to the household. Gather information needed to determine the new member's eligibility. EXCEPTION: Require an application if the household asks to add new members when the only person on MA is an auto newborn and the household has not completed an application or renewal form within the past 12 months.

- People are receiving MA or GAMC automatically with MSA or GA and the cash assistance ends. Gather sufficient information to determine if eligibility for MA or GAMC continues under another basis.

  EXAMPLE:

  John is receiving GA. He reports he started a job and his income will exceed GA standards. Do not require a new application to redetermine eligibility for GAMC. Determine if his income will remain within GAMC limits (or if he can meet a spenddown, if necessary).

- People who live together but must be in separate MA or GAMC households apply on the same CAF or HCAPP. Copy the CAF or HCAPP for the second household's case file if it contains sufficient information and signatures to determine eligibility for the second household. If it does not, send the second household a separate application to complete and sign.

- A person receiving QMB, SLMB or QI requests MA. Note that people cannot receive QI and MA concurrently. See §0907.21.09.03 (Medicare Supplement Programs: QMB), §0907.21.09.05 (Medicare Supplement Programs: SLMB), and §0907.21.09.09 (Medicare Supplement Programs: QI).

- A person enrolled in MA, QMB or SLMB requests the Prescription Drug Program. Check to ensure the enrollee has not had prescription drug coverage in the preceding 4 months. The CAF and HCAPP ask this question, but it may be necessary to update the information if the person requests Prescription Drug after the MA application has been processed. Obtain this information from the case record or by phone if possible. Do not require a written response from the applicant.

  EXAMPLE:

  Sadie applies for MA in November. She indicates on the HCAPP that she has not had prescription drug coverage in the previous 4 months. The MA application is approved in November. In February, she requests the Prescription Drug Program. Check the case record and, if needed, contact Sadie to see if she has had prescription coverage since she completed the HCAPP in November.

  See §0907.21.09.11 (Medicare Supplement Programs: PDP).

- A person enrolled in the Prescription Drug Program requests MA.

< People meet the criteria in §0904.09 (Shared and Transferred Applications).

< The following people convert from GAMC to MA:

- Pregnant women.
- People with Acquired Immune Deficiency Syndrome (AIDS).
- People initially approved for GAMC pending the State Medical Review Team's disability determination.
- People who did not report a disability when initially approved for GAMC but are later found to be disabled by SSA or SMRT.
- People leaving an Institution for Mental Diseases.
- People turning age 65.

< The following people convert from MA to GAMC:

- GA/MA recipients reach age 21.
- People enter an Institution for Mental Diseases.

< People are initially eligible for MA but will become eligible for GAMC within 45 days of the date of application, or are initially eligible for GAMC but will become eligible for MA within 45 days of the date of application.

< MinnesotaCare enrollees request MA or GAMC if they have completed a MinnesotaCare application or renewal within the previous 45 days.

< People who were approved for GAMC Hospital Only (GHO) are rehospitalized and again request GHO within 6 months of the most recent application.

DO require an application in other circumstances when people on 1 health care program request another program. This includes people who no longer meet a basis of MA eligibility, such as MA-only recipients who reach age 21, unless specifically listed above; GAMC recipients who acquire an MA basis unless specifically listed above; and MinnesotaCare enrollees requesting MA or GAMC if it has been more than 45 days since the most recent MinnesotaCare application or renewal.

Although the 2 versions of the HCAPP (DHS 3417 and DHS 3531) and the CAF are each designed for specific populations, accept any DHS-approved health care application. See §0904.05 (Health Care Application Forms).

MinnesotaCare:

People may mail, fax, or bring the application to MinnesotaCare Operations or to a county agency. If a county agency that is not a MinnesotaCare enrollment site receives an application for someone who is requesting only MinnesotaCare, the county agency will forward the application to MinnesotaCare Operations.

If MinnesotaCare Operations receives an application from someone who is requesting only MA or GAMC, forward it to the person's county of residence.

Minnesota Rule 9506.0030 Subp. 1
M.S. 256L.05 Subd. 1

MA/GAMC:

In most cases, people file applications for MA or GAMC with their county of residence. When the county of financial responsibility is different from the county of residence, people may file the application with the county of financial responsibility. People may file applications at other locations in the following situations:

< People requesting only MA or GAMC may mail an application to MinnesotaCare Operations. If MinnesotaCare Operations receives an application for someone requesting only MA or GAMC, MinnesotaCare Operations will forward the application to the county of residence.

< Residents of Regional Treatment Centers (RTCs) may file applications with the RTC reimbursement officer. The RTC reimbursement officer will take the application and forward it to the county of residence for processing.

< Authorized representatives applying on someone's behalf may apply in the client's county of residence, the authorized representative's county of residence, or the county of financial responsibility if different. See §0904.11 (Authorized Representatives) and §0906.07 (County Residence).

Forward the case to the client's county of residence after processing.

- Children and pregnant women who are applying only for MA may apply at locations other than the county agency. Some hospitals and clinics are mandatory outstation locations. Accept applications filed at outstation locations in your own and other counties.

Counties with outstation locations must work with the outstation site to ensure that applications are available. No interview is required. See §0904.07.05 (Application Follow Up). Outstation staff may assist applicants in completing the forms and obtaining verifications, or county agencies may supply staff on request.

- Authorized providers may accept applications and determine presumptive eligibility for MA for Breast and Cervical Cancer (MA-BC). See §0907.19.13 (MA for Breast and Cervical Cancer MA-BC).

- Providers may assist applicants who are unable to request health care at the time of admission to a facility in submitting a request for assistance to the county agency. See §0904.07.03 (Date of Application).

DATE OF APPLICATION 0904.07.03

The date of application determines the order in which MinnesotaCare Operations processes applications. It also determines the earliest possible beginning date of coverage for MA or GAMC. See §0904.07.09 (Eligibility Begin Date).

Record the application receipt date on the application form. Use of a date stamp is recommended.

MinnesotaCare:

The date of application is:

HCAPP SUBMITTED TO MINNESOTACARE OPERATIONS OR A COUNTY AGENCY

< The date a signed and dated HCAPP (DHS 3417 or DHS 3531) containing at least the applicant's name and address is received by MinnesotaCare Operations or by a county agency, regardless of whether the county agency is a MinnesotaCare enrollment site. Accept faxed applications to set the application date and determine initial eligibility.

  County agencies transfer applications to DHS when the county agency is not an enrollment site, or when a type 3 enrollment site receives applications from people who are not current contacts. See §0904.03.03 (MinnesotaCare Enrollment Sites) for a description of enrollment site types.

CAF SUBMITTED TO COUNTY AGENCY

< The date of application is the date a signed and dated CAF Page I is submitted to a county agency for applicants who request MA or GAMC on a CAF. If there is no MA or GAMC eligibility OR the applicant specifically requests MinnesotaCare only on a CAF, use the CAF to determine MinnesotaCare eligibility. Do not require a HCAPP. County agencies that are not MinnesotaCare enrollment sites will forward the CAF to MinnesotaCare Operations if there is no eligibility for MA or GAMC.

ACTIVE MA OR GAMC CASE CLOSED

< County agencies that are MinnesotaCare enrollment sites will determine MinnesotaCare eligibility for enrollees who lose MA or GAMC because of income or assets using available information in the case file. The date of the MinnesotaCare application is the date of the most recent application, annual renewal, or 6-month renewal.

< County agencies that are not MinnesotaCare enrollment sites transfer cases for enrollees who lose MA or GAMC because of income or assets to MinnesotaCare Operations. See §0904.05.05 (When Not to Require an Application). The date of application is the date of the most recent application or renewal form on file.

RENEWAL SUBMITTED IN THE 11 MONTHS BEFORE REAPPLICATION

< If a terminated household reapplies within 11 months of submitting a renewal form, the date of application is the date the renewal form was received.

Pend unsigned applications and return them to the household for signature.

MinnesotaCare Operations processes applications in the order received. Applications forwarded from the county agency are placed in order according to the date the county received them.

Process MinnesotaCare applications received by DHS or a county enrollment site within 30 days of the application date. Process applications forwarded to DHS from county agencies within 30 days of the date MinnesotaCare receives the application from the county. In all cases, the eligibility begin date is the 1st of the month following receipt of the initial premium payment, unless a household member is hospitalized on that date. See §0904.07.09 (Eligibility Begin Date).

M.S. 256L.05 subd. 4

MA:

The date of application is the date a county agency, MinnesotaCare, an RTC reimbursement officer, or a designated outstation receives a signed and dated request including at least the applicant's name and address. The request may be a CAF Page I, either version of the HCAPP, the Request to Apply for Minnesota Health Care Programs (DHS 3417B), or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF or HCAPP completed to the best of the applicant's ability before eligibility can be determined.

The date of application for MA-BC for women approved for presumptive eligibility is the date the provider grants presumptive eligibility. The date of application for women not approved under presumptive eligibility is the date the county agency receives the MA-BC Application/Renewal Form (DHS 3525). See §0907.19.13 (MA for Breast/Cervical Cancer (MA-BC).

Although the two versions of the HCAPP are designed to meet the needs of specific populations, accept any DHS-approved health care application.

Process MA applications within the following time frames:

< 15 days for a pregnant woman. If the woman requests an in-person interview, schedule the interview within 5 days of the date of application. Determine eligibility within 10 days of the date of the interview.

< 60 days for people whose eligibility is based on disability.

< 45 days for all other applicants.

For applications received from MinnesotaCare, the processing time frames begin the date the county agency receives the application.

GAMC:

The date of application is the date a county agency, MinnesotaCare, an RTC reimbursement officer, or a designated outstation receives a signed and dated request including at least the applicant's name and address. The request may be a CAF Page I, either version of the HCAPP, the Request to Apply for Minnesota Health Care Programs (DHS 3417B), or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF or HCAPP completed to the best of the applicant's ability before eligibility can be determined.

If applicants are unable to submit a written request for GAMC because of illness or incapacity, a health care provider may submit the request on their behalf. If the applicant is unable to supply basic identifying information such as name and address, the provider may use a unique identifier, such as the patient ID or chart number, to submit the request. Accept all applications or written requests submitted by providers to set the date of application. Assume that the applicant was unable to submit the request. The provider does not have to be the applicant's authorized representative. The applicant or an authorized representative must submit a completed application before eligibility can be determined. It is the applicant or authorized representative's responsibility to complete the application and supply all necessary information and verifications.

For after hours, weekend and holiday hospital admissions, accept provider requests that were faxed or delivered to the county agency on the date of admission, even if no county staff was available to receive the request. In-person delivery would include methods such as placing the request in a designated after hours mail drop.

Process GAMC applications within 45 days.

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 and the applicant must both sign the application unless the applicant is unable to sign. 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

< 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 the foster parents, social worker, or other representative 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).

All of the health care programs require annual eligibility renewals. Most MA and GAMC cases require income reviews more often than annually, depending on client circumstances.

Approve renewed coverage for people who remain eligible as a result of the renewal process. Terminate coverage for those who are no longer eligible.

MinnesotaCare:

Require a signed Minnesota Health Care Programs Renewal Form (DHS 3418) from all active households every 12 months. Accept and process faxed renewal forms. See §0905.03 (Renewal Timelines) for follow up procedures for faxed renewals. The renewal month is 12 months after the month in which the case was initially pended awaiting payment, regardless of the month coverage begins. Renewals must be processed by the end of the month prior to the renewal month. The "renewal month" is defined as the first effective month of renewed eligibility.

All enrollees age 18 and older who are requesting health care for themselves must sign the renewal form annually. Authorized representatives must also sign. Send a photocopy of the renewal form to enrollees age 18 and over who did not sign the form. Eligibility will end for enrollees who have not provided required signatures by the first day of the renewal month, and for other enrollees whose eligibility depends on that of the person who failed to sign under the All or Nothing Rule. See §0908.11 (All or Nothing Rule).

The renewal month is the first month after the "Redetermination Date" on the RSLT screen in MMIS. The renewal month remains unchanged from year to year as long as the case remains active without a break.

EXAMPLE:

The Andrew family is pended awaiting payment on February 12. MinnesotaCare receives their initial premium payment on February 20, and the case becomes active beginning in March. The Andrew family's renewal month is March. MMIS shows a redetermination date of February 28.

EXAMPLE:

The Burns family is pended awaiting payment on February 12. MinnesotaCare receives their initial premium payment on March 3, and the case becomes active beginning in April. The Burns family's renewal month is March. MMIS shows a redetermination date of February 28.

EXCEPTION:

If an incarcerated individual is removed from an active household at another household member's request and chooses to be opened on a new case, the renewal date on the new case must be the same as the original household's renewal date. Contact the MMIS User Services Help Desk to set the renewal date. If the person is still incarcerated at the time of renewal, cancel coverage. See §0908.13 (Temporary Absence--MinnesotaCare - Part I) and §0915.05 (Removing a Person From the Household).

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

MA/GAMC:

Require a complete signed and dated renewal from all active households every 12 months. See §0905.05 (Annual Renewal–Eligibility) for signature requirements. Accept and process faxed renewals. See §0905.03.01 (Annual Renewal Timelines--MA/GAMC) for follow up procedures for faxed renewals.

Apply the following EXCEPTIONS to the 12-month renewal timeline:

< Renew pregnant women the month following the month in which the 60-day postpartum period ends, UNLESS:

-The woman was on MA before becoming pregnant
OR
-One or more household members are currently open on MA under the same basis of eligibility that would apply to the pregnant woman.

Women meeting either of these conditions are eligible without a spenddown until the next regularly scheduled renewal.

For women who must be renewed at the end of the post-partum period, determine continued eligibility from information in the case record. Request additional information from the enrollee if needed. Approve continued eligibility if the woman is eligible under another basis.

See §0907.19.05 (MA Basis: Pregnant Women).

< Renew infants who are eligible as auto newborns the month following the month of their first birthday. See §0907.19.05.03 (MA Basis: Auto Newborn).

- Do not require a renewal form from people receiving extended MA unless a regular 12-month renewal is due when extended MA ends. Re-evaluate eligibility for MA under another basis. See §0907.19.11.03 (Extended MA for MFIP: 2nd 6 Months) and §0907.19.11.07 (Extended MA for MA-Only: 2nd 6 Months).

- Do not require a renewal form to recertify people eligible for MA under Title IV-E or State adoption assistance. Verify the renewal of the adoption agreement annually. See §0907.19.03.05 (MA Basis: Adoption Assistance).

- For people enrolled in the Prescription Drug Program, the renewal is due at the same time as the annual renewal for QMB and SLMB. See §0907.21.09.11 (Medicare Supplement Programs: PDP).

- GAMC Hospital Only (GHO) eligibility is granted only for the time that the enrollee is hospitalized as an inpatient. There are no reviews or renewals for GHO. See §0907.25.05 (GAMC Hospital Only–GHO).

For all others, the renewal month is:

- 12 months after the first month of the certification period for households who have not had an annual renewal since the most recent application.

  EXAMPLE:
  The Barnes family applied for MA in May and requested consideration of retroactive coverage back to February. They met a spenddown and were opened effective March 10. Their renewal date is February 1.

OR

- 12 months following the effective date of the last annual renewal for households who have been continuously active since the last renewal.

When members of 1 household apply at the same time but are opened on different dates, assign the entire household the earliest renewal date. See §0904.07.09 (Eligibility Begin Date).

EXAMPLE:
Bill, age 65, applies for MA on June 1 and requests retroactive coverage to March. His wife Julie, age 63, applies for GAMC at the same time. Bill is approved effective March 1. Julie is approved effective June 1. The household's renewal date is March 1.

Do not require a separate renewal form for people who receive MA or GAMC with cash. Use the CAF Recertification Form (DHS 3217). Use the Medical Assistance Long Term Care Eligibility Recertification Form (DHS 2128) for clients in long term care. For all others, use the Minnesota Health Care Programs Renewal Form (DHS 3418). Also see §0905.03.01 (Annual Renewal Timelines--MA/GAMC).

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. Send a photocopy of the renewal form to enrollees age 18 and over 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. Authorized representatives must also sign. Send a photocopy of the renewal form to enrollees age 18 and over 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).

The federally funded health care programs require custodial parents and caretakers of children who are requesting or receiving MinnesotaCare or MA to assign their rights to medical support payments from the child(ren)'s non-custodial parent. People assign their rights to medical support and those of their legal dependents by signing the application. People who refuse to assign their rights and the rights of their legal dependents to medical support are ineligible for any of the health care programs. People who are not legally able to assign their rights to medical support, such as children and people under legal guardianship, are eligible even if the people legally responsible for them refuse to assign benefits.

EXAMPLE:

Georgia applies for MA for herself and 2 children. She refuses to assign her and her children's rights to medical support by writing refused on the assignment portion of the application. The children are eligible for MA if they meet all other eligibility requirements. Georgia is ineligible for MA, GAMC, and MinnesotaCare (both federally and state-funded).

EXAMPLE:

Lisa is 16 and lives with her 6-month-old son and her mother. There is an order for medical support against Lisa's father. Lisa is legally unable to assign her rights as she is a minor. If Lisa's mother requests any of the health care programs for herself, she must assign her own and Lisa's rights to medical support as a condition of her own eligibility. If she refuses, Lisa and the child are eligible if they meet all other requirements. Lisa must provide information about her son's father and cooperate to the extent possible with attempts to establish paternity and medical support for him.

The custodial parent or caretaker may also be required to cooperate with the county child support enforcement office, known as IV-D, to establish paternity, establish an order for medical support, and/or enforce an existing order unless the caretaker shows good cause for non-cooperation. Examples of cooperation include:

- Providing information about non-custodial parents
- Establishing paternity of eligible dependent children
- Forwarding any medical support payments received directly from the non-custodial parent to DHS.

IV-D provides information it gets about the non-custodial parent's health insurance coverage of eligible children to the Benefit Recovery Section through the PRISM/MMIS interface.

For information on who must be referred and cooperate with medical support, see §0906.13.03 (Medical Support: When to Refer). For information on good cause, see §0906.13.05 (Good Cause Exemptions--Medical Support) and §0906.13.07 (Good Cause Determination).

The county child support unit is responsible for making determinations of non-cooperation. Do not delay, deny or close health care programs eligibility due to non-receipt of medical support referral forms. If a caretaker fails or refuses to complete support forms without good cause, send all available information to the child support unit following the program-specific instructions in this section after eligibility is determined. IV-D will determine if the caretaker is ineligible due to non-cooperation.

MinnesotaCare and MA-only caretakers are not required to assign their rights to child support or child care support payments but may request these services from the local IV-D agency. Caretakers must report any child support payments, whether court ordered or voluntary. See §0911.09.11 (Child Support Income) and §0911.09.11.01 (Child Support Income--MA/GAMC).

MinnesotaCare:

1. See §0906.13.03 (Medical Support Referrals) to determine if the caretaker is required to cooperate with IV-D.

2. For caretakers who are required to cooperate, send the medical support forms when you determine that a referral is required. Allow 30 days from the date you send the forms for the caretaker to return the forms. Do not require medical support referral forms before approving MinnesotaCare as pending awaiting payment. Do not refer any information to the IV-D agency until you have determined that the child(ren) are eligible AND the household has paid the initial premium.

3. When you receive the referral forms, check to see if the case is active. If yes, send the referral to the county IV-D office within 2 working days. If the case is not active when you receive the forms, do not send the referral until the case is active. Send the referral within 2 working days of confirming that the case has become active.

4. If the caretaker does not claim good cause but fails to return completed forms within 30 days of being requested to do so AND the case is active, refer available information to IV-D.

For all referrals, send the following to the IV-D office in the caretaker's county of residence:

< Notification of Opening/Change/Closing in Public Assistance Case (DHS 2686a).

< A printout of the MMIS RCIN screen. Also include a printout of the RCAD screen if the client refuses to complete the referral form.

< The Referral to Support and Collections (DHS 3163B) if received.

< The Client Statement of Good Cause (DHS 2338) if received.

< A copy of the applicable court order, if available.

Use the DHS 2686a to notify IV-D of case closings and other changes.

The child support unit will notify you if the caretaker fails to cooperate. Send 10-day notice to terminate coverage for caretakers who fail to cooperate without good cause.

When a parent leaves an active household, determine if you need to make a referral for medical support. If yes, send the Referral to Support and Collections (DHS 3163b) and the Client Statement of Good Cause (DHS 2338) to the custodial parent or other primary caretaker to complete. Request return of the forms within 30 days. Make the referral within 2 working days after receiving the forms. If the caretaker fails to return the forms within 30 days and has not claimed good cause, refer available information to IV-D. IV-D will notify the MinnesotaCare worker if the caretaker is ineligible due to non-cooperation.

If IV-D notifies you that a caretaker who was removed from coverage for non-cooperation has now cooperated, reinstate the caretaker's coverage beginning the 1st available month after cooperation.

EXAMPLE:

Rose receives MinnesotaCare for herself and 2 children. On February 10 the child support officer notifies the worker that Rose has failed to cooperate in obtaining medical support. There is no good cause claim. Rose is removed from MinnesotaCare coverage effective March 1. On March 15, the child support officer notifies the worker that Rose has cooperated. Reinstate Rose's coverage effective April 1. Send the DHS 2868a to notify IV-D of the reinstatement.

MA:

1. See §0906.13.03 (Medical Support Referrals) to determine if the caretaker is required to cooperate with IV-D.

2. For caretakers who are required to cooperate, send the medical support forms when you determine that a referral is required. Allow 30 days from the date you send the forms for the caretaker to return the forms. Do not require medical support referral forms before approving MA.

3. If you receive the referral forms after MA has been approved, send the referral to the county IV-D office within 2 working days. If MA has not been approved, hold the referral until you complete the eligibility determination. Make referrals to the IV-D agency within 2 working days of approving eligibility for MA.

4. If the caretaker fails to return the forms within the 30-day period without good cause, refer available information to the child support unit.

For all referrals, complete appropriate MAXIS screens and send the following to the IV-D unit:

< The Notification of Opening/Change/Closing in Public Assistance Case (DHS 2686a).

< The Referral to Support and Collections (DHS 3163B) if received.

< The Client Statement of Good Cause (DHS 2338) if received.

< A copy of the applicable court order, if available.

The child support unit will notify you if the caretaker fails to cooperate. Send 10-day notice to terminate coverage for caretakers who fail to cooperate without good cause.

Use the DHS 2686a to notify IV-D of case closings and other changes.

When a parent leaves an active household, determine if you need to make a referral for medical support. If yes, send the Referral to Support and Collections (DHS 3163B) and the Client Statement of Good Cause (DHS 2338) to the custodial parent or other primary caretaker to complete. Request return of the forms within 30 days. Make a referral to IV-D within 2 working days of receiving the forms. If the caretaker fails to return the forms within 30 days and has not claimed good cause, refer available information to IV-D. IV-D will notify the MA worker if the caretaker is ineligible due to non-cooperation.

If IV-D notifies you that a caretaker who was removed from coverage for non-cooperation has now cooperated, reinstate MA back to the 1st of the month of cooperation. There is no minimum sanction period.

EXAMPLE:

Rose receives MA for herself and 2 children. On February 10 the child support officer notifies the financial worker that Rose has failed to cooperate in obtaining medical support. There is no good cause claim. Rose is removed from MA effective March 1. On March 15, the child support officer notifies the financial worker that Rose has cooperated. Reinstate MA effective March 1.

Some parents who do not live with a child or whose income and assets are not counted toward the child's eligibility are liable for parental fees for MA. See §0906.13.09 (Parental Fees).

See §0906.13.03 (Medical Support Referrals) for additional information.

GAMC:

No provisions.

MEDICAL SUPPORT: WHEN TO REFER 0906.13.03

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

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

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

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

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

< The child was born when the parents were married

OR

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

AND at least one of the following conditions exist:

< There is no court order.

< A court order for medical support health insurance exists, but the non-custodial parent is not meeting the obligation.

< An existing court order does not include a provision for medical support or indicates that medical support has been reserved.

< There are court-ordered medical support cash payments, whether or not the non-custodial parent is currently making the payments.

< The caretaker of a child enrolled in MA or MinnesotaCare notifies you that the non-custodial parent is no longer complying with the medical support order. When a caretaker notifies you of a change in circumstances that requires a referral, take action within 2 working days after you learn of the change. Require the caretaker to complete referral forms. Send the forms to IV-D within 2 working days after you receive them from the client.

< The applicant requests child support services.

EXAMPLE:

Maia applies for MA for her 2 children, Seng and Lou. She is not requesting MA or MinnesotaCare for herself. She is separated from her husband, who is Lou's father. There is no court order. She was not married to Seng's father and there is no court order or ROP establishing paternity. Make a IV-D referral for Lou because her parents were married when she was born and there is no court order. Do not make a referral for Seng because paternity has not been established and Maia is not receiving MA or MinnesotaCare for herself.

EXAMPLE:

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

EXAMPLE:

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

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

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

< There is no ROP or court order.

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

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

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

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

EXAMPLE:

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

EXAMPLE:

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

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

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

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

-Determine if there is a non-custodial parent.

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

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

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

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

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

MinnesotaCare:

No provisions.

MA:

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

The following groups are not eligible for MA-EPD:

< People age 65 and older.

< People under age 16.

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

< SSI recipients.

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

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

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

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

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

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

< QI. See §0907.21.09.09 (Medicare Supplement Programs: QI). QI and MA-EPD may overlap only when a QI enrollee requests retroactive coverage for MA-EPD. If MA-EPD eligibility will continue, close QI for the first month for which you can give 10-day notice.

< GAMC.

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

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

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

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

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

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

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

< Are certified disabled by SSA or SMRT or who have been certified by the county case manager as eligible to receive services through the MR/RC waiver. See §0907.23.05 (MA Waiver Programs: MR/RC). People who are in non-pay status for RSDI continue to be certified disabled by SSA during the period of non-pay status. Do not refer these people to SMRT. Refer people whose SSI, RSDI, 1619(A) or 1619 (b) benefits are terminated, and

people with no current disability certification from either SSA or SMRT. For MA-EPD only, SMRT will determine disability without regard to the person's earnings level. See §0906.15 (Disability Determinations).

People who are eligible for Medicare Part B must enroll as a condition of MA-EPD eligibility, regardless of their income level and the amount of the Part B premium. Approve MA-EPD for Part B eligibles who failed to enroll. Require them to enroll during the next general enrollment period (January-March of each year) as a condition of continued eligibility. Reimburse Part B premiums for MA-EPD enrollees with incomes no greater than 200% FPG who are not eligible for QMB or SLMB. See §0910.05.05 (Medicare Premium Payments).

< Receive earned income from employment or self-employment. See §0907.21.07.06 (MA-EPD: Employment Definition) for a definition of earned income for MA-EPD.

< Have countable assets equal to or less than $20,000, excluding retirement accounts and medical expense accounts. Exclude spousal assets, including the spouse's share of jointly held assets. Follow all other Method B asset exclusions. See §0909.11 (Excluded Assets) and §0909.11.01 (Additional Excluded Assets for Method A/B) for more information. Follow other asset policies in §0909 (Assets), including verification, availability, asset reduction, and treatment of specific types of assets.

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

< Pay required premiums and unearned income obligations.

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

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

People may be eligible for MA-EPD concurrently with QMB and SLMB. To be eligible for QMB or SLMB, MA-EPD enrollees must meet all the eligibility requirements of those programs, including deeming of spousal income and assets. See §0907.21.09.03 (Medicare Supplement Programs: QMB) and §0907.21.09.05 (Medicare Supplement Programs: SLMB).

MinnesotaCare:

No provisions.

MA:

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

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

-Wages, including salaries, commissions, tips, bonuses, vacation pay, sick pay, and severance pay (if based on accrued leave time), if Social Security and Medicare taxes are withheld.
-Payments for work performed in a sheltered workshop or work activities center. Social Security and Medicare taxes must be withheld unless the workshop or center has an exemption from the IRS.
-Earnings from self-employment
-Royalties earned in connection with publication of a person's work
-Honoraria or stipends received for services rendered.

The enrollee must receive wages, payments from a sheltered workshop or work activities center, royalties, honoraria or stipends, or must engage in self-employment activities each month, unless:

-The enrollee changes jobs and receives no pay checks for 1 month because of different pay periods in each job
OR
-The enrollee is on a temporary medical leave. Allow up to 4 calendar months' leave from work without earned income. Require a physician's statement to verify the need for medical leave. If the physician's statement indicates the enrollee is expected to be unable to work for more than 4 calendar months, send 10-day notice to terminate MA-EPD eligibility effective the first day of the month following the first 4 full calendar months the enrollee was unable to work. Determine eligibility for MA under another basis before terminating MA-EPD.

EXAMPLE:

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

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

OR

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

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

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

EXAMPLE:

Joe normally operates his lawn service and landscaping business from May-November. He is eligible for MA-EPD during those months. He is not eligible for a 4-month extension for December through March since the business does not normally operate during those months. He closes the business in October due to unseasonable weather. Extend MA-EPD eligibility through November.

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

-Gratuitous money allowances
-Honoraria or stipends to the extent that these payments only reimburse expenses
-Payments for participation in a clinical trial
-Payments for the sale of blood or blood plasma
-Work study

Require verification of earnings and employment status at application and 6-month and annual renewals. Do not require monthly reports of income. MA-EPD enrollees must report changes in income and employment status within 10 days. Follow delayed verification procedures for applicants who meet delayed verification criteria. See §0904.13.05.01 (Delayed Verification - MA/GAMC).

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

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

WAGES

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

Social Security and Medicare taxes must be withheld from wages. If these taxes are not withheld, do not consider the payment as a wage for MA-EPD. These taxes must also be withheld from payment for services performed in a sheltered workshop or work activities center unless the workshop or center has an exemption from the Internal Revenue Service (IRS).

EXCEPTION:

The IRS does not require Social Security and Medicare tax withholding from wages of people who perform domestic work in another's home if earnings are under a given level ($1400 per year in tax year 2003). If an MA-EPD applicant does domestic work in another's home, verify with the employer whether Social Security and Medicare taxes must be withheld from the employee's wages. If the wages are below the required withholding level, consider the person to be employed if the work otherwise meets the definition of employment.

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

SELF-EMPLOYMENT

< Federal tax forms if the person was required to file Federal income taxes for the previous year. For 1999, people with net earnings of $400 or more were required to file. To be acceptable as verification of self-employment status for MA-EPD, tax forms must show evidence of self-employment earnings (such as entries for net self-employment earnings or loss on the 1040, Schedule C or Schedule F.)

< Business records for people who were not required to file taxes the previous or have not been in business long enough to file a tax return. Advise the person to maintain records and to submit a copy of the federal tax return when it becomes available.

See §0911.09.03 (Self-Employment Income) for more information on verifying and determining net income from self-employment. Count seasonal self-employment income only in the months in which it is received. This is an exception to the policy of annualizing seasonal self-employment for regular MA in §0911.09.09 (Seasonal Income).

ROYALTIES, HONORARIA AND STIPENDS

If royalties, honoraria or stipends are the person's only source of earned income, payments must be received each month to qualify for MA-EPD. Accept the following forms of documentation:

< Tax forms for the previous year showing evidence of royalties, honoraria or stipends, such as entries on Form 1040, Schedule C, Schedule SE or Form 1099-Misc.

< If the person was not required to file tax forms for the previous year, verify if the person received earned income by examining documents showing the nature and amount of payments, the date received, and the frequency of payments.

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

GAMC:
No provisions.

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

The SIS for 1-1-04 through 12-31-04 is $1,692 for all EW applicants or enrollees, regardless of marital status or household size. The SIS for 1-1-03 through 12-31-03 is $1,656. The maintenance needs allowance for 7-1-03 through 6-30-04 is $752 regardless of marital status or household size. Treat each person as a household of 1. The maintenance needs allowance for 7-1-02 through 6-30-03 is $741.

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

People with income equal to or less than the SIS but greater than 120% FPG for a household size of 1 may choose to receive services through Alternative Care (AC) rather than through SIS EW if they meet the eligibility requirements for both programs. See §0918.05 (Alternative Care - AC). However, people in this category who choose AC are NOT eligible for MA with a spenddown, with one exception as described in §0913.13.07 (Relationship Between EW and AC).

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

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

For more information on community spenddowns see

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

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

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

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

< The LTC spouse has had a LTCC screening.
AND
< The LTC spouse requires a nursing facility level of care.
AND
< Home care services began prior to the LTCC date and are anticipated to continue for at least 30 consecutive days after the LTCC date.
OR
< Home care services which are anticipated to last for at least 30 consecutive days will begin within 90 days of the LTCC date.

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

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

GAMC:

No provisions.

MinnesotaCare:

Do not require verification of any asset at any time. Take the following steps to determine if non-exempt adults are within the applicable asset limit at application and renewal.

1. If the value of all assets declared on the asset page is less than the applicable limit, the person meets the asset requirement. Do not request any further information.

   If the asset information is incomplete, attempt to contact the applicant or enrollee by telephone. If you are unable to contact the person by telephone, mail a copy of the asset page and/or a copy of the self-employment asset question with a written request for the applicant/enrollee to complete the information.

2. If the value of all assets exceeds the applicable limit, deduct the value of excluded assets. See §0909.11 (Excluded Assets). If the result is less than the applicable asset limit, the person meets the asset requirement.

   EXAMPLE:

   Joan and Henry apply for MinnesotaCare for themselves and their 2 children. They are both over 21. Joan is not pregnant. On the asset page they list assets totaling $29,000, including one vehicle worth $5,000 and an IRA worth $6,000. Henry is employed, so both of these assets are excluded. Total countable assets are $18,000. Joan and Henry meet the asset requirement. Do not request any further information.

3. If the listed value of all non-excluded assets exceeds the applicable limit, contact the household to ensure assets were assessed correctly. Ask if there are encumbrances on any of the assets that were not deducted from the reported total. Subtract any encumbrances from the fair market value to determine the net value. Use the amount of encumbrances reported by the applicant/enrollee. Do not require verification. If the result is less than the applicable asset limit, the person meets the asset requirement.

   If the applicant/enrollee requests a further examination of assets, allow them to submit additional information and/or complete the Detail of Assets Form (DHS 3499A).

EXAMPLE:

Rolf and Joyce apply for MinnesotaCare for themselves and their 2 children. The children have no asset limit. They list assets totaling $29,000 on the HCAPP, including 3 vehicles valued at $6,000, $7,000 and $8,000. The application shows that Joyce is employed. After excluding the vehicle valued at $8,000, assets remain over the limit. The worker contacts the household and learns that Rolf is not currently employed or seeking employment. The other 2 vehicles cannot be excluded. However, the household reports they owe $5,000 on the 1st car and did not subtract this from the total value of their assets. Deducting the full value of the $8,000 car and counting only the $1,000 equity value of the $6,000 car reduces countable assets to $16,000. Rolf and Joyce are within the $20,000 asset limit.

4. If the net value of countable assets exceeds the applicable asset limit, deny or terminate the person's MinnesotaCare.

EXAMPLE:

Susan, a 35-year-old single adult, applies for MinnesotaCare for herself. She is not pregnant. On the asset page she lists total assets of $28,000, including one vehicle worth $8,000. Susan is employed so the vehicle is excluded. The worker contacts Susan to see if any other assets can be excluded or if there are any encumbrances. Her remaining assets consist of a checking account with a balance of $500 and a money market account valued at $19,500. Countable assets of $20,000 exceed the $10,000 asset limit. Susan is not eligible for MinnesotaCare.

MA Method A:

Follow MinnesotaCare to determine the countable value of assets. Verify liquid assets at application, 6-month income/asset renewal, and annual renewal if total assets are within $300 of the asset limit.

EXAMPLE:

Cory and Kari apply for MA for themselves and their 2 children. All household members use Method A. Cory and Kari have an asset limit of $20,000. They claim total countable assets of $19,900 on the application. Send the Assets Detail Page (DHS 3499A) to determine the type and value of each asset. Verify liquid assets since the total is within $300 of the limit.

Types of verifications for liquid assets include:

< Bank statements.

< Bank verification forms.

< Copies of bonds. You may need to consult a savings bond value book to determine the current value.

< Stock ownership statements. If the statement does not show the current value, consult a newspaper or other current stock listing to determine the value.

< Copies of life insurance policies or statements from insurance companies showing current cash surrender value.

< Other documents verifying ownership and value.

Do not verify non-liquid assets. Assist the applicant or enrollee in providing enough information to determine the equity value of a non-excluded asset.

EXAMPLE:

Mortimer and Matilda apply for MA for themselves and their children. They claim 2 vehicles. One is excluded because it is used for employment. The equity value of the 2nd vehicle must be counted toward the asset limit. Mortimer and Matilda are unsure of the vehicle's value. Ask for the vehicle's year, make, and model. Use this information to determine the vehicle's value in the NADA book.

MA Method B:

Use the information reported on the HCAPP to determine countable assets. Both the HCAPP (DHS 3417) and HCAPP for People Who Have a Disability and Seniors age 65 and Older (DHS 3531) ask about all types of assets that may affect eligibility. The DHS 3531 asks more specific questions and requests verifications for asset types more likely to be held by the elderly and disabled population. Follow up with the household if the application does not contain sufficient information to determine countable asset value.

Verify the following assets for adults:

< Liquid assets if total countable assets reported on the HCAPP are within $300 of the asset limit. See Method A for details on when and how to verify liquid assets.

< The following assets to ensure they are assessed correctly according to §0909.17.03 (Determining the Burial Fund Exclusion) and §0909.17.05 (Burial Space Items). Verify these items for all adult applicants who report them regardless of whether total reported assets are within $300 of the asset limit:

-Life insurance face value and cash surrender value
-The value of all revocable and irrevocable burial agreements.
-The value of insurance- and annuity-funded burial agreements.

< Trusts and annuities reported by adults, regardless of whether total reported assets are within $300 of the asset limit.

< All assets included in an asset assessment. Also verify all assets for LTC clients with community spouses at the time of application and the 1st annual renewal. See §0904.13 (Verification), §0904.13.01 (Verification - MA/GAMC), §0905.05 (Annual Renewal--Eligibility), and §0909.25 (Spousal Asset Assessments).

Except for assets included in an asset assessment or for LTC clients with community spouses, do not routinely require verification of non-liquid assets such as non-excluded vehicles and real property not used as a home. Follow Method A policy in assisting clients to provide sufficient information to determine the equity value of non-liquid assets. Request written verification if the value or ownership of an asset is unclear or if total countable assets exceed the asset limit and the applicant/ enrollee disputes the market value of an asset. For vehicles, require an estimate of value from a licensed dealer. For real property, require an estimate from a licensed appraiser. See §0909.13.03 (Real Property: Non-Homestead).

GAMC :

Follow MA Method A verification procedures for GAMC and GHO, except do not verify assets at the 6-month renewal.

MinnesotaCare:

No provisions.

MA:

The following provisions apply to married people when 1 spouse:

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

OR

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

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

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

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

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

OR

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

EXAMPLE:

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

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

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

< Admission to a medical hospital.

OR

< Admission to a nursing facility (NF).

OR

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

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

EXAMPLE:

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

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

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

Estimate the community spouse asset allowance as follows:

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

   < The homestead.

   < Personal and household goods.

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

   < Capital assets necessary to operate a trade or business.

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

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

2. Divide the total countable assets in half.

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

4. If half of the total countable assets are:

   < Less than the minimum asset allowance, the estimated allowance is the minimum asset allowance.

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

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

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

FOR TRANSFERS MADE BEFORE 8-11-93:

When a person improperly transfers assets in different months, calculate ineligibility periods individually for each transfer. The ineligibility period begins in the month of transfer. The length of ineligibility for EACH transfer is the lesser of 30 months or the number of months resulting from the calculation in §0909.27.11 (Improper Transfer Ineligibility). If separate periods of ineligibility overlap, continue to impose each penalty individually as calculated.

When multiple asset transfers are made in the same month, combine the value of the assets and apply the penalty calculation to the total.

See §0909.27.11.03 (Transfers Before 8-11-93).

FOR TRANSFERS MADE ON OR AFTER 8-11-93:

Add together the uncompensated values of transfers made in more than 1 month during or after the lookback period to determine the length of the penalty period when the transfers would result in overlapping penalty periods if calculated separately. The penalty period begins to run on the 1st day of the month after the month in which the 1st transfer occurred. Depending on when the transfers occurred, follow the steps in §0909.27.11.05 (Transfers 8-11-93 Through 8-31-94), §0909.27.11.07 (Transfers 9-1-94 Through 4-13-96) and §0909.27.11.09 (Transfers After 4-13-96).

GAMC:

Combine individual transfers made in the same month.

Determine separate ineligibility periods if transfers occur in different months. If those periods overlap, the ineligibility period is the sum of the periods.

There are no transfer provisions for GHO.

MinnesotaCare:

Except for Group 1 children, Medicare eligibility may be a bar to MinnesotaCare. See §0910.03 (Types of Other Coverage). If MinnesotaCare enrollees appear to be eligible for Medicare Part A at no cost, use the Medicare Application Referral Letter (DHS 3444) to refer them to the Minnesota regional Social Security Office. See §0911.03.03 (Applying for Other Benefits).

MinnesotaCare enrollees are not eligible for the Buy-In.

MA/GAMC:

The Medicare program has 2 components. Part A covers hospital, hospice, and some home health care. Part B covers doctor services, x-rays, laboratory, and medical supplies.

The following people are eligible for Medicare Part A at no cost:

< People age 65 and over who are eligible for or receiving RSDI or Railroad Retirement benefits.

< Other people age 65 and over who had Medicare-covered government employment.

< People who have been receiving RSDI or Railroad Retirement benefits based on a disability for more than 24 months.

< People receiving continuous dialysis due to permanent kidney failure or who have had kidney transplants.

Because there is no cost to the enrollee, it is not necessary to review Part A for cost effectiveness for these groups.

People who are age 65 and over who receive only SSI may be eligible for Part A with a monthly premium. People who do not receive SSI but are eligible as QWD's are also eligible with a premium. DHS pays the premium directly to the SSA through the automated Buy-In process. People must be active on QMB or QWD to have Part A premiums paid through the Buy-In. See §0907.21.09.03 (Medicare Supplement Programs: QMB) and §0907.21.09.07 (Medicare Supplement Programs: QWD). For systems instructions, see TEMP Manual TE02.07.327 (Medicare Part A/B and the Buy-In (Part 1). Also see MMIS User Manual II-38 (Buy-In).

If a person who is not eligible for QMB or QWD receives Part A with a premium, determine if the premium is cost effective. If cost effective, send the Medicare Part A payment directly to:

HCFA Medicare Insurance
Medicare Premium Collection Center
PO Box 371384
Pittsburgh, PA 15250-7384

People who are enrolled in Part A can enroll in Part B for a monthly premium. Part B premiums are cost effective unless the client has increased premiums due to late enrollment, or the client participates in a group coverage which would terminate with Medicare enrollment. In these instances, refer the case to Benefit Recovery for review of cost effectiveness. See §0910.05 (Current Health Insurance). In all other cases, refer people who are eligible for Part B but who are not enrolled to the Social Security Administration. They must enroll in Part B as a condition of eligibility for MA.

DHS pays Part B premiums through the Buy-In for people who:

< Are enrolled in QMB, SLMB, or QI-1. See §0907.21.09 (MA Basis: Medicare Supplement Programs).

OR

< Receive MA with SSI, MSA or GRH.

OR

< Receive MA with Title IV-E adoption assistance, Title IV-E foster care, have 1619(a) or (b) status, or receive MA and MFIP.

People must be enrolled in Medicare before payments can begin through the Buy-In. Use the Medicare Buy-In Referral Letter (DHS 3439) to refer people who are eligible for the Buy-In to SSA if necessary outside the open enrollment period.

There is no advantage to QMB enrollment for people who have MA without a spenddown, are eligible for Part A with no premium and are eligible for the Part B buy-in, such as 1619(a) and (b) enrollees. Enroll SSI-only recipients in QMB to allow payment of the Part A premium.

For instructions on adding (accreting) or removing (deleting) people from Buy-In eligibility, see MMIS User Manual II-38 (Buy-In) and TEMP Manual TE02.07.326 (Enrollment in Medicare Part A and Part B) and TE02.07.327 (Medicare Part A/B and the Buy-In (Part 1).

People who become eligible for the Part B Buy-In may receive reimbursement for Part B premiums they have paid. See §0911.09.15.05 (Lump Sum RSDI and SSI Payments) for information on how to treat these payments.

MA-EPD enrollees must apply for and accept Part B if they are eligible for it. See §0907.21.07.05 (MA for Employed Persons with Disabilities MA-EPD). Reimburse Part B premiums retroactive to the date of MA-EPD eligibility for MA-EPD enrollees who

< have incomes no greater than 200% FPG. Do not count spousal income in this determination.

AND

< are not eligible for QMB or SLMB under the rules of those programs, including deeming of spousal income and assets.

EXAMPLE:

Steve receives MA-EPD and Medicare Part B at the standard premium rate. His income is approximately 115% of FPG for a household of 2. His wife, who does not receive MA-EPD, also has income of approximately 115% of FPG for a household of 2. Steve is not eligible for QMB or SLMB because household income exceeds the limits for those programs. Since Steve's income alone is less than 200% FPG, reimburse his Part B premium.

Refer cases in which the enrollee has an increased Part B premium due to late enrollment to BRS for a determination of cost-effectiveness ONLY if the EPD enrollee's income is no greater than 200% FPG. Reimburse the premium if BRS determines it is cost-effective. Do not refer to BRS or reimburse premiums if income is over 200% FPG.

Also reimburse Part B premiums for people on program IM who would be eligible for QMB or SLMB but for their IMD residence. See §0907.27 (MA/GAMC Basis: IMD Residents).

See MMIS User Manual II-37 (Medicare) for instructions on billing DHS for county-reimbursed Medicare payments.

MinnesotaCare:

People who have current access to employer subsidized insurance (ESI) coverage are ineligible for MinnesotaCare. ESI is coverage for which an employer pays at least 50% of the cost of coverage. See §0910.11.05 (Determining the Employer Contribution).

EXCEPTION:

Children under 21 with Group 1 status may have access to ESI and are not required to accept it, regardless of whether it is considered underinsured. If they have current ESI coverage, it must be considered underinsured to be eligible for MinnesotaCare.

If ESI becomes available to current MinnesotaCare children with Group 2 status or adults, they may not refuse the coverage to remain eligible for MinnesotaCare. They are ineligible regardless of whether they actually accept the ESI. See §0910.11.06 (Open Enrollment).

Applicants and enrollees whose employers offer a choice of either

< a higher salary with no ESI (pay in lieu of ESI)

OR

< a lower salary with ESI

will be considered to have access to ESI even if they choose the higher salary with no ESI. This applies only when the employee is offered a choice of compensation for the exact same job. Do not consider an employee to have access to ESI if their choice of compensation also dictates their work schedule or number of hours worked, flex time, job title, etc.

EXAMPLE:

Angie's employer offers her the choice of two compensation plans. Under the first plan, employees are paid $8.00 per hour. They can choose to be covered by the employer's insurance plan at a cost of $195 per month. The employer will not contribute to the cost of the insurance. Under the second plan, employees are paid $7.05 per hour. They must contribute $25.00 per month for the employer's insurance plan, and the employer will pay $170 per month towards the insurance. Angie chooses the first plan, but does not purchase the insurance. Angie is ineligible for MinnesotaCare because she has access to ESI.

EXAMPLE

Katie's new employer offers her a choice of working the day shift with ESI coverage and a lower hourly wage, or working the night shift with fewer hours per week, no health insurance, and a higher hourly wage. At initial application, Katie works the night shift position and cannot get insurance through her employer. She does not have access to ESI.

When determining whether people have access to ESI, do not consider the distance an individual must travel to see a provider enrolled in the ESI plan.

MA/GAMC:

No provisions.

VERIFICATION OF ESI 0910.11.01

MinnesotaCare:

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

Verify access to ESI only when:

< The information about access to ESI provided by the applicant/enrollee is incomplete and the applicant/enrollee is unable to provide the information.

OR

< The information about access to ESI is inconsistent with other information known to the agency and the applicant/enrollee is unable to explain the inconsistency.

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

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

OR

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

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

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

EXAMPLE:

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

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

EXAMPLE:

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

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

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

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

MA/GAMC:

No provisions.

ACCESS TO ESI IN PAST 18 MONTHS 0910.11.03

MinnesotaCare:

People who have had access to employer subsidized insurance (ESI) through a current employer in the preceding 18 months are ineligible for MinnesotaCare. ESI is coverage for which an employer pays at least 50% of the cost of coverage. See §0910.11.05 (Determining the Employer Contribution).

EXCEPTION:

Children under age 21 with Group 1 status may have had access to ESI through a current employer in the preceding 18 months and remain eligible for MinnesotaCare.

At application, renewal, or on receipt of new information, deny or cancel coverage for adults and Group 2 children who have had access to ESI through a current employer within the past 18 months. Do not apply this restriction to Group 1 children. See §0910.11 (Employer Subsidized Insurance).

For more information on this insurance barrier and open enrollment, see §0910.11.06 (Open Enrollment).

Some employers only offer ESI to employees who work a certain number of hours. Full-time employees with access to ESI who lose access to ESI when they voluntarily reduce their hours or their employer reduces their hours, are ineligible for MinnesotaCare because they had access to ESI through a current employer in the past 18 months. However, people who are initially hired at part-time hours that do not make them eligible for ESI would not be ineligible for MinnesotaCare due to this insurance barrier.

EXAMPLE:

Lonnie works 40 hours a week at Acme Grocery. Acme Grocery offers ESI to all employees who work 38 hours or more. Lonnie decides to go to school part-time, so he reduces his hours at Acme Grocery to 20 hours a week. He is no longer eligible for ESI. Lonnie is ineligible for MinnesotaCare because he had access to ESI through a current employer in the past 18 months.

EXAMPLE:

Jaime works full-time for an employer who provides ESI to all its full-time employees. Due to a down-turn in the economy, Jaime's employer reduces Jaime's hours, making him ineligible for ESI. Jaime is ineligible for MinnesotaCare because he had access to ESI through a current employer in the past 18 months.

EXAMPLE: |

Sonya is a full-time college student who accepts a part-time position with an employer that provides ESI to full-time employees, but not to part-time employees. Sonya was never a full-time employee and thus never had access to ESI in the past 18 months. She is eligible for MinnesotaCare. |

M. S. 256L.07 subd. 2

MA/GAMC:

The availability of ESI does not affect people's eligibility for MA and GAMC. However, people must enroll in cost-effective coverage as a condition of eligibility for adults. See §0910.05.01 (Current Health Insurance--MA/GAMC). HIPAA allows current and former MA/GAMC enrollees to enroll in an employer's plan outside of the open enrollment period under the same conditions as MinnesotaCare. People whose MA or GAMC ends will receive a COCC automatically 2 months after termination. See §0916.23 (Certificates of Creditable Coverage). If the former enrollee needs the COCC sooner, request one following your agency's procedures.

EMPLOYER TERMINATES ESI 0910.11.04

MinnesotaCare:

People who lost coverage or access to employer subsidized insurance (ESI) because an employer chose to terminate health coverage as an employee benefit in any of the 18 months prior to the month of application are ineligible for MinnesotaCare. ESI is coverage for which an employer pays at least 50% of the cost of coverage. See §0910.11.05 (Determining the Employer Contribution).

EXCEPTION:

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

EXCEPTION:

Children with Group 1 status may have had an employer terminate health coverage as an employee benefit in the past 18 months and become or remain eligible for MinnesotaCare.

EXAMPLE:

Pascal's employer provides ESI to its employees and their dependents. In October 2003, Pascal's employer stops offering ESI as an employee benefit. Pascal and his son apply for MinnesotaCare. Pascal is ineligible for MinnesotaCare until March 2005, 18 months after the employer dropped ESI as an employee benefit. His son is a Group 1 child and thus is not subject to the insurance barrier.

MinnesotaCare:

Employers who offer health insurance usually allow workers to sign up for the health insurance when they are first hired. Employers may allow employees to sign up for health insurance during open enrollment. Open enrollment means a time each year when employees and dependents can join the employer's health benefit plan. Not all employers offer an open enrollment period.

Applicants and enrollees who have access to ESI during an employer's open enrollment period have current access to ESI. Applicants and enrollees who had access to ESI during an employer's open enrollment period and refused to accept the ESI at that time have had access to ESI in the past. If they refused the ESI during the past 18 months they are ineligible for MinnesotaCare.

EXAMPLE:

Tim's employer offers ESI to Tim, his wife Nancy, and their 2 children. They can sign up for the insurance annually in April. They apply for MinnesotaCare in July, two months after Tim's open enrollment period ended. Tim and Nancy are ineligible for MinnesotaCare because a current employer offered ESI within the past 18 months. The children are eligible if they have Group 1 status.

EXAMPLE:

Janice's employer offers her health insurance when she is first hired. Janice declines the coverage. Janice's employer does not offer open enrollment. Janice applies for MinnesotaCare. She is ineligible for MinnesotaCare for 18-months from the day her employer offered her health insurance.

Some employers offer a special enrollment period. During a special enrollment period an employee has an opportunity to enroll in a group health plan without having to wait for an open enrollment period. A group health plan must provide individuals with an opportunity for special enrollment if they:

< declined coverage under the plan because they had alternative coverage but since have lost that alternative coverage
OR
< have new dependents through marriage, birth or adoption.

Special enrollment may be available to people who declined ESI when it was first offered because they had MinnesotaCare and whose MinnesotaCare coverage later ends. If people are terminated from MinnesotaCare because a current employer offered ESI within the past 18 months, advise them to ask if the employer offers special enrollment. Also advise them to request enrollment under the employer's plan within 30 days of

MinnesotaCare termination to avoid a break in coverage. If there is a break in coverage, the person will not get credit for MinnesotaCare coverage to reduce a pre-existing condition exclusion.

EXAMPLE:

Gary and his family are enrolled in MinnesotaCare. They have Group 2 status. At the time of the annual renewal in July, the enrollment representative discovers that Gary had an opportunity to enroll the entire family in ESI at the time of his employer's annual open enrollment 6 months earlier. Gary chose not to accept the coverage because he had MinnesotaCare. Terminate MinnesotaCare for the first month for which you can give 10-day notice. Advise Gary to ask his employer if he can enroll in ESI without waiting for the next open enrollment period since he has lost his MinnesotaCare coverage. The family remains ineligible for MinnesotaCare for 18 months from the date Gary could have enrolled in the ESI. The 18-month period starts over if Gary again has an opportunity to enroll in the ESI and refuses.

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

MA/GAMC:

No provisions.

MinnesotaCare:

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

MA/GAMC:

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

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

Transportation expenses include:

< Gas and oil costs.

< Parking fees.

< Car insurance.

< Car repairs.

< Interest payments on a car loan.

METHOD A:

Allow the IRS mileage rate (also known as the flat rate) for self-employment transportation. Effective January 1, 2004, the rate is 37.5 cents per mile. The rate for 2003 was 36 cents per mile. Use the flat rate even if itemized self-employment transportation costs exceed the flat rate amount.

METHOD B:

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

MinnesotaCare:

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

MA and GAMC:

If a client receives payments for lodging, meals, or related services from people living in the client's home, the income is roomer/boarder income. Households with roomer/boarder income are self-employed. Count the income as earned income.

< A roomer lives with the household and pays for lodging only.

< A boarder eats with the household and pays for meals only.

< A roomer and boarder lives AND eats with the household and pays for lodging AND meals.

Roomer/boarder income is different from rental property or from shared living expense income. For information on rental property income, see §0911.09.03.13 (Rental Income). For information on shared living expense income, see §0911.05 (Excluded Income).

METHOD A:

Allow a flat rate deduction for each roomer/boarder:

< Roomer: $71 per month.
< Boarder: $141 per month. |
< Roomer and boarder: $212 per month. |

Subtract the flat rate deduction for each roomer/boarder from total roomer/boarder income to get gross self-employment income.

METHOD B:

Allow the following expenses for a roomer/boarder:

< Roomer: The verified expense of providing the room.
< Boarder: The verified expense of providing the food.
< Roomer and boarder: The verified expense of providing the room and board

.

Deduct expenses, up to the amount of the income, to get gross self-employment income. To determine the expense of providing a room, prorate the total shelter expenses based on the ratio of the number of rooms for rent to the total rooms in the house. Do not include bathrooms. Do not include attics or basements unless they are converted to living spaces.

MinnesotaCare:

No provisions.

MA:

Method A:

No provisions.

Method B:

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

< Is under age 22.

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

< Is expecting to attend school at least 1 month in the next calendar quarter, or did attend school at least 1 month of the current calendar quarter.

Limit the disregard to a maximum of $1,370 per month up to a maximum of $5,520 in calendar year 2004 ($1,340 per month up to a maximum of $5,410 in calendar year 2003). Apply the disregard only to the blind or disabled student's earned income. Do not apply it to the income of other people whose income is deemed to the student.

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

GAMC:

No provisions.

PICKLE DISREGARD 0912.05.23

MinnesotaCare:

No provisions.

MA:

METHOD A:

No provisions.

METHOD B:

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

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

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

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

EXAMPLE:

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

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

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

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

OR

< 7-1-82.

This is known as the Pickle threshold date.

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

Current Gross RSDI Amount		
1.021 (1-04 RSDI increase)	=	Benefit Before 1-04 COLA
1.014 (1-03 RSDI increase)	=	Benefit Before 1-03 COLA
Current Gross RSDI Amount 1.026 (1-02 RSDI increase)	=	Benefit Before 1-02 COLA
Current Gross RSDI Amount 1.035 (1-01 RSDI increase)	=	Benefit Before 1-01 COLA
Current Gross RSDI Amount 1.024 (1-00 RSDI increase)	=	Benefit Before 1-00 COLA

Benefit before 1-00 COLA 1.013 (1-99 RSDI increase)	=	Benefit Before 1-99 COLA
Benefit before 1-99 COLA 1.021 (1-98 RSDI increase)	=	Benefit Before 1-98 COLA
Benefit before 1-98 COLA 1.029 (1-97 RSDI increase)	=	Benefit before 1-97 COLA
Benefit before 1-97 COLA 1.026 (1-96 RSDI increase)	=	Benefit before 1-96 COLA
Benefit before 1-96 COLA 1.028 (1-95 RSDI increase)	=	Benefit before 1-95 COLA
Benefit before 1-95 COLA 1.026 (1-94 RSDI increase)	=	Benefit before 1-94 COLA
Benefit before 1-94 COLA 1.030 (1-93 RSDI increase)	=	Benefit before 1-93 COLA
Benefit before 1-93 COLA 1.037 (1-92 RSDI increase)	=	Benefit before 1-92 COLA
Benefit before 1-92 COLA 1.054 (1-91 RSDI increase)	=	Benefit before 1-91 COLA
Benefit before 1-91 COLA 1.047 (1-90 RSDI increase)	=	Benefit before 1-90 COLA
Benefit before1-90 COLA 1.04 (1-89 RSDI increase)	=	Benefit before 1-89 COLA
Benefit before 1-89 COLA 1.042 (1-88 RSDI increase)	=	Benefit before 1-88 COLA
Benefit before 1-88 COLA 1.013 (1-87 RSDI increase)	=	Benefit before 1-87 COLA
Benefit before 1-87 COLA 1.031 (1-86 RSDI increase)	=	Benefit before 1-86 COLA

Benefit before 1-86 COLA 1.035 (1-85 RSDI increase)	=	Benefit before 1-85 COLA
Benefit before 1-85 COLA 1.035 (1-84 RSDI increase)	=	Benefit before 1-84 COLA
Benefit before 1-84 COLA 1.074 (7-82 RSDI increase)	=	Benefit before 7-82 COLA

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

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

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

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

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

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

EXAMPLE:

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

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

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

   < Rent or mortgage payments.

   < Real estate taxes.

   < Homeowner’s or renter’s insurance.

   < Required maintenance charges for a cooperative or condominium.

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

3. Subtract $455 beginning 7-1-03 ($448 from 7-1-02 through 6-30-03) from the total of expenses in step 3. The result is the excess shelter allowance.

4. Add $1,515 beginning 7-1-03 ($1,493 from 7-1-02 through 6-30-03) to the excess shelter allowance. The result, up to a limit of $2,319 ($2,267 from 1-1-03 through 12-31-03), is the maximum monthly income allowance to the community spouse.

   If there is a court order for support in excess of $2,319 ($2,267 from 1-1-03 through 12-31-03), use the court-ordered figure as the maximum amount.

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

EXAMPLE:

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

Determine Leo's maximum allocation as follows:

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

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

3. Subtract $455 from $687. The result, $232, is the excess shelter amount.

4. Add $232 to $1,515. The result, $1,747, is the maximum monthly allocation amount.

5. Subtract Leo's monthly income of $1,050 from $1,747. The result, $697, is the actual allocation amount. Allow this amount in Norma's LTC budget. See §0913.13 (Long Term Care Spenddown Calculation).

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

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

< Meet a spenddown using the allocated income.

OR

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

An LTC spenddown or an LTC/Medical spenddown may include a clothing and personal need allowance. For 2003, the allowance is $72 for all clients except certain veterans and surviving spouses of veterans. For 2004, the allowance is $74 for all clients except certain veterans and surviving spouses of veterans. Veterans who have no spouse or dependent children and surviving spouses of veterans with no dependent children, and who receive a monthly veterans pension of $90, have a personal need allowance of $90. See §0913.13 (Long Term Care Spenddown Calculation) and §0913.15 (Combination LTC/Medical Spenddown).

GAMC:

No provisions.

For information about spenddowns, see §0913.03 (Spenddowns--MA).

MinnesotaCare:

All MinnesotaCare enrollees must pay a premium to establish and maintain coverage. MMIS computes the premium amount based on the household size, income, and number of people covered. The MinnesotaCare program pays the rest of the enrollee's cost of coverage through the Health Care Access Fund.

Premiums are computed and billed on a monthly basis. Most enrollees make monthly payments. However, enrollees may choose to pay premiums in advance for up to 1 year.

Enrollees may pay premiums by check, money order, automatic withdrawal, payroll deduction, or through the tax refund premium payment plan. Enrollees also have the option of making check or credit card payments via the DHS web site. See §0913.02 (Premium Payment Options). DHS collects and posts all initial and ongoing payments regardless of the household's choice of enrollment site. If you receive a premium at the county agency in error, forward it to DHS-MinnesotaCare, attn. Cashier, PO Box 64834, St. Paul, MN 55164-0834. Return initial premium payments received with applications to the applicants. Inform applicants that they will receive a First Premium Notice if their applications are approved.

Once the initial payment is received and a case becomes active, monthly premiums are billed approximately 6 weeks before the first day of the coverage month and are due approximately 2 weeks before the first day of the coverage month. For example, MMIS sends October premium billings on August 15. The October premium is due by the September cutoff date (approximately September 15). If the premium has not been received by the September cutoff date, MMIS sends an overdue notice and a cancellation notice effective the end of the current month.

Except for pregnant women and children under 2, coverage is terminated unless the payment is received by noon on the last business day before the coverage month. For example, if the October premium payment has not been received by September 15, MMIS sends a cancellation notice. Coverage terminates September 30 unless the October payment is received by noon on the last business day of September. Households canceled only for nonpayment may be reinstated back to the date of cancellation if they pay all billed premiums by noon on the 20th day following cancellation. See §0915.11.05 (Fail to Pay Premium/Reinstatement). Households who are not reinstated must serve a 4-month penalty period unless they show good cause for nonpayment. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

Treat a dishonored payment as failure to pay the MinnesotaCare premium. This includes checks returned for insufficient funds and returned automatic bank withdrawals. Enrollees must replace dishonored payments by a guaranteed form of payment (cashier's check, money order or cash). If the household fails to make a guaranteed replacement payment, coverage will terminate and the household must serve a 4-month penalty period unless they show good cause for non-payment. See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

Require a guaranteed form of payment ONLY for dishonored payments. Do not require a guaranteed form of payment for any other current or future premiums owed. If an enrollee's premium payment check is returned for non-sufficient funds (NSF) or an automatic bank withdrawal has been returned, MMIS User Services will return the check or other bank documentation with a letter requiring a guaranteed form of payment and will send the enrollment representative a copy of the screen print. The MMIS User Services Help Desk also processes chargebacks of payments made via the DHS web site and notifies the enrollee and the worker. Document the returned payment in case notes.

EXAMPLE:

MinnesotaCare receives Joe's September premium payment on August 15. On August 29, MMIS User Services is notified that Joe's check was returned for NSF. MMIS User Services returns the check to Joe with the MS-0811/J. requesting guaranteed payment. MMIS will terminate Joe's coverage for nonpayment if he fails to replace the NSF check with a guaranteed form of payment and he will be subject to a 4-month penalty period. If Joe does replace the NSF check with a guaranteed form of payment, reinstate coverage.

Take action to change the premium amount:

< At the time of the annual renewal if the household's income or household size has changed. See §0905 (Reviews and Renewals) and §0915.07 (Change in Income).

< At any time the household reports a change in income that results in a lower premium amount. See §0915.07 (Change in Income).

< When the household size changes. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).

< When household member is removed from coverage.

- The income guidelines change because of a change in law or the annual update of the federal poverty guidelines.

MMIS will make mass changes resulting from a change in law on the new FPG guidelines automatically. In all other situations, the representative must enter the required information for MMIS to recalculate the premium.

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

MA:

See §0913.03 (Spenddowns--MA) for spenddown information.

People enrolled in MA for Employed Persons with Disabilities (MA-EPD) must pay monthly premiums. If they have unearned income, they must also pay an unearned income obligation. See §0913.01.03 (MA-EPD Premiums) and §0913.02 (Premium Payment Options).

Take action to change the premium amount:

- At the time of the 6-month review or annual recertification.
- When an enrollee reports decreased income and/or increased household size, resulting in a lower premium.
- When the income guidelines change because of a change in law, the annual increase in the FPG standards, or the annual COLA increase.

GAMC:

GAMC has no spenddown provisions. GHO enrollees have a copayment of the first $1,000 of inpatient hospital charges for each hospitalization.

MinnesotaCare:

No provisions.

MA:

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

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

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

   Unless both spouses are applying for or enrolled in MA-EPD, determine the household size as you would for any MA applicant or enrollee. See §0908.05 (Determining MA/GAMC Household Size). Count spouses and children in the household size even though spousal income is not deemed.

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

2. Enter all required information on MAXIS. MAXIS will calculate the premium on the EBUD panel. See TE09.13.05 (HCRW: Premiums for MA-EPD). The minimum monthly premium for all enrollees is $35. If MAXIS computes a premium of less than $35 based on the sliding fee scale, the premium amount will default to $35.

EXAMPLE:

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

EXAMPLE:

Shannon and Matt, a married couple, apply for MA-EPD. Shannon is self-employed as an in-home day care provider with net income of $625 per month. She receives RSDI of $800 per month based on disability. Matt has earned income of $3,000 per month and is certified disabled by SMRT. They

have joint assets of $25,000, or $12,500 each, which is within the $20,000 asset limit for each spouse.

MAXIS will determine eligibility and premium amount separately for each spouse, using each spouse's income and a household size of 1.

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

3. If the enrollee has unearned income, MAXIS will calculate an Unearned Income Obligation (UIO) of one-half of one percent of the unearned income. The UIO will be added to the monthly premium.

EXAMPLE:

Yvonne has a premium of $42 based on her earnings. Her gross unearned income is $800. Her UIO is $4 ($800 x .005 = $4) each month. This amount is added to her premium invoice.

County agencies are responsible for issuing initial premium notices and collecting the following premiums:

< Initial premiums for applicants, including the premium for each retroactive month requested and the application month. If the application is processed after the application month, also bill and collect the premium for all months through the processing month. If the application is processed on or after the 15th day of the month in which coverage is approved, collect the premium for the next month as well.

< Any overdue premiums for previous MA-EPD coverage.

< Initial and overdue premiums for MA-EPD enrollees who have been removed from the Special Recovery Unit (SRU) billing system. This includes former enrollees who are reapplying, enrollees removed from or not entered on the system in error, and enrollees closed and reopened in the same month

EXAMPLE:

Karen applies for MA-EPD on October 10 and does not request retroactive coverage. The worker determines she must pay a premium of $35 to qualify for MA-EPD. She also owes an overdue premium of $35 for coverage she had in July. The worker issues an Initial Premium Notice for the July and October premiums on October 12. Both premiums ($70) must be collected before MA-EPD can be approved for October.

EXAMPLE:

Mai applies for MA-EPD on October 5 and requests 3 months of retroactive coverage. The worker determine that Mai must pay a premium of $35 for each month to qualify for MA-EPD. The worker completes the Initial Premium Notice on October 20. Because the initial notice is created after the 15th, the notice includes premiums for July, August, September, October and November. October and November premiums must be collected before MA-EPD can be approved. The premium for each retroactive month must be collected before coverage is approved for that month.

After determining MA-EPD eligibility and premium amount, take the following steps:

1. Approve MAXIS and MMIS results if the applicant is present and pays the premium immediately. Otherwise, pend the results in MAXIS.:
2. Review the MA-EPD Overdue Report to determine if there are overdue premiums. This report prints at the county by the 20th day of each month.
3. Complete the Initial Premium Notice (DHS 3547). Mail or give the original notice to the applicant. Include a return envelope addressed to the county agency. Retain a copy in the case file.
4. Enter a MAXIS case note including the monthly premium amount, total amount of Initial Premium Notice, and date notice mailed or given to applicant. Set up a TIKL message for 30 days from the date the notice is mailed or given to the applicant.

Allow 30 days from the date of the Initial Premium Notice to pay the premium. Applicants must pay all current and overdue premiums before MA-EPD can be approved. Take the following actions if the premium is paid on or before the due date:

1. Enter a MAXIS case note with the amount paid and the month(s) covered. Document that E-mail was sent to MADE to initiate billing.
2. Approve eligibility results in MAXIS.

3. Send MAXIS E-mail to MADE with subject of MA-EPD Premium New/Changes. Include:
   -Enrollee Name
   -Case number
   -PMI
   -Billing Address
   -Representative Payee
   -Month/Amounts Paid
   -SRU Premium Billing Begin Date
   -Premium Amount
   -County and worker name, worker E-mail code, and comments if any
4. Approve eligibility results in MMIS.
5. Forward payment and Initial Premium Notice stub to DHS at
   DHS - MA-EPD
   Attn. Cashier
   P. O. Box 64836
   St. Paul, MN 55155-0836
   Include the following information with each premium:
   -Enrollee name
   -PMI number
   -Amount paid
   -Which month(s) the payment applies to

If the required premiums are not receive within 30 days of the initial notice, deny MA-EPD and determine MA eligibility under another basis. Add the following worker comments to the notice:

"You are denied Medical Assistance for Employed Persons with Disabilities (MA-EPD) because we did not receive your premium payment by the due date. You may claim "good cause" for late payment. This must be approved by the Department of Human Services (DHS). To claim "good cause", send a letter with your name, address, case number, and reason for late payment to:
MA-EPD Good Cause
444 Lafayette Road
St. Paul, MN 55155-3848"

Applicants must pay premiums for each retroactive month before coverage can be approved for those months.

SRU will issue ongoing premium notices and collect all ongoing MA-EPD premiums. SRU mails premium notices on the 4th day of each month, or the next business day if the 4th falls on a weekend or holiday. Premiums are due on the 15th day of the month prior to the month of coverage. Premium decreases due to changes reported during the 6-month budget period are effective with the next available billing cycle.

Review the MA-EPD Overdue Premiums Report between the 20th and cut-off the following month. Terminate MA-EPD with 10-day notice for enrollees who have failed to pay their premiums without good cause. Take the following steps when closing MA-EPD for non-payment:

1. Redetermine eligibility for MA for the following month.

   < If MA eligibility exists, approve MAXIS results and enter eligibility information in MMIS. Add the following worker comments to the approval notice:

   "Your Medical Assistance for Employed Persons with Disabilities (MA-EPD) program eligibility will end DD/MM/YY because we did not receive your premium by the due date. You may claim "good cause" for late payment. This must be approved by the Department of Human Services (DHS). To claim good cause, send a letter with your name, address, case number, and reason for late payment to:

   MA-EPD Good Cause
   444 Lafayette Road
   St. Paul, MN 55155-3848"

   < If MA eligibility does not exist, close MA-EPD on MAXIS on STAT/PACT using reason code A3 (Refused/Failed Required Info) and end eligibility in MMIS. Add the same worker comments to the closing notice.

2. Notify SRU via MAXIS E-mail that the enrollee's MA-EPD is being closed and to discontinue billing. Include the enrollee's name, PMI number and effective date of closure. SRU will not discontinue billing without an E-mail.

   < If DHS approves good cause for late payment, DHS will send a copy of the approval letter and/or a MAXIS E-mail. Enrollees who have been granted good cause and set up a payment plan will continue to appear on the MA-EPD Overdue Premiums Report. Do not close these enrollees for late payment unless instructed to do so by DHS.

   < In some cases, enrollees may pay premiums after the overdue report is generated.

If an enrollee reports the premium was paid, verify the payment with SRU. Do not end coverage. Reopen MA-EPD if it has been closed.

EXAMPLE:

Joshua fails to pay his August MA-EPD premium by the 15th. On the 20th of the month the Overdue Premium Report is printed at the county. The worker reviews the report on the 21st and sends 10-day notice to terminate MA-EPD for non-payment. Joshua pays his premium on the 23rd and calls his worker when he receives the termination notice. The worker verifies the payment with SRU. MA-EPD remains open.

Determine the premium at application, 6-month review, renewal, and at the time of the annual COLA increase. Do not change the premium at other times unless the client reports a change that would result in a decreased premium. See §0913 (Premiums and Spenddowns). If a reported change results in a decreased premium, E-Mail MADE. Include the same information required for an initial premium, as well as the new premium amount and the effective date of the change. SRU will bill the new amount on the next billing cycle. SRU will not decrease the premium retroactively except in the case of worker error.

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

< Use actual income received in any retroactive months

< Anticipate income for current and future months by multiplying biweekly income by 2.16 and weekly income by 4.3.

When people perform work every month but are paid less often than monthly, average the earnings over the 6-month budget period.

EXAMPLE:

John works part time at a convenience store and is paid weekly. He is also a member of his town's council, for which he receives payment quarterly, or twice in a 6-month period. Average the council income over the 6-month period and combine it with the convenience store income to arrive at a consistent monthly premium.

If John's only employment was attending quarterly council meetings, he would only be considered employed in the months he attends meetings, and the entire payment would be counted in the month received.

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

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

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

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

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

See §0913.02 (Premium Payment Options) for information on acceptable premium payment methods and procedures for dishonored payments.

GAMC:

No provisions.

MinnesotaCare:

People may pay premiums by:

< Check or money order. Treat payments made with dishonored checks as failure to pay. See §0913 (Premiums and Spenddowns).

< Automatic withdrawal plan (AWP). Enrollees may choose to have premiums deducted automatically from their bank accounts on the 10th of each month. To sign up for automatic withdrawal, enrollees must complete the form Automatic Withdrawal Plan (DHS 3389) and send it with a voided check or deposit slip to:

MinnesotaCare Automatic Withdrawal Plan
PO Box 64834
St. Paul, MN 55164-0834

The MinnesotaCare Information form (DHS 3104) and the AWP brochure (DHS 3389) contain information on AWP.

Automatic withdrawal begins approximately 60 days after the enrollee submits the form. Financial Management (FM) sends the enrollee a confirmation letter. Enrollees may end AWP at any time. Financial Management will stop AWP when they receive a request or if there is no bill generated. If no bill is generated because the enrollee's renewal is received late, FM will stop AWP. The enrollee must pay premiums using another mechanism until they again sign up for AWP.

< Payroll deduction. MMIS will accept payments from employers and other 3rd parties. Enrollees who wish to use payroll deduction must make arrangements with the employer. The employer will be assigned a provider number.

< Tax refund payment plan. Enrollees may choose to have MinnesotaCare intercept their state tax refunds to prepay premiums for up to 1 year. Eligible state tax refunds include:

- state income tax refunds
- state property tax refunds
- state political contribution refunds
- lottery winnings.

Enrollees request the tax refund payment plan by completing the Tax Refund Payment Plan authorization form (DHS 3372) and returning it to:

DHS Receipts Processing
Tax Refund Premium Payment Plan
444 Lafayette Road North
St. Paul, MN 55155-3811

The MinnesotaCare Information form (DHS 3104) includes information about the tax refund premium plan. Refer enrollees with questions about the plan to DHS Financial Management (FM) at 651-296-7695 or 1-888-234-1321.

Enrollees must designate the amount of the refund they want collected on the authorization form. They may designate the entire amount or a portion. FM will collect the refund when it is available and will credit the enrollee's account. Enrollees will continue to receive premium notices and must pay the premium until the notice shows a credit balance.

FM sends a copy of the Confirmation Letter (MS 1456) to the enrollment representative when the authorization is complete. Retain the copy of the MS-1456 in the case file and enter a case note that the enrollee is using the tax refund payment plan.

If an enrollee is no longer active on MinnesotaCare when FM receives the refund, FM will issue a check to the enrollee and will send the Termination of Tax Refund Premium Payment Plan Letter (MS 1461) to the enrollee with a copy to the enrollment representative. Retain the copy of the MS 1461 in the case file and enter a case note.

If the enrollee is enrolled in MinnesotaCare when FM receives the refund, FM will credit the enrollee's account. Any past due premiums will be credited 1st with the balance applied to future premiums. The premium notice will continue to show a credit until the tax refund is exhausted. The enrollee must pay any balance due shown on the premium notice once the refund is used up.

Tax refund premium payment plan authorizations are valid for 1 year. Enrollees must submit a new authorization each year if they want to continue in the plan.

Enrollees may request a refund of the credit balance at any time for any reason. If the enrollee contacts FM to request termination of the tax refund premium payment plan, FM will send the enrollee a Termination of the Tax Refund Premium Payment Plan letter (MS-1461) with a copy to the enrollment representative. The letter instructs enrollees to contact the enrollment representative if they believe they have a credit balance and want a refund.

< Through the DHS Web site at www.MinnesotaCare411.com. Enrollees should click on the link "Pay your MinnesotaCare Premium Online here." They will need their case number and invoice number. Enrollees may make online payments by:

-Visa or MasterCard. Enrollees will need to enter the card number, 3-digit security code on the back of the card (Visa only), and card expiration date.
OR
-Checking account. Enrollees will need to enter the bank routing number and checking account number.

Online payments made by 6:00 PM on a business day will be credited that day. Online payments made after 6:00 PM on a business day or on weekends and holidays will be credited the next business day.

MA:

After the county collects the initial premium and SRU assigns an invoice number, people may pay premiums for the MA-EPD program by:

< Personal or cashier's check
< Money order
< Automatic withdrawal plan (AWP). Enrollees may choose to have premiums deducted automatically from their bank accounts each month. To sign up for the automatic withdrawal, enrollees must complete the form Automatic Withdrawal Plan (DHS 3389) and send it with a voided check or deposit slip to:

DHS - Automatic Withdrawal Plan
PO Box 64834
St. Paul, MN 55164-0834

Automatic withdrawal begins approximately 60 days after the enrollee submits the form. Financial Management (FM) sends the enrollee a confirmation letter. Enrollees may end AWP at any time. Financial Management will stop AWP when they receive a request or if there is no bill generated. If AWP is stopped, the enrollee must pay premiums using another mechanism until they again sign up for AWP.

< Credit card--Visa or MasterCard.

< Bank debit card with a VISA logo.

To pay by credit or debit card, instruct clients to call 651-296-7525 or 1-888-234-1321.

Consider payment with a dishonored personal check or automatic withdrawal to be failure to pay the premium by the due date. The enrollee must replace the dishonored payment with a guaranteed form of payment (cashier's check or money order). See §0915.11 (Fail to Pay Premium/Voluntary Cancellation).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

Follow the steps below to determine eligibility under SIS EW:

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

2. Compare the result to the SIS. See SPECIAL INCOME STANDARD in §0902.37 (Glossary: Sole...). The SIS for 1-1-04 through 12-31-04 is $1,692. The SIS for 1-1-03 through 12-31-03 is $1,656.

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

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

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

   EXCEPTION:

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

   See MAINTENANCE NEEDS ALLOWANCE in §0902.21 (Glossary: Insurance...). The maintenance needs allowance for 7-1-02 through 6-30-03 is $741. The maintenance needs allowance for 7-1-03 through 6-30-04 is $752.

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

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

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

EXAMPLE:

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

EXAMPLE:

Tony is single and has gross income of $1,200. He is covered by Medicare Part A and B. After deducting his Medicare premium of $66.00 and maintenance needs allowance of $752, he has income of $382 remaining. This is his waiver obligation.

EXAMPLE:

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

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

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

EXAMPLE:

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

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

EXAMPLE:

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

EXAMPLE:

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

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

Access services plans must cover reimbursement for the following items:

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

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

- Mileage reimbursement at the current IRS rate to volunteer drivers registered with the county who use their vehicles to transport enrollees. Effective January 1, 2004, the IRS rate is 37.5 cents per mile. The rate for 2003 was 36 cents per mile. |

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

- Actual cost of parking.

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

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

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

Do not allow the following transportation costs in access plans:

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

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

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

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

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

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

  EXAMPLE:

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

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

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

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

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

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

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

Access plans must require prior authorization for:

< Lodging and meal expenses for people accompanying the enrollee.

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

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

Access plans may not require prior authorization for emergency services.

MinnesotaCare:

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

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

MA and GAMC:

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

< Sign language and foreign language interpreters if needed to receive medical services.

< Reimbursement for transportation and child care if needed for a state appeal hearing related to the health plan's denial, reduction or termination of a health service.

< Common carrier transportation to receive medical services.

Health plans are not required to provide:

< Reimbursement to enrollees for personal mileage or parking unrelated to an appeal.

< Lodging, meals or out-of-state airfare related to obtaining medical services.

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

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