This version of the manual is no longer in effect as of December 1, 2006.

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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #38

September 2003

Effective Date: July 1, 2003 and October 1, 2003

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 covering July 1, 2003, legislative changes was previously issued in Bulletin #03-21-06 (2003 Legislative Changes Effective July 1, 2003, Affecting Minnesota Health Care Programs) dated June 9, 2003. New material covering October 1, 2003, legislative changes was previously issued in Bulletin #03-21-08 (2003 Legislative Changes Effective October 1, 2003, Affecting Minnesota Health Care Programs) dated August 22, 2003. Some sections contain changes from both bulletins. Please note the effective dates of the various changes in Attachment A.

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HIGHLIGHTED CHANGE #1: This manual letter eliminates the EGAMC program and GAMC for people who are undocumented and non-immigrant. Except for people receiving services from the Center for Victims of Torture (CVT), these changes were included in the June 9, 2003, bulletin and were effective July 1, 2003. People receiving CVT services transfer to state-funded MA (program NM) effective October 1, 2003 as noted in the August 22, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #2: This manual letter eliminates the 21% earned income disregard for children ages 2 through 5 effective July 1, 2003. This change was included in the June 9,

2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #3: This manual letter changes the asset limit for MinnesotaCare and MA Method A effective July 1, 2003. These changes were included in the June 9, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #4: This manual letter reduces the automatic eligibility period for infants born to women on MinnesotaCare or MA (auto newborns) from 2 years to 1 year effective July 1, 2003. This change was included in the June 9, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #5: This manual letter adds a $50,000 annual income limit for parents, legal guardians, foster parents and relative caretakers, except for pregnant women, on MinnesotaCare effective July 1, 2003. This change was included in the June 9, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #6: This manual letter removes 1-month rolling eligibility for MA and GAMC managed care enrollees who are terminated due to failure to submit scheduled renewals on time effective July 1, 2003. This change was included in the June 9, 2003, bulletin. It adds that children receiving IV-E or state adoption assistance are excluded from managed care but may enroll voluntarily, and that enrollees for whom the county is paying cost-effective health insurance premiums are excluded. Both of these changes were the result of 2003 legislation and were effective July 1, 2003. It adds that effective October 1, 2003, infants born to women on MA or MinnesotaCare and enrolled in managed care will no longer be added to the mother's health plan retroactively for the month of birth. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #7: This manual letter removes instructions and references to delayed verification procedures. The authority to approve health care pending receipt of required verification ended July 1, 2003. This change was included in the June 9, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #8: This manual letter removes income deductions and spenddown provisions for GAMC effective October 1, 2003. Eligibility is now based on gross income for a

6-month budget period. There is no distinction between adults with and without children under age 21 in the home. This change was included in the August 22, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #9: This manual letter removes retroactive eligibility for GAMC. Effective October 1, 2003, eligibility can begin no earlier than the date of application. This change was included in the August 22, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #10: This manual letter adds information on the GAMC Hospital Only (GHO) program effective October 1, 2003. Eligibility for full GAMC benefits is limited to people with incomes no greater than 75% of FPG and assets of $1,000 per household or less. GHO eligibility is available for inpatient hospitalization and physician's charges to people with incomes between 75% and 175% of FPG and assets within the MinnesotaCare limits. This change was included in the August 22, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #11: This manual letter updates affected sections to reflect the change in funding for program IM and for people receiving services from a center for victims of torture (CVT) who are not MA-eligible. These programs have been moved from GAMC to state-funded MA effective October 1, 2003. This change was included in the August 22, 2003, bulletin. See Attachment A for a list of sections affected by this change.

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HIGHLIGHTED CHANGE #12: This manual letter updates affected sections to reflect the following long-term-care-related changes effective July 1, 2003:

- Change in the onset of the penalty period for improper transfers from the month of the transfer to the month following the transfer.
- New provisions for determining the uncompensated value of transfers into annuities when there is a medical condition that would shorten the estimated life expectancy.
- Expansion of potential cause of action filings to all transfers not reported timely.
- Decrease in the minimum income level allowing a choice between SIS-EW and AC, from the maintenance needs allowance to 120% FPG when the person is otherwise eligible for MA.

These changes were included in the June 9, 2003, bulletin. See Attachment A for a list of affected sections.

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HIGHLIGHTED CHANGE #13: This manual letter includes the following MinnesotaCare

changes effective October, 1, 2003:

- Elimination of coverage for dependent siblings.
- Limited benefits for adults without children with incomes greater than 75% FPG but no more than 175% FPG.
- Elimination of extended coverage for adults without children whose income exceeds 275% FPG.
- Exemption from the 4-month insurance barrier for people transferring from MA to MinnesotaCare who had cost-effective health insurance paid by MA or applied to a spenddown.

These changes were included in the August 22, 2003, bulletin. See Attachment A for a list of affected sections.

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HIGHLIGHTED CHANGE #14: This manual letter changes the definition of the MinnesotaCare renewal month to "the first effective month for which coverage was renewed." This terminology change was made to align renewal terminology for the health care programs. It does not affect current renewal policies or procedures. See Attachment A for a list of affected sections.

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

Submit health care eligibility policy questions through the HealthQuest system.

Sincerely,

BRIAN OSBERG
Assistant Commissioner Health Care

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MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #38
ATTACHMENT A
REVISED AND DELETED SECTIONS

Revised Sections	Deleted Sections
0902.07	0902.07
0902.09	0902.09
0902.11	0902.11
0904.03	0904.03
0904.05.03	0904.05.03
0904.05.03.03	0904.05.03.03
0904.05.05	0904.05.05
0904.07	0904.07
0904.07.01	None (new)
0904.07.03	0904.07.03
0904.07.05	0904.07.05
0904.07.07	0904.07.07
0904.07.09	0904.07.09
0904.07.09.03	0904.07.09.03
0904.09.07	0904.09.07
0904.09.11	0904.09.11
0904.11	0904.11
0904.13	0904.13
0904.13.01	0904.13.01
None (deleted)	0904.13.05
None (deleted)	0904.13.05.01
0905	0905
0905.03	0905.03
0905.03.01	0905.03.01
0905.07	0905.07
0905.09	0905.09
0906.03	0906.03
0906.03.03.03	0906.03.03.03
0906.03.05	0906.03.05
0906.03.09	0906.03.09
0906.03.11	0906.03.11
0906.03.11.01	0906.03.11.01
0906.03.13	0906.03.13
0906.05.07	0906.05.07
0906.09.01	0906.09.01
0906.11.01	0906.11.01
0906.17	0906.17
0907	0907

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0907.05	0907.05
0907.07	0907.07
0907.15	0907.15
0907.09.03	0907.09.03
0907.17	0907.17
0907.19.03	0907.19.03
0907.19.05	0907.19.05
0907.19.05.03	0907.19.05.03
0907.19.05.05	0907.19.05.05
0907.19.11	0907.19.11
0907.23.11	0907.23.11
0907.25	0907.25
0907.25.03	0907.25.03
0907.25.05	0907.25.05
0907.25.07	0907.25.07
0907.25.09	0907.25.09
0907.27	0907.27
0907.29	0907.29
None (deleted)	0907.29.03
None (deleted)	0907.29.05
0908.03	0908.03
None (deleted)	0908.03.03
0909	0909
0909.05	0909.05
0909.05.03	0909.05.03
0909.07	0909.07
0909.11	0909.11
0909.11.01	0909.11.01
0909.11.03	0909.11.03
0909.13	0909.13
0909.13.05	0909.13.05
0909.15	0909.15
0909.17	0909.17
0909.19	0909.19
0909.27	0909.27
0909.27.05	0909.27.05
0909.27.07	0909.27.07
0909.27.09	0909.27.09
0909.27.11	0909.27.11
0909.27.13	0909.27.13
0909.29	0909.29
0910.07	0910.07
0911.09.15.05	0911.09.15.05
0912.03	0912.03
0912.03.03	0912.03.03
0912.05	0912.05

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0912.05.03	0912.05.03
0912.05.05	0912.05.05
0912.05.07	0912.05.07
0912.05.09	0912.05.09
0912.05.09.03	0912.05.09.03
0912.05.27	0912.05.27
0912.07.075	0912.07.075
0912.07.175	0912.07.175
0913	0913
0913.03	0913.03
0913.05	0913.05
0913.07	0913.07
0913.09	0913.09
0913.09.03	0913.09.03
0913.09.05	0913.09.05
0913.11	0913.11
0913.13.07	0913.13.07
0913.19	0913.19
0913.19.03	0913.19.03
0913.19.05	0913.19.05
0913.21	0913.21
0913.21.03	0913.21.03
0913.21.05	0913.21.05
0913.21.07	0913.21.07
0913.21.09	0913.21.09
0913.23	0913.23
0914	0914
0914.03.03	0914.03.03
0914.03.03.03	0914.03.03.03
0914.03.05	0914.03.05
0914.03.07	0914.03.07
0914.03.09	0914.03.09
0914.03.11	0914.03.11
0914.03.13	0914.03.13
None (deleted)	0914.03.19
0914.03.21	0914.03.21
0915.03	0915.03
0915.11.05	0915.11.05

§0901 (Table of Contents) removes obsolete sections, adds a new section, and changes the name of several sections.

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

§0902.07 (Glossary: Client...) removes the definition of delayed verification effective July 1, 2003. See Highlighted Change #7.

§0902.09 (Glossary: Denial...) removes a reference to the 30+1/3 disregard from the definition of DISREGARD CYCLE. It removes GAMC from the definitions of DISREGARD and DISREGARD CYCLE since only MA Method A uses the disregard cycle effective October 1, 2003. It removes the definition of DEPENDENT SIBLING effective October 1, 2003.

§0902.11 (Glossary: Effective...) removes the GAMC definition of EMERGENCY. The EGAMC program ended effective July 1, 2003. See Highlighted Change #1.

§0904.03 (Initial Requests) adds that providers may assist in setting the date of application.

§0904.05.03 (When to Require an Application) and §0904.05.05 (When Not to Require an Application) add that former GHO enrollees who are rehospitalized within 6 months of the date of the most recent application do not have to complete new application forms. The GHO program begins effective October 1, 2003. See Highlighted Change # 10.

§0904.05.03.03 (Who May Apply) changes the text and example to state that all applicants age 18 and over must sign the application. This change is required to be in compliance with HIIPA.

§0904.07 (Accepting and Processing Applications) removes the instructions for accepting applications from correctional inmates in advance of release. This information is now contained in a new section. It adds that providers may assist in setting the date of application.

§0904.07.01 (Applications in Advance of Inmate's Release) is a new section with updated instructions on accepting and processing applications for inmates scheduled to be released from correctional institutions. These instructions were most recently updated in Bulletin #03-21-07 (Procedural Updates to Bulletin #03-31-04 Eliminating Delayed Verification Procedures for Soon to be Released Correctional Inmates Applying for Health Care Programs) dated July 22, 2003.

§0904.07.03 (Date of Application) adds information under GAMC about how providers can submit requests to set the date of application for patients who are unable to do so, including hospital admissions outside of county business hours. Although the policy on allowing providers to submit requests to set the application date is not new, some provisions were added effective October 1, 2003, with the implementation of GHO. See Highlighted Change #10.

§0904.07.05 (Application Follow Up) and §0904.07.07 (Pending the Application) remove references to delayed verification effective July 1, 2003. See Highlighted Change #7.

§0904.07.09 (Eligibility Begin Date) revises the GAMC instructions to eliminate retroactive eligibility before the date of application effective October 1, 2003. See Highlighted Change #9. It adds that people may apply for GAMC Hospital Only (GHO) in advance but cannot be approved until they are hospitalized. See Highlighted Change #10.

§0904.07.09.03 (Retroactive MinnesotaCare) adds a reference to GHO to the 1st reference to GAMC. GHO is effective October 1, 2003. See Highlighted Change #10. It deletes references to delayed verification effective July 1, 2003. See Highlighted Change #7.

§0904.09.07 (MinnesotaCare with Retroactive MA/GAMC) removes GAMC from the provisions since there is no longer retroactive eligibility effective October 1, 2003. See Highlighted Change #9.

§0904.09.11 (MinnesotaCare/MA Overlap) adds instructions for approving MinnesotaCare for people being terminated from GHO effective October 1, 2003.

§0904.11 (Authorized Representatives) adds that providers may assist in setting the date of application and adds a cross reference to §0904.07.03 (Date of Application).

§0904.13 (Verification) deletes references to delayed verification effective July 1, 2003. See Highlighted Change #7.

§0904.13.01 (Verification - MA/GAMC) adds cross references to sections on verifying immigration status and pregnancy. It revises or eliminates several items under GAMC to reflect that undocumented and non-immigrant people are no longer eligible effective July 1, 2003, and that retroactive coverage and spenddowns are eliminated effective October 1, 2003. See Highlighted Change #1, #8 and #9.

§0904.13.05 (Delayed Verification - MinnesotaCare) and §0904.13.05.01 (Delayed Verification - MA/GAMC) are deleted effective July 1, 2003. See Highlighted Change #7. These sections will remain available in the MAXIS on-line manual for footer months 06 03 and earlier.

§0905 (Reviews and Renewals) adds a new definition of renewal month for MinnesotaCare. The renewal month is the 1st effective month for which coverage was renewed. This change was made to align renewal terminology for the health care programs. It does not affect current procedures for processing renewals. Under MA and GAMC, it updates the age for auto newborns effective July 1, 2003, and updates an example when household members have different renewal dates. It adds that there are no reviews or renewals for GHO effective October 1, 2003.
See Highlighted Change #10.

§0905.03 (Renewal Timelines) deletes references to delayed verification effective July 1, 2003. See Highlighted Change #1. It updates other material to conform to the new MinnesotaCare definition of renewal month.

§0905.03.01 (Annual Renewal Timelines--MA/GAMC) deletes a reference to 1-month rolling eligibility effective July 1, 2003. See Highlighted Change #6.
§0905.07 (Monthly Reporting) separates GAMC from MA and replaces GAMC with “no provisions.” There are no longer any monthly reporters for GAMC because there are no spenddowns effective October 1, 2003. See Highlighted Change #8.

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

§0905.09 (6-Month Reporting) adds under GAMC that there are no reviews or renewals for GHO effective October 1, 2003. See Highlighted Change #10.

§0906.03 (Citizenship and Immigration Status), §0906.03.03.03 (Qualified Non-Citizens--Program Provisions), §0906.03.05 (Non-Citizens Ineligible for Federal Funding) and §0906.03.09 (Undocumented and Non-Immigrant People) delete references to GAMC for people who are undocumented and non-immigrant effective July 1, 2003. See Highlighted Change #1.

§0906.03.11 (Verification of Immigration Status) deletes references to GAMC for people who are undocumented and non-immigrant and EGAMC effective July 1, 2003. See Highlighted Change #1.

§0906.03.11.01 (Systematic Verification for Alien Entitlements--SAVE) deletes references to GAMC for people who are undocumented and non-immigrant, EGAMC and delayed verification effective July 1, 2003. See Highlighted Changes #1 and #7.

§0906.03.13 (MinnesotaCare Major Program) removes references to dependent siblings and adds new benefit set and coding information for adults without children on major program BB effective October 1, 2003. See Highlighted Change #13.

§0906.05.07 (State Residence--GAMC) deletes references to EGAMC for non-Minnesota residents who incur expenses due to an accident in Minnesota effective July 1, 2003. See Highlighted Change #1. It clarifies that people with medical emergencies as defined for the EMA program can qualify for regular GAMC without regard to the 30-day residence requirement.

§0906.09.01 (Institutional Residence–MA/GAMC) moves information on people who would be eligible for federally-funded MA if they were not in an IMD from the GAMC to the MA section because of the funding change effective October 1, 2003. See Highlighted Change #11. It changes the cross reference for inmates who apply in advance of their release dates.

§0906.11.01 (Social Security Number--MA/GAMC) updates the age limits for auto newborns in the 1st bullet under MA. See Highlighted Change #4. Under GAMC, it removes references to eligibility for people who are undocumented and non-immigrant and EGAMC. Both changes were effective July 1, 2003. See Highlighted Change #1.

§0906.17 (Technical Requirements--GAMC) removes references to delayed verification effective July 1, 2003. See Highlighted Change #7.

§0907 (Eligibility Groups and Bases of Eligibility) removes references to dependent siblings under MinnesotaCare. See Highlighted Change #13.

§0907.05 (MinnesotaCare Eligibility Group 2) adds that there is a $50,000 income limit for adults in this group, other than pregnant women, effective July 1, 2003. See Highlighted Change #5. It removes references to dependent siblings effective October 1, 2003. It removes references to extended eligibility for people with excess income related to these changes. See Highlighted Change #13.

§0907.07 (MinnesotaCare Eligibility Group 3) removes references to dependent siblings and to extended enrollment for people whose income exceeds 175% FPG effective October 1, 2003. See Highlighted Change #13. It adds that Group 3 coding is primarily used to identify the benefit set on MMIS. Group 3 is now used for adults without children who are eligible for the MinnesotaCare Limited Benefit (MLB) set.

§0907.09.03 (MinnesotaCare Auto Newborns) changes the text and examples to reflect that auto newborns are now eligible until age 1 rather than age 2 effective July 1, 2003. See Highlighted Change #4.

§0907.15 (MinnesotaCare Adults Without Children) adds that benefit sets for this group depend on income and removes references to extended enrollment for people whose income exceeds 175% FPG effective October 1, 2003. See Highlighted Change #13.

§0907.17 (MA/GAMC Bases of Eligibility) removes references to GAMC for undocumented and non-immigrant people effective July 1, 2003, and people in IMDs effective October 1, 2003. See Highlighted Change #1 and #11.

§0907.19.03 (Families and Children Basis: Child Under 21) removes a reference to GAMC for undocumented children and updates the age for auto newborn eligibility. Both changes were effective July 1, 2003. See Highlighted Changes #1 and #4.

§0907.19.05 (MA Basis: Pregnant Women) updates the age for auto newborn eligibility. See Highlighted Change #4. It removes references to delayed verification. Both changes were effective July 1, 2003. See Highlighted Change #7.

§0907.19.05.03 (MA Basis: Auto Newborn) and §0907.19.05.05 (Adding/Removing Auto Newborns) update the text and examples to reflect the change in age for auto newborn eligibility effective July 1, 2003. See Highlighted Change #4. §0907.19.05.05 also adds that effective October 1, 2003, infants born to women enrolled in managed care are no longer added to the mother's health plan retroactively. See Highlighted Change #6.

§0907.19.11 (Transitional/Transition Year MA) deletes an example due to the end of the 21% disregard effective July 1, 2003. See Highlighted Change #2.

§0907.23.11 (MA Waiver Programs: EW) changes the minimum income level at which people can choose between AC and SIS-EW from the maintenance needs allowance to 120% FPG effective July 1, 2003. See Highlighted Change #12.

§0907.25 (GAMC Program Types) changes the name of the section from GAMC Bases of Eligibility and revises the text. GAMC no longer distinguishes between adults with and without children under age 21 in the home. Anyone who does not have an MA basis is potentially eligible for GAMC if they meet all other GAMC requirements. Income and asset levels determine whether people qualify for full GAMC benefits or hospital only effective October 1, 2003. See Highlighted Change #10.

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

§0907.25.03 (GAMC With Full Benefits) changes the name of the section from GAMC Basis: Families with Children and describes the income and asset requirements for full GAMC effective October 1, 2003. See Highlighted Change #10.

§0907.25.05 (GAMC Hospital Only: GHO) changes the name of the section from GAMC Basis: Adults Without Children and describes the eligibility requirements and benefits for GHO effective October 1, 2003. See Highlighted Change #10.

§0907.25.07 (State-Funded MA Basis: Victims of Torture) changes the section title and text to reflect that people receiving services from a center for victims of torture (CVT) who are not otherwise MA-eligible are eligible for state-funded MA (program NM) effective October 1, 2003. See Highlighted Change #11.

§0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals) deletes the first bullet stating that certain adults without children are mandatory MinnesotaCare referrals effective October 1, 2003 and changes the income level for parents and caretakers from those with incomes up to 275% FPG to those with incomes up to 75% FPG, the GAMC limit. See Highlighted Change #8. It deletes a reference to EGAMC effective July 1, 2003. See Highlighted Change #1.

§0907.27 (MA/GAMC Basis: IMD Residents) updates the text to reflect that people who would be eligible for federally-funded MA if they were not in an IMD qualify for program NM except for coverage of nursing homes that are IMDs effective October 1, 2003. See Highlighted Change #11. Under GAMC it deletes a reference to an obsolete income standard and states to use gross income to determine eligibility effective October 1, 2003. See Highlighted Change #8.

§0907.29 (Emergency Medical Assistance–EMA) changes the section title from Medical Emergency Programs, combines information in this section with information previously found in §0907.29.03 (Emergency MA), which is deleted, and deletes references to EGAMC. Section §0907.29.05 (Emergency GAMC) is deleted. The EGAMC program ended July 1, 2003.

§0908.03 (Determining MinnesotaCare Household Size) removes references to dependent siblings effective October 1, 2003. See Highlighted Change #13.

§0908.03.03 (Dependent Sibling Requirements) is deleted effective October 1, 2003. See Highlighted Change #13.

§0909 (Assets) deletes a reference to EGAMC effective July 1, 2003, and adds that GHO follows MinnesotaCare asset policies, while full GAMC follows MA Method B effective October 1, 2003. See Highlighted Change #1 and #10.

§0909.05 (Asset Limits) updates the asset limits for MinnesotaCare and MA Method A which were effective July 1, 2003. See Highlighted Change #3. It adds to follow Method A for GAMC Hospital Only (GHO) effective October 1, 2003. See Highlighted Change #10.

§0909.05.03 (Verification of Assets) removes a reference to delayed verification under MinnesotaCare. See Highlighted Change #7. It updates examples under MinnesotaCare and MA Method A to reflect the new asset limits effective July 1, 2003. See Highlighted Change #3.

§0909.07 (Jointly Owned Assets), §0909.11 (Excluded Assets), §0909.11.01 (Additional Excluded Assets for Method A/B), §0909.11.03 (Excluded Assets for Self Support), §0909.13 (Real Property: Homestead), §0909.13.05 (Contracts for Deed), §0909.15 (Vehicles), §0909.17 (Burial Funds/Life Insurance: Fund Types), and §0909.19 (Pension and Retirement Funds) change program headings to indicate that GHO follows MinnesotaCare and MA Method A, while GAMC follows MA Method B effective October 1, 2003. See Highlighted Change #10.

§0909.27 (Asset Transfers), §0909.27.05 (Asset Transfer Exceptions), §0909.27.07 (Transfer Lookback Period), §0909.27.09 (Determining Uncompensated Value), §0909.27.11 (Improper Transfer Ineligibility), and §0909.27.13 (Improper Transfers - Onset of Ineligibility) add that there are no transfer penalty provisions for GHO effective October 1, 2003. See Highlighted Change #10. §0909.27.13 also deletes a reference to delayed verification effective July 1, 2003. See Highlighted Change #7. §0909.27.09 also adds provisions for determining whether transfers into annuities are uncompensated when there is a shortened life expectancy. §0909.27.11 changes the onset of the ineligibility period to the month after the transfer and expands possible cause of action filings to all transfers that are not reported timely. See Highlighted Change #12.

§0909.29 (Excess Assets--Applicants) updates examples under MinnesotaCare to reflect the new asset limits effective July 1, 2003. See Highlighted Change #3. It eliminates a reference to retroactive coverage for GAMC, which is eliminated effective October 1, 2003. See Highlighted Change #9.

§0910.07 (4-Month Rule) adds that people transferring from MA to MinnesotaCare are exempt from the 4-month insurance barrier if they had cost-effective insurance effective October 1, 2003. See Highlighted Change #13.

§0911.09.15.05 (Lump Sum RSDI and SSI Payments) updates the example under MinnesotaCare to reflect the new definition of renewal month.

§0912.03 (MinnesotaCare Income Eligibility) adds the $50,000 gross income limit for parents and caretakers effective July 1, 2003. See Highlighted Change #5.

§0912.03.03 (MinnesotaCare Excess Income) revises the text to reflect the $50,000 gross income limit for parents and caretakers effective July 1, 2003. See Highlighted Change #5. It adds to terminate coverage for adults without children whose income increases over 175% FPG at the time of renewal or when adding a household member, as they are no longer eligible for the MCHA exception or 18-month disenrollment effective October 1, 2003.

§0912.05 (Determining Net Income), §0912.05.03 (Determining Net Income–Order of Deductions), §0912.05.05 (Work Expense Deduction), §0912.05.07 (Dependent Care Deduction), §0912.05 .09.03 (Earned Income Disregard Cycle–Method A), and §0912.05.27 (Child Support

Deduction) change GAMC to "no provisions" since there are no longer any income deductions or disregards effective October 1, 2003. See Highlighted Change #8.

§0912.05.09 (Earned Income Disregards–Method A) deletes references to the 21% earned income disregard for children ages 2 through 5 effective July 1, 2003. See Highlighted Change #2. It changes GAMC to "no provisions" since GAMC is based on gross income without disregards effective October 1, 2003. See Highlighted Change #8.

§0912.07.075 (75 Percent of FPG Standards) and §0912.07.175 (175 Percent of FPG Standards) change the descriptions to reflect differing benefits for GAMC and MinnesotaCare based on income level. See Highlighted Change #10 and #13.

§0913 (Premiums and Spenddowns) removes GAMC from the introductory statement and adds a GAMC section stating that there are no premiums or spenddowns for GAMC, but that there is a $1,000 copayment for GHO effective October 1, 2003. See Highlighted Change #8 and #10.

§0913.03 (Spenddowns–MA/GAMC) changes the title to Spenddowns–MA and adds that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8. It updates a bullet referring to auto newborns from the 2nd birthday to the 1st birthday effective July 1, 2003. See Highlighted Change #4.

§0913.05 (Which Spenddown Type to Use) updates an example with current income standards and disregards and adds that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8.

§0913.07 (6-Month Spenddown Calculation) adds that there are no provisions for GAMC and removes a reference to retroactive GAMC. Both changes are effective October 1, 2003. See Highlighted Change #8 and #9.

§0913.09 (Automated Monthly Spenddown Calculation), §0913.09.03 (Client Option Spenddown), §0913.09.05 (Designated Provider Option), and §0913.11 (Manual Monthly Spenddown Calculation) add that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8.

§0913.09 (Shortened Spenddown) removes the bullet on using shortened spenddowns with 1-month rolling eligibility effective July 1, 2003, and adds that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8.
§0913.09.03 (When to Interrupt 6-Month Cert. Period) removes a reference to retroactive GAMC from an example effective October 1, 2003. See Highlighted Change #9.

§0913.09.05 (When Not to Interrupt 6-Month Cert. Period) removes a reference to retroactive GAMC and adds GHO to the GAMC provisions. Both changes are effective October 1, 2003. See Highlighted Change #9 and #10.

§0913.13.07 (Relationship Between AC and EW) changes the minimum income level at which people can choose between AC and SIS-EW from the maintenance needs allowance to 120% FPG

effective July 1, 2003. See Highlighted Change #12.

§0913.21 (Allowable Medical Bills to Meet Spenddown) removes GAMC from spenddown provisions and adds that the $1,000 GHO copayment may be used to meet the spenddowns of MA household members. The GHO co-payments are treated as "H" bills on MAXIS. Both changes are effective October 1, 2003. See Highlighted Change #8 and #10.

§0913.21.03 (Determine Net Medical Expenses) adds that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8.

§0913.21.05 (MinnesotaCare Expenses to Meet Spenddown) removes GAMC from the instructions and adds that there are no provisions effective October 1, 2003, and replaces GAMC with MA in some examples. See Highlighted Change #8.

§0913.21.07 (MinnesotaCare Inpatient Hospitalization) adds GHO to the GAMC section effective October 1, 2003. See Highlighted Change #10.

§0913.21.09 (Bills Reported After Approval) and §0913.23 (Spenddown Notice Provisions) add that there are no provisions for GAMC effective October 1, 2003. See Highlighted Change #8.

§0914 (Service Delivery) adds new managed care counties effective September 1, 2003.

§0914.03.03 (Managed Care Exclusions) adds that adoption assistance children and enrollees for whom the county pays cost-effective health insurance are excluded effective July 1, 2003. See Highlighted Change #6. It moves the exclusion for people receiving CVT services from the GAMC section to the general section because of the funding change to program NM effective October 1, 2003. See Highlighted Change #11.

§0914.03.03.03 (Managed Care Voluntary Enrollment) adds that adoption assistance children may enroll voluntarily effective July 1, 2003. See Highlighted change #6.

§0914.03.05 (Managed Care Enrollment Process) updates the list of items to include in the MinnesotaCare enrollment packet.

§0914.03.07 (Health Plan Changes) adds change options for the 1st 90 days of enrollment in a new health plan and after a break of more than 2 full calendar months (formerly 12 months for MA/GAMC) in managed care enrollment, effective October 1, 2003.

§0914.03.09 (Managed Care Re-Enrollments and Reinstatements) removes an outdated example from MinnesotaCare. Under MA/GAMC, it revises an example to eliminate references to 1-month rolling eligibility effective July 1, 2003. See Highlighted Change #6.

§0914.03.11 (Managed Care Disenrollment) deletes a reference to 1-month rolling eligibility effective July 1, 2003. See Highlighted Change #6.

§0914.03.13 (Adding/Removing People From Managed Care) updates an example to remove a

reference to excluding children in foster care from managed care. It adds that effective October 1, 2003, infants born to women enrolled in managed care are no longer added retroactively to the mother's health plan for the birth month. See Highlighted Change #6.

§0914.03.19 (Managed Care: 1-Month Rolling Eligibility) is obsolete effective July 1, 2003. See Highlighted Change #6.

§0914.03.21 (Managed Care Covered Services) updates the paragraph referring to cost-effective health insurance to reflect the new exclusion effective July 1, 2003. See Highlighted Change #6.

§0915.03 (Adding a Person to the Household) deletes a reference to delayed verification effective July 1, 2003. See Highlighted Change #7.

§0915.11.05 (Fail to Pay Premium/Reinstatement) revises a paragraph to reflect the change in the definition of renewal month.

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CLIENT:

A person who is an APPLICANT or ENROLLEE.

CLOTHING AND PERSONAL NEEDS ALLOWANCE:

MA:

The amount of monthly income institutionalized clients may retain or receive for their day to day expenses.

CO-INSURANCE:

An insured person's share of the cost of treatment. For example, if an insurance policy covers 80% of the cost, the co-insurance amount is 20%.

CO-PAYMENT:

A fixed amount that an insured person is required to pay for each episode of a particular treatment, medical supply, or equipment. For example, a policy might require a $5 co-payment for each prescription while the insurance pays the remainder.

COBRA COVERAGE:

A provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA) which requires employers to allow former employees to continue coverage through the employer's group plan for 18 months after the employment has ended (29 months if the employee is disabled). In most cases, the former employee must pay the full cost of COBRA coverage.

COLA:

Cost of Living Adjustment. An increase in income to compensate for inflation. COLAs are usually made annually.

COMBINED APPLICATION FORM (CAF):

A form on which people can apply for multiple programs administered by DHS, including GENERAL ASSISTANCE (GA), GENERAL ASSISTANCE MEDICAL CARE (GAMC), FOOD STAMPS, MINNESOTA FAMILY INVESTMENT PLAN (MFIP), MEDICAL ASSISTANCE (MA), MINNESOTA SUPPLEMENTAL AID (MSA), Emergency Assistance (EA), EMERGENCY MEDICAL ASSISTANCE (EMA), and EMERGENCY GENERAL ASSISTANCE MEDICAL CARE (EGAMC).

COMMUNITY ALTERNATIVE CARE (CAC):

A federally approved home and community based services WAIVER program for chronically ill people under age 65. See §0907.23.07 (MA Waiver Programs: CAC).

COMMUNITY SPOUSE:

A person who does NOT reside in a medical institution, LTCF, or receive EW services whose spouse DOES reside in a medical institution, LTCF, or receives EW services and meets the definition of a LONG TERM CARE SPOUSE. A community spouse may or may not receive MA.

COMPREHENSIVE COVERAGE:

MINNESOTACARE:

A term used by insurance companies to describe a broad range of covered services including the diagnosis and treatment of most illnesses and injuries. Coverage may vary under individual policies.

CONSERVATOR:

A person, official, or institution designated to protect the interests of an incompetent person. A conservator has some, but not all, of the duties and powers of a legal guardian and is not counted in the person's household for any of the HEALTH CARE PROGRAMS.

CONTINUED ABSENCE:

MA:

A BASIS OF ELIGIBILITY for PARENTS and RELATIVE CARETAKERS of a DEPENDENT CHILD. See §0907.19.07 (MA Families & Children: AFDC-Related Adults).

CONTINUOUS ENROLLMENT:

MINNESOTACARE:

Enrollment in MINNESOTACARE, MA, or GAMC with a break in coverage of less than 1 calendar month.

CONTINUOUS PERIOD OF INSTITUTIONALIZATION:

MA:

A stay in a medical or LONG TERM CARE FACILITY which is expected to last at least 30 consecutive days from the date of entry. Count the date of entry and the date of discharge to determine whether a stay has lasted at least 30 consecutive days. A new continuous period of institutionalization begins after a client re-enters an institution after having been discharged for at least 30 consecutive days.

CONTRACT FOR DEED:

A conditional sales contract for purchase of real estate. The contract is held by a

private party as opposed to a lending institution. Consider contracts for deed to be PERSONAL PROPERTY. See §0909.13.05 (Contracts for Deed).

COUNTY AGENCY:

The local human services office responsible for determining eligibility for MA and GAMC. Some county agencies also determine eligibility for MinnesotaCare.

COUNTY OF FINANCIAL RESPONSIBILITY:

The county responsible for the county costs of an ENROLLEE's MA or GAMC.

CUSTODIAL PARENT:

A PARENT who has physical custody of his or her CHILD.

CUTOFF DATE:

The date by which information must be entered in MAXIS or MMIS to effect a change for the following month.

DECLARATION OF PARENTAGE (DOP):

A form printed by the Minnesota Department of Health, Vital Records Section, that serves as an ACKNOWLEDGMENT OF PATERNITY. This form may be signed before or after the child's birth. However, to be valid, it must be executed before 8-1-95. Effective 8-1-95, clients must use the RECOGNITION OF PARENTAGE (DHS 3159). Notarized signatures of both parents must be on the form.

DEDUCTIBLE:

The amount of health care expenses an insured person is required to incur before benefits are payable under a health insurance policy. For example, if an insured person has a $1,000 deductible, he or she must incur $1,000 in medical costs before the policy begins paying benefits.

DEDUCTION:

MA and GAMC:

An amount of income not counted in the computation of a person's income because its use or intended use is for certain specific expenses. For example, employed people are allowed a deduction for DEPENDENT CARE.

DEED:

Legal document which conveys ownership of property between parties.

DEEM:

To count the income or ASSETS of 1 person when determining the eligibility of another. See §0908.07 (Household Composition: Deeming).

DEEMED SSI RECIPIENT:

MA:

An individual who for Medicaid purposes is considered to be receiving SSI. This includes people eligible under 1619(a) and (b); children eligible under the TEFRA waiver; people eligible for the Pickle disregard; Disabled Adult Children; Disabled Widows and Widowers; and people not receiving SSI payment because of recoupment or 1-month suspension due to excess income. See the following sections:

§0907.21.07.03 (MA Basis: 1619 A and B)
§0907.23.09 (MA Waiver Programs: TEFRA)
§0911.09.15.01 (Income from RSDI and SSI--MA/GAMC)
§0912.05.17 (Widow and Widower's Disregard)
§0912.05.19 (Disabled Adult Children Disregard)
§0912.05.21 (Disabled Widow/Widower's Deduction)
§0912.05.23 (Pickle Disregard)

DENIAL:

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

DEPENDENT CARE DEDUCTION:

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

DEPENDENT CHILD:

MINNESOTACARE:

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

MA:

A person less than 18 years old, or an 18-year-old FULL-TIME STUDENT expected to graduate by age 19.

DEPENDENT HEALTH INSURANCE:

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

DHS:

The Minnesota Department of Human Services.

DISABILITY:

MA:

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

DISABILITY INSURANCE:

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

DISREGARD:

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

DIVIDEND:

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

DOMESTIC VOLUNTEER SERVICE ACT:

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

EARNED INCOME :

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

EARNED INCOME DISREGARD:

MA :

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

EARNED INCOME DISREGARD CYCLE:

MA :

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

EARNED INCOME CREDIT (EIC):

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

EFFECTIVE DATE:

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

EIGHTEEN-MONTH RULE:

MINNESOTACARE:

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

ELDERLY:

MA:

Age 65 or older. Used interchangeably with AGED.

ELDERLY WAIVER (EW):

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

ELIGIBILITY BEGIN DATE:

The date an ENROLLEE is eligible for coverage under 1 of the HEALTH CARE PROGRAMS.

ELIGIBILITY GROUP:

MINNESOTACARE:

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

ELIGIBILITY VERIFICATION SYSTEM (EVS):

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

EMANCIPATED MINOR:

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

EMERGENCY:

MA:

A sudden onset of a physical or mental condition OR a chronic medical condition which, if left untreated, could reasonably be expected to place the person's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. This includes prenatal care, labor, and delivery. See §0907.29.03 (Emergency MA).

EMPLOYER SUBSIDIZED INSURANCE (ESI):

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

ENCUMBRANCE:

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

ENROLLEE:

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

ENROLLMENT REPRESENTATIVE :

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

EQUITY:

The FAIR MARKET VALUE of property minus any ENCUMBRANCE.

ESCROW:

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

ESTATE CLAIMS:

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

ESTIMATED MARKET VALUE (EMV):

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

EW:

See ELDERLY WAIVER above.

EXCESS ASSETS:

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

EXCLUDED INCOME :

Income not used to determine eligibility or MINNESOTACARE premium amount.

EXCLUDED TIME:

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

EXCLUDED TIME RESIDENCE/FACILITY:

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

EXCLUDED TIME SERVICES:

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

EXPENSES COVERED BY GAMC OR MA:

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

EXTENDED MEDICAL ASSISTANCE:

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

FACE-TO-FACE INTERVIEW:

A face-to-face meeting arranged to determine initial or ongoing eligibility for MA, GAMC or MINNESOTACARE. Face-to-face interviews are at the option of the CLIENT for people who are requesting only health care coverage.

FAIR MARKET VALUE:

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

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 the HCAPP. 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 1st, 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 1st, 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 a HCAPP or LTC form to people who inquire in person. Offer to mail the application to people who inquire by phone. Also, advise them that the HCAPP is available on the DHS web site at www.dhs.state.mn.us.

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. 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. 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).

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

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 for MinnesotaCare when people apply for health care programs on a CAF or LTC application. Use the CAF or LTC application to determine eligibility for all health care programs. Counties that are not enrollment sites will transfer the CAF or LTC application 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 2nd household and/or does not have sufficient information to determine eligibility. In that case, send an application to the 2nd 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 1st 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 2nd application will be the same as for the 1st 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 as the application form for MA and GAMC unless:

- The household is requesting long term care (LTC) or elderly waiver (EW) services. Use the Long Term Care Application (DHS 3342). However, if an applicant requesting LTC or EW 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 1 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.

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

Require all applicants age 18 or over 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 that do not contain the signatures of all applicants age 18 or over.

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. The children are under age 18. If either child was age 18 or over, the child would also be required to sign.

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.

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.

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

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 2nd household's case file if it contains sufficient information and signatures to determine eligibility for the 2nd household. If it does not, send the 2nd household a separate application to complete and sign. The application date for the 2nd application

will be the same as for the 1st 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 a HCAPP and was approved effective May 1. In October, she enters a LTC facility. Do not require a CAF or an LTC application.

- An applicant submits a form designed for a different population. For example, do not require a long term care resident who submits a HCAPP to complete a Long Term Care application. Gather necessary 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 2nd household's case file if it contains sufficient information and signatures to determine eligibility for the 2nd household. If it does not, send the 2nd 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.

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

Although the HCAPP, CAF and Long Term Care applications 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).

People scheduled for release from correctional institutions may apply for health care 45 days before their scheduled release date. Department of Corrections (DOC) case managers assist the inmate in completing the HCAPP and the Individual Discharge Information Sheet (IDIS) (DHS 3443). The case manager sends the HCAPP and IDIS to the county in which the inmate resided before entering the correctional system unless the previous county of residence is unknown or the inmate came from another state. In those cases, the case manager sends the HCAPP and IDIS to the county in which the inmate plans to live.

Review the application to determine if verifications are needed. If the inmate anticipates receiving earned or unearned income, accept a statement of estimated income to determine eligibility. If other verifications are needed, send a verification checklist and pend the application.

When verifications are received, or if no verifications are needed:

1. Determine eligibility for MA first. If ineligible for MA, determine eligibility for GAMC. If there is no eligibility for GAMC, refer for a determination of MinnesotaCare eligibility.

2. Enter the correctional facility's address as the mailing address. If eligibility exists, approve the application according to the program-specific instructions in this section.

3. Enter a worker comment on the approval notice stating eligibility starts the date of release. The MA ID card and approval notice will be mailed to the correctional facility. The facility will give the card to the inmate on the date of release.

4. If the inmate fails to provide a new address within 30 days of the release date, update the mailing address to the address of the field service agent listed on the IDIS. Terminate coverage for the first available month with 10-day notice. This will allow the field agent to assist with providing required information to continue coverage. Reinstate eligibility if appropriate when the needed information is received.

MinnesotaCare:

Pend the application if verifications are needed. The case will auto-deny if verifications are not received within 30 days.

If verifications are received or none are needed, determine eligibility. If the applicant meets all eligibility factors, pend awaiting payment immediately to allow billing to occur.

MA:

Approve eligible applicants effective the first day of the month of release.

GAMC:

Approve eligible applicants effective the date of release.

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 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.

  If the application originally submitted to the county agency is a long term care application, use the date of the LTC application as the MinnesotaCare application date.

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, HCAPP, Long Term Care application, or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF, HCAPP or LTC application 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 HCAPP and Long Term Care application 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, address, and social security number if required. The request may be a CAF Page I, HCAPP, LTC application, or any other written request containing the required information. Applicants or their authorized representatives must submit a CAF or a 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.

All of the health care programs require that applications be processed as soon as possible, and within a certain number of days from the date of application. See §0904.07.03 (Date of Application). Processing standards are the maximum time allowed to process the application. Do not treat this time as a waiting period.

Processing the application means gathering and reviewing all the information you need to determine eligibility. During the processing period:

- Review the application for completeness. Do not require that all questions on the HCAPP be answered to determine if people are eligible.
- Contact the applicant to complete any missing items or clarify information on the application.
- Verify mandatory items. See §0904.13 (Verification) and§0904.13 .01 (Verification--MA/GAMC).
- Request the original application if the application was submitted by fax.
- Determine eligibility for each person requesting coverage.
- Send a notice approving, pending, or denying coverage. See §0916 (Notices) and §0904.07.07 (Pending the Application).
  - If the application is complete and includes all required verifications, approve or deny eligibility within the time frames in §0904.07.03 (Date of Application). If the original application was submitted by fax and includes all information and verifications needed to determine eligibility, approve the case. The household must submit the original application within 30 days of the date of the fax for eligibility to continue. If the household does not submit the original application within 30 days, send 10-day notice to terminate coverage for the 1st available month.
  - If you do not have enough information to determine eligibility, pend the application following §0904.07.07 (Pending the Application). If the original application was submitted by fax, notify the household that they must submit the original application as well as the other missing information before eligibility can be determined.

Also see the program-specific sections below.

MinnesotaCare:

Review the application and any verifications included with it as soon as it is assigned to you. If an applicant requests a personal interview, schedule it as soon as possible. Enter initial application data on MMIS within 2 working days. If the application is complete and contains all required verifications, process the application using standard processing procedures. Enter the necessary information on MMIS. If there is eligibility, enter the case as pending awaiting payment. See PEND AWAITING PAYMENT in §0902.27 (Glossary: Non-Citizen...) and §0904.07.07 (Pending the Application). If no one qualifies, deny the application.

If you cannot determine eligibility based on the information on the application, determine if you can get the necessary information by phone. If so, attempt to call the applicant. If the applicant provides the necessary information or clarification, process the application as soon as possible.

If you need information that you cannot get by phone or you are unable to reach the client and the information on the application is not sufficient to determine eligibility, send a pending notice with a verification request explaining what you need. See §0904.07.07 (Pending the Application).

When you receive all the information you need, process the application as soon as possible. Enter the case as pending awaiting payment if one or more members of the household qualifies. If no one qualifies, deny the application.

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

MA/GAMC:

Do not require a personal interview as a condition of eligibility. If the applicant requests an interview or is applying for health care with another program that requires an interview, go over the application forms with the applicant during the interview. Obtain and clarify missing information. Request mandatory verifications.

Schedule a personal interview upon request. Because LTC and EW eligibility determinations can be especially complex, counties may strongly encourage the applicant or authorized representative to meet with a worker, but may NOT require them to do so as a condition of eligibility. If the client or authorized representative requests an interview, the interview may be conducted by the servicing county, financially responsible county, or county where the authorized representative lives.

Enter available application information from the HCAPP, CAF, or LTC application on MAXIS within 2 working days of receiving the application, regardless of whether your agency is the county of residence. If you forward the application to another county, pend it on MAXIS first.

If the applicant is requesting only health care and no personal interview is scheduled, review the application forms and any verifications included with it for completeness as soon as you receive them. If you have enough information to determine eligibility for everyone requesting coverage, process the application. Enter the necessary information on MAXIS and MMIS and approve or deny for each person.

If you do not have enough information to determine eligibility for everyone, follow up with the applicant by phone or mail. If you need additional verifications, you may call the applicant and ask him/her to send the items or you may request them by mail. Pend the application following §0904.07.07 (Pending the Application).

Allow at least 10 days for the applicant to respond to the request for more information. If the applicant fails to respond, deny the application for failure to provide required information at the end of the processing period or 10 days, whichever is later. You must give the applicant 10-day notice of the proposed denial. See §0916 (Notices).

If you receive all the information you need, process the application right away. Enter the necessary information on MAXIS and MMIS and approve or deny for each person.

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

Enter applications on MAXIS or MMIS when they are received. See the program specific sections. This is known as pending the application on the system.

All 3 health care programs also have processes to pend applications when the agency cannot determine eligibility within the processing period. MinnesotaCare also pends applications when the agency needs additional information to determine eligibility and when people are eligible but have not yet sent the 1st premium payment.

MinnesotaCare:

Enter information for each person in MMIS when the application is received. Check to see if each person has a PMI number. See PERSON MASTER INDEX (PMI) NUMBER in §0902.29 (Glossary: Pension...). Ensure that a PMI number is assigned for each person who does not have one. Assign a provider number and a case number. MMIS will show the case status as pending rep review (PRR) until you determine eligibility.

If you determine that anyone in the household is eligible, enter a pending awaiting payment span for each eligible person. MMIS will determine the premium amount and generate the initial premium notice. The household has 4 months from the date the case is pended awaiting payment to make the 1st payment. MMIS automatically activates the case when the 1st payment comes in and is credited to the system. If the household does not send the initial payment within 4 months, MMIS denies the case for no payment. The household must contact MinnesotaCare and provide updated information if they want MinnesotaCare after MMIS has denied the case for initial premium not received. A new application is not required if the household makes the request within 11 months of the initial application. See §0904.05.05 (When Not to Require an Application) and §0904.05.09 (Updating the Application).

If you need more information to determine eligibility, enter a pending/incomplete span on MMIS with a begin date of the 1st of the following month. Enter the appropriate pending reason codes on the RIND screen. MMIS will generate a pending notice listing the information needed to complete the application. If MMIS still shows eligibility for any household member as pending/incomplete at the time of the following month's billing run, MMIS will generate a notice informing the household that they must submit missing information for those member(s) in 30 days. The notice will include all reasons listed on RIND. If MMIS still shows any applicant as pending/incomplete on the next month's billing date, MMIS will send a notice denying the application.

EXAMPLE:

Teresa submits an application on March 12. The representative reviews the application on March 26 and determines that Teresa needs to supply income verification. The representative enters the pending information on MMIS with a

pending span begin date of April 1. MMIS generates a pending notice requesting the income verification. If the case is still pending/incomplete on May 15, MMIS sends a notice advising Teresa that her application will be denied unless she submits the required information by June 15. If the case is still pending/incomplete on June 15, MMIS sends a denial notice.

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

MA/GAMC:

If an applicant submits only a CAF Part I, pend the application on PND1 on MAXIS. Follow the CAF instructions in the DHS Combined Manual and POLI TEMP. Although MA and GAMC do not require a personal interview, MAXIS will auto deny the application after 30 days for failure to attend the interview because the CAF I does not indicate which program(s) applicants are requesting.

If an applicant submits any other written request for health care programs (a signed, dated HCAPP or other written request that meets the requirements in §0904.07.03 (Date of Application), pend the application on PND2. In this case the agency knows the applicant is requesting only health care and a personal interview is not required. If you receive a partially completed application, contact the applicant to supply missing information. If the applicant fails to cooperate in supplying missing information within 45 days, deny the request for failure to follow through with the application process.

If you receive a complete HCAPP or a CAF II requesting only MA/GAMC, enter the application on PND2. Send a pending notice if you have not determined eligibility by the end of the processing period. See §0904.07.03 (Date of Application). The notice must explain the reason for the delay.

If the delay is due to the applicant's failure to provide information, send a pending notice 10 days before the last day of the processing period. The notice must say that the agency will deny the application unless the applicant provides the information within 10 days of the date of the notice. If the client fails to respond, send a denial notice. However, do not deny if the applicant is attempting to cooperate but is having difficulty obtaining the information. Help the applicant obtain the information. If the applicant must pay a fee for a particular document and cannot afford it, pay for the document using MA or GAMC administrative funds.

For additional information on pending the application, see TEMP Manual TE02.07.243 and TE02.07.244 (REPT/PND2, MAPP, MAPS (Parts I and II) and TE02.08.006 (Reviews: Missing Verifications).

For MinnesotaCare, the eligibility begin date depends on the date the agency receives the 1st premium payment. Some MinnesotaCare applicants can qualify for retroactive coverage. See §0904.07.09.03, (Retroactive MinnesotaCare). For MA and GAMC, the eligibility begin date depends on the date of application, the date all eligibility factors are met, and for MA, whether eligibility is retroactive.

In most cases, people cannot be open on more than 1 health care program in the same month. When an applicant is already open on 1 program and requests a different program, the begin date of the new program must be coordinated with the termination date of the 1st program. When processing an application, always check MMIS to see if any members of the household are active on another health care program. Check the status of each household member. If people are open on another program, ensure that the applicant understands they cannot remain open on both programs and that their coverage may change. Coordinate opening and closing dates with the other program. See §0904.09 (Shared and Transferred Applications).

MinnesotaCare:

The eligibility begin date is the 1st day of the month following the month in which the agency receives the initial premium payment. The payment must be received by noon on the last working day of the month for eligibility to begin the following month.

For people who are hospitalized on the date coverage would otherwise begin, coverage begins the day after the person is discharged from the hospital.

M.S. 256L.05 subd. 3

MA:

The earliest possible begin date is the 1st day of the month 3 months before the month of application for people who request retroactive coverage. People must meet all of the eligibility factors, including having an MA basis of eligibility, in each of the retroactive months. Determine eligibility for each month in the retroactive period for which people request coverage. People may be eligible for some but not all months in the retroactive period.

EXAMPLE:

Georgia, age 23, applies for MA-PW on March 25. Her estimated date of conception is February 15. February is the earliest possible month of MA-PW eligibility. She is requesting retroactive coverage to December. She did not meet an MA basis of eligibility in December or January. GAMC does not

allow retroactive coverage. Georgia is not eligible for December and January. Determine MA eligibility beginning in February.

Check MMIS to see if any household members had active MinnesotaCare spans during the retroactive months. For household members who were active on MinnesotaCare, the earliest begin date is the 1st of the month after MinnesotaCare is closed.

If any household members had pending, but not active, MinnesotaCare spans during the retroactive months, they may be eligible for MA for those months. Notify the MinnesotaCare representative when you approve MA.

For people who are not requesting or are not eligible for retroactive coverage, the begin date of eligibility is the 1st day of the month of application or the date all eligibility factors are met, whichever is later. People do not have to be eligible in the month of application. Eligibility may begin at a later date if the applicant meets all eligibility factors by the end of the processing period.

EXAMPLE:

Elmer applies for MA on November 25. He will be 65 on December 10. He does not meet an MA basis for November. He has countable assets of $2500. He has no medical bills for November and does not wish to reduce to $1000 for GAMC eligibility. He is requesting MA effective December 1. Approve the November 25 application effective December 1 if Elmer meets all eligibility factors.

Deny the application if you are unable to confirm eligibility by the end of the processing period.

The earliest date of eligibility for MA-BC is 3 months before the date of application or the 1st day of the month in which the woman was screened under MBCCCP, whichever is later. Women who are granted presumptive eligibility for MA-BC must be found eligible for ongoing MA-BC before retroactive eligibility is granted. See §0907.13.19 (MA for Breast /Cervical Cancer (MA-BC).

The earliest date of eligibility for MA-EPD is the 1st day of the month 3 months before the month of application for people who request retroactive coverage. Eligibility cannot be approved for people who have a premium until the premium is paid. Applicants who request retroactive coverage must pay the premium for each retroactive month before coverage can be approved for that month. See §0913.01.03 (MA-EPD Premiums).

GAMC:

The earliest possible begin date for GAMC with full benefits is the date of application or the date all eligibility factors are met, whichever is later. Retroactive coverage is not available for applications received on or after 10/1/03.

The earliest possible begin date for GAMC Hospital Only (GHO) is the date of application or the date all eligibility factors including hospital admission as an inpatient are met, whichever is later.

People do not have to be eligible for full GAMC or GHO in the month of application. Eligibility may begin at a later date if the applicant meets all eligibility factors by the end of the processing period. People with planned hospitalizations, such as elective surgery, may apply for GHO up to 45 days in advance. Do not approve coverage until you confirm that the admission has taken place.

People who met an MA basis of eligibility in any of the 3 months before the month of application may be eligible for retroactive MA coverage in those months.

EXAMPLE:

Eleanor applies for GAMC on March 25. She is requesting retroactive coverage to December. She lives with her daughter, Amy, who turned 18 on December 10 and is not in high school. Eleanor met an MA-AFDC related basis in December since Amy met the definition of a dependent child. Eleanor does not have an MA basis beginning in January. Determine MA eligibility for December only. Determine GAMC eligibility beginning. March 25. Eleanor is not eligible for January, February, or March 1-24 coverage because she did not meet an MA basis in those months and GAMC does not allow coverage before the date of application.

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

MinnesotaCare:

People who are terminated from MA or GAMC are eligible for retroactive MinnesotaCare if they:

1. Apply for MinnesotaCare within 30 days after the MA/GAMC termination. Consider enrollees to have met this requirement if:

   - Their MA or GAMC closes due to excess income or assets, or because a GHO enrollee is discharged from the hospital. County agencies that are MinnesotaCare enrollment sites must determine MinnesotaCare eligibility for these enrollees without requiring a new application. County agencies that are not MinnesotaCare enrollment sites must refer the case to MinnesotaCare Operations for a mandatory MinnesotaCare determination using the most recent renewal form or application. See §0904.05.05 (When Not to Require an Application) and §0904.07.03 (Date of Application).
     OR
   - People who are closed for reasons other than excess income or assets submit a HCAPP no more than 1 month after MA or GAMC ends. When processing a new HCAPP, check the MMIS RELG screen to see if there is an MA/GAMC span that will be ending or has ended no more than 1 month before receipt of the HCAPP. If so, consider the application timely.

     If the application was filed between 30 and 60 days of MA/GAMC termination, send a denial of retroactive MinnesotaCare if the applicant requested retroactive coverage on the HCAPP or by any other written request. Consider the applicant to have requested retroactive coverage if the HCAPP shows a request for coverage to begin any time before and/or including the month of application. No denial notice is needed if the application was filed less than 30 or more than 60 days after MA/GAMC termination.

2. Return all requested MinnesotaCare verifications by the end of the month following the month in which verifications are requested . The Retroactive MinnesotaCare Notice (DHS 3446) explains that the applicant has 30 days from the date of request to submit verifications. However, MMIS will not deny retroactive MinnesotaCare for lack of verifications until the end of the month following the request.
3. Are eligible for ongoing MinnesotaCare. Send the Retroactive MinnesotaCare Notice (DHS 3446) to clients who request MinnesotaCare

within 30 days of MA/GAMC termination and are:

- Verified eligible for ongoing MinnesotaCare. Send the DHS 3446 when you determine eligibility. These applicants have met the verification requirement for retroactive MinnesotaCare.

OR

- Pended for more information. Send the DHS 3446 with the Verification Request Form (DHS 3271).

Applicants pended for more information remain potentially eligible for retroactive MinnesotaCare if they return verifications by the due date and are determined eligible for ongoing MinnesotaCare. If applicants return verifications by the due date but the verifications indicate ineligibility, deny ongoing and retroactive MinnesotaCare.

If verifications are not returned by the due date, MMIS will deny retroactive MinnesotaCare.

4. Pay the initial and optional (retroactive) MinnesotaCare premiums by the end of the month following the month of premium billing. The Retroactive MinnesotaCare Notice (DHS 3446) explains that the applicant has 30 days from the date of billing to pay the premium. However, MMIS will not deny retroactive MinnesotaCare for nonpayment until the end of the month following the request.

   MMIS will deny retroactive MinnesotaCare if the initial premium is not received by the end of the month following the initial premium billing. Ongoing MinnesotaCare will remain pending for up to 3 additional months on MMIS.

   If the initial premium is received by the end of the month following the billing month, MMIS will send the optional premium notice if the household meets all requirements for retroactive coverage. The enrollee must pay the optional premium by the end of the month following the optional billing month to receive retroactive coverage. If the premiums are received, MMIS will approve retroactive MinnesotaCare from the date that MA or GAMC closed to the date ongoing MinnesotaCare began. Enrollees must accept retroactive coverage for all months in this period.

   If the optional premium is not received by the due date, MMIS will deny

retroactive MinnesotaCare. Ongoing MinnesotaCare remains active.

EXAMPLE:

Carol's extended MA ends effective July 1. She is not eligible for regular MA because of income. Her county of residence is a MinnesotaCare enrollment site. She meets the requirement of requesting MinnesotaCare within 30 days of MA termination. The county worker has all information required to determine MinnesotaCare and determines that Carol and her children are eligible. The worker approves the case as pending awaiting payment on July 6 and sends Carol the DHS 3446. Carol must pay her initial premium by the end of August (the month following the month of approval) to be considered for retroactive MinnesotaCare.

Carol's premium is received on July 23. Ongoing MinnesotaCare will begin August 1. MMIS computes Carol's retroactive premium for July and sends the optional premium notice on July 25. Carol must pay the optional premium by the end of August to have coverage for July.

EXAMPLE:

Colleen submits a HCAPP to MinnesotaCare Operations on July 10. The worker checks the MMIS RELG screen and finds that Colleen's MA ended June 30. She meets the requirement of requesting MinnesotaCare within 30 days of MA termination. The MinnesotaCare worker learns from the county worker that Colleen's MA closed because she failed to return her renewal. The MinnesotaCare worker needs new income information to determine eligibility. There is not enough information to approve the case with delayed verifications. The worker pends the case for more information on July 15 and sends the DHS 3446 with the request for income information. Colleen must return the verifications by the end of August to be considered for retroactive MinnesotaCare.

The worker receives the verifications on August 3 and determines that Colleen is eligible. The worker approves the case as pending awaiting payment. Colleen's initial premium payment must be received by the end of September to qualify for retroactive MinnesotaCare.

Colleen's initial premium is received on September 7. Ongoing MinnesotaCare will begin October 1. MMIS computes the retroactive premium amounts for July, August and September and sends the optional premium notice on September 8. Colleen must pay the retroactive premiums by the end of October to have coverage for the retroactive months. She may

not pay for only 1 or 2 months in the retroactive period.

If Colleen does not pay the optional premium for the 3 retroactive months by the end of October, MMIS will deny retroactive MinnesotaCare. Ongoing MinnesotaCare will remain active if current premiums are paid.

MMIS will generate a letter informing enrollees that coverage during the retroactive period will be fee-for-service. Enrollees who received services during the retroactive period should contact the provider and ask the provider to bill the state directly.

MMIS will base the optional premium on current household size and income. The premium amount includes all household members eligible for retroactive coverage. Apply the All or Nothing Rule if households request coverage for only some members. See §0908.11 (All or Nothing Rule).

EXAMPLE:

Jane's MA ends on June 30 for herself and her daughter Jill. They are determined eligible for MinnesotaCare on July 10. They meet all requirements for retroactive MinnesotaCare. MMIS computes the retroactive premium for both Jane and Jill. Jane contacts her worker and says she wants retroactive coverage only for Jill. Jane did not have any bills since MA ended. The worker contacts the MMIS User Services Help Desk to request an adjustment. MMIS will not generate a replacement premium notice. The worker informs Jane of the retroactive premium amount for Jill only.

Jane cannot request retroactive coverage for only herself because parents who do not have other insurance or access to ESI cannot be covered unless eligible children are covered.

Household members who are added to an active case after losing MA or GAMC do not have to pay a premium for retroactive coverage. See §0915.03 (Adding a Person to the Household).

Applicants who request ongoing MinnesotaCare with retroactive MA may submit the HCAPP to MinnesotaCare or their county of residence. If MinnesotaCare Operations receives an application requesting retroactive coverage, immediately send the original HCAPP with the Inter-Program Transfer Form (DHS 3279) and any verifications included with the HCAPP to the applicant's county of residence. Work with the county agency to process the applications simultaneously.

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

MinnesotaCare:

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

M.S. 256L.04 subd. 9

MA:

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

GAMC:

No provisions.

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

People cannot receive ongoing coverage from more than 1 health care program. In some situations, people may receive overlapping MinnesotaCare and MA for a limited period. Allow overlapping coverage when:

- MinnesotaCare enrollees eligible with benefit limits (programs XX, BB, FF or JJ) are found eligible for ongoing MA (program MA or NM). MMIS will prevent overlap with program FF. Close programs XX, BB and JJ for the first available month.

  See §0907.21.07.05 (MA for Employed Persons With Disabilities) for information on MinnesotaCare enrollees who are found eligible for MA-EPD.

- MinnesotaCare enrollees with an MA basis of eligibility apply for MA for hospital bills not covered by MinnesotaCare. See §0913.21.07 (MinnesotaCare Inpatient Hospitalization).

- MinnesotaCare enrollees apply for and are found eligible for MA for services not covered under MinnesotaCare.

  Both MinnesotaCare and MA cover some pregnancy terminations. In some cases, the procedure may be covered by MA but not MinnesotaCare. MinnesotaCare enrollees may apply for MA to cover these costs. Determine if the woman is eligible for MA-PW. Open and close MA on MAXIS and MMIS in 1 action. Allow overlapping coverage for the month of the service only. Leave MinnesotaCare open unless the enrollee requests ongoing MA. To ensure that these enrollees have expanded benefits during the 60-day post partum period, open program LL or KK for the 2 months following the month of pregnancy termination. Do not change the eligibility type for children under 21 on program LL or KK from C1/C2 to pregnant woman eligibility type P1/P2 as they already receive full MA benefits.

  MinnesotaCare does not cover certain services such as long term care or waivered services for adults who are not pregnant women (programs XX, BB, FF or JJ). Allow coverage to overlap when MinnesotaCare enrollees apply for and are found eligible for MA to cover these services. Close MinnesotaCare for the first available month if the client needs ongoing MA. If the client received short term MA services and wishes to remain on ongoing MinnesotaCare, open and close MA in 1 action.

  See the MMIS User Manual, MinnesotaCare, Coordination of Coverage for more information.

  MinnesotaCare and GAMC may not overlap. This includes people who are changing from GAMC Hospital Only (GHO) to MinnesotaCare Limited Benefit (MLB) or the

reverse. In some cases, MMIS may require both programs to remain open for 1 month if changes occur after capitation or 10-day notice cutoff.

If it is not possible to close GAMC Hospital Only (GHO) before the approval month for MinnesotaCare, contact the MMIS User Services Help Desk to back date the GHO closing span before approving MinnesotaCare.

EXAMPLE:

Kwame is hospitalized from November 20-23. He is approved for GHO for those dates on November 28. He is then determined to qualify for retroactive MinnesotaCare Limited Benefit (MLB) starting December 1. It is not possible to close the GHO span until December 31. Contact the MMIS User Services Help Desk before approving MinnesotaCare.

EXAMPLE:

Eloise receives MLB. She enters the hospital on March 28 and voluntarily cancels MinnesotaCare the same day. April capitation has already been paid. MinnesotaCare will close at the end of April. Eloise is still hospitalized on April 1, so she requests GHO. MMIS will allow GHO and MLB to overlap for April only.

See Bulletin #99-21-1 (Prevention of Overlapping GAMC and MinnesotaCare Eligibility) dated August 13, 1999, and the MMIS User Manual for more information.

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 on the authorized representative question on the HCAPP, or the appropriate designation on the CAF or LTC 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 HCAPP, CAF or LTC 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).

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

Verification means 3rd party or other documentation of an eligibility factor. The most common sources of verification are documents in the client's possession, such as pay stubs and immigration documents, and written verification from 3rd parties such as employers. Do not request 3rd party verification without the client's signed permission. The signed release must identify the source and the specific information to be requested.

Do not require more than 1 type of verification for the same eligibility factor. For example, do not require an employer's statement and pay stubs for the same period if 1 source contains all the required information. For MinnesotaCare, consider W-2s and tax forms to be a single type of verification.

Assist clients in obtaining verification if the client is unable to provide it. If neither the client nor the agency is able to obtain outside verification, accept the client's written statement.

Verify information for which verification is not mandatory ONLY if ALL of the following conditions exist:

- The information is necessary to determine eligibility or the amount of the premium or spenddown.
- The information is inconsistent with other information the agency has (or with a client's own statements).
- The client cannot satisfactorily explain an inconsistency.

Document the following information in the case record:

- A description of the inconsistency.
- An explanation of why verification was necessary.
- A description of the verification.

MinnesotaCare:

Verify the following:

- Immigration status for people who are requesting coverage who indicate they are non-citizens. Do not require verification of U.S. citizenship. See §0906.03 (Citizenship and Immigration Status) and §0906.03.03 (Qualified Non-Citizens).
- Social Security Number (SSN). Require a number for each adult and child who is

requesting coverage or who is required to be included in the household under the all or nothing rule according to the instructions in §0906.11 (Social Security Number--MinnesotaCare). Do not require copies of social security cards or other documents for people who report a number. Require proof of application for an SSN for any person who does not have one.

- Pregnancy. See §0907.09 (MinnesotaCare Pregnant Women) for a list of acceptable verifications. If an enrollee reports she is pregnant, change her status to pregnant woman pending verification. See §0915.13 (Enrollee Becomes Pregnant).

- Earned income. For people who are not self-employed, accept pay stubs, employer statements obtained with the client's signed permission, the previous year's tax forms or other documentation verifying current earnings. Request pay stubs or employer statements verifying the past 30 days of earnings for employed clients who submit no verification of earnings with the application or renewal or who submit verifications that do not reflect current employment. Do not require additional verification if the client submits documentation reflecting current employment with the application or renewal.

  EXAMPLE:

  Mae submits her annual Renewal Form. She includes her previous year's tax forms and W-2s. The W-2 for her current employer reflects 5 months of earnings. Use the W-2 to determine Mae's earnings for the coming year. Do not require additional verification.

  If Mae did not have a W-2 from her current employer, you would request other verification of current earnings.

Request the most recent year's tax forms for self-employed people. Accept business records from people who have had a significant change since the most recent tax forms or who did not file taxes. See §0911.09.03 (Self-Employment Income).

See §0911.11 (Computing Countable Income--MinnesotaCare) and §0911.11.01 (Computing Income--MinnesotaCare - Part 2) for instructions on computing countable earned income.

For seasonally employed people, accept verification of earnings for the most recent 30-day period in which the person was seasonally employed, the most recent year's tax forms and W-2s or other documentation reflecting the current

seasonal earnings. See §0911.09.09 (Seasonal Income) for policy on computing annual income for seasonally employed people.

Verify countable earned income of all household members. Do not require verification of earnings of dependent children under age 19 who are students. See §0911.09.05 (Dependent Child Income).

- Good cause for non-cooperation with medical support enforcement. See §0906.13.07 (Good Cause Determination).

M.S. 256L.04 subd. 2b, 10
M.S. 256L.05 subd. 2
M.S. 256L.09 subd. 4
Minnesota Rule 9506.0020 subp. 1a, 1f, 1g
Minnesota Rule 9506.0030 subp. 2a

See §0904.13.01 (Verification - MA/GAMC) for MA and GAMC verifications.

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

See §0904.13 (Verification) for general provisions and MinnesotaCare verifications.

MA:

Verify the following:

- Immigration status for people who are requesting coverage who indicate they are non-citizens. Do not require verification of U.S. citizenship. See §0906.03 (Citizenship and Immigration Status) and §0906.03.03 (Qualified Non-Citizens). Follow the time frames in §0906.03.11 (Verification of Immigration Status).

- Social Security Number (SSN). Do not require social security cards or other documents showing the number. Require proof of application for an SSN for people who do not have one. See §0906.11.01 (Social Security Number--MA/GAMC).

- Blindness and disability for people claiming a blind or disabled basis of MA eligibility. See §0906.15 (Disability Determinations).

- Good cause for non-cooperation with medical support enforcement. See §0906.13.07 (Good Cause Determination)

- Eligibility for state and Title IV-E adoption assistance. See §0907.19.03.05 (MA Basis: Adoption Assistance).

- Pregnancy. See §0907.19.05 (MA Basis: Pregnant Women) for information on types of verification and time lines.

- Enrollment in Medicare Part A when required for eligibility for QMB, SLMB, QWD, or QI. See §0907.21.09 (MA Basis: Medicare Supplement Programs).

- Liquid assets if total reported assets are within $300 of the asset limit. See §0909.05.03 (Verification of Assets).

  EXCEPTION:

  For spousal asset assessments, verify all assets at the time of the assessment, application, and first recertification.

- Reduction of assets on medical bills for a retroactive period. See §0909.29 (Excess Assets--Applicants).

- Earned and unearned income. Require verification of earned and unearned income in the 30 days before application. Require verification of actual income received in each retroactive month for people requesting retroactive coverage. Examples of verification sources include pay stubs and employers' statements, tax forms, copies of checks for some types of unearned income, award letters, and court orders. See the specific income sections in §0911 (Income) for more information.

- Allowable self-employment expenses. Request the most recent year's tax forms. Accept business records for people who did not file taxes or who report a significant change. See §0911.09.03 (Self-Employment Income).

See §0907.21.07.06 (MA-EPD: Employment Definition) for specific requirements for verifying earnings and self-employment income for MA-EPD.

- Medical expenses to meet spenddown. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determine Net Medical Expenses), and §0913.21.05 (MinnesotaCare Expenses to Meet Spenddown).

- Long Term Care Consultation (LTCC). See the long term care sections in §0913 (Premiums and Spenddowns).

GAMC:

Verify the following:

- Immigration status for non-citizens. See §0906.03.11 (Verification of Immigration Status).

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

- State residence. See §0906.05.07 (State Residence--GAMC).

- Liquid assets if total reported assets are within $300 of the asset limit. See §0909.05.03 (Verification of Assets).

- Earned and unearned income. Require verification of earned and unearned income in the 30 days before application. Examples of verification sources include pay stubs and employers' statements, tax forms, copies of checks for some types of unearned income, award letters, and court orders. See the

specific income sections in §0911 (Income) for more information.

- Allowable self-employment expenses. Request the most recent year's tax forms. Accept business records for people who did not file taxes or who report a significant change. See §0911.09.03 (Self-Employment Income).

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

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.

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 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. 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 1st 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 1st 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).

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

MinnesotaCare:

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

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

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

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

If the renewal is received in the renewal month, treat the renewal form as a new application. If a terminated household reapplies more than 1 month after they submit a renewal form, contact the household to update the information on the renewal form. Do not require a new application if the renewal was completed in the 11 months preceding reapplication. See §0904.05.05 (When Not to Require an Application).

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

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

EXAMPLE:

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

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

EXAMPLE:

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

EXAMPLE:

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

notice reflecting the new amount for November and December the same day. The family remains active as long as the November premium is received by the last working day of October.

EXAMPLE:

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

If the renewal was received via fax and includes all information and verifications needed to determine renewed eligibility, continue coverage. The household must submit the original renewal form within 30 days from the date of the fax. If the household fails to submit the original renewal form, send 10-day notice to terminate coverage for the 1st available month.

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

MA/GAMC:

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

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

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 2nd month before the month the renewal is due. For monthly reporters, MAXIS mails the form around the 27th of the 2nd 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 2nd 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 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.

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 a 10-day notice to terminate for the 1st 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 or verifications, 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 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.

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

MinnesotaCare:

No provisions.

MA:

Require people to complete a monthly Household Report Form (HRF, DHS 2120) if they have:

- A manual monthly spenddown.

OR

- An LTC spenddown with income changes each month.

See §0913.11 (Manual Monthly Spenddown Calculation) and §0913.13 (Long Term Care Spenddown Calculation).

MAXIS will send the HRF to households 6 working days before the end of the month the HRF covers. The household must submit the report by the 8th day of the month following the month it covers. MAXIS will send a Notice of Late Household Report Form (DHS 2114) if the household does not submit the report on time.

MAXIS will send a 10-day notice of termination if the household does not submit the report by 10-day notice cutoff. If the HRF has not been received by the end of the month, the case remains closed. Reinstate the case if the household returns the HRF before the end of the month and remains eligible.

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

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

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

EXAMPLE:

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

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

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

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

EXAMPLE:

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

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

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

NON-LONG TERM CARE CASES:

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

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

Require verification of current income (previous 30 days) to determine eligibility for the next 6-month budget period. Do not require enrollees to verify all income for the previous 6-month period. MA does not reconcile actual income against income used in a projection. Base projections on the most accurate information available at the time of the renewal. Also see §0911.11.03 (Computing Countable Income--

MA/GAMC).

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

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

LONG TERM CARE CASES:

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

GAMC:

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

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

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

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

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

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

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

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

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

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

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

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

MinnesotaCare:

Qualified non-citizens are eligible for MinnesotaCare if they meet all other eligibility requirements. Pregnant women and children up to age 21 who meet the citizenship and immigration requirements for Medicaid are eligible to receive federal financial participation under program LL. Low income parents and caretakers who meet the Medicaid citizenship and immigration requirements are eligible to receive federal financial participation under program FF.

Lawful non-citizens who do not meet a qualified status may be eligible for state-funded MinnesotaCare. See §0906.03.05 (Non-Citizens Ineligible for Federal Funding) and §0906.03.13 (MinnesotaCare Major Programs) for more information.

MA:

Non-citizens who meet a qualified status can receive federally funded MA (program MA) if they meet all other requirements. See §0906.03.03 (Qualfied Non-Citizens).

Non-citizens who meet a basis of MA eligibility but do not qualify for federally funded MA because of date of entry or length of time in the U.S. qualify for program NM if they meet all other eligibility factors. See §0906.03.05 (Non-Citizens Ineligible for Federal Funding).

GAMC:

Non-citizens who are in the U.S. lawfully and meet residency requirements but who do not meet a basis of MA eligibility may be eligible for GAMC. There is no federal funding for GAMC. See §0906.03 (Citizenship and Immigration Status) and §0907.25 (GAMC Bases of Eligibility).

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

Non-citizens who do not meet the criteria in §0906.03.03 (Qualified Non-Citizens) and §0906.03.03.03 (Qualified Non-Citizens--Program Provisions) are ineligible for the federally funded health care programs (MinnesotaCare programs LL and FF and program MA). They may be eligible for 1 of the state-funded programs: MinnesotaCare programs KK, BB, JJ, or XX, NM or GAMC. See the program-specific provisions below. See §0906.03.09 (Undocumented and Non-Immigrant People).

MinnesotaCare:

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

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

MA:

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

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

- Lawful Permanent Residents. See §0906.03.11.03.

  NOTE:

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

- Immigrants granted parole for at least 1 year. See §0906.03.11.11.
- Conditional entrants. See §0906.03.11.09.

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

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

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

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

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

- Deferred Enforced Departure.

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

- Family Unity Beneficiary.

- Lawful Temporary Resident (LPR).

- Temporary Protected Status.

- Applicant for Asylum.

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

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

GAMC:

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

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

- Students and their dependents admitted on a student visa.

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

- Tourists.

- Diplomats and their dependents.

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

MinnesotaCare:

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

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

People with 1 of the Other Lawfully Residing statuses may be eligible for MinnesotaCare. See §0906.03.11.23 (Other Lawfully Residing) and §0906.03.13 (MinnesotaCare Major Programs).

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

Public Law 104-193
42 CFR 435.403 - 435.408
M.S. 256L.09 subd. 2

MA:

Most non-immigrants are ineligible for MA program MA and program NM. Although they are legally present in the U.S., their temporary immigration status prevents them from having a qualified status and from meeting state residency requirements. People with 1 of the Other Lawfully Residing statuses may be eligible. See §0906.03.11.23 (Other Lawfully Residing). Most undocumented people are ineligible for MA program MA and program NM.

EXCEPTIONS:

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

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

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

Non-immigrant and undocumented people who have a medical emergency may be eligible for emergency MA (EMA, program EH). They must meet an MA basis of eligibility and meet all other MA requirements except for citizenship and immigration status. See §0907.29.03 (Emergency MA).

GAMC:

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

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

- EMA

OR

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

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

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

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

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

MinnesotaCare:

Follow general provisions.

M.S. 256L.04 subd. 10

MA:

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

GAMC:

Follow general provisions.

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

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

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

- MA. This includes state-funded MA (program NM), except for undocumented and non-immigrant people receiving services from the Center for Victims of Torture (CVT) or undocumented/non-immigrant pregnant women.
- Refugee Medical Assistance (RMA).
- GAMC.
- MinnesotaCare for families with children.

Do NOT use SAVE for the following programs:

- EMA.
- State-funded MA (program NM) for people whose eligibility is based solely on receipt of services from the Center for Victims of Torture (CVT) or who are undocumented/non-immigrant pregnant women.
- MinnesotaCare for adults without children.

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

To use SAVE for applicants:

1. Request verification of immigration status if required for the programs(s) for which the person is applying. See §0906.03.11 (Verification of Immigration Status).
2. Determine eligibility for the appropriate program(s).

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

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

1. Request verification of the new status.

2. Redetermine eligibility based on the new status.

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

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

Do NOT use SAVE:

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

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

- For people who are not requesting coverage for themselves.

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

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

MinnesotaCare:

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

MA:

Follow general provisions. Do not use SAVE for EMA.

GAMC:

Follow general provisions.

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

MinnesotaCare:

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

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

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

- U.S. citizens.

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

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

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

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

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

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

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

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

- Deferred Enforced Departure.
- Entered the U.S. before 1-1-72 and has maintained continuous residence under Section 249 of the INA.
- Family Unity Beneficiary.
- Lawful Temporary Resident (LTR).
- Temporary Protected.
- Applicant for asylum.
- Paroled for less than 1 year.

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

Use Program XX (some co-payments and hospital benefits limitation without FFP, $500 dental cap with no co-pay on restorative dental) for adults with children with family income over 275% FPG but less than $50,000, eligibility type M2.

Use Program BB for all adults who are not parents and who have family income equal to or less than 175% FPG. Some people may be ineligible due to citizenship or residency. See §0906.03.09 (Undocumented and Non-Immigrant People) and §0906.05 (State Residence). Use program BB with eligibility type M1 and "G" indicator on the RIMG screen for adults without children with incomes equal to or less than 75% FPG. These enrollees receive the same benefit set as program XX except for a 50% co-pay on restorative dental. Use program BB with eligibility type M3 and "1" or "2" income indicator on the RIMG screen for adults without children with incomes greater than 75% FPG but no more than 175% FPG. These

enrollees are eligible for the MinnesotaCare Limited Benefit (MLB) set.

Use program FF (with FFP) for parents and relative caretakers who are not pregnant, have income at or under 275% FPG, and who:

- Are U.S. citizens.

- Have 1 of the following immigration statuses regardless of date of entry:

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

- Have 1 of the following immigration statuses with date of entry before 8-22-96:

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

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

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

- All legal guardians and foster parents.

- Non-citizen parents and relative caretakers with 1 of the following

immigration statuses and date of entry on or after 8/22/96:

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

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

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

Program JJ adults with incomes less than or equal to 175% FPG have restorative dental with a 50% co-pay and no inpatient hospital co-payment or cap. Program JJ adults with incomes over 175% FPG but equal to or less than 275% FPG have restorative dental without a co-pay and a $10,000 inpatient hospital cap. They do not have an inpatient hospital co-payment.

MinnesotaCare:

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

MA:

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

GAMC:

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

Do not apply the 30-day residency requirement if:

- A household member has a medical emergency meeting the definition in 0907.29 (Emergency MA). Although there is no emergency program under GAMC, people who are eligible for regular GAMC and have an emergency may be approved before the 30-day period is up.
- The county waives the 30-day residency requirement for GA. Waive the GAMC requirement as well.
- A household member is a migrant worker who verifies that the household worked and earned at least $1,000 in Minnesota within 12 months preceding the month of application. The $1,000 may have been earned from sources other than migrant work.

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

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

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

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

Residence in certain types of facilities or institutions may affect people's eligibility for health care programs.

MinnesotaCare:

See §0906.09 (Institutional Residence--MinnesotaCare).

MA:

In general, people living in public institutions are ineligible for MA. A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises control. The term public institution does not include:

- A publicly operated community residence that serves no more than 16 residents.
- A public child care facility that meets federal child care institution criteria.
- A public educational or vocational training institution where people reside for purposes of securing education or training.

People placed in public institutions for a temporary period pending other specifically planned arrangements appropriate to their needs are not considered to be residents of public institutions and eligible for MA if they meet other eligibility requirements.

EXAMPLE:

Alex is eligible for MA and is to be placed in a foster home, but there are no openings available for 2 weeks. He is placed in a correctional facility in which permanent placements are not eligible for MA. Alex remains MA-eligible during his temporary placement.

People living in public or private Institutions for Mental Diseases (IMDs) are ineligible for federally-funded MA (even if they are getting MSA) unless they meet one of the exceptions below. An IMD is defined as a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

The following people are eligible for MA while residing in an IMD if they meet ALL of the other MA eligibility requirements:

- Residents age 65 or older.
- Residents of IMDs accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) who are receiving inpatient psychiatric treatment, if the residents are under age 21 or have lived continuously in an IMD since before their 21st birthday and are under age 22.
- People enrolled in MA managed care plans who are placed in an IMD by their health plan. These people remain on MA with the same basis and budget as they had when placed by the health plan.
- Residents released from IMDs on convalescent leave or conditional release.

People who live in an IMD who are ineligible for federally-funded MA solely due to IMD residency are eligible for state-funded MA benefits through program IM, except for coverage of nursing homes that are IMDs.

See §0907.27 (MA/GAMC Basis: IMD Residents).

People sentenced to correctional or penal facilities, including people participating in work release programs, are ineligible for MA. Consider people to be under the control of the penal system from the time of arrest. They cease to be under the control of the penal system when they are released:

- On their own recognizance.
- On bail.
- As not guilty.
- On probation.

  EXCEPTION:
  People released on probation but placed in public institutions as a condition of probation are ineligible for MA.

- On parole or supervised release, or, in the case of a juvenile, on extended furlough (usually 90 days).

- On pardon.
- Upon completing sentence.

Inmates scheduled for release from correctional facilities may apply for MA or GAMC 45 days before their release date. Eligibility cannot begin until they are actually released. See§0904.07.01 (Applications in Advance of Inmate's Release).

Do not consider people to be released from the control of the penal system when they are transferred from a correctional facility to a medical facility for treatment.

Do not consider people under civil court hold orders to be under the control of the penal system.

The Department of Corrections (DOC) licenses some private and public (as defined at the beginning of this section) facilities that are not state correctional or penal facilities. Residents of secured juvenile facilities licensed by the DOC which are for holding, evaluation, or detention purposes only, are not eligible for MA. Residents of group homes licensed by the DOC which are not secured and are not primarily for detention purposes may be eligible for MA.

People who reside in chemical dependency (CD) residential treatment facilities licensed under Rule 35 who meet eligibility criteria are eligible to have treatment costs paid through the Consolidated Chemical Dependency Treatment Fund (CCDTF). If they are otherwise eligible for MA, MA will pay for services unrelated to the treatment.

GAMC:

People may be eligible for GAMC if they live in institutions. However, GAMC does not pay for the cost of care in an institution. GAMC will pay for medical and remedial care which is not provided by the institution.

People who live in an IMD who do not meet a basis of eligibility for MA may be eligible for GAMC for medical and remedial care which is not provided by the institution.

See §0907.27 (MA/GAMC Basis: IMD Residents).

People are ineligible while residing in a penal institution unless they meet the following conditions:

- Detainment must be for less than 1 year in a county correctional or detention facility, or the person must be an inpatient in a hospital on a criminal hold order.

AND

- The person must have been a recipient of GAMC at the time of arrest or admission to the hospital on a criminal hold order.

AND

- The person must be otherwise eligible for GAMC.

People who reside in chemical dependency (CD) residential treatment facilities licensed under Rule 35 who meet eligibility criteria are eligible to have treatment costs paid through the Consolidated Chemical Dependency Treatment Fund (CCDTF). If they are otherwise eligible for GAMC, GAMC will pay for services unrelated to the treatment.

MinnesotaCare:

See §0906.11 (Social Security Number--MinnesotaCare).

MA:

Applicants or enrollees who do not provide or apply for an SSN are ineligible with the following EXCEPTIONS:

- Children eligible as auto newborns are not required to apply for or provide a SSN through the end of the month of their 1st birthday. Children who were eligible as auto newborns and turned age 1 prior to July 1, 2003, are not required to apply for or provide a SSN through the month of the 2nd birthday. See §0907.19.05.03 (MA Basis: Auto Newborn).

- Children meeting all other eligibility requirements are eligible even if their parents refuse to provide or apply for SSNs for them. The parents are ineligible.

- Undocumented people and non-immigrants who are applying for or enrolled in EMA are not required to provide SSNs.

- Undocumented people and non-immigrants who receive state-funded MA (program NM) as pregnant women or because they receive services from the Center for Victims of Torture (CVT) are not required to provide SSNs.

- Adults who refuse to obtain SSNs are eligible if they provide convincing evidence that the refusal is based on well established religious objections. A person who claims this exemption must show membership in a recognized sect or division. A statement that the person objects to obtaining a SSN for religious reasons or other personal beliefs is not sufficient.

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

- Refugee Medical Assistance (RMA) applicants and enrollees are not required to apply for or provide SSNs. See §0907.21.13 (MA Basis: Refugee medical Assistance - RMA).

Use the SSA/DHS data exchange to verify the social security number for all

applicants or enrollees. Enter each person's reported social security number (SSN) and appropriate code on the MAXIS STAT/MEMB panel. Do not require people to submit documents to verify the number pending verification through the data exchange.

The computer system will verify the social security number by entering a validation code on the MAXIS STAT/MEMB panel. If the client information does not match the social security number, you will get a DAIL/DAIL message. The message will list the discrepancy. Clarify the information by comparing the information on the STAT/MEMB panel to the case file or by contacting the client for more information. You may ask the client to submit documents if necessary to clarify the discrepancy. Do not deny or terminate MA if the client is unable to submit documents containing the SSN.

If applicants or enrollees do not have or do not know their SSNs:

1. Get a completed or partially completed and signed Application for Social Security Number (SS-5) for each person without a reported SSN.

2. Highlight areas on the SS-5 that are not complete.

3. Enter the MAXIS Person Master Index (PMI) number in the NPN block at the bottom of the SS-5.

   2 4 0 (3 digit state code)
   ___ ___ ___ ___ ___ ___ ___ ___ (8-digit PMI number, including zeros added to the beginning of the number as fillers).

   EXAMPLE:
   If the PMI is 12345, the PMI for the SS-5 is 240-00012345.

4. Keep a photocopy of the signed SS-5 in the case file.

5. Tell the client to mail or take the SS-5 form with supporting evidence to the local Social Security Administration office. The client must be able to verify age, identity, and lawful non-citizenship status. The SS-5 form describes acceptable types of supporting evidence.

After SSA assigns a number, the data exchange system will supply the number to MAXIS. Follow up at the time of the scheduled recertification if no number has been assigned. Have the client complete a new SS-5 if necessary.

A parent may request a Social Security Number (SSN) for a newborn child on the birth certificate application. The state vital statistics office forwards the birth registration data to the Social Security Administration (SSA), where an SSN is issued and a Social Security card is sent to the parent(s) for the child.

Accept form SSA-2853-OP4 (Information About When You Will Receive Your Baby's Social Security Card) as verification that an SSN application has been made. Retain the form or a copy of the form in the case file.

Remind the parent(s) that they must report the SSN to the county agency when the number is received. The SSN assigned to the child will not be included on the SSA/DHS tape exchange.

GAMC:

GAMC applicants and enrollees must provide SSNs with the following exception:

- People who provide convincing evidence that their refusal to obtain a SSN is based on well established religious objections. See MA.

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

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

GAMC applicants must complete the form Required Questions for GAMC (DHS 3423) at the time of application.

People are ineligible for GAMC if they admit in writing on the form that they:

- Were convicted of a drug felony on or after 7-1-97. This disqualification also applies if the county agency has other reliable verified documentation that a person has been convicted of a drug felony.

  A person convicted of a drug felony is ineligible for 5 years from the date of completion of the terms of the court-ordered sentence, UNLESS the person meets 1 of the following conditions:

  - Participates in a drug treatment program.
  - Has successfully completed a drug treatment program.
  - Has been assessed as NOT needing a drug treatment program.

  People who meet one of the above conditions are eligible for GAMC if they meet all other eligibility requirements. However, the convicted person is subject to random drug testing as a condition of eligibility. DHS suggests that county agencies coordinate efforts with local probation or court services to establish procedures and share costs of random drug testing for these clients.

  If the client fails a drug test, or the county is informed by a probation officer or other official entity that the client has failed a drug test, the client is ineligible for assistance for 5 years beginning the 1st of the month following the month of the positive test result for an illegal controlled substance.

  A subsequent drug conviction while receiving assistance results in ineligibility for the convicted person beginning the month after the date of conviction, and continuing for 5 years after completion of sentence.
  Do not disqualify other household members because of 1 member's drug

conviction or drug test failure. Continue to deem the ineligible member's income and assets. See §0908.07 (Household Composition: Deeming).

- Are currently in violation of a condition of probation, parole, or supervised release. This disqualification also applies if the county agency has other reliable verified documentation that the client is a parole violator.

  Parole violators are ineligible until they provide documentation that they are no longer in violation. Other household members remain eligible. Continue to deem the ineligible person's income and assets. See §0908.07 (Household Composition: Deeming).

- Are currently fleeing prosecution, custody, or confinement after being convicted of a felony. This disqualification also applies if the county agency has other reliable verified documentation that the client is a fleeing felon.

  Fleeing felons are ineligible until they provide documentation that the issue has been resolved. Other household members remain eligible. Continue to deem the ineligible person's income and assets. See §0908.07 (Household Composition: Deeming).

- Have been convicted of making a fraudulent statement regarding residence in order to receive duplicate assistance simultaneously within a state or from 2 or more states. These people are ineligible for 10 years from the date of conviction. This disqualification also applies if the county agency has other reliable verified documentation that the client has been convicted of fraud based on false statements about residency.

  Other household members remain eligible. Continue to deem the ineligible person's income and assets. See §0908.07 (Household Composition: Deeming).

- Received SSI or RSDI that ended after 3-29-96 because of drug addiction and/or alcoholism. If the person responds "no" to this question but the case record contains contradictory information, submit a question to DHS via HealthQuest with a heading of "DA&A Review". Fax all necessary documentation. Continue eligibility unless the HealthQuest response directs otherwise. Close GAMC if the person responds "yes" to this question.

  If you deny or terminate GAMC due to DA&A, send E-mail to Julie Skoy MAXIS E-mail GTW) with the following information:

Subject: DA&A Denial/Termination
(Enrollee Name) (PMI Number) has been denied/terminated from GAMC due to DA&A effective (date). He answered "yes" to DA&A.

Require people to complete Required Questions for GAMC (DHS 3423) only at the time of application. Do not require the form at any other time, including renewal.

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

People's eligibility for the health care programs may vary depending on certain characteristics. The relevant characteristics vary by program but may include age, disability, pregnancy, and presence of children in the home.

MinnesotaCare:

All MinnesotaCare enrollees are assigned to 1 of 4 eligibility groups. Eligibility group status mainly affects insurance barrier requirements and MMIS coding for benefits. Certain characteristics within groups such as pregnancy, age, and income may also affect benefits. See the following sections for more specific information:

§0907.09	MinnesotaCare Pregnant Women.
§0907.11	MinnesotaCare Children Under 21.
§0907.13	MinnesotaCare Parents/Guardians/Caretakers.
§0907.15	MinnesotaCare Adults Without Children.

Adults and children in the same household may be assigned to different eligibility groups. Re-evaluate group status at each renewal. Once people are assigned an eligibility group, their group status remains unchanged between renewals unless:

- They do not maintain continuous enrollment. For purposes of group status, continuous enrollment means that a person has been enrolled in MinnesotaCare without a break in coverage of one month or more.

OR

- They have a change in circumstances that results in a more favorable group status. This includes Group 2 parents or caretakers who report income decreases resulting in Group 4 status. See §0915.15 (Change in MinnesotaCare Eligibility Group).

OR

- A parent loses parental status.

OR

- A child turns age 21.

EXCEPTION:

Children who were enrolled in the Children's Health Plan on or before 6-30-93 who have maintained continuous enrollment retain Group 1 status until they reach age 21. See §0907.03 (MinnesotaCare Eligibility Group 1).

See §0907.03 (MinnesotaCare Eligibility Group 1), §0907.05 (MinnesotaCare Eligibility Group 2), §0907.07 (MinnesotaCare Eligibility Group 3) and §0907.08 (MinnesotaCare Eligibility Group 4).

M. S. 256L.02 subd. 4
M. S. 256L.03 subd. 1, 3, and 5

MA:

Each person must meet a basis of eligibility for MA. A basis of eligibility is a set of characteristics such as age, disability, or family status. The bases of eligibility are based on federal eligibility categories. See §0907.17 (MA/GAMC Bases of Eligibility).

GAMC:

People who do not meet a basis of eligibility for MA may be eligible for GAMC. See §0907.17 (MA/GAMC Bases of Eligibility).

MinnesotaCare:

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

Group 2 includes:

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

  EXCEPTION:

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

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

NOTE:

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

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

- Legal guardians and foster parents.

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

- Reach age 21.

OR

- Are no longer part of a family with children.

If people who originally enrolled in Group 2 reapply after losing coverage for 1 month or

more, redetermine eligibility based on current circumstances.

EXAMPLE:

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

EXAMPLE:

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

EXAMPLE:

Bruce moves out of his parents' household. Assign his parents to a non-parent major program (BB and the appropriate group status) for the next available month with 10-day notice. If their income exceeds 175% FPG, terminate coverage for the 1st available month with 10-day notice. When Bruce submits an application for coverage on his own MinnesotaCare case, re-evaluate his group status and assign him to the appropriate group status if his income is equal to or less than 175% FPG.

When Group 2 parents report an income decrease that results in meeting Group 4 criteria, change group status for the 1st available month. Act on income increases at the time of the next renewal.

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

The income limit at application for Group 2 children, pregnant women and minor parents is 275% FPG. The income limit for other parents, relative caretakers, legal guardians and foster parents is 275% FPG or $50,000, whichever is less.
Group 2 enrollees who maintain continuous enrollment can have income over the limit and remain enrolled, except for parents (other than pregnant women and minor

parents), relative caretakers, legal guardians and foster parents whose income exceeds $50,000. See §0912.03.03 (MinnesotaCare Excess Income).

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

MA/GAMC:

No provisions.

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

MinnesotaCare:

Also see §0907 (Eligibility Groups and Bases of Eligibility), §0907.03 (MinnesotaCare Eligibility Group 1), §0907.05 (MinnesotaCare Eligibility Group 2) and §0907.08 (MinnesotaCare Eligibility Group 4).

Group 3 includes adults who:

- Are not pregnant.

AND

- Do not have children under 21 (including foster children or children under guardianship in the household) living with them.

AND

- Have incomes greater than 75% FPG but no more than 175% FPG.

This includes adults previously enrolled in Group 2 or Group 4 who have lost their parental status.

NOTE: Group 3 status is used to identify people who are eligible for MinnesotaCare Limited Benefit (MLB) on MMIS. Adults without children with incomes equal to or less than 75% FPG have a different benefit set and MMIS coding.

EXAMPLE:

John, age 26, is applying for MinnesotaCare for the first time. He has no children under 21 in his household. His income is 100% of FPG. Assign John to Group 3.

EXAMPLE:

Mary and Joe are Group 2 parents. Their children have left the household. Since Mary and Joe no longer have minor children in their household, re-determine their eligibility as adults without children.

Group 3 members are subject to all the insurance barriers. See §0010 (Other Health Coverage).

The income limit for Group 3 is 175% FPG.

M. S. 256.9354 subd. 1 and 5
M. S. 256.9357 subd. 1, 2, and 3
M. S. 256.9366 subd. 1, 2, 3, and 4
MA/GAMC:

No provisions.

MinnesotaCare:

Children born to mothers who were enrolled in MinnesotaCare during the month of delivery are automatically eligible for MinnesotaCare as long as the child continues to live with the mother. Automatic eligibility begins on the 1st day of the month of the child's birth and continues through the last day of the month of the child's 1st birthday without regard to premium payments, income, household composition, or insurance availability. If other insurance exists, notify Benefit Recovery so benefits can be coordinated. See §0910 (Other Health Coverage).

NOTE:

The age limit for auto newborn eligibility changed from age 2 to age 1 effective July 1, 2003. Children who were enrolled as auto newborns and who turned age 1 before July 1, 2003, remain eligible as auto newborns through the month of the 2nd birthday.

EXAMPLE:

Nora is born on February 2. Her mother, father, and brother are enrolled in MinnesotaCare at the time of her birth. The family loses eligibility at the time of the next scheduled renewal in May because they have insurance. Nora remains eligible as an auto newborn through the month of her 1st birthday as long as she continues to live with her mother. Notify Benefit Recovery if Nora has other health insurance.

If the mother applied after the end of her pregnancy or too late in the course of her pregnancy to be determined eligible for any month she was pregnant, transfer the application to the applicant's county of residence for retroactive MA coverage if the mother requests it. See §0904.09.07 (MinnesotaCare With Retroactive MA/GAMC).

EXAMPLE:

Tina applies for MinnesotaCare on May 28. She is determined eligible on June 7. Her initial premium payment is received on June 20 and enrollment begins July 1. Tina has a baby on June 15. Tina requests MA to cover the costs of the birth. Transfer the application to her county of residence for determination of retroactive MA eligibility. If Tina is eligible, she may choose to enroll her child in either MinnesotaCare or MA as an auto newborn.

Children who are eligible as auto newborns on MA are also eligible as auto newborns on MinnesotaCare if the mother chooses to receive coverage for the child through MinnesotaCare instead of MA at any time between the child's birth and the month of the child's 1st birthday. See §0907.19.05.03 (MA Basis: Auto Newborn).

Consider the child to live with the mother through the 60-day postpartum period even if the child remains in the hospital after the woman is discharged. If the child leaves the hospital but lives apart from both parents for more than 1 full calendar month, cancel MinnesotaCare. If a foster parent or relative caretaker applies for MinnesotaCare for the child, the child must meet all eligibility criteria.

EXAMPLE:

Brian is born on March 4 to a woman enrolled in MinnesotaCare. Brian remains in the hospital because of medical problems until April 15, when he is placed in foster care. Terminate MinnesotaCare for Brian effective May 1.

If the mother legally relinquishes control of the child before the child leaves the hospital, consider the child to be out of the mother's household starting with the 1st full calendar month for which you can give 10-day notice after papers are signed giving custody and control of the child to an agency or person other than the mother. This could be a pre-adoptive placement or foster home placement of any duration. Terminate MinnesotaCare for the 1st available month. Advise the child's foster or pre-adoptive family that they may apply for MinnesotaCare for the child unless the child is on MA. The child is no longer eligible as an auto newborn and must meet all eligibility criteria. See §0908.03 (Determining MinnesotaCare Household Size).

If the child is legally adopted, terminate MinnesotaCare for the 1st available month. The adoptive parents must apply for the child as part of their household.

If legal custody and control of the child is returned to the mother, the child again becomes automatically eligible for MinnesotaCare through the month of the child's 1st birthday.

EXAMPLE:

Brian was born on March 4 to a woman enrolled in MinnesotaCare. He was placed in foster care on April 15. MinnesotaCare was terminated and MA was approved effective May 1. Brian returns to live with his mother on August 10. MA is terminated effective September 1. His mother requests continued MinnesotaCare coverage for him, although she is no longer eligible and is not requesting coverage for herself. Approve MinnesotaCare for Brian effective September 1. Do not require a new application even if the last application is more than 11 months old.

Auto newborns will continue on the existing renewal schedule even if no other household members remain eligible. Do not cancel an auto newborn for non-renewal

before the month following the child's 1st birthday. If auto newborns are canceled by the system for non-renewal, the MMIS Help Desk will send E-Mail to MinnesotaCare representatives to reinstate eligibility for the newborn only. If the renewal is received, continue coverage for the newborn regardless of information reported on the renewal. Redetermine the newborn's eligibility for the month after the 1st birthday.

M.S. 256L.05 Subd. 3
M.S. 256B.057

MA:

See §0907.19.05.03 (MA Basis: Auto Newborn).

GAMC:

No provisions.

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

MinnesotaCare:

MinnesotaCare adults without children include people age 21 and over who are not pregnant and are not parents, relative caretakers, or foster parents of children under 21 in their care. This includes relative caretakers and foster parents who have no biological or adoptive children living with them and who choose not to apply for relative or foster children in their care.

It also includes adults previously enrolled in Group 1, Group 2 or Group 4 who are now age 21 and over and do not have children in their home.

Being an adult without children affects MinnesotaCare eligibility in the following ways:

> Adults without children are not eligible for federal financial participation regardless of group status. They must meet the residency requirements for MinnesotaCare adults without children and must have or apply for a social security number. See §0906.05.05 (State Residence--MinnesotaCare Adults) and §0906.11 (Social Security Number--MinnesotaCare).

> The income limit for adults without children is 175%. Adults without children with incomes equal to or less than 75% FPG are eligible for the Basic Benefit Set Plus One. Adults without children with incomes greater than 75% FPG but equal to or less than 175% FPG are eligible for MinnesotaCare Limited Benefit (MLB) set.

Certain disabled adults without children must apply for MA. Refer the following MinnesotaCare applicants to MA:

> People who receive SSI based on disability or blindness. Refer SSI recipients under age 65 regardless of whether they indicate they are disabled on the application.

> People who receive other benefits, including RSDI, based on disability or blindness if they are potentially eligible for MA without a spenddown. Income must be equal to or less than 100 percent of FPG for the household size. See §0912.07.100 (100 Percent of FPG Standard). Refer these people if information on the application indicates assets are equal to or less than $3,000 for a household of 1 or $6,000 for a household of 2. Also refer them if the asset information on the application is missing or incomplete. See §0909.05 (Asset Limits).

Refer people ages 21 to 62 who receive RSDI and are potentially eligible without a spenddown regardless of whether they indicate they are disabled on the application.

Refer people who meet these criteria to their county of residence to apply for MA. They may request to have the HCAPP transferred or they may choose to contact the county directly. Advise people who choose to contact the county directly that they will have to complete another HCAPP. See §0904.09.03 (Transfers From MinnesotaCare to MA/GAMC).

Approve MinnesotaCare for people who meet MinnesotaCare eligibility criteria while the MA application is pending. People may receive MinnesotaCare for up to 60 days beginning with the 1st day of the month coverage begins. People who have not cooperated with the MA determination by the end of the 60-day period must be canceled for the next available month.

At the end of the first month of eligibility, check MAXIS to determine if the client appears to be cooperating with MA or if the client is eligible for MA.

> For clients who have not yet been determined MA eligible, send a letter reminding them that MinnesotaCare eligibility will end if they fail to cooperate with the MA determination and that, if eligible for MA without a spenddown, they must accept MA and MinnesotaCare will be closed.

> If the client has already been determined MA eligible, cancel MinnesotaCare for the 1st available month.

For clients who have not yet been determined MA eligible at the end of the 1st month of MinnesotaCare eligibility, check MAXIS again at the end of the 2nd month.

> If the client has been denied MA for non-cooperation, cancel MinnesotaCare effective the last day of the month following the end of the 60-day time period.

> If the client has been approved for MA, cancel MinnesotaCare for the 1st available month.

> If MA eligibility has not yet been determined and the client is cooperating, allow MinnesotaCare to continue until a determination is made.

Contact the county financial worker if you are unsure of the client's status after

checking MAXIS.

EXAMPLE:

Marcia, an adult without children, applies for MinnesotaCare on October 13. She indicates she is disabled and receives SSI. MinnesotaCare notifies her that she must apply for MA. She does not wish to have her application transferred and indicates that she will contact her county of residence. She is found eligible for MinnesotaCare and is enrolled effective November 1 after making her initial premium payment.

The MinnesotaCare representative checks MAXIS at the end of November and finds that Marcia has not yet applied for MA. The representative sends a letter reminding Marcia that she must cooperate with the MA determination and that MinnesotaCare will end if she fails to cooperate. MinnesotaCare eligibility continues for December. At the end of December, the enrollment representative checks MAXIS and finds that Marcia has not yet submitted an application. Send a notice terminating MinnesotaCare effective February 1.

M. S. 256.9354 subd. 5

MA:

No provisions.

GAMC:

See §0907.25 (GAMC Program Types).

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

MinnesotaCare:

No provisions.

MA:

Each person must meet a basis of eligibility for MA. A basis of eligibility is a set of characteristics such as age, disability, or family status. The bases of eligibility are based on federal eligibility categories.

Generally, all children under age 21 meet a basis of eligibility. See §0907.19.03 (Families and Children Basis: Child Under 21). Some children may meet more than one basis. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility).

Adults meet a basis of eligibility if they are:

- Pregnant. See §0907.19.05 (MA Basis: Pregnant Women).
- Caretakers who meet a parent/caretaker basis. See §0907.19.07 (MA Families & Children: Parents/Caretakers).
- Age 65 or older. See §0907.21.03 (MA/Medicare Savings Basis: Age 65 & Over).
- Blind. See §0907.21.05 (MA/Medicare Savings Basis: Blindness).
- Disabled. See §0907.21.07 (MA/Medicare Savings Basis: Disability).

Adults who receive MSA or RCA or who are eligible for TMA/TYMA also meet a basis. People who receive MSA or RCA do not have to accept automatic MA.

See the following sections:

§0907.19.09 (MA Determination for MFIP)
§0907.19.11 (Transitional/Transition Year MA)
§0907.21.11 (MA Basis: MSA Recipients)
§0907.21.13 (MA Basis: Refugee Medical Assistance - RMA)

Certain qualified immigrants who do not meet immigration status requirements for federally funded MA program MA may qualify for MA services through state-funded MA program NM if they meet an MA basis of eligibility. The instructions in this chapter governing MA bases of eligibility apply to both program MA and program

NM.

People who are age 65 or over, blind, or disabled may be eligible for QMB, SLMB, QWD, or QI benefits instead of or in addition to MA. See §0907.21.09 (MA Basis: Medicare Savings Programs) for an explanation of these programs.

Some people are eligible for a waiver of certain eligibility requirements or additional covered services through the waiver programs. The waiver programs have disability and/or age requirements. See §0907.23 (MA Waiver Programs).

Except for certain waivers, people who meet a basis must meet all other program requirements to be eligible.

EXAMPLE:

Maria is 16. She has an MA basis of eligibility as a child under 21 and has income within the MA limits. She is an undocumented non-citizen. Because she doesn't meet the citizenship and immigration requirements for MA program MA or MA program NM, she is not eligible for MA. She could be eligible for EMA if she has a medical emergency. See §0907.29 (Medical Emergency Programs).

EXAMPLE:

Paul meets a disabled basis of eligibility for MA. His assets exceed the limit. He is not eligible for MA even though he meets a basis because he does not meet the asset requirements of the program.

Assist people who meet more than one basis of eligibility in determining which basis is most advantageous. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility).

The basis of eligibility determines which eligibility method to use. There are 2 methods. Method A is based on the rules of the former AFDC program in effect as of 7-16-96. People using a families with children basis of eligibility use Method A. See §0907.19 (MA Families and Children Bases).

Method B is based on the rules of the SSI program. People with an aged, blind, or disabled basis of eligibility used Method B. See §0907.21 (MA Basis: Age 65 and Over/Blind/Disabled).

The eligibility method governs the determination of countable income and assets, including exclusions and allowable income deductions. Chapter 9 (Assets) and Chapter 11 (Income) contain instructions on treatment of various types of income and

assets. In some cases, Method A and Method B do not differ. When Method A and Method B have different rules, follow the instructions for the appropriate method.

EXAMPLE:

Susan and Bill are both self-employed and claim depreciation on their tax forms. Susan uses Method A and Bill uses Method B. Method A does not allow a deduction for depreciation, while Method B does. Compute Susan's net income using Method A rules. Compute Bill's net income using Method B rules.

If people become ineligible under one basis, determine if they meet another basis. Leave MA open under the original basis while the determination is in process. See §0915.15.01 (Change in MA/GAMC Basis of Eligibility).

GAMC:

Consider eligibility for GAMC for people between age 21 and age 65 who do not meet an MA basis. See §0907.25 (GAMC Program Types).

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

MinnesotaCare:

No provisions.

MA:

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

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

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

Asset limit:

There is no asset limit for children under age 21.

Income limit:

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

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

For children ages 2 through 18, the income standard is 170% FPG (MAXIS Standard G). See §0912.07.170 (170 Percent of FPG). Children with incomes over 170% FPG may be eligible by spending down to the 100% FPG standard (MAXIS Standard E). See §0912.07.100 (100 Percent of FPG).
For children ages 19-20, the income standard is 100% of FPG. See §0912.07.100

(100 Percent of FPG). Children ages 19-20 with incomes over this standard may be eligible by spending down to 100% of FPG.

MinnesotaCare:

See §0907.09 (MinnesotaCare Pregnant Women).

MA:

All pregnant women have a basis of eligibility for MA (program MA or program NM). See §0906.03 (Citizenship and Immigration Status). The pregnancy must be verified by a physician, registered nurse, licensed nurse midwife or physician's assistant. If the pregnancy has already been verified by MinnesotaCare or a cash program, do not require additional verification. If an applicant or enrollee states she is pregnant, contact her to obtain the estimated date of conception and delivery. If you are unable to reach her, use an estimated date of delivery pending receipt of verification. Verification of pregnancy must be submitted within 60 days. If verification is not received, determine whether the woman is eligible under another basis.

Pregnant non-immigrants and undocumented non-citizens are eligible for program NM through the 60-day postpartum period. They may be eligible for EMA for labor and delivery costs. It is not necessary to change pregnant women's eligibility from NM to MA for labor and delivery. MMIS will identify any emergency claims and submit them to EMA.

Eligibility may begin on the 1st day of the verified month of conception, but no sooner than 3 months before the month of application.

Use Method A.

There is no asset limit for pregnant women.

Consider the pregnant woman to be a household of 2, or more if she is expecting a medically verified multiple birth.

The income standard for pregnant women (program MA and program NM) is 275% of FPG (MAXIS Standard C). See §0912.07.275 (275 Percent of FPG Standards). Women with income in excess of this standard must spend down to100% of FPG (MAXIS Standard E) to qualify. See §0912.07.100 (100 Percent of FPG Standards).

Expedite applications from pregnant women. See §0904.07.03 (Date of Application). Allow pregnant women who want to apply for MA-only to file an application at certain locations other than the county agency. See §0904.07 (Accepting and Processing Applications).

If a woman applied before or after the end of her pregnancy and was eligible without a spenddown for the budget period, her eligibility continues through the last day of the month in which the 60-day postpartum period ends. The pregnancy can end with birth, abortion, miscarriage, or stillbirth. Once you determine verified eligibility as a pregnant woman, do not consider changes in income during the pregnancy or 60-day post partum period.

If the woman was eligible with a spenddown, she must continue to meet the spenddown to remain eligible through the post partum period. Do not increase the spenddown due to increases in income. However, changes in earned income disregards or household composition may affect the spenddown amount.

Assess continued MA eligibility for women during the 60-day post partum period. If the woman was on MA before she became pregnant, OR other household members are on MA with the same basis that would apply to the woman after pregnancy, continue eligibility with no spenddown without further review until the next regularly scheduled review date. For other women, redetermine eligibility using information in the case record. Request other information from the woman if necessary. If eligibility continues under another basis, leave MA open under the new basis. If eligibility does not exist under another basis, close MA on the last day of the month after the 60-day post partum period. See §0905 (Reviews and Renewals).

Children up to age 1 born to a woman eligible for MA at the time of the birth have a basis of eligibility which is not dependent on the mother's continued eligibility, as long as the child continues to live with the mother. This includes children born to women who applied after the birth and were made eligible retroactively to the date of birth or before. See §0907.19.05.03 (MA Basis: Auto Newborn).

EXAMPLE:

Christine applies for MA when she is 3 months pregnant. She is single and has no other children. She is found eligible for MA-PW. She marries the child's father 3 months later. His income combined with Christine's exceeds the income limits. Do not terminate Christine's MA. If she applies for continued MA at the end of the 60-day postpartum period, consider her husband's income. The child remains eligible through the month of the 1st birthday, if living with Christine, without regard to Christine or the father's income.

Do not require a pregnant woman to cooperate with any paternity or medical support matter for any child in her household during the pregnancy or 60-day postpartum period. See §0906.13.03.03 (Medical Support Referral--Newborns).

EXAMPLE:

Maureen receives MFIP and MA for herself and her son Patrick. On May 15, she reports she is pregnant and due in November. On June 10, the child support officer reports that she is not cooperating in establishing paternity for Patrick. Do not terminate Maureen's MA for non-cooperation. Follow MFIP rules to determine her continued eligibility for cash. At the end of the 60-day postpartum period, she must cooperate with the child support office if she wants continued MA for herself.

Require pregnant women to cooperate with TPL and tort requirements as a condition of initial and continued eligibility. See §0910 (Other Health Coverage).

EXAMPLE:

Greta is pregnant and applies for MA. She has insurance through her job which will cover some of the pregnancy costs. The insurance is determined to be cost effective. The county must pay the premiums and Greta must keep the insurance as long as it remains cost effective and available to her. Terminate or deny MA if Greta refuses to cooperate with the cost effectiveness determination or with keeping the cost effective coverage in effect.

NOTE:

Do not consider leaving employment or taking a maternity leave as non-cooperation.

Apply state residency requirements to pregnant women. See §0906.05.03 (State Residence--MinnesotaCare Families, MA).

EXAMPLE:

Marlene is 6 months pregnant and has been receiving MA for 4 months. She reports she is moving to Utah permanently. Terminate MA effective the 1st month for which you can give 10-day notice following the move.

GAMC:

No provisions.

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

MinnesotaCare:

See §0907.09.03 (MinnesotaCare Auto Newborns).

MA:

All children born to women who applied for MA before or after the birth and were eligible at the time of the birth are automatically eligible and remain eligible for MA through the month of their 1st birthday without regard to income, assets, or household composition as long as the child continues to live with the mother in Minnesota.

NOTE:

The age limit for auto newborn eligibility changed from age 2 to age 1 effective July 1, 2003. Children who were enrolled as auto newborns and who turned age 1 before July 1, 2003, remain eligible as auto newborns through the month of the 2nd birthday.

Auto newborn eligibility includes:

- Children born to women on MA program MA.
- Children born to women on MinnesotaCare program LL or KK, if they choose to receive MA rather than MinnesotaCare for the newborn.
- Children born to women on program NM or EMA.

EXAMPLE:

Joan receives MFIP and MA. Her daughter Melissa is born on January 12. Joan's 60-day postpartum period ends March 31. On April 10 she marries Melissa's father, Pete. MFIP for Joan and Melissa and MA for Joan terminate effective April 30 because Pete's income exceeds the limits for both programs. Melissa remains eligible for MA as an auto newborn through the month of her 1st birthday.

EXAMPLE:

Marike is an immigrant permanently admitted to the U.S. She does not meet the immigration status requirements for program MA and receives program NM. She has a child on October 12. EMA pays for the delivery costs. The child is eligible for MA program MA throughout the month of the 1st birthday as long as the child continues to live with Marike.

EXAMPLE:

Brad and Sandra are enrolled in MinnesotaCare with their 2 children. Sandra is pregnant and receives program LL. They have a baby on November 2 and choose to enroll the baby in MA instead of MinnesotaCare. The baby is eligible as an auto newborn throughout the month of the 1st birthday.

If a child eligible as an auto newborn is part of a household who loses eligibility for MA under another basis, such as TMA or TYMA, continue the child's eligibility as an auto newborn through the month of the child's 1st birthday.

EXAMPLE:

Renee gives birth to a son, Greg, while receiving MA. When Greg is 6 months old, Renee's earnings increase and she now has a spenddown. She is eligible for TYMA. Greg remains eligible as an auto newborn throughout the TYMA period and through the month of his 1st birthday.

Consider the child to live with the mother through the 60-day postpartum period even if the child remains in the hospital after the woman's discharge. If the child leaves the hospital but lives apart from both parents for more than 1 full calendar month, redetermine the child's eligibility using only the child's income, starting with the 1st full calendar month apart.

EXAMPLE:

Barbara gives birth to a son on August 12. She is discharged from the hospital on August 14. The child remains hospitalized until October 16 due to medical problems. On October 16, the child leaves the hospital and goes to live with Barbara's mother. Consider the child eligible as an auto newborn on Barbara's case through October. Remove the child from Barbara's case effective November 1. The grandmother may apply for MA for the child.

If the child returns to live with Barbara before the 1st birthday, the child regains auto newborn status through the month of the 1st birthday.

See §0907.19.05.05 (Adding/Removing Auto Newborns) for additional provisions relating to auto newborns.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

If the mother legally relinquishes control of the child before the child leaves the hospital, consider the child to be out of the mother's household starting with the 1st full calendar month for which you can give 10-day notice after papers are signed giving custody and control of the child to an agency or person other than the mother. This could be a pre-adoptive placement or foster home placement of any duration. The most common forms of documentation are the Voluntary Foster Care Placement Agreement, the Agreement Conferring Authority to Place Child for Adoption, or a court order. Redetermine eligibility using only the child's income. Continue basing eligibility on only the child's income until either:

- The child is legally adopted. Begin deeming the adoptive parents' income starting with the 1st full calendar month after the adoption is finalized, unless the child receives adoption assistance. See §0907.19.03.05 (MA Basis: Adoption Assistance).

OR

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

EXAMPLE:

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

All children born to a woman on MA are eligible to be added to the mother's case as an auto newborn for the month of birth, including children who are placed for adoption immediately. If the mother is enrolled in a managed care plan, enroll the newborn in the same plan effective the 1st of the next available month. See §0914.03.13 (Adding/Removing People From Managed Care).

Obtain the newborn child's name and birth date. For MA-only cases, do not require

an addendum. Document the information in the case record. Also do not require a name as a condition of adding a child for whom the mother has relinquished care or control.

EXAMPLE:

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

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

EXAMPLE:

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

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

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

Minnesota residency.

EXAMPLE:

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

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

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

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

MAXIS will determine potential eligibility for TMA or TYMA separately for each family member who:

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

AND

- Is one of the following:

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

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

AND

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

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

EXAMPLE:

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

EXAMPLE:

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

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

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

AND

- Remain in a household that includes a dependent child.

AND

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

EXAMPLE:

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

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

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

EXAMPLE:

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

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

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

EXAMPLE:

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

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

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

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

EXAMPLE:

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

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

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

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

EXAMPLE:

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

Melissa's income increases above 100% FPG when her disregard cycle ends.

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

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

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

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

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

  EXAMPLE:

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

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

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

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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 1-1-03 through 12-31-03 is $1,656 for all EW applicants or enrollees, regardless of marital status or household size. The SIS for 1-1-02 through 12-31-02 is $1,635. 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 1st day of the month.

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

For more information on community spenddowns see

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

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

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

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

- The LTC spouse has had a LTCC screening.

AND

- The LTC spouse requires a nursing facility level of care.

AND

- Home care services began prior to the LTCC date and are anticipated to continue for at least 30 consecutive days after the LTCC date.

OR

- Home care services which are anticipated to last for at least 30 consecutive days will begin within 90 days of the LTCC date.

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

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

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

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

  EXAMPLE:

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

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

- Receive GRH payments and do not have an MA basis of eligibility.

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

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

There are 2 benefit sets for GAMC with different income and asset limits. People with incomes equal to or less than 75% FPG and assets equal to or less than $1,000 receive full GAMC benefits. People with incomes between 75% and 175% FPG and assets equal to or less than $10,000 for a household of 1 and $20,000 for a household of 2 or more may qualify for limited coverage while in the hospital through the GAMC Hospital Only (GHO) program. See §0907.25.03 (Full GAMC) and §0907.25.05 (GAMC Hospital Only).

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

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

People who do not have a basis of eligibility for MA and who meet the technical eligibility requirements for GAMC are eligible for all GAMC covered services if they meet the income and asset limits.

Asset limit:

- $1,000 per household. Follow MA Method B to determine which assets to exclude and how to evaluate countable assets.

  See §0909.05 (Asset Limits).

Income standard:

- 75% of FPG for a 6-month budget period. See §0912.07.075 (75 Percent of FPG Standard). Use gross income. Follow Method B to determine what income is excluded.

There are no spenddown provisions. People with incomes between 75% FPG up to 175% FPG may qualify for GAMC Hospital Only (GHO) or MinnesotaCare. People with incomes greater than 175% FPG do not qualify for GAMC.

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

MinnesotaCare:

No Provisions.

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

Asset limit:

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

See §0909.05 (Asset Limits).

Income standard:

More than 75% FPG but no more than 175% FPG for a 6-month budget period. See §0912.07.075 (75 Percent of FPG Standards) and §0912.07.175 (175 Percent of FPG Standards). Use gross income. Follow MA Method B to determine what income to exclude.

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

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

MinnesotaCare:

No provisions.

MA:

People receiving care and rehabilitation services from the Center for Victims of Torture (CVT) who do not meet MA eligibility criteria are eligible for state-funded MA (program NM) while they receive CVT services.

Do not require verification of receipt of CVT services for people who are otherwise eligible for federally-funded or state-funded MA. MA will pay for covered services received through CVT.

Determine MA eligibility for applicants receiving CVT services. If an applicant is ineligible for federally-funded or state-funded MA because of:

- Citizenship/immigration status

OR

- Assets

OR

- Income in excess of the standard to qualify without a spenddown

OR

- Lack of an MA basis of eligibility.

Request a copy of the CVT acceptance letter dated within the past 30 days. If the applicant submits an acceptance letter more than 30 days old, request updated verification to determine if the applicant is still receiving services. Approve program NM for the period of CVT services.

Verify continued receipt of CVT services at each income review and recertification. If services end and the person is not otherwise eligible for MA, terminate program NM.

EXAMPLE:

Raoul submits a HCAPP. He includes a CVT acceptance letter dated within 30 days of the date of application. He is undocumented and ineligible for MA. Approve program NM for the period in which he receives CVT services. Verify continued receipt of CVT services at each income review and recertification.

EXAMPLE:

Olga submits a HCAPP. She includes a CVT acceptance letter dated within 30 days of the date of application. She meets all eligibility requirements for federally-funded MA. Approve MA. If MA eligibility ends due to immigration status, assets, income or lack of an MA basis, verify whether she continues to receive CVT services. If so, approve program NM for the period in which she receives the services.

If current enrollees indicate they have begun receiving CVT services, take no action if they remain eligible for MA. If MA eligibility ends, request verification of continued CVT services. Approve program NM while the CVT services continue.

EXAMPLE:

Keisha receives MA. At the time of her annual renewal, she reports increased income. She is unable to meet a spenddown for continued eligibility. She submits a current CVT acceptance letter. Approve program NM for the period of CVT services.

Use MAXIS eligibility type GS with income standard X for people who are eligible for program NM only because they receive CVT services.

When you identify a case as receiving CVT services, contact the MAXIS Help Desk to request security. Once the Help Desk has established security, the primary worker may add a secondary worker. In SPEC/XFER, select "Transfer Information" or "Transfer County to County" and transmit. PF9 to edit the panel. Add the secondary worker number after the "Servicing Worker" number. Only the primary and secondary workers, mentors, and supervisors will have access to these cases. The security will remain as long as the case is active on MAXIS, regardless of whether the person continues to receive CVT services.

MinnesotaCare:

No provisions.

MA:

No provisions.

GAMC:

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

- Stepparents and spouses of non-parent caretakers with gross family incomes equal to or less than 75% FPG. See §0912.07.075 (75 Percent of FPG Standards).

- Adult caretakers with gross family incomes equal to or less than 75% FPG if no child in the home meets the MA definition of a dependent child. See §0902.09 (Glossary: Denial...). This includes:

  - Caretakers of children age 18 who are not in high school or are not expected to graduate by the 19th birthday.

  - Caretakers of children ages 19 and 20.

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

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

- Receive GAMC automatically with GA.

- Have a pending disability status from SSA or SMRT. If they are found disabled, they meet an MA basis. If they are determined not to be disabled, refer them to MinnesotaCare if they appear to meet all requirements.

- Appear ineligible for MinnesotaCare due to:

  - Current health insurance.

  - Lack of state residence.

- Immigration status.

- Residence in Group Residential Housing (GRH) or an Institution for Mental Diseases (IMD).

➢ Have incomes between 75% and 175% FPG and are eligible for GAMC Hospital Only (GHO). Determine MinnesotaCare eligibility when GHO ends. However, GHO enrollees are not required to accept MinnesotaCare as a condition of future GHO eligibility.

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

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

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

When people meet MinnesotaCare criteria:

1. Determine MinnesotaCare eligibility if your county is a MinnesotaCare enrollment site unless the client asks to have MinnesotaCare eligibility determined at MinnesotaCare Operations. See §0904.03.03 (MinnesotaCare Enrollment Sites). If your county is not an enrollment site or the client requests service at MinnesotaCare Operations, transfer the complete application to MinnesotaCare Operations with the STTD (DHS 3392). Send or give the Mandatory Referral Form Letter (DHS 3398) to the client. Leave GAMC open during the MinnesotaCare determination.

2. Monitor for MinnesotaCare eligibility. If you are not processing the MinnesotaCare application, check the MMIS RELG screen monthly.

3. When MinnesotaCare is approved, terminate GAMC for the 1st month for

which you can give 10-day notice. Calculate a shortened spenddown for any months in the 6-month certification period before MinnesotaCare begins. See §0913.19 (Shortened Spenddown).

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

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

EXAMPLE:

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

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

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

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

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

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

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

MA-EPD:

- $20,000

No asset limit for children under 21.

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

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

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

MA-EPD:

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

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

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

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

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

EXAMPLE:

Mary, age 35, receives MA for herself and 2 children. She is placed in an IMD for an estimated stay of 3-4 months. She is ineligible for MA solely due to IMD residence. Determine eligibility for program IM eligibility using the MA Parent/Caretaker asset limit ($6,200 for Mary and 2 children) and income limit (100% of FPG). Use Method A.

People who are eligible for program IM are eligible for MA if they have been discharged from the IMD or are on convalescent or conditional leave. See §0906.09.01 (Institutional Residence --MA/GAMC).

People who are enrolled in program IM solely due to IMD residence are also

ineligible for the Medicare Supplement Programs. Reimburse cost-effective Medicare premiums for this group. See §0910.05.05 (Medicare Premium Payment).

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

GAMC:

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

Asset limit:

- $1,000 per household.

See §0909.05 (Asset Limits).

Income standard:

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

EXAMPLE:

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

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

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

MinnesotaCare:

No provisions.

MA:

People who are not otherwise eligible for MA because of immigration status or deemed income and assets of a sponsor who is not a household member may be eligible for emergency MA (EMA, program code EH) if they have a medical emergency. DHS may be able to claim federal reimbursement for people enrolled in program NM who have medical emergencies.

To be eligible for EMA, people must:

- Meet 1 of the MA bases of eligibility described in sections §0907.19 through §0907.23 of this chapter.
- Meet MA income and asset limits. See §0912.07 (Income Standards) and §0909.05 (Asset Limits).
- Have a medical emergency.
- Be ineligible for regular MA solely due to their immigration status or deeming of sponsor income and assets. See §0906.03 (Citizenship and Immigration Status).

A medical emergency for EMA purposes occurs when a person meets any of the following 3 circumstances:

- Has a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

  - Place the person's health in serious jeopardy.

  OR

  - Cause serious impairment to bodily functions.

  OR

  - Cause serious dysfunction of any bodily organ or part.

  Accept the client's statement that the client was in severe pain at the time of treatment. Verify medical service dates and open EMA only from the date the medical emergency begins until the medical emergency ends.
  Examples of such conditions include stroke, heart attack, abscessed teeth,

broken bones, ear infections, and kidney failure.

➢ Has a chronic medical condition which, if left untreated, could reasonably be expected to:

- Place the person's health in serious jeopardy.

OR

- Cause serious impairment to bodily functions.

OR

- Cause serious dysfunction of any bodily organ or part.

Examples of such conditions include insulin dependent diabetes, HIV positive with complications, cancer, kidney disease, and tuberculosis.

Verify with a physician's statement confirming both the condition and the consequences if left untreated. Open Emergency MA for as long as the chronic condition persists. Reverify the condition and consequences of not receiving medical treatment at each recertification, or sooner if the client's health is expected to improve.

➢ Gives birth.

Pregnant women who are ineligible for MA solely due to their immigration status are eligible for program NM for the duration of the pregnancy and the 60-day postpartum period. EMA will cover the labor and delivery costs. MMIS will identify these costs and seek federal reimbursement through EMA. It is not necessary to change pregnant women's eligibility from program NM to EH for labor and delivery.

For pregnant women who are requesting EMA for labor and delivery costs only, approve EMA for the period from the onset of labor through delivery. EMA will not cover prenatal or postpartum care. If the woman is open on program NM, leave program NM open throughout pregnancy and postpartum period. Program NM will cover prenatal and postpartum care. The MMIS claims system will automatically seek federal reimbursement for labor and delivery costs.

EMA is available for the duration of the medical emergency. People with chronic conditions as described in §0907.29 (Medical Emergency Programs) may be eligible indefinitely if the condition persists. EMA does not cover preventive care, organ transplants, or home and community based waivered services. See the DHS Provider

Manual for more information on covered services.

Children who are ineligible for MA due to immigration status may receive EMA under the TEFRA option if they have a medical emergency. See §0907.23.09 (MA Waiver Programs: TEFRA).

GAMC:

No provisions.

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

Include the following people in the MinnesotaCare household:

- Parents, spouses, stepparents, and children ages birth to 21 who live in the same household. Except for temporary absences, children must live in the household at least 50% of the time to be included. See §0908.13 (Temporary Absence--MinnesotaCare - Part 1) and §0908.13.01 (Temporary Absence--MinnesotaCare - Part 2).

  Consider adopted children to be members of the household beginning on the 1st day of the month in which they are placed for adoption.

See §0908.03.05 (MinnesotaCare HH Size/Non-Parent Caretakers) for instructions on determining the household size when foster parents, relative caretakers, or legal guardians apply for children in their home.

Emancipated minors and their spouses and children must be separate households. See §0908.09 (Who Must Be Excluded From the Household).

Count an unborn child (or children, if a multiple pregnancy is verified) in a pregnant woman's household size.

Count the following people in the same household:

- All people who have a parental OR a marital relationship. If 2 people in the same household both have a parental or marital relationship to a 3rd household member, those people will be in the same household even if they do not have a parental or marital relationship with each other. Paternity does not need to be legally established for a parental relationship to exist. Accept applicants' and enrollees' statements on the health care application unless there is contradictory information.

  EXAMPLE:

  Bob and Sue are an unmarried couple who live with their daughter. Because both Bob and Sue have a parental relationship to the daughter, they are included in the same household even though they have no parental or marital relationship with each other.

  EXAMPLE:

  George and Martha are a married couple who each have a child from a previous marriage living with them. Because George and Martha have

a marital bond, and each has a parental bond with the children, include everyone in the same household.

EXAMPLE:

Debra and Mark are an unmarried couple who live together and are expecting a child. They do not anticipate a multiple birth. Debra is a household of 2. Mark is a separate household of 1 because he and Debra do not have a marital bond. Until the baby is born, he does not have a parental bond. When the baby is born, they will become a combined household of 3.

EXAMPLE:

Marsha lives with her 2 minor children and her friend Tim, who is not the children's father. Marsha and the children are a household of 3. Tim is a separate household of 1 because he does not have a marital or parental bond with another household member.

Follow the steps below to determine eligibility for a 3-generation household (grandparent(s), minor parent(s) and child(ren) of the minor parent(s) The household may include both parents of the 3rd generation child.

1. Determine eligibility for the entire household. If all members are eligible, treat as a single household.

2. Determine eligibility separately for the 3rd generation child(ren) using only the income of the minor parent(s) and the child(ren), if the 3rd generation child(ren) are ineligible because:

   - Total household income under step 1 is over 275% FPG.

   OR

   - Total household income under step 1 is over 150% FPG and the minor parent's child(ren) are underinsured.

   OR

   - The grandparents refuse to cooperate in providing information needed to determine the 3rd generation child(ren)'s eligibility under step 1.

   Set up a separate case for the 3rd generation child(ren).

   If the other parent of the 3rd generation child(ren) also lives in the household but is not married to the minor parent include the 2nd parent and his/her income in the calculations in steps 1 and 2 above. If total household income

including any income of the 2nd parent is equal to or less than 275% FPG, treat as a single household. If the 3rd generation child is ineligible under step 1 or step 2, determine eligibility separately for the 2nd parent and the 3rd generation child. Include the minor parent in the household size and include his/her income in the eligibility calculation, but deny coverage for the minor parent .

EXAMPLE:

Anne lives with her unmarried 16-year-old daughter Sara and Sara's 1-year-old son Jacob. Because Sara has a parental relationship with both Jacob and Anne (she is Anne's daughter and Jacob's mother), all 3 are included in the same household even though there is no parental relationship between Jacob and Anne. Total household income is under 275% FPG and no one in the household has other insurance or access to ESI. All 3 household members are determined to be eligible. Include all 3 on a single case.

EXAMPLE:

Bob and Grace live with their 19-year-old daughter Linda, her 1-year-old daughter Rachel, and Rachel's father Justin. Linda and Justin apply for MinnesotaCare for themselves and Rachel. Total household income, including Bob and Grace, is over 275% FPG. Redetermine eligibility for Rachel and Justin only using a household size of 3 and Linda, Justin and Rachel's income, if any. Linda is not eligible because her parents' income must be counted for her.

M.S. 256L.01 Subd. 3a and subd. 13
Minnesota Rules 9506.0010 subp. 11 and 17

MA/GAMC:

See §0908.05 (Determining MA/GAMC Household Size).

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

Assets are things people own like bank accounts, stocks and bonds, cars, and real estate. Liquid assets include cash and property that can be easily converted to cash. Non-liquid assets are property that has a cash value only when sold.

MinnesotaCare limits the amount of assets adults can own to be eligible for coverage. Pregnant women and all children under age 21 are exempt from the asset limits. See §0909.03 (Exemptions From Asset Limits). Apply the MinnesotaCare asset provisions of this chapter to all other applicants and enrollees.

MA and GAMC limit the amount of assets people can own to be eligible for coverage. Some people are exempt from the asset limit. See §0909.03 (Exemptions From Asset Limits).

Apply the MA provisions of this chapter to people who are not exempt from the asset limits. The asset limits are the same for federally funded MA (program MM) and state-funded MA (program NM). Also apply the asset limits to people applying for or receiving EMA.

Apply the GAMC provisions of this chapter to GAMC Apply GHO provisions only to the GAMC hospital only (GHO) program. GHO follows MinnesotaCare asset policies. Full benefit GAMC has a separate asset limit but follows MA Method B policies to determine the value of countable assets.

All of the programs exclude some assets from consideration. See §0909.11 (Excluded Assets), §0909.11.01 (Additional Excluded Assets–Program Provisions), and §0909.11.03 (Excluded Assets for Self-Support). Also see the sections covering specific types of assets.

The countable value of most non-excluded assets is the equity value. The equity value is the asset's market value less any encumbrances. There are special rules for determining the value of some types of assets. See the sections of this chapter covering specific types of assets.

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

MinnesotaCare and MA Method A:

The asset limits for adults age 21 and over who are not pregnant are:

- $10,000 for a household of 1.
- $20,000 for a household of 2 or more.

To determine which limit applies, count everyone in the adult's MA or MinnesotaCare household size, including children, pregnant women and people who are not requesting coverage.

EXAMPLE:

Gretchen, age 35, applies for MinnesotaCare. She is not pregnant so the asset limit applies. She lives with her 10-year-old daughter, who receives MA. Gretchen has a household size of 2 and an asset limit of $20,000.

Do not count children's assets toward the total for adults in the household. Count half the value of assets owned jointly by a child and an adult.

MA Method B:

The asset limits are:

- $3,000 for a household of 1.
- $6,000 for a household of 2, regardless of the age of the household members.

EXAMPLE:

Nanette is disabled and receives RSDI. She applies for MA for herself and her 10-year-old daughter. Nanette's asset limit is $6,000 if she uses Method B. The daughter has no asset limit.

- For households with more than 2 members, add $200 for each additional household member.

EXAMPLE:

Joyce is disabled and applies for MA for herself and her 2 children, ages 5 and 9. Joyce's asset limit is $6,200 if she uses Method B. The children have no asset limit.

See §0908.05 (Determining MA/GAMC Household Size).

Apply the deeming rules in §0908.07 (Household Composition: Deeming) to determine whose assets to count for each Method B adult. Do not count children's assets for parents. Count spouse's assets unless the Method B client is considered a household of 1 due to receipt of waivered services.

The asset limits for QWD are:

- $4,000 for a household of 1.
- $6,000 for a household of 2 or more.

The asset limits for QMB, SLMB, QI and the Prescription Drug Program (PDP) are:

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

Do not apply deeming waivers to these programs.

EXAMPLE:

Herman lives with his wife and receives CADI services. He is a household of 1 with a $3,000 asset limit for MA. His wife's assets are excluded. He is a household of 2 with an $18,000 asset limit for QMB, SLMB, QI and/or PDP. His wife's assets are counted.

See §0907.21.09 (MA Basis: Medicare Supplement Programs) for a description of these programs.

The asset limit for Medical Assistance for Employed Persons with Disabilities (MA-EPD) is $20,000 regardless of household size. Count only the assets of the MA-EPD applicant or enrollee. Do not count spousal assets. Exclude all Method B excluded assets plus the assets listed under MA-EPD in §0909.11.01 (Additional Excluded Assets for Method A/B).

GAMC:

For GAMC Hospital Only (GHO), follow MinnesotaCare/Method A.

For all other GAMC applicants and enrollees, the asset limit is $1,000 per household

regardless of the number of people in the household or the number requesting GAMC. Follow Method B asset exclusions. See §0908.05 (Determining MA/GAMC Household Size).

Apply the deeming rules in §0908.07 (Household Composition: Deeming), to determine whose assets to count for each household member. Do not count:

- Children's assets for parents.
- Siblings' assets for siblings.

EXAMPLE:

Household includes Rhonda, age 35, her husband Steve, age 36, and Rhonda's children Stephanie, age 10, and Brandon, age 8. Rhonda has a MA Parent/Caretaker basis of eligibility. See §0907.19.07 (MA Families & Children: Parents/Caretakers). The children have a Child under 21 Basis. See §0907.19.03 (Families and Children Basis: Child Under 21). Steve does not have an MA basis. He has a GAMC basis as an adult without children. See §0907.25.05 (GAMC Basis: Adults Without Children).

Rhonda has an asset limit of $20,000 (MA Method A limit for households of 2 or more). Steve has an asset limit of $1,000. The children have no asset limit. Consider Rhonda's and Steve's non-excluded assets toward each of their asset limits.

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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. If the only missing item is a signature on the asset page, approve eligibility and allow the household 30 days to return the form as a courtesy. Do not terminate for failure to return the form.

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. They checked that they own 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 totalling $29,000 on the HCAPP. The check that they have 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. She checks that she has 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 asset page of the HCAPP as a starting point to determine countable assets. If the applicant reports owning any of the assets in question 3, follow up to determine whether those assets were correctly assessed. If you are unable to reach the applicant by phone or the applicant is unable to supply sufficient information, send the Detail of Assets page (DHS 3499A).

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 on the asset page of the HCAPP, 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).

Send the Detail of Assets Page (DHS 3499A) to people who apply for long term care services or home- and community-based waivers on the HCAPP to determine if the applicant has made any uncompensated transfers. See §0909.27 (Asset Transfers).

GAMC :

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

MinnesotaCare/ MA Method A/ GHO:

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

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

EXCEPTION:

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

- For savings bonds, divide the value among all owners listed, excluding those listed as POD beneficiaries.

- For bank accounts held jointly by adults, consider the entire balance to belong to each owner.

EXAMPLE:

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

EXAMPLE:

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

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

EXAMPLE:

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

EXAMPLE:

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

MA METHOD B:/GAMC

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

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

  EXAMPLE:

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

- For other assets, follow Method A.

Exclude the following assets for all health care programs:

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

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

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

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

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

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

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

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

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

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

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

from non-excluded funds.

- Low Income Energy Assistance Program (LIHEAP) payments.
- Payments for tribal land claim settlements listed in §0911.09.21 (Tribal Land Settlements and Trusts).
- Benefits from the Women, Infant, and Children (WIC) nutrition program.
- Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970.
- Payments received from youth incentive entitlement projects and youth community conservation and improvement projects.
- Reparation payments to Aleut people and people of Japanese ancestry under Public Law 100-383.
- Agent Orange payments to veterans and their dependents.
- Payments made under the Radiation Exposure Compensation Act (Public Law 101-426).
- Payments made by federal agencies under a presidential declaration of disaster including, but not limited to, individual and family grants from the Federal Emergency Management Agency (FEMA).
- Payments for disaster relief made by state and local governments and disaster relief organizations such as Red Cross and Salvation Army.
- Title VII, Nutrition Program for the Elderly funds.
- VISTA payments made to volunteers (not permanent staff salaries).
- Accrued interest on assets if any excess is properly reduced at the eligibility recertification.
- Payments from the Vietnamese Commandos Compensation Act.
- Blood Product Litigation settlement payments.

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

See §0909.11.01 (Excluded Assets–Program Provisions) for additional excluded assets for MinnesotaCare/ MA Method A/ GHO and MA Method B/GAMC.

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

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

MinnesotaCare/MA Method A/GHO:

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

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

- Court-ordered settlements up to $10,000. Exclude the 1st $10,000 indefinitely. It does not have to be held in a separate account or identifiable from other assets. Count any amount over $10,000 if it is legally available to the applicant or enrollee. See §0909.09 (Availability of Assets).

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

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

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

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

- Exclude the following sources of student financial aid indefinitely:

  - Pell Grants.
  - SEOG.
  - Perkins Loans.
  - Student Educational Loan Funds.
  - Guaranteed Student Loans.
  - Minnesota State Student Loans.
  - State Student Incentive Grants.
  - Minnesota State Scholarships and Grants.
  - Federal College Work Study funds.

- Any other financial aid funded in whole or in part by Title IV.

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

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

- Proceeds from the sale of a homestead for 6 months after the month of receipt. The client must keep the proceeds in a separate account and intend to use them to buy another home.
- Home Improvement loans from the Minnesota Housing Finance Agency for 9 months after the month of receipt.

MA Method B/GAMC:

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

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

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

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

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

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

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

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

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

- Exclude as an asset for 6 months any retroactive SSI or RSDI lump sum payments if retained after the month of receipt.

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

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

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

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

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

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

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

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

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

MinnesotaCare and MA Method A/ GHO:

Exclude capital and operating assets of a trade or business needed for a client to earn income up to a maximum net value of $200,000. Examples of assets that can be excluded for use in a trade or business include but are not limited to:

- Real property, such as farmland that is not contiguous to the homestead. See §0909.13.03 (Real Property: Non-Homestead). Do not exclude rental property unless it is part of a trade or business.

  EXAMPLE:

  Darlene inherited her mother's house and rents it out. Although it produces an income, it is not part of a trade or business. Count the equity value toward the asset limit.

  EXAMPLE:

  Darrin farms 60 acres and rents 10 acres to a neighbor. Exclude the rented acres because they are part of Darrin's farming business.

- Vehicles.

- Tools, machinery, and farm implements.

- Unsold inventory.

- Business checking accounts, including those also used for personal expenses.

Accept the client's statement of the value of business assets and the amount of encumbrances. Apply the net total value of all business assets to the $200,000 limit. If the net value of the combined business assets exceeds $200,000, count the excess toward the applicable asset limit.

Exclude capital and operating assets up to $200,000 of a self-employment enterprise that are temporarily not being used due to the self-employed person's illness or disability for up to 1 year, if the person is expected to resume self-employment by the end of that time.

MA METHOD B/ GAMC:

Exclude real or personal property, including liquid assets, currently used in a trade or business necessary for the client's ability to earn income.

Exclude personal property the client currently uses as an employee for work, whether or not the employer requires it.

EXAMPLE:

Tom is an auto mechanic. His employer provides tools on site, but Tom prefers to use his own. Exclude the value of any tools Tom uses on the job.

Exclude up to $6,000 equity value of real or personal property the client currently uses to produce goods or services needed for daily activities and used solely by the client's household. This includes property and equipment used to produce food or clothing for the household.

Allow the exclusions above for property not in current use for reasons beyond the client's control, if the client expects to resume use within 1 year. Extend the exclusion for 1 more year if the nonuse is due to a disabling condition. To qualify for this extension, the client must sign a statement stating all the following:

- The nature of the disabling condition.
- When the self-support activity ceased.
- When the self-support activity will resume.

Exclude up to $6,000 equity value of income-producing non-liquid personal property or real property, including rental property, not used in a trade or business if the property produces an annual net return equal to at least 6% of the equity value. Non-liquid personal property includes items such as household goods, machinery, vehicles, livestock, and non-cash business property.

EXAMPLE:

Darlene inherited her mother’s home and rents it out. The home is valued at $40,000 with a mortgage balance of $30,000. Darlene receives net rental income of $300 per month, or $3,600 per year. See §0911.09.03.13 (Rental Income) for allowable expenses from rental income.

Because the property produces net income in excess of 6% of the equity value (6% of the equity value of $10,000 is $600 per year), exclude the 1st $6,000 of equity. Count the remaining $4,000 equity toward the asset limit.

Do not exclude liquid personal property such as bank accounts, stocks, bonds, mutual

funds, or property agreements unless used as part of a trade or business. If the earnings drop below 6% for reasons beyond the client's control, allow up to 24 months for the property to resume producing a 6% return.

If a person owns more than 1 piece of income-producing property, each piece must meet the 6% return on equity requirement. However, apply the $6,000 equity value exclusion to the combined equity value of the properties.

Exclude assets covered in a Plan to Achieve Self-Support. See §0912.05.11 (Plan to Achieve Self-Support).

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

MinnesotaCare/MA Method A/GHO:

Exclude the homestead. The homestead is defined as the home which is owned by and is the usual residence of the applicant or enrollee along with all the surrounding land and any buildings on that land, provided the land is not separated from the home by any property owned by others. Public rights-of-way which separate property from the home do not affect the exclusion.

Continue to exclude the homestead if it is temporarily unoccupied due to employment, illness, or an employability plan approved by the county human service agency which includes education, training, or job search within the state, but outside the immediate geographic area. Also continue to exclude a homestead temporarily unoccupied because it is not habitable due to casualty or natural disaster. Exclude the homestead during periods it is unoccupied only if the applicant or enrollee intends to return.

MA METHOD B/GAMC:

Exclude the home owned and occupied by an applicant or enrollee, or by an applicant or enrollee's spouse or disabled or dependent child. The homestead includes all the surrounding land and any buildings on that land, provided the land is not separated from the home by any property owned by others. Public rights-of-way that separate property from the home do not affect the exclusion. The shelter can be real or personal property, fixed or mobile, and located on land or water.

For people not living in a long term care facility (LTCF), exclude the home:

- In which the applicant or enrollee or dependent relative resides and considers his or her principal home.

AND

- In which the applicant or enrollee has an ownership interest.

AND

- To which, if absent, the applicant or enrollee intends to return.

For people living in an LTCF, exclude the home for the longest of the following:

- For the 1st 6 calendar months of LTCF residence, starting with the 1st full calendar month after entry into an LTCF. Exclude any initial partial month. If the person entered the LTCF directly from a hospital, include the hospital stay when determining the months of exclusion.

EXAMPLE:

Ted was admitted to the hospital on June 15. On July 3 he was admitted to a nursing home. Exclude his homestead for 6 months beginning with July, the 1st full month of institutionalization.

OR

➢ For as long as the LTCF resident intends to return home and can reasonably be expected to return home.

Document the client's intent to return home and whether the client can reasonably expect to return home. If the client's intent contradicts the information about the anticipated length of stay on the Physician's Certification Statement (DHS 1503) or the client's health or condition, get a doctor's statement saying when the person can reasonably be expected to return to the home. Also document that MA or other sources will meet the cost of care upon the client's return home. This could include eligibility for MA home care, Elderly Waiver, Community Alternatives for Disabled Individuals, or Alternative Care.

Obtain oral verification from the Long Term Care Consultation team in the county where the client's homestead property is located of the availability of appropriate home care services and document in case notes.

EXAMPLE:

Betty entered an LTCF on October 16 after she broke her hip. Her home was excluded through the following April (the 1st 6 full months of institutionalization). The DHS 1503 indicates an anticipated discharge date of August 1. Betty has made arrangements with a niece to help with cleaning and yard work when she returns home. Continue to exclude the homestead. Review the exclusion in August.

OR

➢ For as long as it is the residence of 1 or more of the following relatives of the LTCF resident:

- Spouse.
- Child under 21.

- Disabled child of any age. Use the MA definition of disability. See §0907.21.07 (MA/Medicare Supplement Basis: Disability) and §0907.15 (Disability Determinations). For purposes of this exclusion, the child can become disabled at any age.

  EXAMPLE:

  Horace, age 80, resides in a LTCF. His daughter Louella had a heart attack and became unable to work at age 55. She receives RSDI disability payments and lives in Horace's home. Exclude the homestead as long as Louella lives there.

- Sibling, if the sibling lived in the home for at least 1 year immediately before the date of the client's admission to the LTCF and has an equity interest in the home.

  EXAMPLE:

  Emma and her sister Esther purchased a home together after they both were widowed. Emma contributed $40,000 toward the purchase and Esther contributed $10,000. Two years after they purchased the home, Esther entered an LTCF and applied for MA. Her stay is expected to be permanent. Because Emma has an equity interest in the home and lived there for more than 1 year before Esther entered the LTCF, exclude the homestead as long as Emma continues to live there.

- Adult child or grandchild, if the child or grandchild lived in the home for at least 2 years immediately before the date of the client's admission to the LTCF and provided verifiable care to the client to permit the client to live at home instead of in an LTCF. Require a physician's statement to verify that the adult child or grandchild provided such care.

  EXAMPLE:

  Georgette enters an LTCF from the home she shared with her adult daughter, Carol. Georgette is expected to remain in the LTCF permanently. Carol has lived in the home all her life but does not have an ownership interest. Carol states she took over most of the household responsibilities and expenses when her mother became unable to care for herself. Request a physician's statement. Exclude the homestead beyond the 1st 6 months of LTCF residence if the doctor verifies that Carol

provided care that allowed Georgette to remain at home. Carol must continue to live in the home to maintain the exclusion.

Count contracts for deed and other property agreements (deeds-of-trust, mortgages held by the seller, land contracts, etc.) as personal property of the seller. Consider the buyer's interest in property purchased under a contract for deed to be real property. See §0909.13.03 (Real Property: Non-Homestead) and §0909.13 (Real Property: Homestead).

EXAMPLE:

June resides in an LTCF. She sold her home on a contract for deed. Consider the value of the contract as personal property.

EXAMPLE:

Tim is purchasing June's home on a contract for deed. He resides in the home. Consider the home as homestead real property for Tim. The contract for deed has no value as an asset for Tim.

Evaluate the availability of property agreements jointly owned with someone outside the unit according to §0909.07 (Jointly Owned Assets).

If a property agreement is owned with others as tenants-in-common, rather than joint tenancy, each person's share can be sold separately from, and without the permission of, the co-owners(s). Count the health care program applicant/enrollee's share of the equity toward the asset limit regardless of whether the other owners are willing to sell their shares.

MinnesotaCare/ MA METHOD A /GHO:

For the seller of a contract for deed or other property agreement, count the outstanding principal balance less any encumbrances as an asset, unless documented that it is not legally available. See §0909.09 (Availability of Assets).

EXAMPLE:

George and Liz apply for health care for themselves and their 3 children. They are selling their cabin property, valued at $25,000, on a contract for deed. The balance owed to them on the contract is $15,000. They owe the bank $2,000 on the property. Count $13,000 toward the asset limit.

Count the principal portion of each payment as an asset. The outstanding principal will decrease with each payment.

EXAMPLE:

George and Liz receive a monthly payment of $500 from the buyer of the contract for deed. $300 of each payment is applied to the principal. The outstanding principal of the contract is $13,000. The principal portion of the payment is considered a

conversion of assets from one form to another, and is not counted as income. The payment reduces the outstanding principal of the contract to $12,700.

Count the interest portion of each payment as income.

EXAMPLE:

George and Liz receive a monthly payment of $500 from the buyer of the contract for deed. $200 of each payment is interest. Count the $200 each month as income.

For the purchaser of property via a contract for deed or other property agreement, count the portion of the principal paid as an asset, unless it is an excluded asset.

EXAMPLE:

Peter and his pregnant wife, Charlotte, are purchasing property via a contract for deed. They have paid $10,000 on the principal portion of contract for deed. This portion is applied toward their asset limit. They make a payment of $500 each month on the contract for deed. $300 of the payment is applied to the principal balance and $200 toward interest. The total value applied to the asset limit increases $300 each month the payment is made.

MA METHOD B/ GAMC:

Count the outstanding principal balance on a contract for deed or other property agreement as an asset to the seller. The value of a property agreement is the principal balance less any encumbrances.

EXAMPLE:

Lee sold his home on a contract for deed. The principal balance on the contract is $30,000. Lee still owes $20,000 on a 1st mortgage on the home. The countable value of the contract is $10,000.

Add the value of the property agreement to other countable assets. If total assets exceed the asset limit, the client must reduce assets by liquidating or trying to liquidate the property agreement.

At the time of application or renewal, if a non-excluded property agreement creates excess assets, the client must:

- Contact at least 2 businesses or individuals who routinely engage in the business of buying property agreements to solicit reasonable offers to buy the property agreement.

AND

- Document that the client is continuing to make a reasonable effort to sell the property agreement.

In addition to soliciting offers from individuals and businesses, reasonable efforts to sell include advertising the agreement in the official county newspaper, the newspaper with the largest circulation in the county, or the local shopper newspaper.

The client must accept any offer to buy the property agreement that is at least 2/3 of its value as defined above. If the client gets no such offer, consider the property agreement unavailable as long as the client continues to make a reasonable effort to sell.

If there is a legal bar to the sale of a property agreement, consider the value of the agreement unavailable until the legal bar is removed. See §0909.09 (Availability of Assets).

EXAMPLE:

Alice applies for MA. She is the seller of a contract for deed with a principal balance of $72,320. There are no encumbrances. The county worker advises Alice that she must make reasonable efforts to sell the contract. Alice verifies that she placed an ad in the newspaper offering the contract for sale. She also contacted 2 parties who had advertised an interest in purchasing contracts for deed. The highest offer she received was at a 40% discount or $43,392. Because this is less than 2/3 of the principal balance, Alice is not required to accept the offer. She must continue to make reasonable efforts to sell.

EXAMPLE:

George was approved for MA after demonstrating a reasonable effort to sell his contract for deed. At the time of his annual renewal, he has not advertised the contract for 9 months. Advise George that he must initiate and document reasonable efforts to sell the contract within 10 days. If he fails to do so, count the outstanding balance less any encumbrances toward his asset limit.

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

MinnesotaCare/MA Method A/GHO:

Exclude 1 vehicle for each household member of legal driving age used for employment or seeking employment. This includes vehicles used for employment or job search by household members who are not requesting or are not eligible for coverage. Exclude the highest valued vehicle(s), regardless of which vehicles the employed household members actually drive to work.

EXAMPLE:

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

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

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

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

MA Method B/GAMC:

Exclude a vehicle used as the client's principal place of residence.

Exclude vehicles necessary for self-support. See §0909.11.03 (Excluded Assets for Self-Support).

Exclude 1 vehicle if any household member needs it for 1 or more of the following reasons:

- For employment.
- To get medical treatment for a specific or regular medical problem.

- It has been modified for operation by or transportation of a disabled person.

- It is needed to perform essential daily activities because of climate, terrain, distance, or similar factors.

Exclude only 1 vehicle under this provision even if the household has more than 1 vehicle meeting 1 or more of the conditions for exclusion. Count the equity value of other vehicles toward the asset limit.

EXAMPLE:

Mr. and Mrs. Jones apply for MA for themselves and their 17-year-old son, Dick. The family owns 3 vehicles. Mrs. Jones and Dick are both employed. Mr. Jones has a disability and receives regular medical treatment. Although all 3 vehicles meet an exclusion category, only 1 can be excluded under these provisions under Method B. Exclude the vehicle with the highest equity value. Count the equity value of the other 2 vehicles toward the asset limit.

Because of Minnesota's climate, vehicles that are not used for employment or medical care can usually be excluded for use in essential daily activities. However, if the household has no vehicle meeting 1 or more exclusion conditions, exclude the 1st $4,500 of the market value of 1 vehicle.

EXAMPLE:

Mavis, age 85, lives alone and receives MA. She no longer drives but has a vehicle registered to her. Her daughter takes her shopping and to perform other daily activities, using the daughter's car. Mavis's car has a value of $5,000 with nothing owed on it. Since the car does not meet any of the exclusion criteria, it cannot be totally excluded. Exclude the 1st $4,500 of the market value. Count the remaining $500 toward the asset limit.

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

Use the NADA trade-in value to determine the FMV of all non-excluded vehicles. To determine the equity value, subtract the balance owed on secured loans from the FMV. A secured loan is any loan for which the vehicle is held as collateral and/or the lender holds title to the vehicle.

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

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

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

  EXAMPLE:

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

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

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

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

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

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

  - The statement of goods and services is for the same amount as the purchase price of the life insurance policy or annuity.

  AND

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

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

  EXAMPLE:

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

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

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

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

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

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

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

MinnesotaCare/MA Method A/GHO:

Follow general provisions.

MA Method B/GAMC:

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

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

MinnesotaCare/MA Method A/GHO:

Exclude individually owned pension and retirement funds and plans sponsored through employers, such as employer-based 401-K plans. See §0909.11 (Excluded Assets).

Count the full amount of employer- or union-owned pension and retirement funds if available. See MA/GAMC Method B.

MA Method B/GAMC:

Count the full amount of pension and retirement funds if available, whether owned individually or through an employer or union.

EXCEPTION:

Exclude individually owned pension and retirement funds for MA-EPD. See §0909.11.01 (Additional Excluded Assets for Method A/B).

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

EXAMPLE:

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

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

EXAMPLE:

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

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

EXAMPLE:

Mary is a former county employee. She has $3,000 in a PERA account.

Mary must apply for the available funds. Count the money as income in the month it is received and as an asset if retained the following month.

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

EXAMPLE:

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

Minnesota Rules 9505.0065 subp. 3

MinnesotaCare:

No provisions.

MA:

The transfer of an asset without adequate compensation may result in a period of ineligibility for all or some services. Several factors affect this determination, including:

- Whether the transfer is exempt from consideration as an improper transfer. See §0909.27.03 (Spousal Asset Transfers) and §0909.27.05 (Asset Transfer Exceptions).

- When the transfer occurred. See §0909.27.07 (Transfer Lookback Period) and §0909.27.11 (Improper Transfer Ineligibility).

- The value of the transferred property for which adequate compensation was not received. See §0909.27.09 (Determining Uncompensated Value). This amount, along with when the transfer occurred, determines the length of the ineligibility period. See §0909.27.11 (Improper Transfer Ineligibility).

- Whether there are multiple transfers in the affected period. See §0909.27.13.03 (Multiple Asset Transfers).

The CAF and the HCAPP ask if anyone has transferred property in the last 60 months. 60 months is the maximum lookback period for MA transfers into certain trusts. For all other MA transfers, the lookback period is 36 months. Do not require information for a longer lookback period than applies. See §0909.27.07 (Transfer Lookback Period). Do not request information until evidence is presented which indicates transfers of assets have occurred or until the client or authorized representative reports the transfer of assets.

DO NOT assume, at the time of application, that any improper transfer of assets has occurred and DO NOT automatically request information such as bank statements or tax returns going back 36 or 60 months. There must be information reported or evidence presented before any such information is requested.

EXCEPT as specified in §0909.27.03 (Spousal Asset Transfers) and §0909.27.05 (Asset Transfer Exceptions), consider any transfer of assets improper if it is done to establish or maintain eligibility for MA as defined below. If a penalty for an improper transfer causes undue hardship, a waiver of the penalty may be appropriate. See §0909.31 (Waiver of Asset Rules).

If the total amount transferred for less than fair market value in any month by the client and spouse combined does not exceed $200 ($500 before 7-1-02) in total value for the month, including the month of application, disregard that amount and do not calculate a penalty period. This does not apply if the transfer occurs during a pre-existing penalty period. See §0909.27.11.09 (Transfers After 4-13-96).

Apply all transfers made by either spouse toward the $200 exclusion. Do not allow $200 for each spouse even if both resided in an LTCF.

A transfer occurs when any of the following gives away, sells, conveys ownership and/or reduces control, or disposes of any asset or an interest in an asset:

- The client.
- The spouse of the client.
- The client's representative, including a court or administrative body with legal authority to act in place of or on behalf of the person or spouse.
- A person, court or administrative body acting at the direction of or on request of the client or spouse.

A transfer may occur through a sale, trade or giving away of an asset or income, including transferring the remainder interest in a life estate to another person, or taking an action to reduce or eliminate the person or person's spouse's ownership or control of income or assets held in common with another person or persons.

When an asset is placed into joint ownership with another person or persons, the asset is considered to be transferred by the person when any action is taken either by the person or another, which reduces or eliminates the person's ownership or control of the asset. This includes placing another person's name on the account or asset which limits the person's right to sell or dispose of the asset.

GAMC:

There are no improper transfer provisions for GHO.

For others, the transfer of any asset is improper if:

- It occurred within 60 months before application, while the application is pending or during GAMC eligibility. Prior to 7-1-95, the lookback period

was 30 months.

AND

- It was transferred at less than fair market value.

Presume the purpose of the transfer was to obtain or maintain eligibility unless the client gives convincing evidence it was exclusively for another purpose.

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

MinnesotaCare:

No provisions.

MA:

The following transfers are EXCEPTIONS to the provisions in §0909.27 (Asset Transfers) and §0909.27.01 (MA Transfers--Cont.), are not considered improper, and are exempt from penalty:

- Excluded assets other than a homestead.
- Non-excluded assets or a homestead if there is convincing evidence of intent to receive fair market value.
- Non-excluded assets or a homestead if there is convincing evidence to show the purpose of the transfer was not exclusively to obtain or maintain MA for the client.
- Allowable asset transfers to a spouse as specified in §0909.27.03 (Spousal Asset Transfers).
- Transfer of assets to a representative of the spouse, provided the transferred assets are to be used for the sole benefit of the client's spouse.
- Non-excluded assets or a homestead to a child of any age of the client or the client's spouse if the child is blind or permanently and totally disabled. Blindness and disability must be verified. See §0906.15 (Disability Determinations).
- Transfer of a homestead is exempt when made to:
  - A spouse.
  - A child under age 21 of the client or the client's spouse.
  - A child (of any age) of the client or the client's spouse, when the child lived in the home for at least 2 years before the client entered the long term care facility and provided verifiable care (physician's statement of needed care) that allowed the client to remain at home rather than enter a facility.
  - A sibling of the client or the client's spouse, when that sibling has equity interest in the home, and lived in the home at least 1 year immediately before the client entered the LTCF.

In addition, the following transfers are exempt from penalty ONLY if made on or after 8-11-93:

- Transfer of assets into a trust established solely for the child of a client or the client's spouse. The child may be of any age and must be blind or disabled according to SSI or SMRT criteria. See §0906.15 (Disability Determinations).

- Transfer of assets into a trust established solely for any disabled person under age 65, who is disabled according to SSI or SMRT criteria.

- Transfer of assets to client's spouse or to another for the sole benefit of the client's spouse. Although this type of transfer does not result in a penalty period, the transferred amount (including the corpus of a trust for the sole benefit of the spouse) is counted in the asset assessment and considered available at application in the division of assets. See §0909.25 (Spousal Asset Assessments) and §0909.25.05 (Transfer of Income Producing Asset to Spouse).

  SOLE BENEFIT means that no one but the spouse or disabled person can benefit now or in the future, unless it will revert to the state to repay MA paid. The trust instrument must provide for the funds to be spent for the benefit of the spouse or disabled person based on that person's estimated life expectancy. The trust may provide for reasonable and necessary administrative costs associated with managing the trust.

When the transfer of a homestead is exempt from penalty, it may be transferred while occupied or while vacant. It does not have to be the primary residence of the person receiving the transferred homestead.

EXAMPLE:

Mordecai has resided in a LTCF for 6 months. He has no community spouse and his home is vacant. His daughter Lydia provides a physician's certification that she lived with Mordecai and provided care to enable him to remain at home for 3 years before he entered the LTCF. The homestead cannot be exempted under §0909.13 (Real Property: Homestead) because Lydia has since moved out. However, Mordecai may transfer the home to Lydia without penalty.

GAMC:

There are no improper transfer provisions for GHO.

For regular GAMC, all asset transfers without adequate compensation are considered improper.

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

MinnesotaCare:

No provisions.

MA:

For transfers of assets or income made on or after 8-11-93, there are 2 time periods to look back from to determine if an improper transfer has occurred. The length of time you review depends on what has been transferred.

Look back 36 months for the following transfers:

- Transfers of a homestead or any non-excluded asset.
- Transfers into an irrevocable trust when all or part of that trust may be disbursed to the client, the client's spouse or the person, court or administrative body acting in place of or on behalf of the client or the client's spouse.
- Transfers into annuities. The date of the transfer is the date of annuitization. See §0909.23 (Annuities).

These transfers are improper if:

- The transfer(s) occurred within 36 months before application, while the application is pending, or during MA eligibility.

AND

- The transfer(s) were for less than fair market value.

The lookback period increased from 30 to 36 months for transfers made on or after 8-11-93 and was phased in as follows:

IF DATE OF LTC SERVICES WHEN APPLYING FOR/RECEIVING MA IS:	LOOKBACK PERIOD IS:
1-1991 through 2-96	30 months before
3-96	31 months before
4-96	32 months before
5-96	33 months before
6-96	34 months before
7-96	35 months before
8-96 & thereafter	36 months before

There is a longer lookback period for the following transfers:

- Transfers from a revocable trust that are NOT made to or for the benefit of the client or the client's spouse.

- Transfers into an irrevocable trust when all or part of the trust CANNOT be disbursed UNDER ANY CIRCUMSTANCES to the client, client's spouse or person, court or administrative body acting in place of or on behalf of the client or client's spouse.

This type of transfer is improper if:

- The transfer occurred within the applicable number of months before application, as reflected on the chart that follows.

AND

- The transfer was for less than fair market value.

When the trust is revocable, the transfer is considered to take place on the date the payment is made to someone other than the grantor. If the trust is irrevocable, the transfer is considered to have been made as of the date the trust was established or, if later, the date upon which payment to the grantor was foreclosed.

The lookback period increases from 30 months to eventually reach 60 months for trust transfers made on or after 8-11-93, by a phase-in as follows:

IF DATE OF LTC SERVICES WHEN APPLYING FOR/RECEIVING MA IS:	LOOKBACK PERIOD IS:
1-91 through 2-96	30 months before
3-96	31 months before
4-96	32 months before
5-96	33 months before
6-96	34 months before
7-96	35 months before
8-96	36 months before
9-96	37 months before
10-96	38 months before
11-96	39 months before
12-96	40 months before
1-97	41 months before

2-97	42 months before
3-97	43 months before
4-97	44 months before
5-97	45 months before
6-97	46 months before
7-97	47 months before
8-97	48 months before
9-97	49 months before
10-97	50 months before
11-97	51 months before
12-97	52 months before
1-98	53 months before
2-98	54 months before
3-98	55 months before
4-98	56 months before
5-98	57 months before
6-98	58 months before
7-98	59 months before
8-98 and thereafter	60 months before

GAMC:

The lookback period is 60 months before application for all transfers. See §0909.27 (Asset Transfers).

There are no improper transfer provisions for GHO.

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

MinnesotaCare:

No provisions.

MA:

Determine the uncompensated value of a non-exempt transfer made during the lookback period. The uncompensated value of improperly transferred assets is the market value minus encumbrances and compensation received for it.

Consider compensation to the client in the form of services only if the care or services directly benefitted the person and the amount was reasonable. The amount is reasonable if it is consistent with a charge for a similar service performed in the community.

If the care or services were provided by a relative, a notarized written agreement signed and dated by the involved parties on or before the date the services began is required. A notarized agreement is not required if payment for the care or services is made within 60 days after the care or service was provided, or if the care or services were provided by a person who is not a relative of the client.

Apply the following policies to determine the uncompensated value of transfers into annuities. See §0909.23 (Annuities). The client must provide the following verification from the person or entity that sold the client the annuity:

- Under what circumstances, if any, the annuity can be sold, cashed in, or assigned to someone else, including whether there is any commuted cash value.
- Cash value of the annuity on the day of annuitization.
- Information about the free look period.
- Anyone other than the client named as annuitant.
- Any beneficiaries named.
- The settlement option chosen, including how often payments are made, the amount of each payment and how long payments will be made.

Any annuity purchased on or after March 1, 2002, is an improper transfer unless it meets ALL of the following requirements:

- The annuity is a commercial annuity purchased from an insurance company or financial institution regulated or licensed by a government agency

AND

- Principal and interest payments are made in equal monthly installments

AND

- Principal and interest payments begin at the earliest possible date after the payment option is selected.

If any one of the requirements is not met, consider the purchase of the annuity to be an improper transfer. Calculate the uncompensated value as of the date of annuitization.

Apply the following steps to determine if there is an uncompensated transfer for:

- Annuities purchased before March 1, 2002, that are annuitized within 36 months before applying for or while receiving MA.

- Annuities purchased on or after March 1, 2002, that meet all of the requirements listed above and are annuitized within 36 months before applying or while receiving MA.

Determine whether the transfer was made for less than fair market value. This is based on whether the client or spouse is likely to receive a return of the value of the transfer during his or her lifetime, depending on which person made the transfer. Annuities purchased by 1 member of a couple, naming the other spouse or someone else as the annuitant, should be evaluated on the life expectancy of the person who purchased the annuity (the owner), not on the life expectancy of the annuitant.

Evaluate the settlement option to determine if the cash value as of the date of annuitization is likely to be returned to the client during his or her estimated lifetime. Calculate the value of the annuitization transfer as follows, except as noted below:

1. Multiply the amount of each annuity payment by the number of payments in a year to get the total annual payments.

2. Multiply the result from #1 above by the estimated life expectancy of the client (or spouse, if annuitized by spouse) from the table in §0909.23.03 (Life Expectancy Tables - Annuities), using the age of the client (or spouse) on the date of annuitization.

Use a period shorter than the estimated life expectancy found in the table if the client has a medical condition that would shorten the life expectancy and that was diagnosed before funds were placed in the annuity. If it appears the client has such a condition, request a physician's statement documenting the medical condition, date of diagnosis, and life expectancy. Treat any amount not expected to be returned during the client's lifetime as an improper transfer.

3. Subtract the result in #2 above from the cash value on the date of annuitization.

4. Use the result of #3 above to calculate a penalty for client's receipt of MA payment for long term care services.

Do not consider the transfer of funds into an annuity as an improper transfer if:

- The client or spouse is the owner and the annuity has not yet been annuitized. In this case, count the annuity toward the asset limit. See §0909.23 (Annuities).

- A long term care client names the community spouse as the SOLE annuitant or beneficiary. The cash value as of the date of annuitization must be expected to be returned to the community spouse during his/her lifetime. Annuities purchased on or after March 1, 2002, must meet the conditions listed earlier in this section. See §0909.25 (Spousal Asset Assessments) and §0909.27.05 (Asset Transfer Exceptions) for information on treatment of sole benefit transfers to annuities.

Apply the following policies to determine the uncompensated value of transfers into trusts.

The value of a transfer into an irrevocable trust is the amount that can never under any circumstances be returned to the person who established the trust, measured at the time the trust is established. If any part of the principal can be returned to the person who established the trust under any circumstances, consider the amount that could be returned as an available asset to the person. See §0909.21 (Trusts).

GAMC:

The uncompensated value of an improperly transferred asset is the fair market value at the time it was given away, sold, or disposed of minus encumbrances and compensation received. Consider compensation in the form of services only if the

care or services directly benefitted the person and the amount was reasonable. The amount is reasonable if it is consistent with a charge for a similar service performed in the community.

If the care or services were provided by a relative, a notarized agreement signed and dated by the involved parties on or before the date the services began is required. A notarized agreement is not required if payment for the care or services is made within 60 days after the care or service was provided, or if the care or services were provided by a person who is not a relative of the client.

There are no improper transfer provisions for GHO.

MinnesotaCare:

No provisions.

MA:

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

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

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

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

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

For more information, see the following:

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

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

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

- Both spouses apply for MA:

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

- One spouse applies for MA:

  - When both spouses are receiving LTC services, apply the entire penalty period to the applicant regardless of who owned the transferred asset.

- One spouse currently receiving MA and subject to a penalty period at the time the other spouse applies for MA to receive LTC services:

  - When a spouse makes a transfer that results in a penalty for his/her spouse who is on MA in LTC, and later begins receiving long term care services himself/herself, any remaining penalty must be split evenly between the spouses.

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

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

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

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

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

GAMC:

There are no improper transfer provisions for GHO.

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

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

1. Determine the uncompensated value of an improperly transferred asset. See §0909.27.09 (Determining Uncompensated Value).

2. Divide the uncompensated value of the asset by the statewide average monthly per person payment for skilled nursing facility care (SAPSNF). Use the amount in effect on the date of the client's application that covers the current application processing period or period of GAMC eligibility. Effective 7-1-03, that amount is $3,171. From 7-1-02 through 6-30-03, the amount is $3,102.

Apply a partial month of ineligibility to both applicants and enrollees. If the transferred amount is less than $3,171, deny eligibility for payment of services equal to the amount transferred. If a fractional part of a month remains after calculating a period of ineligibility for a transfer of more than $3,171, multiply the remainder (rounded to hundredths) by $3,171. The result is the dollar amount of medical expenses the client is responsible for in the 1st month of possible eligibility.

There is no limit on the period of ineligibility.

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

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

MinnesotaCare:

No provisions.

MA:

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

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

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

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

AND

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

AND

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

OR

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

OR

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

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

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

EXAMPLE:

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

GAMC:

Begin the ineligibility period for enrollees in the month the transfer was reported or, if not reported, in the month the county agency discovers the transfer. Close the case for the 1st month for which you can give 10-day notice.

Begin the ineligibility period for applicants in the 1st month in which the client could have been eligible for GAMC payment of incurred medical expenses.

The period of ineligibility may exceed 30 months.

There is no ineligibility period for GHO.

MinnesotaCare:

Deny MinnesotaCare for people with assets in excess of the applicable limit. If people denied for excess assets reapply and claim assets within the limits, ask how assets were reduced. If assets were reduced in ways that do not increase the value of other non-excluded assets, approve MinnesotaCare if countable assets are now within limits. Do not require verification of the reduction.

EXAMPLE:

Peter's MinnesotaCare application was denied in July because his countable assets of $12,000 exceeded the $10,000 limit. In October, he calls the worker asking to reapply and states that his assets are now less than $10,000. He is not required to complete a new application or asset list. The worker asks how he reduced the excess $2,000. Peter reports that he paid off $3,000 in debts to credit card companies and friends. If Peter meets all other eligibility requirements, approve MinnesotaCare.

EXAMPLE:

Hermione's MinnesotaCare application was denied in July because she reported assets of $3,000 in savings and a boat with equity value of $12,000 ($16,000 value with $4,000 owed). Her assets exceeded the $10,000 limit. She contacts the worker in September asking to reapply, stating she now has only $1,000 in savings, The worker asks how she reduced the excess $5,000. She reports she paid off the boat, which is still worth $16,000. She continues to have excess assets.

MA:

Applicants who have excess assets in the month of application or in any of the retroactive months in which they are requesting eligibility must reduce those assets by the end of the 45- or 60-day processing period to be eligible. You may request applicants to reduce the excess within 15 days or by the end of the month of application, whichever is earlier, as a means of expediting the eligibility determination. However, do not deny the application for excess assets before the end of the processing period. Pend the application beyond the processing period if applicants are unable to complete the reduction because of circumstances beyond their control.

EXAMPLE:

Steve applies for MA on December 10. The worker reviews the application on December 17 and discovers that Steve has excess assets. The worker sends Steve a notice to reduce his assets within 15 days. He has not completed the

reduction as of January 2. The worker sends a reminder notice advising Steve that he must reduce the assets by January 25 or the application will be denied. The worker codes MAXIS to send 10-day notice of denial on January 15. Steve provides verification that he has properly reduced the assets on January 23. The worker processes the application.

Applicants requesting Medical Assistance to begin with the month of application may reduce excess assets in any way that does not result in an improper transfer. See §0909.27 (Asset Transfers) and §0909.27.01 (MA Transfers--Cont.)

Applicants requesting MA for any of the 3 months before the month of application who had excess assets in those months may reduce excess assets by:

- Retroactively designating burial funds up to $1,500 for each applicant, spouse (regardless of whether the spouse is MA-eligible) and MA-eligible dependent child. The applicant must sign and date a statement that indicates the date they intend the funds to be set aside for burial.

  Applicants who reside in a LTCF or who receive services through the Elderly Waiver (EW) may retroactively designate burial funds up to $1500 for a community spouse. They may retroactively designate burial funds for dependent children living with the community spouse if the children are MA-eligible.

  The applicant may purchase a burial fund of up to $1,500. Applicants may not reduce excess assets in the retroactive months by purchasing burial space items or irrevocable burial funds of $2,000. See §0909.17 (Burial Funds/ Life Insurance: Fund Types).

- Applying the excess on net medical bills incurred in the retro months. Start the reduction with the oldest net bill in the retroactive period. After excess assets are reduced, MA begins with the next dollar of medical bills incurred in the retroactive period.

  EXAMPLE:

  Thomas applied for MA on January 1, 1994. He requests MA retroactive to October 1, 1993. On October 1 he owned excess assets and continues to own the same assets. He was hospitalized on October 5, 1993, and also has a $200 clinic bill for October 2, 1993. To reduce assets, Thomas may:

- Establish a burial fund of $500 or more if he has not already used his $1,500 burial exclusion. His MA effective date (assuming he has no spenddown) would be 10-1-93.

OR

- Pay the $200 clinic bill and the 1st $300 of the hospital bill. He must verify that he has actually paid $500 toward the asset spenddown. His MA effective date (assuming he has no spenddown) would be 10-5-93.

Follow the appropriate instructions in §0913.03 (Spenddowns--MA/GAMC) if there is an asset and an income spenddown.

EXAMPLE:

Leslie applied for MA on April 1 requesting MA retroactive to March 1. She had excess assets of $4,000 on March 1, which she still owns. Her March medical bills total $1,000. She incurred no medical bills in January or February. She has already used up her $1,500 burial exclusion.

Since Leslie cannot properly reduce the excess, retroactive eligibility is not possible. Leslie may reduce the excess in any way other than an improper transfer for April eligibility. The worker informs her of the need to reduce on April 6. She must complete the reduction by April 30 (within 15 days of being notified of the need to reduce OR by the end of April, whichever is later). Leslie completes the reduction on April 25. Consider eligibility beginning April 1. Do not delay the effective date of eligibility until the day after the assets are reduced.

If applicants spend excess assets in any way other than the 2 methods allowed for retroactive coverage, retroactive coverage may be limited or unavailable. If applicants spend the excess during the retroactive period, they may:

- Become eligible on the day after the assets were reduced to within limits

OR

- Use other remaining assets to properly reduce the excess.

EXAMPLE:

Marvin applied for MA on April 1 requesting MA retroactive to January 1. On January 1 he had excess assets of $1,000. On January 8 he used $1,000 of his assets to purchase a stereo. He has not used any of his $1,500 burial exclusion. Marvin may either:

- Use $1,000 of his remaining assets to properly reduce assets by designating a burial fund.

OR

- Pay $1,000 of his remaining assets on the 1st $1,000 of medical bills incurred in January.

OR

- Request eligibility to begin on January 9, the day after assets were improperly reduced.

EXAMPLE:

Caroline applied for MA on June 1, requesting MA retroactive to April 1. On April 1 she had excess assets of $4,000. On April 5 she transferred $4,000 to her granddaughter. Caroline does not have sufficient remaining assets to properly reduce the excess. She may either:

- Request eligibility to begin April 6.

OR

- Have her granddaughter return all or part of the transferred money to allow Caroline to reduce properly. For example, if she has $3,000 remaining in assets, she could have her granddaughter return $1,000 and reduce the entire $4,000 by designating a $1,500 burial fund and applying the rest to the oldest medical bills in April.

GAMC:

Follow MA, EXCEPT there is no retroactive period.

MinnesotaCare:

Determine if any member of the household had other health coverage in any of the 4 months preceding the month of application. People who had other health coverage in the past 4 months are not eligible for MinnesotaCare with the following exceptions:

- People with Group 1 status. See §0907.03 (MinnesotaCare Eligibility Group 1) and §0910.05 (Current Health Insurance).
- People whose other coverage was through CHAMPUS/TRICARE.
- MA enrollees with cost-effective health insurance who convert from MA to MinnesotaCare. Apply this exemption when the insurance was determined to be cost-effective and was either being paid directly by MA or applied to the enrollee's spenddown at the time MA ended .

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

EXAMPLE:

Marcia's MA is terminated effective May 1 because she cannot meet a spenddown. She had other cost effective health insurance in effect for which MA paid the premium. She dropped the other coverage effective April 30, because she felt the premium was not affordable. She applies for MinnesotaCare on May 10, and has Group 2 status. She is exempt from the 4-month barrier. If she had received GAMC instead of MA, or the other coverage was not cost-effective under MA, she would be ineligible for MinnesotaCare until September 1.

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

M. S. 256.9357 subd. 3

MA/GAMC:

No provisions.

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

MinnesotaCare:

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

EXAMPLE:

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

MA/GAMC:

METHOD A:

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

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

METHOD B:

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

Count retroactive RSDI lump sum payments as unearned income in the month received.

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

For Medicare Part B reimbursements for non-LTCF recipients:

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

For Medicare Part B reimbursements for LTCF recipients:

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

MinnesotaCare:

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

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

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

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

Household income must be equal to or less than the income eligibility standard that applies at the time of initial enrollment. If income increases beyond the limit, people do not automatically lose eligibility as long as they do not have a lapse of coverage of 1 month or more. See §0912.03.03 (MinnesotaCare Excess Income).

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

EXAMPLE:

MinnesotaCare receives an application for Penny and her 20-year-old son Jack on July 17. Jack turns 21 on August 2. The enrollment representative processes the application on August 10. Consider both Penny and Jack as Group 3 adults.

EXAMPLE:

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

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

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EXAMPLE:

Larry and Sue and their minor children have been continuously enrolled in MinnesotaCare for 3 years. Their income exceeds 275% FPG but is less than $50,000 and they pay the maximum premium for their household size. MinnesotaCare is canceled because of other health coverage. The family reapplies a year later because the other coverage is no longer available. Their countable income continues to exceed the 275% FPG limit for their household size. They are no longer eligible for MinnesotaCare.

EXAMPLE:

Jeanne, age 22, was originally enrolled with her parents as a minor child and has remained continuously enrolled after reaching age 21. She is now a household of 1 with income between 175% FPG and 275% FPG. MinnesotaCare is canceled because Jeanne moves out of state. She returns to Minnesota and reapplies a year later. Her income continues to exceed 175% FPG. She is no longer eligible for MinnesotaCare because there has been a break in coverage of more than 1 month. Jeanne is now subject to the income limits for an adult without children.

M. S. 256.9366 subd. 1
M. S. 256.9354 subd. 5
M. S. 256.9366 subd. 4
M. S. 256.9357 subd. 1

MA/GAMC:

No provisions.

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

MinnesotaCare:

At the time of renewal or when a new household member is added to an existing case, evaluate households with gross annual income above the MinnesotaCare income standard for their household size. Terminate coverage for the 1st available month for:

- Adults without children whose income exceeds 175% FPG, including adults who lose parental status between renewals.

- Parents and caretakers, other than pregnant women, whose gross annual income exceeds $50,000.

Take the following steps for all children under age 21 and pregnant women, and for parents and caretakers whose gross income remains under $50,000:

- Determine if 10% of their gross annual income is less than the premium amount for a policy with a $500 deductible available through Minnesota Comprehensive Health Association (MCHA). See §0912.03.05 (Annual MCHA Premiums). Include all household members in the household size whether or not they are enrolled in MinnesotaCare.

- If the income is equal to or greater than the annual MCHA premium, send the MinnesotaCare Over Income Letter (DHS 3407) advising the household that their MinnesotaCare will end in 18 months. Start the 18-month notice period effective the 1st of the next month.

- If 10% of the gross annual income is less than the household's MCHA premium, eligibility continues. Do not send 18-month notice of cancellation.

EXAMPLE:

A household consists of John, age 35, Abby, age 31, and their minor child, age 12. When the worker processes their renewal on March 15, the household's gross annual income is determined to exceed the MinnesotaCare income standard of 275% FPG for a family of 3. Gross income remains under $50,000. To determine whether to send the DHS 3407, calculate the household's annual MCHA premium by adding together the following amounts from §0912.03.05 (Annual MCHA Premiums):

For Abby, age 31, add the amount for an adult age 30 to 34.
For John , age 35, add the amount for an adult age 35 to 39.
For the dependent child, add the amount for a child under age 15.

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

Multiply the household's gross annual income by 10% and compare that figure to the MCHA premium. If 10% of the annual income is greater than the MCHA premium, send the DHS 3407 notifying the household that coverage will end in 18 months. The 18-month period begins April 1.

Parents and caretakers whose income exceeds the $50,000 (regardless of whether the income exceeds the 275% standard for their household size) are not eligible for the extension. Apply the MCHA test to the children. Send the DHS 3407 if 10% of gross income is equal to or greater than the premium amount for an MCHA policy with a $500 deductible. Include the parents' premium amounts in the calculation. Terminate the parents' coverage for the 1st available month.

EXAMPLE:

Aman, his wife and 3 daughters receive MinnesotaCare. At the time of their annual renewal, gross income exceeds $50,000. It also exceeds the 275% FGP standard for the household size. Aman and his wife are no longer eligible for MinnesotaCare. The children may remain eligible if 10% of their gross income is less than the premium amount for an MCHA policy with a $500 deductible. If 10% of gross income is equal to or greater than the applicable MCHA premium, they are eligible for the 18-month extension. Send the DHS 3407.

Take the following steps when a household that has received the DHS 3407 later reports decreased income OR requests to add a new household member before the next renewal:

- Determine if the new income amount remains equal to or greater than the appropriate standard. If the new income amount is now under the standard, send the MinnesotaCare Income Change Evaluation Letter (DHS 3408) to notify the household that they will not be closed.

- If income remains equal to or greater than the standard, determine if 10% of the new income amount is equal to or greater than the MCHA premium for their household. If 10% of the income is no longer equal to or greater than the MCHA premium for the household, send the DHS 3408 to notify the household that they will not be closed.

If the income is under the standard or 10% of the new income amount is less than the MCHA premium, end the 18-month over income period. If the household's income later increases beyond the limit, begin a new 18-month period.

- If the new income is equal to or greater than the appropriate standard AND 10% of the new income is equal to or greater than the applicable MCHA premium, the household remains in the original 18-month over income period. Review the income again 12 months from the date of the original DHS 3407. Coverage for new members added to the household will end at the same time as the rest of the household.

Reevaluate the household's income at the end of 12 months. See §0905.05 (Annual Renewal--Eligibility).

Also reevaluate the household's income 16 months from the date of the original DHS 3407 (2 months before disenrollment).

- Contact the household to determine if employment or income has changed since the last evaluation. If the household reports that employment and income have not changed, document in case notes. No further action is needed.

- If the household reports a change in employment or income, request verification of the new income for the past 30 days. Document the request in case notes. Allow the household 30 days to return the income verification.

- If the household does not return the verifications in 30 days, document in case notes. No further action is needed.

- If the household returns the verifications, determine if the new income figure is within the MinnesotaCare limits.

  - If the household's income continues to be equal to or greater than the applicable standard AND 10% of the household's income continues to be equal to or greater than the household's annual MCHA premium, the household remains in the 18-month disenrollment period. Send the DHS 3408 to notify the household of the results of the evaluation for both 12 and 16-month reevaluations. For 12-month renewals, also send the MinnesotaCare Over Income Disenrollment-12 Month Reminder Letter (DHS 3388) and the Private Insurance in Minnesota

Flyer (DHS 3416). Do not adjust the income on MMIS if it is higher than the previous amount.

- If the household's income is less than the applicable standard OR 10% of the income is less than the household's annual MCHA premium, send the DHS 3408 to notify the household that they will not be canceled.

EXCEPTION:
Terminate coverage for parents and caretakers if income now exceeds $50,000.

For others, end the 18-month over income period. If the household's income later increases beyond the limit, begin a new 18-month period.

Reevaluate the household's income at the end of the 18-month notice period. Follow the same steps as for the 16-month evaluation, except:

- If the household reports that employment and income have not changed, document in case notes and cancel MinnesotaCare for the 1st month for which you can give 10-day notice.

- If the household fails to submit verification within 30 days of the request, cancel MinnesotaCare for Over Income for the 1st month for which you can give 10-day notice.

- If the household submits verification of new income within 30 days, determine if the new income is within MinnesotaCare limits.

  - If the household's income continues to be equal to or greater than the applicable standard AND 10% of the household's income continues to be equal to or greater than the household's annual MCHA premium, give the household 10-day notice and cancel MinnesotaCare at the end of the month. Mail a DHS 3408 with the results of the evaluation and a Certificate of Creditable Coverage (COCC) to the household. See §0916.23 (Certificates of Creditable Coverage).

  - If the household's income is less than the applicable standard OR 10% of the income is less than the household's annual MCHA premium, send the DHS 3408 to notify the household that they will not be canceled. Begin a new 18-month period if the household's income

later increases beyond the standards.

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

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

MA/GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

Determine the household's net income by subtracting deductions and disregards from gross income.

The following deductions and disregards apply only to earned income:

- Work expense deductions. See §0912.05.05.
- Dependent care deduction. See §0912.05.07.
- Earned income disregards. See §0912.05.09.
- Special personal allowance disregard. See §0912.05.09.07.
- Blind and disabled student child disregard. See §0912.05.09.09.

The following deductions may apply to either earned or unearned income:

- Plan to Achieve Self Support (PASS). See §0912.05.11.
- Standard deduction. Apply the standard deduction 1st to unearned income. Apply any remainder to earned income. See §0912.05.13.
- Allocations to relatives of people who reside in long term care facilities or receive services through the elderly waiver (EW). See §0912.05.25.
- Child support deduction. See §0912.05.27.

The following deductions apply only to RSDI income:

- QMB/SLMB/QI COLA disregard. See §0912.05.15.
- Widow and widower's disregard. See §0912.05.17.
- Disabled adult children disregard. See §0912.05.19.
- Disabled widow or widower's disregard. See §0912.05.21.
- Pickle disregard. See §0912.05.23.

To determine countable net income, subtract the disregards and deductions that apply to each person's circumstances from countable gross income in the specific order listed below. Compare the result to the applicable income standard. See §0912.07 (Income Standards).

See §0912.05.03 (Determining Net Income--Order of Deductions).

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Also see §0912.05 (Determining Net Income).

METHOD A:

LTCF RESIDENTS:

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

See the following for more information about LTC spenddowns:

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

NON-LTCF RESIDENTS:

1. Work expense deductions from earned income for pregnant women and infants who are not eligible as auto newborns. See §0912.05.05.
2. Earned income disregard. See §0912.05.09.
3. Dependent care deduction. See §0912.05.07.
4. Child support deduction. See §0912.05.27.

METHOD B:

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

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

See the following for more information:

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

QMB OR SLMB FOR LTCF RESIDENTS:

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

MA FOR NON-LTCF RESIDENTS:

1. Disabled widow/widower disregard. See §0912.05.21.
2. Widow and widower's disregard. See §0912.05.17.
3. Pickle disregard. See §0912.05.23.
4. Disabled adult children disregard. See §0912.05.19.
5. Income used to fulfill an approved Plan to Achieve Self Support for disabled or blind people. See §0912.05.11.
6. Earned income disregard for blind or disabled student children. See §0912.05.09.09.
7. The 1st $65 of the earned income disregard. See §0912.05.09.05.
8. Work expense deduction for disabled clients. See §0912.05.05.
9. One-half the remaining earned income. See §0912.05.09.05.
10. Work expense deduction for blind clients. See §0912.05.05.

QMB OR SLMB FOR NON-LTCF RESIDENTS:

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

METHOD A:

There are no work expense deductions except for pregnant women and infants.

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

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

Household Size	Work Expense Deduction for Pregnant Women and Infants
1	$136
2	$140
3	$145
4	$149
5	$156
6	$161
7	$165
8	$170
9	$177
10	$181
Each Additional Person	$ 5

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

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

EXAMPLE:

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

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

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

METHOD B:

Clients who use Method B because of age:

- Do not allow a deduction for work expenses.

Clients who use Method B because of disability:

- Allow IMPAIRMENT RELATED work expenses as a deduction. The client must reasonably show the expenses relate directly to the disability and are necessary to produce the earned income. (For instance, do not allow expenses for a transportation method also used by non-disabled people such as a bus or unmodified vehicle.) If transportation expenses are allowed, use the same rate allowed as a flat rate deduction for self-employed people. See §0911.09.03.09 (Self-Employment Transportation).

Clients who use Method B because of blindness:

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

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

See §0912.05.03 (Determining Net Income--Order of Deductions) for the order in which to apply the disregards and deductions.
Do not allow work expense deductions for items reimbursable or paid for by another source. When an expense qualifies both as a work expense and a PASS deduction, the

client must choose whether to allow the expense as a PASS deduction or a work expense deduction. See §0912.05.11 (Plan to Achieve Self-Support).

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

METHOD A:

Deduct costs of care for a dependent child or incapacitated adult from the earned income of anyone whose income is used to determine eligibility when that person is:

- At work or in transit to or from work.
- Not at work, but needs dependent care to maintain employment.
  For example, allow the expense for a client who works nights and pays for dependent care while sleeping during the day.

Deduct the costs of dependent care up to:

- $200 per month for each dependent under age 2.
- $175 per month for each dependent age 2 and older.

Do not allow a deduction for care provided by a parent, stepparent, or sibling under age 19 of the dependent child.

If both parents are in the household, allow the dependent care deduction only if the non-working parent in the household is incapacitated or otherwise unable to provide care.

When both parents are working during the same hours, allow half the day care costs as a deduction for each parent.

Allow dependent care costs as a deduction in the month incurred or paid.

Do not require verification of dependent care costs.

Allow the dependent care deduction from the earned income of the parent or other caretaker to determine the parent or caretaker's eligibility and to determine the amount of parental earned income to deem to each child applying for or receiving MA.

EXAMPLE:

Thelma applies for MA for herself and her 2 children, Brett, age 13, and Mandy, age 9. Thelma is employed and pays $250 per month for dependent care for Mandy. She has no dependent care costs for Brett. Allow a dependent care deduction of $175 (maximum allowable for a child over age 2) when determining Thelma's earned income. Use the same net earned income figure for Thelma's, Brett's, and Mandy's eligibility.

Count child support payments that are specifically ordered for dependent care costs as child support income to the child. Do not deduct amounts ordered for dependent care from the parent or other caretaker's dependent care deduction. Allow the full deduction to which the parent or other caretaker is entitled.

EXAMPLE:

Alice applies for MA for herself and her daughter Linda, age 9. Alice receives court ordered child support payments for Linda of $450 per month. The court order specifies that $300 is for child support and $150 is for dependent care. Alice is employed and pays $200 per month for dependent care for Linda. Allow $175 as a deduction from Alice's earned income to determine her own eligibility and the amount to deem to Linda. Count $450 as child support income to Linda.

See §0911.09.11 (Child Support Income)

Do not allow child care costs paid by the child care fund or other 3rd parties (other than child support as described above) as a deduction.

NOTE:

Do not consider payments made by an employer to the day care provider but paid in full by the employee's own funds (such as Dependent Care Expense Accounts) to be 3rd party payments.

EXAMPLE:

Melinda has child care costs of $375 for her 3-year-old son. The Sliding Fee Child Care Program pays $275 to the provider. Melinda is responsible for the remaining $100. Allow $100 as a deduction from Melinda's earned income when determining her eligibility and the amount to deem to her son.

METHOD B:

Do not allow a dependent care deduction for people who use Method B due to age or disability.

Allow the actual cost of dependent care as a deduction from earned income for people who use Method B due to blindness if the dependent care expense is essential to earning the income. Do not allow a deduction for amounts paid by 3rd parties (other than child support or payments funded by the employee as described under Method A).

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

METHOD A:

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

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

There is no earned income disregard for children ages 2-18 using the 170% FPG standard.

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

EXAMPLE:

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

Pregnant women and infants through the month of their 2nd birthday and children ages 2 through 18 whose income is equal to or below the applicable standard (275% FPG for pregnant women; 280% FPG for children through the month of their 2nd birthday; 170% FPG for children ages 2 through 18) do not receive an earned income disregard because the disregard is included in the standard. See §0912.05.05 (Work Expense Deductions).

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

If a pregnant woman's gross income exceeds 275% FGP, or an infant's income exceeds 280% FPG after applying the work expense deduction in §0912.05.05 (Work Expense Deduction), the 17% disregard may be used to spend down to 100% of the FPG standard. See §0912.07.100 (100 Percent of FPG Standard).

EXAMPLE:

Stella, a single woman with no other children, applies for MA/PW in April. Her child is due July 15. She is employed and is not requesting retroactive MA because the health insurance she has through her employer has covered all her bills to date. Her income is under 275% FPG. Stella begins a maternity leave on June 30 and receives her last pay check on July 7. She returns to work on September 15 and receives her 1st pay check on September 22.

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

EXAMPLE:

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

If a child ages 2 through 18 has income that exceeds 170% FPG, the 17% disregard may be used to spend down to 100% FPG. See §0912.07.100 (100 Percent of FPG Standard).

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

The maximum length of the earned income disregard cycle is 4 consecutive months. Once the disregard runs out, it is not available again until the wage earner, spouse, or child under 21 files a new MA application after being off MA for 12 consecutive months. Also, for 12 consecutive months, the wage earner's income must not have been used to determine MA eligibility for the wage earner's spouse or child under 21 before the wage earner, wage earner's spouse, or child are eligible for the disregards. Do not count disregards used to determine eligibility for a cash program with automatic MA toward the client's MA-only disregard cycle.

Begin counting the 12 continuous months off assistance with the month after the last month for which the client's income was used to determine MA eligibility.

EXAMPLE:

Sandra applies for MA for herself and her son Derek beginning in July. Her husband Keith, Derek's stepfather, is not requesting MA or GAMC for himself. His earned income is used to determine Sandra's eligibility and the 17% disregard is applied for July, August, September, and October.

Keith's 18-year-old son moves in with the household and Keith requests coverage for him beginning in December. Do not apply an earned income disregard when deeming Keith's income to his son because the disregard has been used to determine Sandra's eligibility within the previous 12 months.

EXAMPLE:

Sherry received TYMA from March through the following February. She used 4 months of the earned income disregards while receiving MFIP and MA. She requests continued MA when her extended MA ends. She is not entitled to a new 4-month disregard cycle because she has not been off MA for 12 consecutive months.

Begin the earned income disregard cycle when there is at least $1 of earned income. Apply the disregard even if the client would be income eligible without it.

Start the 4-month cycle over if there is no earned income to apply to the disregard or the person does not receive MA in the 2nd, 3rd or 4th months. This includes clients on manual monthly spenddowns who are ineligible for 1 month.

EXAMPLE:

Annette applies for MA for herself and her daughter in March and requests coverage beginning that month. She is employed but will not receive any earnings in April, because her employer has no work for her. She will begin receiving earnings again in May. She is entitled to the earned income disregard in March. Start the cycle over in May since she had no earnings in April.

Clients may not request termination of MA to avoid using the earnings disregard. The disregard cycle does not stop in this case. People lose their earned income disregards the month following the month they voluntarily request termination of assistance to avoid using the earned income disregard.

EXAMPLE:

Joe applies for MA for himself and his children beginning in June. He is employed. His earnings are under the applicable standard when the earnings disregard is applied but will exceed the standard when the cycle ends. He requests to be terminated in September and asks to reapply for October to start a new 4-month cycle. Continue to count September as the 4th month of the cycle in this case.

Ignore earned income disregards received in another state. Also ignore receipt of MA in another state in determining whether people have been off MA or have not had their income counted toward another person's eligibility in the past 12 months.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

METHOD A:

Deduct court-ordered child support that a person in the MA household pays to another household. Apply this deduction to current cash payments for child support, medical support, child care, and payments on arrears. Apply the deduction only to the income of the person with the legal obligation to pay support. Do not allow this deduction from the income of other household members.

A person with a legal obligation to pay support whose financial circumstances change after the support order goes into effect must petition the court to modify the support order. Adding a member to the household is not considered a change in circumstances. Allow the deduction for support paid until the next 12-month renewal is due even if you determine a petition must be filed. A person who does not petition to modify a support order by renewal when financial circumstances have changed loses the child support deduction until the month in which verification of filing a petition is received. If the support ordered has decreased by the time of the renewal, the client does not have to petition for a reduction in the order.

Base the deduction on the amount of current support and payments on arrears actually paid. If the order is too new to establish a payment history, allow the ordered amount in the budget. Determine the actual amount paid at the time of the next renewal or 6-month income/asset review. Request verification of the amount actually paid if the reported amount is questionable (for example, the support is paid through IV-D, or the person receiving the support also receives assistance through your agency, and the reported amounts differ).

If the client is using a 6-month spenddown, a monthly automated spenddown, or has no spenddown for a 6-month certification period, do not allow a deduction for child support unless the client has established a pattern of paying the ordered support. To determine whether there is a pattern, allow an average of the past 3 months as a deduction for future months of the income certification period. Allow the actual amounts paid for the retroactive and application months. Document how you arrived at the amount to allow in MAXIS case notes.

Require clients who make sporadic payments to use a manual monthly spenddown. For clients using a manual monthly spenddown, use the amount of support paid each month

as a deduction.

METHOD B:

No provisions for clients residing in the community. For clients using an LTCF spenddown, allow a deduction for court-ordered support garnished from income up to a maximum of $250. See §0913.13 (Long Term Care Spenddown Calculation) and §0912.05.25 (Allocations).

GAMC:

No provisions.

GAMC Standard for Full Benefits
MinnesotaCare Adults Without Children Standard for Basic Plus One Benefits
MA Method B Spenddown Standard (MAXIS Standard H)

75% of Federal Poverty Guidelines (FPG) effective 7-1-03:

Household Size	Monthly Standard	90%	6-Month Standard	90%	Annual Standard
1	$ 562	$ 506	$ 3,372	$ 3,036	$ 6,744
2	$ 758	$ 683	$ 4,548	$ 4,098	$ 9,096
3	$ 954	$ 859	$ 5,724	$ 5,154	$11,448
4	$ 1,150	$1,035	$ 6,900	$ 6,210	$13,800
5	$ 1,347	$1,213	$ 8,082	$ 7,278	$16,164
6	$ 1,543	$1,389	$ 9,258	$ 8,334	$18,516
7	$ 1,739	$1,566	$10,434	$ 9,396	$20,868
8	$ 1,935	$1,742	$11,610	$10,452	$23,220
9	$ 2,132	$1,919	$12,792	$11,514	$25,584
10	$ 2,328	$2,096	$13,968	$12,576	$27,936
Additional People	$ 197	$ 178	$ 1,182	$ 1,068	$ 2,364

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

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

175% of Federal Poverty Guidelines effective 7-1-03.

Household Size	Monthly Standard	Annual Standard
1	$ 1,310	$15,720
2	$ 1,768	$21,216
3	$ 2,226	$26,712
4	$ 2,684	$32,208
5	$ 3,142	$37,704
6	$ 3,600	$43,200
7	$ 4,058	$48,696
8	$ 4,515	$54,180
9	$ 4,973	$59,676
10	$ 5,431	$65,172
Additional People	$ 458	$ 5,496

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

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. 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 1st day of the coverage month and are due approximately 2 weeks before the 1st 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. 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.

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

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.

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

MinnesotaCare:

See §0913 (Premiums and Spenddowns).

MA:

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

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

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

See the income standards in the following sections:

§0912.07.275	275 Percent of FPG Standards.
§0912.07.280	280 Percent of FPG Standards.
§0912.07.170	170 Percent of FPG Standards.
§0912.07.100	100 Percent of FPG Standards.
§0912.07.075	75 Percent of FPG Standards.

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

EXAMPLE:

Beth applies for MA for her 16-year-old son Thomas. Countable income exceeds 170% of FPG (the appropriate standard for a child under age 18 on Method A) for a household of 2.

Because income exceeds the 170% FPG standard, Thomas is not eligible without a spenddown. You must determine if he can meet a spenddown using the 100% of FPG standard.

There are no spenddown provisions for:

- Transitional/Transition Year MA (TMA/TYMA). See §0907.19.11 (Transitional/Transition Year MA). There is no income limit for the 1st 6 months of eligibility. The income limit for the 2nd 6 months is 185% FPG. See §0912.07.185 (185 Percent of FPG Standards). People whose income exceeds the limit for the 2nd 6 months are no longer eligible for TYMA. Redetermine eligibility under another basis.

- QMB, SLMB, QWD and QI. See §0907.21.09 (MA Basis: Medicare Supplement Programs). Income must be within the applicable standards for QMB, SLMB, QWD, or QI benefits. People with income in excess of these standards are not eligible for these programs. They may be eligible for MA if they meet a spenddown based on the 75% of FPG standard. See §0912.07.075 (75 Percent of FPG).

- Pregnant women from the month they are found eligible under the 275% of FPG standard through the 60-day postpartum period. See §0907.19.05 (MA Basis: Pregnant Women).

- Infants eligible as auto newborns through the month of their 1st birthdays. See §0907.19.05.03 (MA Basis: Auto Newborn).

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

EXAMPLE:

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

EXAMPLE:

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

See the following sections for instructions on calculating the spenddown:

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

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

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

For deceased clients, use a shortened income certification period beginning with the month of application or the 1st retroactive month and ending with the month of death. See §0913.19 (Shortened Spenddown).

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

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

EXAMPLE:

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

EXAMPLE:

Fred applies for MA for his son Ben, born 3-12-90, in July. He requests MA retroactive to April. Fred is employed and had net income of $800 per month in April, May, June, and July. His net income is anticipated to increase to $925 per month in August and September. Ben has no income. Ben's income standard is 100% FPG ($904 per month effective April 1, 1998). His monthly income is less than the standard for April-July but exceeds the standard for August and September. Anticipated income for the 6-month certification period totals $5,050, which is less than the 6-month standard of $5,424. Ben is eligible without a spenddown for April-September. If anticipated income continues to exceed the standard at the time of the 6-month review, Ben will have a spenddown for the next certification period (October-March).

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

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

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

EXAMPLE:

Merrillee and Don apply for MA for themselves and their 2 children, ages 3 and 4. All household members meet an MA basis of eligibility. See §0907.17 (MA/GAMC Bases of Eligibility). The children have an income standard of % 170% FPG. See §0912.07.170 (170 Percent of FPG Standards). Merrillee and Don have an income standard of 100% of FPG. See §0912.07.100 (100 Percent of FPG). Countable income for the 6-month certification period is less than the children's standard but exceeds the standard for Merrillee and Don. The children have no spenddown. Merrillee and Don may choose either a 6-month or a 1-month spenddown. Both must use the same spenddown type.

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

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

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

EXAMPLE:

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

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

EXAMPLE:

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

To calculate the spenddown for applicants:

1. Determine total countable income for the 6-month certification period. See §0912 (Income Eligibility). Use actual income for the month of application and any retroactive months. Anticipate income for the remaining months in the certification period. See §0911.11.03 (Computing Countable Income--MA/GAMC).

2. Enter the appropriate eligibility type and income standard for each month of the certification period on MAXIS. See §0912.07 (Income Standards). The

difference between anticipated income for the 6-month certification period and the appropriate 6-month income standard is the spenddown amount. MAXIS will compute the spenddown amount for each month of and for all 6 months of the income certification period.

3. Enter gross verified medical expenses on the MABI panel in MAXIS. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determine Net Medical Expenses) and TEMP Manual TE02.07.078 (MA ELIG - MABI & MASD Panel Enhancements).

4. Request a bill sort calculation from MAXIS. MAXIS determines the spenddown satisfaction date and recipient amount, if any. The recipient amount is the amount of medical bills the client is responsible for on the day the spenddown is met. Follow the instructions in TEMP Manual TE02.07.296 (MABI: 6-Month Spenddowns) to determine and approve eligibility.

5. Enter the appropriate information on MMIS. See MMIS User Manual II-23 (Six-Month Spenddown).

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

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

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

2. Enter anticipated income in MA ELIG on MAXIS for the next 6-month period based on the review. If the client wants to switch to a monthly spenddown, see §0913.11 (Manual Monthly Spenddown Calculation) and §0913.09 (Automated Monthly Spenddown Calculation). Enter the gross verified medical expenses on the MA Medical Bill Entry (MABI) panel. Use actual

dollars and cents. Request a spenddown summary calculation.

3. Enter the appropriate information on MMIS. See MMIS User Manual II-23 (Six-Month Spenddown). If eligibility continues, schedule an income or eligibility review for the 5th month of the next review period. See §0905.09 (6-Month Reporting).

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

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

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

To calculate the spenddown for applicants:

1. Determine the total actual monthly net income for the month of application and each retroactive month for which the client is requesting assistance. See §0912 (Income Eligibility).

2. Enter the appropriate eligibility type and assistance standard on MAXIS. See §0907.17 (MA/GAMC Bases of Eligibility) and §0912.07 (Income Standards). The spenddown amount is the difference between the net income and the monthly assistance standard. MAXIS will calculate the spenddown amount for each month.

3. Enter the gross verified medical expenses on the MABI panel in MAXIS. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determine Net Medical Expenses) and TEMP Manual TE02.07.078 (MA ELIG - MABI & MASD Panel Enhancements). If the client expects to pay Medicare premiums each month and you are not using an LTC budget, enter the Medicare premium as an expense on the MABI panel for each month of the income certification period. Use actual dollars and cents (use the gross amount; do not round or truncate). Also enter health insurance premiums if they are paid on a monthly basis rather than on a quarterly basis or some other interval. If health insurance premiums are not paid monthly, do not enter them as an automated monthly spenddown expense.

If a client using an LTC budget expects to pay Medicare premiums each month, enter Medicare premiums on the LTC budget in the Medicare Premium field as a deduction. Use actual dollars and cents. Use the gross amount; do not round or truncate.

4. Request a bill sort calculation from MAXIS. MAXIS determines the spenddown satisfaction date and recipient amount, if any, for any month(s) that the spenddown is met. Follow the instructions in TEMP Manual TE02.07.132 (MABI: Automated Monthly Spenddowns) to determine and approve eligibility.

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

6. Anticipate income for the remaining months of the review period. Do not verify income and medical expenses monthly. Schedule an income review for completion during the 5th month of the review period. Tell the client to report any changes. See §0905.09 (6-Month Reporting). Unless income changes, MMIS continues the current spenddown amount for the remainder of the 6-month review period.

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

1. Do not take a new application when the 6-month certification review period expires. Use the income review in the 5th month as a guide to determine continued eligibility for the next period. Also request verification of medical expenses incurred in the 5th month.

2. Calculate a monthly spenddown amount for the next 6-month income certification period using the information from the review and your best estimate of the client's income and expenses for the new certification period. If the client wants to switch spenddown methods, see §0913.07 (6-Month Spenddown Calculation) and §0913.11 (Manual Monthly Spenddown Calculation). Clients must use a manual monthly medical spenddown if they still want a monthly spenddown, but their income or medical expenses now vary.

3. If you determine that the client will continue to meet a spenddown in the next period, extend eligibility for another 6-month period. Use anticipated income for the next period. Schedule an income or eligibility review for the 5th month of the next review period. See §0905.09 (6-Month Reporting).

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

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

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

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA:

Clients eligible for an automated monthly spenddown may choose to prepay their spenddown to DHS. This is called client option spenddown. The client option spenddown cannot be used with the 1-month manual, 6-month, or LTC spenddowns. It can only be used with the 1-month automated spenddown.

Clients who have a waiver obligation under the SIS EW program and Prescription Drug enrollees may not use the client option spenddown. See §0913.13.05 (Waiver Obligation--SIS EW) and §0907.21.09.11 (Medicare Supplement Programs: PDP).

Explain the client option spenddown to clients who ask about it or who may benefit from using the option. Give the client a copy of the Agreement to Prepay Medical Assistance (MA) Spenddown (DHS 3081) to read and sign. Retain a copy of the signed agreement in the case file.

Begin the client option spenddown the month after the client completes the DHS 3081. MMIS will send the 1st monthly bill when client option case data is entered on or before the 15th day of the initial request month. County agencies must send the 1st bill when client option case data is entered on MMIS after the 15th day of the initial request month. Use the Client Option Spenddown Bill (DHS 3180). MMIS will send subsequent bills.

See the MMIS User Manual II-32 (Client Option Spenddown) for instructions on opening client option spenddown cases on MMIS.

Clients must pay their spenddown to DHS by the 20th of the preceding month. See MMIS User Manual II-32 (Client Option Spenddown: Billing Cycle and Client Option Payments) for information on payments received after the 20th of the month.

Late payment, non-payment, or partial payment does not affect the client's eligibility for MA, nor does it result in a loss of the client option spenddown. However, clients who send personal checks with non-sufficient funds will be terminated from client option spenddown and must pay the full amount of the NSF check and the next month’s payment with a money order or cashier's check before they can be reinstated on the client option spenddown.

If the amount of the client's spenddown changes, MMIS will send a bill for the new amount.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Some clients may designate 1 provider to whom they will pay their spenddown each month. Clients using the long term care (LTC) spenddown must use this option. Other clients may choose this option if they meet ALL the following conditions:

- They have a 1-month automated spenddown.

AND

- They receive Personal Care Attendant (PCA) services, child welfare targeted case management services, or receive services through 1 of the following home and community based waivers: Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Traumatic Brain Injury (TBI), Community Alternative Care for Chronically Ill Individuals (CAC), or Home and Community Based Services for Persons with Mental Retardation or Related Conditions (MR/RC).

AND

- They are the only members of the MA/GAMC household with a spenddown.

AND

- They can meet their entire spenddown with 1 designated provider. Verify that clients have met their spenddown with the designated provider for the last 3 months and expect to continue to do so.

AND

- They are willing to pay the spenddown amount to the designated provider at the time they receive services. Past payment history or other factors must indicate a strong likelihood that clients will cooperate in paying the spenddown.

Clients who have a waiver obligation under the SIS EW program may use the designated provider option beginning with the month following the month in which eligibility is approved. The designated provider option cannot be added, changed or deleted for a current or retroactive month, including the month of application. SIS EW clients who choose this option must select a waivered service provider as the designated provider. See §0913.13.05 (Waiver Obligation--SIS EW).

Clients who choose the designated provider option must sign the Agreement to Use Designated Provider (DHS 3161). Refer to the MMIS User Manual II-31 (Designated Provider) for instructions on entering designated provider cases on MMIS. Providers cannot refuse to be designated providers.

Clients can meet their spenddown using a provider other than the designated provider only in emergencies. Clients must report emergency use within 5 days of incurring the expense. Send the information below to the DHS Special Recovery Unit by MAXIS E-Mail to COSD or by FAX to 651-282-6744.

- The client's full name.
- Mailing address.
- PMI number.
- Dates of service
- The name(s) of the provider used instead of the designated provider.

SRU will monitor these cases and may bill the client for any unmet spenddown balance for the given month. They will also monitor all designated provider cases to make sure that the provider submits bills within 3 months and that the client incurs enough bills to meet the spenddown.

If the provider indicates that a client has refused or failed to pay the spenddown, remove the client from the designated provider option.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

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

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

EXAMPLE:

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

To calculate the spenddown for applicants:

1. Determine the total actual monthly net income for the month of application and each retroactive month for which the client is requesting coverage. See §0912 (Income Eligibility).

2. Enter the appropriate eligibility type and income standard on MAXIS. See §0912.07 (Income Standards). The spenddown amount is the difference between the net income and the monthly assistance standard. MAXIS will calculate the spenddown amount for each month.

3. Enter the gross verified medical expenses on the MABI panel in MAXIS. See §0913.21 (Allowable Medical Bills to Meet Spenddown), §0913.21.03 (Determine Net Medical Expenses), and TEMP Manual TE02.07.078 (MA ELIG - MABI & MASD Panel Enhancements).
4. Request a bill sort calculation from MAXIS. MAXIS determines the

spenddown satisfaction date and recipient amount, if any, for any month(s) that the client meets the spenddown. Follow the instructions in TEMP Manual TE02.07.295 (MABI: Manual Monthly Spenddowns) to determine and approve eligibility.

5. Enter the appropriate information on MMIS. See MMIS User Manual II-24 (Manual Monthly Spenddown).

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

1. Use the information on the monthly Household Report Form (HRF) to calculate a new spenddown amount and satisfaction date for each month remaining in the 6-month income certification period. The client must provide the HRF with income and medical expense verification by the last day of the month after the budget month. See §0905.07 (Monthly Reporting). Clients may meet the spenddown in some months and not in others.

2. Follow steps 1-4 for applicants above.

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

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

People cannot receive services through Alternative Care (AC) and the Special Income Standard-Elderly Waiver (SIS-EW) at the same time. People who meet the MA asset limit may be able to choose between AC and EW depending on their income level.

People cannot choose to receive AC if they are:

- Eligible for MA without a spenddown (income equal to or less than 100% FPG).

OR

- Eligible for SIS-EW with gross income at or below 120% FPG). MA applicants with incomes at or below 120% FPG may receive AC for up to 60 days pending the MA eligibility determination.

EXAMPLE:

Marge requests home and community based services beginning in January. She applies for MA on January 15 and requests retroactive coverage for November and December. Her assets are within the MA limit. Her income is less than 20% FPG. AC services can be used to pay for home and community based services for up to 60 days or until MA is approved, whichever is earlier.

People who meet the MA asset limit and who have incomes over 120% FPG but no more than the special income standard (SIS) can choose to receive home and community based services through either SIS-EW or AC. People who choose AC are not eligible for MA with a spenddown.

EXCEPTION:

If people choose AC and later apply for EW, AC may remain open while the MA application is processed. The applicant may use AC expenses to meet a spenddown during the 3-month retroactive period and the processing period. Once SIS-EW is approved, the enrollee will have a waiver obligation. See §0913.17 (Begin/End Use of LTC Spenddown-Part 1).

EXAMPLE:

Bob has been receiving AC services for 12 months. His assets are within MA limits. He applies for SIS-EW on April 5. Based on his income, he has a monthly MA spenddown of $300 and will have a waiver obligation for SIS-EW of $80. He can use expenses paid by AC to meet his spenddown while his SIS-EW

eligibility is determined. Once SIS-EW is approved, AC services end. Bob will have a waiver obligation instead of a spenddown beginning with the first full month of SIS-EW services.

EXAMPLE:

Marge is approved for AC services beginning in January. She applies for MA on January 15 and requests retroactive coverage for November and December. Her assets are within the MA limit. Her income is more than the maintenance needs allowance but less than 120% FPG. She has a spenddown for MA and will have a waiver obligation for SIS-EW. She can use AC-paid services to meet her spenddown beginning in January while SIS-EW eligibility is determined. AC services can continue during the MA processing period or until SIS-EW is approved. Since she did not receive AC services in November and December, she must meet her spenddown for those months with other medical expenses.

People with assets within the MA limits and incomes more than the SIS may choose to receive services through either AC or EW. People who choose AC may be eligible for MA with a spenddown, using AC expenses to meet the spenddown. People who choose EW and MA with a spenddown cannot apply expenses paid by EW to the spenddown. They may apply costs incurred under EW that remain their financial responsibility to the spenddown.

EXAMPLE:

Elaine's assets are within MA limits. Her income is more than the SIS. She would have a monthly MA spenddown of $1,200. She receives monthly AC services of $1,100, reducing her spenddown to $100. She must incur $100 in other medical expenses to meet her spenddown.

MinnesotaCare:

No provisions.

MA:

Use a shortened income certification period when:

- An income certification period with a 6-month spenddown is closed due to the client's enrollment in MinnesotaCare. Inform the client that spenddown eligibility exists for the full 6-month income certification period with the satisfaction of the existing spenddown. If the client opts to change to MinnesotaCare, calculate a shortened spenddown for the months before MinnesotaCare begins.

- Eligibility is terminated during an income certification period with a 6-month spenddown. Calculate a new spenddown and satisfaction date for the months before termination. Notify the household if the calculation results in an earlier satisfaction date. Do not adjust the spenddown if the calculation results in a later satisfaction date or an increased recipient amount on the original date of satisfaction.

  EXAMPLE:

  Delbert and Norma receive MA with a 6-month spenddown. Their income certification period is February-July. They report they moved out of state on April 6. Terminate MA effective May 1. Calculate a new spenddown amount and satisfaction date for February-April. Notify the household if the calculation results in an earlier satisfaction date so they can notify appropriate providers to bill. MA.

- An income certification period with a 6-month spenddown is interrupted. See §0913.19.03 (When to Interrupt 6-Month Cert. Period) and §0913.19.05 (When Not to Interrupt 6-Month Cert. Period).

GAMC:

No provisions.

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

MinnesotaCare:

No provisions.

MA/GAMC:

Also see §0913.19 (Shortened Spenddown) and §0913.19.05 (When Not to Interrupt 6-Month Cert. Period).

Interrupt a 6-month income certification period and begin a new 6-month income certification period:

- When a previously scheduled cash, MA, or Food Stamp annual recertification is due during a current income certification period. Complete the recertification and begin a new income certification period with the recertification month.

  EXAMPLE:

  William and Patsy and their 3 children are receiving Food Stamps and MA. They were approved for Food Stamps effective June 13. They applied for MA the following March and were approved effective March 3 with a 6-month spenddown. The Food Stamp recertification is scheduled for June. The MA income certification period is March-August.

  Redetermine eligibility for both Food Stamps and MA for June. Interrupt the existing MA certification period and begin a new income certification period for June-November. The next Food Stamp and MA annual recertification will be due at the same time in the following June.

  Calculate a new spenddown amount and satisfaction date for March, April, and May using actual income for those months. Apply the same bills as were used to calculate the original spenddown. Notify William and Patsy if the calculation results in an earlier satisfaction date so they can notify appropriate providers who provided services between the old and new satisfaction dates to bill or rebill MA. If the recalculation results in a lower recipient amount on the original satisfaction date, claims will be reprocessed automatically. Do not adjust the spenddown if the calculation results in a later satisfaction date or increased recipient amount on the original satisfaction date.

- When a MinnesotaCare renewal is due during an existing MA or GAMC certification period for other household members. Do not adjust the MA or GAMC certification period if some or all household members receive cash or Food Stamps with a different recertification date. Align the MA or GAMC certification period with the cash or Food Stamps recertification. Do not adjust a MinnesotaCare renewal date to align with any other programs.

  EXAMPLE:

  Leo and Prudence apply for MA and Food Stamps for themselves and their 2 children. Both programs are approved effective July 1. Leo and Prudence apply for MinnesotaCare for themselves the following March and are approved as pending awaiting payment in April. Their MA is terminated effective April 1. The children remain on MA and the entire household remains on Food Stamps. The MA and Food Stamp recertifications will be due in July. The MinnesotaCare renewal will be due in April. Do not adjust the MA certification period to align with the MinnesotaCare renewal.

  EXAMPLE:

  Larry and Liz apply for MA for themselves and their 3 children. MA is approved for the entire household effective April 1. No one in the household is open on cash or Food Stamps. MA is terminated for Larry and Liz effective October 1 because they can no longer meet a spenddown. The children remain on MA without a spenddown. Larry and Liz apply for MinnesotaCare for themselves in November and are approved as pending awaiting payment in December.

  Interrupt the children's existing October-March MA certification period and begin a new certification period for December-May. If the children remain eligible for MA at the time of the 6-month income review, the MA and MinnesotaCare renewals will be due at the same time the following December.

- When adding a person, except a newborn, who increases the household size. Do not interrupt the certification period or recalculate the spenddown when adding a newborn who was already included in the household size as an unborn. The newborn is eligible without a spenddown through the month of the 2nd birthday if the conditions in §0907.19.05.03 (MA Basis: Auto Newborn) are met.

  For all others, end the current 6-month income certification period for the

existing household on the last day of the month before the month the new member is added. See §0915.03.01 (Adding a Person to the Household--MA/GAMC) and §0908.05 (Determining MA/GAMC Household Size).

When the existing household has a 6-month spenddown, compute a shortened spenddown for the existing household when the certification period is interrupted. Also compute a shortened spenddown for the new member using a household size of 1. For the new member, the shortened spenddown runs from the first retroactive month requested through the month before the month the new member is added to the existing household. This will include the month the new member enters the household if he/she enters after the 1st of the month.

For additional information, see TEMP Manual TE02.07.229 (Adding People to the MA/GAMC Household).

EXAMPLE:

Rita applies for MA for herself and her 3 children in June. They are found eligible without a spenddown effective July 1. Rita's husband, Ron, returns home on September 15 and completes an addendum to be added to MA October 3. Interrupt the income certification period for Rita and the children and begin a new income certification period beginning in October. Use both Rita's and Ron's incomes and a household size of 5.

If Ron requests MA retroactive to July, determine his eligibility for July, August, and September using a shortened certification period. Use only Ron's income and a household size of 1. Ron may choose to use either a monthly spenddown or a shortened 6-month spenddown if he has a basis of eligibility for MA. If he has no MA basis and is eligible for GAMC, he is not eligible for retroactive coverage.

- When a person who was included in the existing household size but did not request MA now requests MA for a period BEFORE the household's current income certification period. The new income certification period will begin on the 1st day of the earliest requested retroactive month for all household members. The added member is subject to the spenddown type selected by the household at the time the last certification period was approved. Redetermine the entire household's eligibility using an income certification period starting with the new member's earliest eligible retroactive month.

EXAMPLE:

Mike applied for MA for his 2 children in April. He did not request MA for himself because he had other coverage. The children were found eligible with no spenddown and an income certification period of April-September.

On June 5, Mike requests MA for himself retroactive to March for some bills not covered by his other insurance. Determine eligibility for Mike and his children as follows:

1. Redetermine eligibility using an income certification period for the entire household of March-August based on actual and anticipated income for those months. If Mike has a spenddown, he may choose either a 6-month or a 1-month spenddown because he has a basis of eligibility for MA and the children had no spenddown for any month in the original certification period. See §0913.05 (Which Spenddown Type to Use). Use Mike's bills and any bills the children incurred before becoming eligible for MA to meet the spenddown.

2. If Mike is eligible without a spenddown or can satisfy the spenddown for the new period, end the children's existing income certification period effective July 1 and include them with Mike in the new certification period.

- When a client's automatic MA eligibility ends, such as infants, MSA, IV-E, or 60-day postpartum unless the woman meets the requirements to eliminate the postpartum review. In that case, do not interrupt the budget period. See §0905 (Reviews and Renewals).

- When a client in a single person household dies, end the current income certification period on the last day of the month in which the death occurred. Recalculate the spenddown and satisfaction date using the shortened spenddown period.

EXAMPLE:

Roger receives MA with a 6-month spenddown and an income certification period of May-October. Roger died on September 12. Terminate MA on the date of death.

Recalculate Roger's eligibility for a 5-month period using his income

from May 1 through September 12. If the calculation results in an earlier satisfaction date, notify Roger's representative so that appropriate providers can bill MA.

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

MinnesotaCare:

No provisions.

MA/GAMC:

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

Do not interrupt an income certification period:

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

  EXAMPLE:

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

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

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

EXAMPLE:

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

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

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

- When a client enters or leaves an LTCF. See §0913.17 (Begin/End Use of LTC Spenddown - Part 1), §0913.17.01 (Begin/End Use of LTC Spenddown - Part 2), and §0913.17.03 (Begin/End Use of LTC Spenddown - Part 3).

- When QMB, SLMB or QI eligibility is added to MA. Do not change the certification period or recalculate the spenddown when someone who is active on MA becomes eligible for QMB, SLMB or QI during the certification period. Begin QMB, SLMB or QI in the 1st eligible month.

- When a household size decreases because a person dies or leaves a current MA household. Recalculate the current 6-month income certification period.

  EXAMPLE:

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

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

- When a client's income changes. Redetermine eligibility for the current 6-month certification period.

- When a person who was included in the existing household size but did not request MA or GAMC now requests MA or GAMC within the same income certification period. The added member is subject to the spenddown type selected by the household at the time the last certification period was approved. The added member may request to be added up to 3 months before the month they make the request for MA and effective the date of request for GAMC.

  EXAMPLE:

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

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

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

  EXAMPLE:

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

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

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

- When people on GHO become eligible for full GAMC for the same time period.

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MinnesotaCare:

No provisions.

MA:

Use health care expenses in the order listed below to meet medical spenddowns. See §0913.13 (Long Term Care Spenddown Calculation) for expenses used to meet a long term care spenddown. Use medical expenses incurred by clients, their legal dependents, or financially responsible relatives who live with them. Legal dependents and responsible relatives DO NOT have to be applying for or eligible for MA for the client to use their medical expenses.

Use the actual amount billed for the service rather than what MA will pay. The client must verify health care expenses.

Deduct expenses in the following order:

1. Deduct Medicare and health insurance premiums, including MinnesotaCare premiums (or in some cases the MinnesotaCare capitation payment if higher than the premium) and MA-EPD premiums, for any member of the household if the premiums are paid by the client or a financially responsible relative living with the client and will not be reimbursed by MA, QMB, SLMB, QI, or otherwise paid through the Buy-In or reimbursed as cost-effective. See §0910.05.05 (Medicare Premium Payment), §0910.05.03 (Health Insurance Premium Payment) and §0913.21.05 (MinnesotaCare Expenses to Meet Spenddown).

   If the client has enough medical expenses other than health insurance and Medicare premiums to meet the spenddown, the client may choose to be reimbursed for cost effective premiums rather than applying them to the spenddown. If the client chooses to apply them to the spenddown, they will be deducted first.

   When calculating a 1-month spenddown, deduct the insurance premium on the 1st day of the month in which the premium is due. If the client is expected to pay Medicare premiums each month, allow the Medicare premium as an automated monthly spenddown expense. Allow health insurance premiums as automated monthly spenddown expenses if you verify that they are paid monthly. Verify the payment at the 6-month income review and at the annual recertification. See §0913.09 (Automated Monthly Spenddown Calculation). When calculating a 6-month spenddown, deduct Medicare premiums and all other health insurance premiums for any member of the household which

were due during the month of application and any of the 3 retroactive months on the 1st day of the 1st retroactive month for which the client is requesting MA Do not deduct Medicare or health insurance premiums paid after the month of application as an expense for 6-month spenddowns. Only use indemnity policy premiums to meet spenddowns if the policy benefits are limited to medical payments for medical expenses. Insurance premiums used to meet medical spenddowns do not have to be cost effective.

Also deduct the $1,000 inpatient hospital copay incurred by household members who were enrolled in GHO on the 1st day of the MA household member's 1-month or 6-month spenddown.

2. On the 1st day of the 6-month or 1-month spenddown period, deduct the unpaid balance of medical expenses incurred prior to the income certification period that the client is obligated to pay. The medical expense may be an expense charged directly to the person by a medical provider, an expense which a medical provider has transferred for collection to a person or agency actively pursuing the collection, or a loan payment owed to a person, financial institution, or credit company for which the loan proceeds were specifically paid to a medical provider.

   These expenses must have:

   - Been incurred by the client, the client's dependent if the dependent is included in the client's household size or would have been included in the household size if the client had applied when the bill was incurred, the client's siblings, half-siblings, and step-siblings who are included in the client's household size, or the client's spouse or parent (including stepparent) if the spouse or parent's income is actually used to determine eligibility. See §0908.05 (Determining MA/GAMC Household Size).

   AND

   - Been incurred before the current income certification period.

   AND

   - NOT been used to calculate a spenddown during a prior income certification period, whether or not the calculation resulted in the spenddown being met, unless eligibility for the entire income certification period was denied.

   AND

   - NOT been MA/GAMC covered services incurred in a prior period of MA/GAMC eligibility.

3. Deduct the following expenses on the 1st day of the 6-month or 1-month spenddown period.

   - Non-reimbursable bills incurred during the income certification period not covered by MA/GAMC or reimbursable under the MA Administrative Fund which were NOT reimbursed or paid from the fund, such as transportation. See COVERED SERVICES and TRANSPORTATION COVERAGE in the Minnesota Health Care Programs Provider Manual for information on expenses eligible for reimbursement. See NON-REIMBURSABLE EXPENSES in §0902.27 (Glossary: Non-Citizen...) and MEDICALLY NECESSARY in §0902.23 (Glossary: Managed Care...) For more information on which expenses can be allowed as spenddown deductibles.

     For ongoing non-reimbursable expenses, verify the need for the item at each annual review unless the doctor's recommendation specifies a shorter period.

   - Expenses other than health insurance incurred during the income certification period by dependents or financially responsible relatives who are not requesting or on MA/GAMC. Include both reimbursable expenses (which can be paid through MMIS) and non-reimbursable expenses (which are not covered by MA/GAMC or cannot be paid through MMIS). Include bills paid by MinnesotaCare for family members for whom DHS does not receive FFP. See §0913.21.05 (MinnesotaCare Expenses to Meet Spenddown) for instructions on which MinnesotaCare expenses are allowable.

   - The following medical expenses incurred by the client or financially responsible relatives:
     - Allowable medical care costs for clients in GRH settings.

     To determine the amount of remedial care expenses to allow toward the spenddown for GRH residents who are not eligible for the GRH cash program:
     1. Subtract the current clothing and personal needs allowance in §0912.07.03 from the 75% of FPG standard for 1 in §0912.07.075. This is the MA room and board rate.
     2. Subtract the result from step 1 from the GRH negotiated rate. This is the remedial care amount.

3. Apply the amount from step 2 to the spenddown.

- Alternative Care (AC). See §0913.21.03 (Determine Net Medical Expense) and §0913.13.07 (Relationship Between AC and SIS-EW) for information on when AC expenses can be applied to the spenddown.
- Minnesota Children Special Health Needs (MCSHN).
- Insurance Extension Program.

4. Deduct, on the 1st day of the 1-month spenddown, hospital bills paid by MinnesotaCare for MinnesotaCare recipients who are applying for MA to pay the hospital bill. See §0913.21.07 (MinnesotaCare Inpatient Hospitalization) for specific instructions on MinnesotaCare enrollees who apply for MA to help with hospital costs.

   MinnesotaCare enrollees are not eligible for GAMC to help pay hospital costs incurred while they were active on MinnesotaCare.

5. Deduct MA covered services incurred by the client during the 6-month or 1-month income certification period in chronological order by date of service. Include waivered services received through the CAC, CADI, EW, and MR waivers, the net amount of the MSHO spenddown, and Targeted Case Management expenses. Also include prescription costs paid by the Prescription Drug Program (PDP) and PDP deductibles. MMIS will apply the client's out-of-pocket prescription costs to both the PDP deductible and the spenddown until the spenddown is met. Once the spenddown is met for a given month, the deductible no longer applies.

   Although MA may limit how often they will pay for some services, and require prior authorization limits for others, do not apply these limits when determining what expenses are acceptable to meet a spenddown.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA :

Use net medical expenses to meet a spenddown. See §0913.21 (Allowable Medical Bills to Meet Spenddown). To determine net medical expenses:

1. Determine if 3rd party coverage exists for each gross medical expense incurred. For spenddown purposes, 3rd party means any person or entity other than the client.

2. Verify the amount of 3rd party payments on expenses. Also verify any denials of payment. The client must provide the verifications necessary to determine liable 3rd party payments.

3. With the exceptions below, subtract 3rd party payments from a gross medical expense to determine the client's net responsibility.

Count payments by these 3rd party programs toward meeting a spenddown:

- MinnesotaCare, except bills paid on behalf of MinnesotaCare enrollees for whom DHS receives FFP. See §0913.21.05. (MinnesotaCare Expenses to Meet Spenddown), for instructions on which MinnesotaCare expenses to allow.
- Alternative Care Program (AC) for:
  -SIS-EW applicants while MA eligibility is determined
  -MA enrollees whose income is over the limits for SIS-EW
  See §0913.13.07 (Relationship Between AC and SIS-EW).
- Minnesota Children's Special Health Needs (MCSHN)
- Insurance Extension Program.

Do not delay processing an application beyond the standards in §0904.07.03 (Date of Application) if verification of 3rd party payments or intent to pay is still not available. Do not delay redetermining eligibility beyond the due date for other verifications if 3rd party payment verifications or intent to pay is still not available. When verification is not available, estimate 3rd party payments using coverage information in the insurance policy or other sources. Document in the case file how 3rd party payments were determined.

Sometimes liable 3rd parties will issue 1 payment for several different medical services and not break down the payment by date, type, and cost of each service covered. Try to get a breakdown by date and amount paid on each service from the 3rd party or by examining available coverage information. If this is not possible within the case processing standards (see §0904.07.03, Date of Application), apply the total payment against the services it covers starting with the oldest expense. Continue applying the payment until it is used up. Consider any remaining medical expenses to be the client's responsibility. Use them to meet the spenddown. Document in the case file attempts to get 3rd party information and how 3rd party payments were applied.

Sometimes non-liable 3rd parties, such as a non-responsible relative, pay a client's medical expenses, or vendors write off all or part of a bill. If this happens before the application is processed, deduct the write-off or payment from gross medical expenses. Do not try to anticipate payments from non-liable 3rd parties when determining net medical expenses. Payments made after the county agency approves eligibility have no effect.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Some MinnesotaCare expenses may be used to meet a spenddown for household members who receive MA . Expenses paid by MinnesotaCare for which DHS receives or may receive federal financial participation (FFP) cannot be used to meet an MA spenddown. Generally, DHS may receive FFP for MinnesotaCare expenses paid on behalf of the following groups:

- Pregnant women
- Children under 21
- Parents and relative caretakers in families with household incomes equal to or less than 275% FPG.

To be eligible for FFP, people must be citizens or meet the MA definition of qualified non-citizens. See §0906.03.03 (Qualified Non-Citizens).

Take the following steps when an MA applicant or enrollee is part of a household that includes MinnesotaCare enrollees:

1. Determine which household members are active on MinnesotaCare. Check the MMIS RELG screen for each household member. Check the coverage dates for these individuals to determine if any MinnesotaCare bills can be used to meet a spenddown.

2. Determine whether each member has a $10,000 inpatient hospital cap and whether DHS is receiving FFP for that member's health care coverage according to the major program. See §0906.03.13 (MMIS Major Programs).

3. Determine if the MinnesotaCare household members are enrolled in a health plan through MinnesotaCare by checking the MMIS RPPH screen. In some cases the capitation payment paid by the state to the health plan can be used to reduce a spenddown. County staff with appropriate security may verify the capitation payment by viewing the claims subsystem.

4. Verify the amount of the monthly MinnesotaCare premium through

MMIS, by contacting the MinnesotaCare enrollment representative, or with a copy of the client's premium notice.

5. Determine eligibility for the MA household members. Use a manual monthly spenddown if MinnesotaCare expenses for other household members will be used to meet the spenddown. See §0913.21.07 (MinnesotaCare Inpatient Hospitalization) for spenddown information when MinnesotaCare enrollees apply for MA to help with inpatient hospital costs.

Apply the following MinnesotaCare expenses to meet an MA spenddown for other household members:

PREGNANT WOMEN AND CHILDREN UNDER 21 FOR WHOM DHS RECEIVES FFP

- MinnesotaCare premiums.
- Bills incurred outside the health plan network for which the household is financially responsible.

Do not allow the MinnesotaCare capitation payment or any other expenses paid by MinnesotaCare.

EXAMPLE:

Mark has Medicare coverage and is ineligible for MinnesotaCare. He has outstanding medical expenses and applies for MA on September 5. His wife, Angela, who is 6 months pregnant, and their 3-year-old daughter, Ranae, are enrolled in MinnesotaCare with a monthly premium of $58. Mark has a 6-month spenddown of $350. He has a dental bill for $300 from September and an old unpaid bill for a clinic visit for Ranae for $350 incurred in January, before Angela and Ranae enrolled in MinnesotaCare . MMIS case notes indicate that DHS receives FFP for Angela and Ranae. Allow the MinnesotaCare premium, Ranae's old unpaid bill, and Mark's bills toward his spenddown.

PREGNANT WOMEN AND CHILDREN UNDER 21 FOR WHOM DHS DOES NOT RECEIVE FFP

- The greater of:
  - The MinnesotaCare premium.

  OR
  - The monthly capitation payment.

- Bills incurred outside the health plan network for which the household is financially responsible.

- Expenses paid by MinnesotaCare for household members who are not enrolled in a health plan.

EXAMPLE:

Jesse, applies for MA on September 14 because of bills incurred due to injuries from a farm accident. He has a spenddown of $400. His wife, Donna, and their 5-year-old daughter, Anna, were enrolled in MinnesotaCare effective September 1 with a monthly premium of $98. DHS pays a monthly capitation payment of $212 for Donna and $102 for Anna. Donna is 4 months pregnant. She is a lawful permanent resident but does not meet the MA definition of a qualified non-citizen. Anna is a citizen. DHS receives FFP for Anna only.

Do not allow any of Anna's MinnesotaCare expenses toward Jesse's spenddown. Allow Donna's $212 capitation payment because it is greater than the MinnesotaCare premium. Also allow Jesse's bills from the accident.

PARENTS AND RELATIVE CARETAKERS IN FAMILIES WITH INCOMES OVER 275% FPG AND ADULTS WITHOUT CHILDREN

- The greater of:
  - The MinnesotaCare premium.

  OR
  - The monthly capitation payment.

- Bills incurred outside the health plan network for which the household is financially responsible.

- Expenses paid by MinnesotaCare for household members who are not

enrolled in a health plan.

- MinnesotaCare co-payments and inpatient hospitalization expenses.

EXAMPLE:

Elaine and her 4 children are enrolled in MinnesotaCare with a monthly premium of $150. The household's income exceeds 175% FPG. DHS receives ffp for the children only. Elaine's husband, Randy, has health insurance through work and is ineligible for MinnesotaCare. Randy applies for MA to cover $2,000 in dental expenses not covered by his health insurance. Randy has a $1,300 spenddown.

Do not allow any of the children's MinnesotaCare expenses toward Randy's spenddown. Allow the greater of the MinnesotaCare premium OR Elaine's capitation payment. Also allow Randy's insurance premiums and net medical bills.

PARENTS AND RELATIVE CARETAKERS WITH HOUSEHOLD INCOMES EQUAL TO OR LESS THAN 275% FPG FOR WHOM DHS RECEIVES FFP

- MinnesotaCare premiums.
- Expenses incurred outside the health plan for which the household is financially responsible.
- MinnesotaCare co-payments.

EXAMPLE:

Brett receives MA with a monthly spenddown of $100. His mother, Peggy, has recently been approved for MinnesotaCare and pays a monthly premium of $45. Her income is under 175% FPG. Peggy is enrolled in HealthPartners through MinnesotaCare and DHS receives FFP for her coverage. On July 12, Peggy is injured and is hospitalized. She incurs hospital charges of $15,000. She has a $10,000 inpatient hospital cap.

Apply Peggy's MinnesotaCare premium toward Brett's spenddown every month. Allow Peggy's inpatient charges in excess of the cap toward Brett's July spenddown.

PARENTS OR LEGAL GUARDIANS IN HOUSEHOLDS WITH INCOMES EQUAL TO OR LESS THAN 275% FPG FOR WHOM DHS DOES NOT RECEIVE FFP

- The greater of:

- The MinnesotaCare premium.

OR

- The monthly capitation payment.

- Bills incurred outside the health plan network for which the household is financially responsible.

- Expenses paid by MinnesotaCare for household members who are not enrolled in a health plan.

- MinnesotaCare co-payments and inpatient hospitalization expenses.

GAMC:

No provisions.

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

MinnesotaCare:

Do not disenroll people for failing to apply for MA for inpatient hospitalization costs.

MA:

MinnesotaCare enrollees who have a basis of eligibility for MA may apply for MA to help with inpatient hospitalization costs not covered by MinnesotaCare but are not required to do so. MinnesotaCare enrollees who choose to apply for MA for inpatient hospitalization costs must apply at the county agency.

Take the following steps when you receive an MA application for costs associated with a MinnesotaCare inpatient hospitalization:

1. Ask the client if he/she wants MA for the month(s) of hospitalization only or ongoing. If the client wants MA for the month(s) of hospitalization only, determine MA eligibility for those months only on MAXIS. If the client wants ongoing MA, determine MA eligibility for the months of hospitalization and the remaining months in the budget period.

2. Determine which household members are active on MinnesotaCare by viewing the MMIS RELG screen for each person. Determine whether DHS receives FFP for the person and whether there is a $10,000 inpatient hospital cap according to the major program. See §0906.03.13 (MinnesotaCare Major Programs).

3. Determine if the applicant and other MinnesotaCare household members are enrolled in a health plan through MinnesotaCare by viewing the MMIS RPPH screen. In some cases, the monthly capitation payment to the health plan may be applied toward the spenddown. Authorized county staff may verify the capitation payment amounts by viewing the claims subsystem.

   If the enrollment begin and end dates on RPPH do not correspond with the dates of inpatient hospitalization, the enrollee was receiving health coverage under fee-for-service and no capitation payments were made.

4. Verify the amount of the monthly MinnesotaCare premium through MMIS, by contacting the MinnesotaCare enrollment representative, or with a copy of the client's premium statement.

5. Determine whether there is a spenddown for MA. Use an automated monthly spenddown. See §0913.05 (Which Spenddown Type to Use). Apply the following bills to the spenddown in the order listed for people enrolled in a

health plan through MinnesotaCare:

a. The greater of EITHER the total monthly capitation payments for individuals who receive MinnesotaCare but for whom the state does not receive FFP, OR the monthly MinnesotaCare premium.

   Add together capitation amounts for each non-FFP eligible individual. Do not use capitation payments for any family member for whom DHS receives FFP. If the sum of the capitation payments for non-FFP eligible individuals on MinnesotaCare is greater than the monthly premium, enter the capitation payment total on MAXIS. Enter the first day of the month as the date of service for the capitation payments.

   If the sum of the capitation payments for non-FFP eligible individuals on MinnesotaCare is less than the monthly premium amount, enter the premium amount on MAXIS. Enter the first day of the month as the date of service for the monthly premium.

b. Any old or non-covered medical expenses. Use the appropriate bill type, service code, and actual date of service. MA will not reimburse bills incurred outside the health plan network that MinnesotaCare would have otherwise covered.

c. MinnesotaCare co-payments.

d. MinnesotaCare inpatient hospital expenses for the applicant. MinnesotaCare enrollees who receive services through a health plan may not receive medical bills to verify incurred expenses, such as hospitalization stays. The applicant may not be able to provide you with information on the costs incurred. Do not delay acting on the MA application if you cannot verify inpatient hospital expenses. If the client did not meet the spenddown after entering bills listed in 1-3 above, enter an inpatient hospital bill equal to the amount of the remaining spenddown.

   Enter the actual date of service of the hospitalization. Do not enter any third party payment amounts, even if the hospitalization is covered by the MinnesotaCare health plan.

Apply the following bills in the order listed for people who were not enrolled

in a health plan during the period of hospitalization:

a. Any old or non-covered medical expenses. Use the appropriate bill type, service code, and actual date of service.

b. The monthly MinnesotaCare premium. Enter the first day of the month as the date of service.

c. MinnesotaCare inpatient hospital bill. Enter the actual date of service. Use the gross amount of the bill and do not enter 3rd party payments.

GAMC:

MinnesotaCare enrollees may not receive GAMC, including GHO, for MinnesotaCare inpatient hospitalization costs. When an active MinnesotaCare enrollee applies for GAMC, approve GAMC for the month following the month of application if the applicant is eligible. If the MinnesotaCare capitation payment has been made, allow GAMC and MinnesotaCare to overlap for the first month of GAMC eligibility. The MinnesotaCare health plan must provide GAMC-covered services for that month.

When an active GAMC enrollee applies for MinnesotaCare, is approved, and pays the MinnesotaCare premium after 10-day notice cutoff, allow MinnesotaCare and GAMC to overlap until GAMC can be closed with a 10-day notice. GHO coverage ends on the date of hospital discharge, although the MMIS span remains open until the end of the month. Ten-day notice is not required. See §0904.09.11 (MinnesotaCare/MA Overlap) for more information on allowing overlapping eligibility spans on MMIS, including MMIS spans that extend beyond GHO termination.

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

MinnesotaCare:

No provisions.

MA:

When applicants fail to report medical bills at the time of application but report the bills after the application has been approved, consider the additional bills if they were incurred in any of the retroactive months and were reported within 3 months of the month the bill was incurred. Adjust the spenddown and/or begin date as appropriate.

EXAMPLE:

Betty applies for MA on May 6. She does not request retroactive coverage. On May 15, MA is approved without a spenddown effective May 1. On May 26, Betty calls to report a medical bill incurred on February 10 and requests MA retroactive to February. Redetermine eligibility beginning with February. Approve MA effective February 1 if Betty is eligible without a spenddown. If she now has a spenddown, consider the February 10 bill toward meeting the spenddown.

EXAMPLE:

Barney applies for MA on June 10. He does not request retroactive coverage. He is approved with a 6-month spenddown effective June 5. On July 10, he calls to report a medical bill incurred on April 13 and requests MA retroactive to April. Redetermine eligibility beginning with April. Adjust the eligibility date if the April bill results in the spenddown being met earlier.

Do not redetermine eligibility if the client reports a bill more than 3 months after the month it was incurred, even if the bill was incurred within 3 months before the application month. The bill may be used to meet a future spenddown if it remains unpaid.

EXAMPLE:

Joelle applies for MA with MFIP on June 13. She does not request retroactive MA. On June 25, MFIP is approved with MA effective June 1. On September 5, Joelle calls to report a medical bill incurred on March 15. Do not redetermine eligibility since the bill was incurred more than 3 months before the month it was reported.

GAMC:

No provisions.

MinnesotaCare:

No provisions.

MA:

Spenddown cases have notice requirements in addition to those in §0916 (Notices). These requirements are the same for income reviews, applications, and recertifications.

Notify clients how you calculated the spenddown.

- For all spenddown types:

  MAXIS will send completed income computation worksheets with the opening or denial notice.

  Notify clients of their medical expense obligation. MAXIS does not notify clients which bills were used to meet the spenddown. Add worker comments to the notice to inform the client how the spenddown was met and which bills the client is responsible to pay. See TEMP Manual TE02.07.155 (MA Changes: Spenddown Problems and Workarounds).

- For automated monthly medical spenddowns:

  Notify clients of their spenddown amount. DHS will tell them on the monthly Explanation of Medical Benefits (EOMB) which specific expenses are their obligation.

- For client option spenddowns:

  Follow spenddown notice requirements under automated monthly spenddowns. Before the client option spenddown can begin, the client must sign an Agreement to Prepay Medical Assistance (MA) Spenddown (DHS-3081) to DHS. DHS will send client option bills. A late payment or non-payment does not affect the client's eligibility for MA/GAMC, nor does it result in loss of the prepayment option. The result of a late payment, non-payment, or partial payment is that the client's spenddown balance will be paid using potluck processing. See §0913.09.03 (Client Option Spenddown).

- For manual monthly medical spenddowns:

  Notify clients of their date of eligibility and any remaining spenddown amount. DHS will tell them which specific expenses on or after that date are their obligation.

- For 6-month spenddowns:

  Notify clients of their date of eligibility and any remaining spenddown amount. DHS will tell them which specific expenses on or after that date are their obligation.

- For LTC spenddowns:

  Notify clients of their spenddown amount and their responsibility to apply this obligation toward LTCF costs. Adjustments to LTC spenddowns due to change in income do not require advance notice.

- For combination LTC/Medical spenddowns:

  Notify clients of the spenddown amount. DHS will tell them which specific expenses in addition to the LTCF charges are their obligation.

GAMC:

No provisions.

People enrolled in Minnesota health care programs receive medical services in 1 of 2 ways:

- Managed care. In a managed care system, DHS contracts with a health plan to provide services to people enrolled in MA, GAMC, or MinnesotaCare. The health plan must provide most services covered by the program the person is enrolled in. DHS pays a fixed monthly fee, called a capitation payment, to the health plan. Enrollees must receive services through their health plans. MA services that are not covered in the managed care contract will be billed under fee-for-service.

  All MinnesotaCare enrollees receive services through managed care. Some MA and GAMC enrollees receive services through managed care depending on the county they live in and whether they are excluded from managed care. See §0914.03.03 (Managed Care Exclusions).

  The following are managed care counties for MA and GAMC as of 9-1-03:

  Aitkin, Anoka, Becker, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Chippewa, Chisago, Clay, Cook, Cottonwood, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, LeSueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, St. Louis, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Traverse, Wabasha, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine, Mille Lacs Tribal TANF.

  The following are managed care counties except for dental services. MA, GAMC and MinnesotaCare clients in these counties who are enrolled in managed care receive dental services through fee-for-service. The health plans are not responsible for dental services or transportation to dental appointments. The health plans provide all other managed care services:

  Cass, Crow Wing, Morrison, Todd, Wadena

  In most counties, managed care enrollees choose 1 of 2 or more health plans. If required, enrollees must also choose specific clinics within the health plan

network. See §0914.03.05 (Managed Care Enrollment Process) and §0914.03.05.01 (Managed Care Enrollment Process--MA/GAMC).

Managed care enrollees receive a Minnesota Health Care Programs Identification Card and an identification card from the health plan. See §0914.07 (Minnesota Health Care Programs Card).

- Fee-for-service. MA and GAMC enrollees who are not enrolled in a managed care plan receive medical services on a fee-for-service basis. MinnesotaCare enrollees do not receive care through fee-for-service on an ongoing basis, but may be enrolled in fee-for-service for a limited period in some circumstances. See §0914.05 (Fee-for-Service). In a fee-for-service system, people may receive services from any provider who is enrolled as a Minnesota Health Care Programs provider. Providers bill DHS for each service provided. DHS makes payments for approved services at a predetermined rate.

  Fee-for-service enrollees receive a Minnesota Health Care Programs Identification Card. See §0914.07 (Minnesota Health Care Programs Card).

MinnesotaCare:

There are no exclusions. All MinnesotaCare enrollees must receive services through managed care. People may be enrolled in fee-for-service for a limited period in certain circumstances. See §0914.05 (Fee-for-Service).

M.S. 256L.12 subd. 3

MA/GAMC:
Exclude the following groups from managed care enrollment in MA and GAMC:

- People who receive Refugee Cash Assistance or Refugee Medical Assistance. See §0907.21.13 (MA Basis: Refugee Medical Assistance - RMA).

- Residents of state institutions, including Regional Treatment Centers (RTC), Institutions for Mental Disease (IMD), and state-operated long term care facilities who reside in the institution at the time of initial enrollment. People already enrolled in managed care who enter state institutions will remain enrolled their health plans if the placement has been approved by the health plan..This includes court-ordered placements for which the health plan is responsible. See §0906.09.01 (Institutional Residence--MA/GAMC) and §0907.27 (MA/GAMC Basis: IMD Residents).

  NOTE: Do not exclude residents of Ah Gwah Ching Nursing Facility and Woodhaven Senior Community under this basis.

- People who have private health insurance through the following HMOs certified by the Department of Health. These people may voluntarily enroll in managed care IF THE PRIVATE HMO IS THE SAME AS THE HEALTH PLAN THE CONSUMER WILL SELECT UNDER PMAP. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

  Avera Health Plan of Minnesota
  Blue Plus
  First Plan of Minnesota
  Group Health, Inc.
  HealthPartners, Inc.
  Itasca Medical Care
  Medica Health Plans
  Metropolitan Health Plan
  PreferredOne Community Health Plan
  Sioux Valley Health System

UCare Minnesota

- People eligible with all spenddown types except institutional spenddowns. See §0914.03.25 (Minnesota Senior Health Option - MSHO) for information on people with spenddowns who may voluntarily enroll.

- People who receive EMA. See §0907.29 (Emergency Medical Assistance).

- People under age 65 who are eligible for MA due to blindness or disability. See §0907.21.05 (MA/Medicare Savings Basis: Blindness) and §0907.21.07 (MA/Medicare Savings Basis: Disability). This includes people with blindness or disabilities who receive services under the CAC, CADI, MR/RC and TBI waivers. See §0907.23 (MA Waiver Programs).

- People who are terminally ill with a medical prognosis of 6 MONTHS OR LESS to live and who, at the time of notification of mandatory health plan enrollment, have a permanent relationship with a primary physician who is not part of any available managed care health plan.

- People who are enrolled in the SIS EW program with gross incomes greater than the maintenance needs allowance but less than or equal to the Special Income Standard. These people may enroll in managed care voluntarily. SIS EW enrollees with incomes less than the maintenance needs allowance must enroll in managed care.

- People eligible for QMB, SLMB, QWD, or QI only (eligibility types BQ, BS, BW, DS, DQ, DW, EQ, ES, 1B, 1D, 1E, 2B, 2D, and 2E). See §0907.21.09 (MA Basis: Medicare Savings Programs).

- People who, at the time of notification of mandatory enrollment in managed care, meet ALL the following:

  - Have a communicable disease.
  - Have a prognosis of a terminal illness (may exceed 6 months) because of the communicable disease.
  - The disease and prognosis are verified by a written statement from a licensed physician based on a current medical examination.
  - Currently have a primary physician who is not a participating provider in an available managed care health plan.
  - The physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient stopping recommended medication or other health services.

- Children who are identified to DHS as having severe emotional disturbance (SED) and who are eligible to receive MA-covered mental health case management services.

- Children receiving IV-E or state adoption assistance.

- SED and adoption assistance children may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

- Adults who are identified to DHS as having serious and persistent mental illness (SPMI) and who are eligible to receive MA-covered mental health case management services.

These adults may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

- American Indians living on an Indian reservation, if the tribal government of that reservation chooses to exclude these people.

- Women receiving MA under the MA-BC basis. See §0907.19.13 (MA for Breast/Cervical Cancer MA-BC).

Enrollees receiving care and rehabilitation services from the Center for Victims of Torture (CVT). See §0907.25.07 State-Funded MA Basis: Victims of Torture).

People with cost-effective employer-sponsored health insurance or people enrolled in an individual health plan determined to be cost-effective and for whom the state or county is paying the premium.

Also exclude the following groups from enrollment in GAMC managed care:

- GAMC recipients eligible for Medicare benefits.

- GAMC recipients living in nursing facilities.

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

MinnesotaCare:

No provisions.

MA/GAMC:

The following excluded people may volunteer to enroll in MA or GAMC managed care:

- People who currently have private health insurance through an HMO licensed by the Department of Health. The private HMO must be the same as the health plan the person will select under managed care. See §0914.03.03 (Managed Care Exclusions).
- Children with severe emotional disturbance (SED).
- Adults with serious and persistent mental illness (SPMI).
- People age 65 and over who are eligible for MA with an automated monthly spenddown or a combination LTC/medical spenddown and who live in Anoka, Carver, Dakota, Hennepin, Mille Lacs, Ramsey, Scott, Sherburne, Washington or Wright counties. These people may voluntarily enroll in Minnesota Senior Health Options (MSHO). See §0914.03.25 (Minnesota Senior Health Option - MSHO).
- People enrolled in SIS EW with a waiver obligation (those with gross incomes over the maintenance needs allowance but less than or equal to the Special Income Standard).
- People under age 65 who are certified as disabled but who choose a non-disabled basis of eligibility. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility).
- People ages 18 through 64 who are certified disabled with a primary diagnosis of physical disability and who reside in Anoka, Dakota, Hennepin or Ramsey counties. These people may voluntarily enroll in Minnesota Disability Health Options (MnDHO). See §0914.03.27 (Minnesota Disability Health Options (MnDHO).
- Children receiving IV-E or state adoption assistance.

Volunteers may choose to disenroll at any time for the next available month on

MMIS. Request a written statement from the enrollee or authorized representative that the enrollee wishes to disenroll from the health plan. See §0914.03.11 (Managed Care Disenrollment).

MinnesotaCare:

The managed care enrollment process is done through the mail and is completely automated on MMIS. When MinnesotaCare coverage is approved as pending awaiting payment, MMIS automatically chooses a default health plan and generates a health plan enrollment form. The default plan is the plan the household will be enrolled in if they fail to choose a health plan. The default plan is determined by the following criteria:

- If anyone in the household is enrolled in managed care through MA or GAMC, the default plan is the plan the MA or GAMC person is enrolled in unless that plan is not available through MinnesotaCare.

  If more than 1 household member is enrolled on MA or GAMC in different health plans, the system will select the 1st plan that is available to MinnesotaCare as the default plan.

- If no one in the household is enrolled in managed care through MA or GAMC but anyone in the household has previously been enrolled in managed care through MinnesotaCare, the default plan is the plan in which they were previously enrolled if that plan is still available.

- If neither of the above circumstances applies, MMIS assigns a default plan based on the plans available in the household's county of residence.

DHS sends the household a health plan enrollment packet and a premium notice packet. The health plan enrollment packet includes:

- Mailing envelope (DHS 3254A)
- MinnesotaCare Health Plan Enrollment Information (DHS 3272B)
- Health Plan Enrollment Form
- Guide to Managed Care Enrollment Including Notice about Your Rights and Responsibilities (DHS 3303)
- MinnesotaCare Health Plan Enrollment Return Envelope (DHS 3253)
- Network lists for each health plan available in the enrollee's county of residence, known as PCNLs.

The household must choose the same health plan for all household members. However, the household may choose different primary care clinics within the health plan for different household members.

If the household returns the enrollment form before the date that capitation payments

are made to the health plans for the next month, MMIS is updated to show the household's health plan choice. The capitation date is usually 6 business days before the end of the month. However, if the household returns the form after the 15th of the month, there may not be time to enter the enrollment information before capitation. Refer the household to their MinnesotaCare enrollment representative or financial worker to complete a manual enrollment form to ensure enrollment in the plan of their choice for the next month. If the household has been found eligible but there is no enrollment information entered as of the capitation date, either because the household has not returned the form or returned it after the 15th and did not use the manual enrollment process, MMIS will enroll the household in the default plan. If new enrollment information is entered before the next capitation date, MMIS will enroll the household in the plan of their choice beginning the following month..See §0914.03.07 (Health Plan Changes).

EXAMPLE:

John is approved for coverage awaiting payment on October 3. MMIS mails John a premium notice packet and a health plan enrollment packet on October 5. MMIS also selects UCare as John's default plan. John returns his premium payment and enrollment form on October 22 indicating HealthPartners as his choice of plan. There is not time to process his enrollment form before capitation on October 23, and John does not use the manual enrollment process. He will be enrolled in UCare for November and will be switched to HealthPartners beginning December 1.

If MinnesotaCare is approved after the capitation date but before reinstatement (usually the last business day of the month), the household must choose a health plan by the reinstatement date. Otherwise, MMIS will enroll the household in the default plan.

M.S. 256L.12 subd 3
Minnesota Rule 9506.0200 subp 3, 4, 5, 6

MA/GAMC:

See §0914.03.05.01 (Managed Care Enrollment Process--MA/GAMC).

MinnesotaCare:

Once enrolled in a health plan, households may change to a new plan:

- Once during the 1st year of enrollment. This is known as the 1st year change option. This option is available for 12 months beginning with the initial date of enrollment. The 12 months continues to run regardless of whether the household remains continuously enrolled in MinnesotaCare during that time. Apply the 1st year change option to households, not individuals.

- Annually during open enrollment. MinnesotaCare enrollees receive open enrollment materials approximately 90 days before the due date for returning enrollment forms. If enrollees choose a different plan, enrollment in the new plan will begin on January 1 of the following year.

- If they move to another county and the plan they are enrolled in is not available in the new county. MMIS will generate a new enrollment form and assign a new default plan.

  If a household moves to another county and the plan they are enrolled in is available, they may choose a new plan within 60 days of the move date. However, MMIS will not automatically generate an enrollment form.

- A health plan terminates its contract with DHS.

- The primary care provider is inaccessible. The DHS Managed Care Ombudsman decides inaccessibility on a case-by-case basis.

- Within the 1st 90 days of health plan enrollment. This change option will be available to households each time they are enrolled in a new health plan for 90 days or less.

- After a break in managed care enrollment of more than 2 full calendar months. The household must request the change within 90 days of being re-enrolled.

When a household changes plans, the change is effective the 1st day of the next available month after receipt of the new enrollment form. For changes completed before capitation, the next available month is the month after capitation. For changes completed after capitation, the next available month is the 2nd month after capitation.

EXAMPLE: The Browns exercise their 1st year change option. They return their enrollment form for the plan they wish to select on August 10. All

information is entered before capitation in August. The Browns will be enrolled in the new plan effective September 1.

EXAMPLE: The Greens move to a new county where their health plan is not available. They return their enrollment form on August 26 after capitation. They will be enrolled in the new plan effective October 1. If MinnesotaCare has paid a capitation to their previous health plan for September, they must receive medical services through the previous health plan or make arrangements with their old health plan to receive services elsewhere.

M.S. 256L.12 subd. 3
Minnesota Rule 9506.0200 subp. 5

MA/GAMC:

At the time of the annual recertification, review each person's circumstances to determine whether or not the person should be excluded from managed care. See §0914.03.03 (Managed Care Exclusions). Track known future changes and process changes in exclusion status when you become aware of changes in circumstances.

If an excluded person is now a mandatory managed care enrollee, refer the person to a managed care presentation or assist the person in choosing a health plan. See §0914.03.05 (Managed Care Enrollment Process) and §0914.03.13 (Adding/Removing People From Managed Care). If a managed care enrollee is now in an excluded group, disenroll the person for the next available month on MMIS. See §0914.03.11 (Managed Care Disenrollment).

People enrolled in managed care may voluntarily change health plans at the following times:

- Once during the 1st year after initial enrollment in managed care. The first day of enrollment is the initial effective date of health plan enrollment. The 12 months runs continuously from that date regardless of whether the enrollee remains eligible during that time.

- During the annual open enrollment period.

- When the client's health plan ends its contract with DHS.

- Within 60 days of enrollment into a new health plan when the enrollment is a result of the contract termination of the previous health plan.

- When the person's residence is inaccessible to the enrollee's primary care provider. Inaccessibility in the Twin Cities metropolitan area is defined as the travel time to an enrollee's primary care provider which exceeds 30 minutes or 30 miles from the enrollee's residence. In the rest of the state, inaccessibility is when travel time is considered excessive by community standards. The DHS Managed Care Ombudsman must approve the change. See §0914.03.23 (Managed Care Complaints and Appeals).

- When transferring between counties, if the client requests a change within 60 days of the move date. See §0914.03.17 (Managed Care County Transfers).

- After a break of more than 2 full calendar months in MA or GAMC eligibility. The enrollee must request the change within 90 days of being re-enrolled. See §0914.03.09 (Managed Care Re-Enrollments & Reinstatements).

- When changing programs between MA, GAMC and MinnesotaCare. Follow these procedures for enrollment when there is a change in health care program:

  - If the same health plan is available with the new program, MMIS will re-assign the enrollee to the same plan with the new product ID.

  - If the same health plan is not available for the new program, code RPPH with exclusion code YY (Delayed Decision) and an exclusion begin date. Code a closing date for the previous enrollment span. Begin tracking on the MMIS RTRK screen. Refer the client to a managed care presentation or mail the information. Medical services may be covered by fee-for-service until the client is enrolled in a new health plan.

If there is a change in basis of eligibility with no change in medical program, do not allow a change in health plan.

- Within the 1st 90 days of health plan enrollment. This change option will be available to enrollees each time they are enrolled in a new health plan for 90 days or less.

Do not change the enrollment status or health plan of a recipient who is hospitalized in an acute care facility on the effective date of the change. Follow these procedures:

- Delay initial enrollment of a hospitalized enrollee into managed care until the 1st of the next available month after discharge.

  EXCEPTION: Enroll hospitalized MSHO enrollees for the 1st available month. The health plan is not responsible for hospital charges before the effective date of enrollment.

- Delay changing health plans for a hospitalized MA or GAMC managed care enrollee who is eligible to change until the 1st of the next available month after discharge.

- Disenroll a hospitalized GAMC managed care enrollee who becomes excluded from managed care for the next available month.

If you discover after an enrollment change that a household member was in the hospital on the effective date, refer the case to your managed care unit or DHS for an adjustment. See §0914.03.15 (Managed Care Adjustments).

Document dates the person went into and out of the hospital and how you verified the dates in MMIS case notes. Explain the delay in changing the health plan or enrollment status in MMIS case notes.

MinnesotaCare:

Reinstatements are enrollments or re-enrollments completed between capitation and the last business day of the month. Reinstatements occur when:

- A renewal is completed after capitation.

- A household is canceled from MinnesotaCare or disenrolled from a managed care plan and reinstated before the effective date of disenrollment.

  EXAMPLE:

  Bob calls on October 9 to request to have his MinnesotaCare canceled. He expects to have other insurance in November. On October 23 he calls to report that the other insurance is no longer available. He requests reinstatement. He mails his premium the same day and it is received on October 26. Bob is reinstated into his health plan for November.

When an initial enrollment is completed after capitation, it will be processed the same way as initial enrollments completed before capitation but will appear on the health plan's reinstatement record. See §0914.03.05 (Managed Care Enrollment Process).

Re-enrollments occur when a household is reopened on MinnesotaCare and re-enrolled in managed care after the effective date of cancellation. If the household has been terminated for 12 months or less, MMIS will re-enroll them in the same health plan unless they have moved to a county where the old plan is unavailable. If the case has been canceled for more than 12 months, MMIS will send a new health plan enrollment packet when the case is pended awaiting payment.

M.S. 256L.12

MA/GAMC:

Reinstatements for MA and GAMC occur when:

- An individual or household is reinstated between capitation and the last working day of the month. If you enter the GAMC or MA reinstatement on the MMIS RELG screen on or before the last working day of the month in which the case closed, the managed care enrollment will be active the 1st day of the next month. There will be no break in health plan coverage.

  EXAMPLE:

Marcia's annual recertification is due for October. She has not returned her recertification forms by the September cutoff date. MA is canceled. She submits a new application and all required verification on October 27. She remains eligible for MA and is reopened effective October 1. Reinstate MA with the same health plan effective November 1.

- An individual or household is reinstated after the effective date of closing with no break in MA or GAMC eligibility. If you enter the MA or GAMC reinstatement on the MMIS RELG screen after the last working day of the month in which the case was closed, reopen managed care the 1st day of the next available month. Create a new enrollment span on the MMIS RPPH screen with the new enrollment begin date and an exclusion span for the current month. Fee-for-service may cover medical needs during the interim month(s). See MAXIS/MMIS Calendar in the TEMP Manual index for managed care enrollment cutoff dates. Also see §0914.03.19 (Managed Care: 1-Month Rolling Eligibility).

Follow MinnesotaCare for re-enrollments. Re-enroll MA and GAMC applicants who have been terminated from MA or GAMC with less than a 12 full calendar month break in eligibility in the same health plans they had before the termination. The effective date of the re-enrollment will be the next available month on MMIS. See MAXIS/MMIS Calendar in the TEMP Manual for enrollment cutoff dates. Fee-for-service may cover the interim month(s).

EXAMPLE:

Louis is canceled from GAMC effective March 1 because he has excess income and is unable to meet a spenddown. He reapplies on April 10 because his income has dropped. He is found eligible without a spenddown effective April 1. Re-enroll Louis in his previous health plan. If the required information is entered on MMIS before the cutoff date in April, his managed care enrollment will be effective May 1. If the information is entered after April cutoff but before May cutoff, managed care enrollment will be effective June 1. He will be eligible on a fee-for-service basis for the month(s) before managed care enrollment.

MinnesotaCare:

MMIS will automatically disenroll people from a health plan when:

- They are canceled from MinnesotaCare.
- They change health plans. MMIS will disenroll the household from the current plan to enroll in the new plan.

Disenroll people effective the 1st day of the 1st available month. If disenrollment is completed before capitation, the disenrollment will be effective the next month. If disenrollment is completed after capitation, disenrollment will be effective the 2nd month after the disenrollment is completed and the client will be responsible for any premium payments due for months for which a health plan capitation has been paid.

EXAMPLE:

John calls to request cancellation for himself and his son on June 26. Capitation for July was made on June 23. Inform John that his health plan has already been paid for the month of July and that MinnesotaCare cannot be closed until July 31. He will be responsible for his July premium.

See §0914.03.15 (Managed Care Adjustments) for information on retroactive disenrollment.

M.S. 256L.12

MA/GAMC:

Disenroll people from a health plan when:

- You receive information that an enrollee is now in an excluded group. See §0914.03.03 (Managed Care Exclusions). End the health plan enrollment span on MMIS for the last day of the month using reason code EX. Enter the appropriate exclusion code and an exclusion date span on the MMIS RPPH screen.

  Disenroll people who are certified disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT) if the person is under age 65 AND becomes eligible for MA with a disability basis. When you get confirmation of the disability certification from SSA or SMRT, enter an enrollment end date, disenrollment reason of EX, exclusion reason and exclusion begin date on RPPH. Enter the managed care end date on

RPPH for the next available month.

People under age 65 who are certified disabled but who choose a non-disabled basis of eligibility may enroll in managed care voluntarily. See §0907.17.03 (MA Basis: Multiple Bases of Eligibility) and §0914.03.03.03 (Managed Care Voluntary Enrollment).

Disenroll people who are in the hospital when certified disabled effective for the next available month. The disenrollment may be delayed for an additional month if you cannot enter the information on MMIS on or before the managed care enrollment cutoff date.

- A person who should have been excluded was enrolled in a health plan in error. End the health plan enrollment span on MMIS for the last day of the month in which the error is discovered. If you discover the error before any capitation payments are made, delete the enrollment span on RPPH.

  If capitation payments have been made and the enrollee appears to have issues with continuity of care, refer the case to your managed care unit or DHS for a possible adjustment for any retroactive months. The county managed care unit and DHS determine the need for an adjustment on a case-by-case basis.

- MA or GAMC eligibility ends. If you are closing MA or GAMC after the managed care enrollment cutoff date, close MA or GAMC and disenroll the individual or household from the health plan for the next available month on MMIS. In this case, the health plan will receive a capitation payment for a month in which there is no eligibility. The individual or household is ineligible for MA and GAMC even if the health plan has received a capitation payment.

  Do not reinstate MA eligibility on MAXIS for the additional month for which a capitation payment was made unless the individual or household is reinstated effective the 1st of the month for which the additional payment was made. If the client requested closure and you cannot close MMIS because a capitation payment has already been made, notify the client that health plan coverage exists if all MA or GAMC eligibility factors are met.

MinnesotaCare:

Add children born to a woman who is enrolled in a health plan through MinnesotaCare to the parent's health plan effective the 1st available month meeting managed care cutoff. Add other new members to the household's health plan effective the day they become eligible for MinnesotaCare coverage.

Disenroll people who are removed from coverage in an active household effective the 1st day of the next available month. If a capitation has already been made, coverage cannot be canceled until the next available month and the enrollee will be responsible for the premium payment. See §0914.03.11 (Managed Care Disenrollment).

Terminate coverage when an enrollee dies effective the date of death. DHS identifies and recovers any capitation claims after the date of death.

Minnesota Rule 9506.0030 subp. 4

MA/GAMC:

Enroll children born to a woman who is enrolled in a health plan through MA in the same health plan as the mother effective the 1st of the next available month meeting managed care cutoff.

Enroll the newborn into the same health plan as the mother for the next available month meeting managed care cutoff. The newborn will have a health plan change available if requested.

When adding a non-excluded person, offer the person being added a choice of health plans. If the person does not want the same health plan as other household members, refer the person being added to a managed care presentation or mail a managed care education packet. See §0914.03.05 (Managed Care Enrollment Process).

If the person being added does not choose a health plan within 30 days of the presentation or receipt of an education packet, MMIS will assign the added person to the default health plan listed on the RCHP screen. Once MMIS assigns a default plan to the case, any other added members will have the same default plan regardless of whether any other household members are enrolled in that plan.

EXAMPLE:

John has been living with his father and was not enrolled in a health care program. He returns to his mother's home. His mother (person 01) receives MA for her other 2 children (person 03 and person 04) but is not eligible for

MA herself. She fails to choose a health plan for John within 30 days. MMIS will assign John to the default health plan shown on the RTRK screen.

When adding a person to a household in which no other members are receiving MA or GAMC or are excluded from managed care, refer the applicant for a managed care presentation or provide a managed care education packet. When you approve eligibility, code the RENR screen with either an exclusion reason or a health plan contract number. If the person fails to choose a health plan within 30 days, MMIS will assign a default plan. Review RPPH to verify that the exclusion or enrollment is correct.

See MAXIS/MMIS Calendar in the TEMP Manual index for managed care enrollment cutoff dates. MA fee-for-service may cover medical services the client receives in the initial months before the enrollment effective date.

Health plans that have contracted with the DHS to provide services to MinnesotaCare, MA, or GAMC enrollees must provide most medical and dental services covered by those programs. Health plans are not responsible for case management services for people with serious and persistent mental illnesses or severe emotional disturbances.

See the Prepaid Minnesota Health Care Programs Manual, section 9.03.01 for a list of other non-covered services.

Health plans may provide services in addition to those available under MinnesotaCare, MA, or GAMC.

If an MA enrollee resides in a nursing facility on the effective date of enrollment in Minnesota Senior Health Options (MSHO), the nursing facility per diem is not a health plan covered service. If a person covered by MA enrolls in MSHO while living in the community and later enters a nursing facility, the health plan is responsible for payment of the nursing facility services for 180 days.

A person enrolled in a health plan must obtain all health care services through the health plan's network of providers unless:

- The enrollee receives services from a provider who is not a health plan provider because of a medical emergency.
- The enrollee is outside the health plan service area and requires urgent or emergency medical care.
- A health plan physician or provider has prescribed or recommended non-emergency services outside of the health plan network.
- The enrollee moves out of the health plan service area, and MMIS has not been updated to disenroll the client from the health plan. Except for emergency services, the health plan may require prior authorization for out-of-plan services. Providers must contact the health plan to receive payment from the plan. Inform enrollees who report a move out of county that they may be responsible for bills incurred without health plan authorization.
- An MA enrollee enrolls in a health plan while in her 3rd trimester of a high-risk pregnancy. The enrollee must contact the health plan to approve out-of-network services. There are no special provisions for pregnant

PGAMC recipients.

- A person enrolled in a health plan through MA resides in a long term care facility, and a health plan physician or dentist orders covered services from a non-plan provider. There are no special provisions for MinnesotaCare or GAMC recipients in long term care facilities.

- A person who is enrolled in a health plan through GAMC who is certified disabled must be disenrolled for the next available month. The health plan will remain responsible for all GAMC covered services until the date of disenrollment. If the enrollee receives MA services not covered under GAMC, the provider rendering the MA service should bill DHS directly as fee-for-service.

When an enrollee obtains services outside the health plan provider network and does not meet 1 of the exceptions above, the provider may bill the enrollee directly. In such cases, the provider must notify the enrollee in writing before the service is delivered that payment may be required.

When required by contract, health plans provide common carrier transportation to their enrollees for the purpose of obtaining health care services.

The county is responsible for reimbursing the MA/GAMC enrollee for private automobile transportation to a non-emergency covered service, and meals and lodging as necessary, in accordance with the county's health care access plan.

Advise people who are enrolled in health plans through MinnesotaCare, MA, or GAMC who also have private coverage or Medicare that they must get medical services through the managed care health plans. The health plans are responsible for coordination of benefits for managed care enrollees. The enrollee must inform the MinnesotaCare representative or MA/GAMC financial worker of changes in coverage.

The cost effective coverage provisions for MA and GAMC enrollees described in §0910.05.03 (Health Insurance Premium Payment) apply to managed care clients. Enrollment in a managed care health plan is not a criterion used in determining cost effectiveness. Enrollees for whom the county pays cost effective health insurance premiums are excluded from managed care. See §0914.03.03 (Managed Care Exclusions).

MinnesotaCare:

When a new person moves into the household, the new person MUST be added to the MinnesotaCare household at the next renewal. The household may choose to add the new member prior to the next renewal. If the household chooses not to add the new person until the next renewal, document in case notes. Do not add the person to the household size and do not include their income until the next renewal.

EXAMPLE:

Julie, age 16 lives with her parents. She reports that she got married and her new husband, Brad, moved in with her and her parents. Julie is now an emancipated minor and should be closed on her parents' case and opened on a new MinnesotaCare case with Brad. Julie may choose to either:

- Remain on the case with her parents until their next renewal. At that point she must apply separately with Brad.

OR

- Add Brad now. This would require Julie to be closed on her parents' case and opened on a separate MinnesotaCare case with Brad. See §0915.05 (Removing a Person From the Household).

EXAMPLE:

Marge reports that her boyfriend, Fred, moved in with her and her daughter Crystal. Fred is Crystal's father. He must be included in the household because of his parental bond with Crystal. He does not want coverage for himself. Marge may choose to add him to her MinnesotaCare case now or wait until her next renewal. At the point that he is added to the case, he must enroll in MinnesotaCare if he is eligible and does not have other heath care coverage. If he is otherwise eligible and refuses coverage, cancel Marge's coverage.

Take the following steps at the time you add the new household member. If the household chooses to wait until the next renewal to add the new member, DO NOT take any of these steps until you process the renewal.

1. Determine if the new household member must be counted in the MinnesotaCare household. See §0908 (Household Composition). Contact the household if you need more information on the person's relationship to other household members.

2. If the new person will be counted in the MinnesotaCare household, determine

if the new member is requesting coverage. If not, determine if the new member must accept coverage, if eligible, in order for other household members to remain covered. See §0908.11 (All or Nothing Rule).

3. Request all information needed to add the new person to the MinnesotaCare household and determine the new household member's eligibility, including:

   - Income. See §0911 (Income).
   - State residence. See §0906.05 (State Residence).
   - Social security number. See §0906.11 (Social Security Number--MinnesotaCare). Do not require a SSN for a child under age 2. Do not require a SSN or immigration status information for any household member not requesting coverage, unless that person must accept coverage under the All or Nothing Rule.
   - Pregnancy, if applicable. See §0907.09 (MinnesotaCare Pregnant Women).
   - Insurance information. See §0910 (Other Health Coverage).
   - Medical support and good cause information if the person being added is a minor child for whom a medical support referral is required. See §0906.13 (Assigning Rights to Medical Support).
   - Citizenship or immigration status if appropriate. See §0906.03 (Citizenship and Immigration Status).

   The household must provide all required information before the new member can be added.

   If a new household member is not being added for coverage but is part of the household size, determine if the new household size results in a decreased premium. If yes, the new premium amount is effective the month the person is added to the household size. If there is no change in income, request an adjustment for any future months for which the higher premium has already been billed. If there is a change in income, MMIS will automatically adjust the premiums.

4. Determine the new household member's group status based on current circumstances. See §0907 (Eligibility Groups and Bases of Eligibility) and

   §0915.15 (Change in MinnesotaCare Eligibility Group). Determine if the person is eligible for coverage.

5. Enter all information on MMIS to add the person and the person's income to

the household size and to add the person to coverage, if applicable. Enroll the person being added in the same health plan as the rest of the household. See §0912.03.03 (MinnesotaCare Excess Income) if the new member's income causes the household's total income to exceed the MinnesotaCare standard.

6. Infants born to a woman enrolled in MinnesotaCare for the month of delivery are automatically eligible beginning the 1st day of the month of birth. See §0907.09.03 (MinnesotaCare Auto Newborns). Infants born to a woman who is not enrolled in MinnesotaCare for the month of delivery are not automatically eligible. If other family members are enrolled and the newborn is eligible, eligibility begins the 1st day of the month of birth.

   EXAMPLE:

   Eric is born on January 5. His mother is not enrolled in MinnesotaCare but 2 siblings are active. Eric is not eligible as an auto newborn. If he meets eligibility requirements, he is eligible beginning January 1, the 1st day of the month of birth. He will receive fee for service coverage for January.

   Children placed in the home of an enrolled family for adoption are eligible to be added the 1st day of the adoption placement month.

   For all other people being added to the household size, the effective date of coverage is the 1st day of the month following the determination of eligibility for the new household member.

M.S. 256L.04 subd. 1b

MA/GAMC:

See §0915.03.01 (Adding a Person to the Household--MA/GAMC).

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

MinnesotaCare:

Reinstate MinnesotaCare back to the date of closing for households who:

- Were canceled only for nonpayment of premiums

AND

- Pay all billed premiums by the end of the 20th calendar day after disenrollment. The month following disenrollment is called the reinstatement month. If the 20th day falls on a weekend or holiday, the household must pay all billed premiums by the end of the following business day.

MMIS sends a notice on the 1st day of the reinstatement month to households who are canceled for non-payment. The notice informs the household of the reinstatement option and includes the total amount due and the due date. If all billed premiums are received by the due date, MMIS reinstates coverage back to the date of cancellation and sends each enrollee a letter explaining that MinnesotaCare has been reinstated. Enrollees receive coverage through fee-for-service for the reinstatement month. MMIS will reenroll them in their previous health plan beginning the month after reinstatement.

Enrollees who are canceled for nonpayment and another reason are not eligible for reinstatement. Other household members are eligible for reinstatement if they were canceled only for nonpayment. MMIS will calculate the amount due based on the number of people who had coverage during the cancellation month and the number who could have coverage in the reinstatement month and the following month.

EXAMPLE:

Mike, Judy and their daughter Debbie are enrolled in MinnesotaCare with a monthly premium of $100. MinnesotaCare is canceled effective July 31 due to nonpayment of the August premium. Mike's coverage also ends because he has access to ESI. Judy and Debbie would be eligible beginning August 1 with a premium of $67 per month. On August 1, MMIS generates a notice informing the household that they must pay $134 ($67 for August and $67 for September) by August 20 to have coverage reinstated for Judy and Debbie. If payment is received by the due date, MMIS will reinstate coverage for Judy and Debbie back to August 1.

Track cases for enrollees who cancel for nonpayment and noncooperation with medical support. The child support indicator on the MMIS RIND screen cannot be changed during the 20-day reinstatement period. See the MMIS User Manual and Bulletin #00-23-1 (DHS Introduces MinnesotaCare Reinstatement for Payment of Past Due Premiums) dated June 7, 2000 for further information.

If a household asks to add new members during the 20-day reinstatement period, the new member must pay all billed premiums during the 20-day period to reinstate household coverage and begin coverage the following month for the new member. After the 20-day period, the new member must pay only the new member's future premium to begin coverage for the new member.

EXAMPLE:

Sally and John's MinnesotaCare coverage ends on April 30 due to nonpayment of the May premium. On May 5, John requests to add his daughter Melanie, who has moved into the household. Melanie is determined eligible and is approved as pending awaiting payment. MMIS automatically changes the pending awaiting payment span to denied for nonpayment. The household must pay the May and June premiums during the 20-day reinstatement period for John and Sally to be reinstated effective May 1 and Melanie's coverage to begin June 1. After the 20-day reinstatement period, the household must pay the future month's premium for Melanie only to begin Melanie's coverage beginning the month after payment is received. Enter a new pending awaiting payment span for Melanie. John and Sally will have a 4-month penalty period unless they show good cause for nonpayment.

If an enrollee is approved for MA during the 20-day reinstatement period and pays the MinnesotaCare premiums, MMIS will not automatically reinstate MinnesotaCare. MMIS will generate a worker message for the worker to follow up with the enrollee to confirm that they want continued MA. The MinnesotaCare re-bill procedure will recalculate the premium and create a credit.

If the reinstatement month is the month prior to the renewal month, MMIS will send a closing notice to enrollees who have not paid all billed premiums by the reinstatement month billing date advising them that they must pay all billed premiums and submit a completed renewal by the 20th to be eligible for reinstatement.

EXAMPLE:

Joelle's MinnesotaCare coverage is canceled for nonpayment on July 31. Her renewal date on MMIS is August 30. If she has not paid the August premium by billing on August 15, MMIS generates a notice advising her that she must pay the premiums and submit her renewal by August 20 to be eligible for reinstatement. The notice also advises her that she will be canceled for failure to renew if she fails to submit the renewal. If she pays the premium but fails to submit the renewal, no further notice is required.