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

MDHS HEALTH CARE PROGRAMS MANUAL
MANUAL LETTER #46

April 2006

Effective Date: April 2006

TO: MinnesotaCare Operations
County Agencies
and Other Manual Holders

SUBJECT: Revised Material for the MDHS Health Care Programs Manual

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

This information is available in other forms to people with disabilities by calling 651-431-2670, toll-free at 1-800-657-3739, or contact us through the Minnesota Relay Service at 1-800-657-3529 (TTY) or 1-877-627-3848 (speech-to-speech relay service).

This manual letter contains new and revised information for the Health Care Programs Manual. Following is a list of the new and revised sections and a brief description of each change. Information is added for the MA asset verifications effective October 1, 2005; IEVS Match effective March 1, 2005; MSHO effective February 1, 2005; ESI verification effective April 1, 2006. Otherwise, except for minor clarifications and corrections of existing policy or otherwise noted effective dates, all new and revised instructions are EFFECTIVE APRIL 1, 2006.

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HIGHLIGHTED CHANGE #1: This manual letter incorporates the changes to asset verification policy that was relayed in Bulletin 05-21-09 Legislative Changes Affecting Medical Assistance and MinnesotaCare. These changes were effective October 1, 2005.

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HIGHLIGHTED CHANGE #2: This manual letter incorporates the policy change that all applicants and enrollees must verify ESI. This information was in Bulletin 06-21-03

Verification of Employer Subsidized Health Insurance Required for MinnesotaCare Enrollees and Applicants.

HIGHLIGHTED CHANGE #3: This manual letter incorporates policy to look back to prior periods of eligibility for IEVS Matches effective April 1, 2006. This information was in Bulletin 06-21-02 Determination of Medical Assistance Overpayments from Income and Eligibility Verification System (IEVS) Matches.

See below for a list of all the changes.
Submit questions through the HealthQuest system.

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REVISED AND DELETED SECTIONS

<u>Revised Sections</u>	<u>Deleted Sections</u>
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0912.05.25.03	0912.05.25.03
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0913.02	0913.02
0914.03.03	0914.03.03
0914.03.03.03	0914.03.03.03
0914.03.25	0914.03.25
0915.07	0915.07
0916.21.03	None (new section)



§0904.13 (Verification) adds requirement for mandatory verification of ESI for all employed applicants and enrollees.

§0904.13.01 (Verification-MA/GAMC) adds requirement to verify all countable assets at application, 6-month income/asset renewal and annual renewal for MA.

§0905.05 (Annual Renewal-Eligibility) adds requirement to verify all countable assets for MA.

§0905.09 (6-Month Reporting) adds requirement to verify all countable assets for MA.

§0910.11.01 (Verification of ESI) adds policy to verify ESI for all MinnesotaCare employed applicants and enrollees.

§0911.09.03.17 (Roomer/Boarder Income) adds October 1, 2005, rates for boarder and roomer/boarder deduction Method A.

§0912.05.25.03 (Allocation-Community Spouse) adds the utility allowance effective March 1, 2006.

§0913 (Premiums and Spenddowns) adds an exception. MA-EPD premium may be increased for the next available month due to an IEVS match.

§0913.01.03.03 (MA-EPD Premiums-Ongoing) adds an exception. Premium may be increased for the next available month due to an IEVS match.

§0913.02 (Premium Payment Options) clarifies when online payments are applied to a MinnesotaCare account. Tax refund and payroll deduction information is removed.

§0914.03.03 (Managed Care Exclusions) changes procedure for MSHO applicants and enrollees with a medical spenddown or combination LTC/medical spenddown.

§0914.03.03.03 (Managed Care Voluntary Enrollment) clarifies enrollment in MnDHO-PD for specific counties.

§914.03.25 (Minnesota Senior Health Option –MSHO) clarifies applicants with a medical spenddown or LTC/medical spenddown cannot enroll in MSHO.

§0915.07 (Change in Income) adds instructions to act on income increases between renewals for MinnesotaCare.

§0916.21.03 (MA Overpayments from IEVS Matches) is a new section adding policy and procedures to determine MA overpayments from IEVS match.

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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. Verifications for ongoing cases should be retained according to your agency's retention policy. Your agency's policy should be based on and concurrent with the retention schedule from DHS. In most ongoing cases, verification can be destroyed after three years. However, some verifications may need to be retained throughout the life of the case file. For example, alien identification cards, birth certificates, divorce decrees, employment information, and asset information should be retained throughout the life of the case up until three years after the case has closed. If the records are being scanned for electronic filing purposes, the original documents are retained until the scanned documents are verified and backed up. Any verification that has been received verbally needs to be clearly case noted. See Bulletin #02-85-01 (County Human Services Records Retention Schedule).

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.

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

MinnesotaCare:

Verify the following:

ESI

Verify access to ESI for all employed applicants and enrollees at the time of application and renewal and whenever a job change is reported.

See §0910.11.01 Verification of ESI.

- < 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 and unearned income. Require verification of earned and unearned income is the 30 days before application. For unearned income accept bank statements, copies of checks, award letters or court orders. 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

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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

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M.S. 13.46 subd. 2(a)
45 CFR part 431.17

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

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).
- < **All countable assets at application, 6 month income/asset renewal and annual renewal. Do not verify excluded assets.** 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

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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).

MinnesotaCare:

When processing a renewal:

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

For households who were determined to have income over the limit at the last renewal but were found eligible for the MCHA exemption under §0912.03.03 (MinnesotaCare Excess Income), compare the household's current income to the appropriate standard as well as to the applicable MCHA premium.

-If income remains above 275% FPG for families with children AND 10% of the income is now greater than the MCHA premium for the family in §0912.03.05 (Annual MCHA Premiums), send the MinnesotaCare Over Income Letter (DHS 3407). Also send the form Private Health Insurance in Minnesota (DHS 3416).

-If the income is now equal to or less than the applicable standard, OR 10% of

the household's income remains equal to or less than the appropriate MCHA premium, send the MinnesotaCare Income Change Evaluation Letter (DHS 3408) advising the household that the children's coverage will continue.

For households with children who are in the 12-month extension period, compare the household's current income to the appropriate standard as well as to the applicable MCHA premium.

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

-If the household's income remains greater than 275% FPG, continue coverage for the remainder of the 12-month extension period.

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

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

EXAMPLE:

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

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

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

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

MA/GAMC:

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

For other renewals:

- < Review the renewal form. Contact the household to complete missing items or request additional information. Obtain all required signatures. See §0905.03.01 (Annual Renewal Timeline MA/GAMC).
- < Check to see if anyone has moved in or out of the household. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).
- < Check to see if anyone is pregnant. If yes, request verification of pregnancy. Once the pregnancy is verified, treat the pregnant household member as a

pregnant woman. See §0907.19.05 (MA Basis: Pregnant Women).

- < Review the health insurance information. Obtain new health insurance information if the household has obtained other health coverage or the coverage has changed.
- < For MA: Verify all countable assets. Do not verify excluded assets. Advise people with excess assets of the need to reduce. See §0909.29.03(Excess Asset-Enrollees). Follow up on reported transfers that may affect eligibility. See §0909.27 (Asset Transfers).
- < For LTC clients with community spouses, verify that all assets allocated to the community spouse have been legally transferred to the community spouse at the time of the first annual recertification. After the first renewal, verify all countable assets.
- < Obtain current income verification. Redetermine income eligibility for each person who is requesting continued coverage. Change spenddown amount or type if applicable. See §0913.05 (Which Spenddown Type to Use).
- < Obtain the original renewal form if the form was received by fax. See §0905.03.01 (Annual Renewal Timelines--MA/GAMC).
- < Determine if there have been any changes in parental or medical support status. Enter new information on MAXIS. If necessary, send new information to the local county IV-D office. Review good cause determinations if needed. See §0906.13 (Assigning Rights to Medical Support).
- < Determine if any GAMC enrollees meet the mandatory MinnesotaCare referral criteria. See §0907.25.09 (GAMC: Mandatory MinnesotaCare Referrals).
- < Review managed care status.

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

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MinnesotaCare enrollment sites will forward the renewal to MinnesotaCare Operations as an application. See §0904.09.05 (Transfers **from** MA/GAMC to MinnesotaCare).

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

GAMC:

- < Review asset information. Request verification of liquid assets if total reported assets are within \$300 of the asset limit unless you have received verification as part of an application or review for another program within the last 30 days. Advise people with excess assets of the need to reduce. See §0909.29.03 (Excess Assets--Enrollees). Follow up on reported transfers that may affect eligibility. See §0909.27 (Asset Transfers).

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, food stamps or a cash program. Use the information on the monthly reports to complete the MA review. 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, MFIP, 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 as well as to regular MA. Do not require 6-month renewals for QMB, SLMB, QWD, QI 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. These enrollees must **verify all countable assets.**

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.

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 or 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

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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.

MinnesotaCare:

Access to ESI.

Verify access to ESI for all employed MinnesotaCare applicants and enrollees reporting employment. Deny or terminate eligibility for applicants and enrollees who report access to ESI. Do not require verification prior to denial or termination.

If an applicant or enrollee indicates that he or she is employed, their spouse is employed or their child(ren) are employed, verify whether there is access to ESI for each employer listed.

Do not delay or deny coverage for children in households with verified family incomes at or below 150% FPG regardless of their parents' failure to verify access to ESI.

Require verification of access to ESI for each employer listed by an applicant or enrollee, regardless of whether the worker or agency has knowledge of a particular employer's policy on offering health insurance.

Do not verify access to ESI for applicants and enrollees who are:

- Children with verified family incomes at or below 150% FPG;
- Farmers with no other type of employment in the household; or
- Self employed with no other type of employment in the household

All applications and renewals must be pended (P30 or C47), awaiting verification of access to ESI from all employers listed on the application or renewal form unless verification has already been provided with the application or renewal. Request ESI verification and document all actions and requests for verification in case notes.

Applicants and enrollees have 30 days to provide verification of access to ESI. Applicants and enrollees who fail to provide this verification will be denied or terminated automatically by MMIS in 60 days or for enrollees renewing coverage, at the end of the renewal period.

Require verification of access to ESI at each renewal, for all currently employed enrollees, for all employers listed, regardless of whether verification was collected previously.

Require verification of access to ESI between renewals if the enrollee reports new employment or a change in employers for themselves, their spouse or their children.

Acceptable forms of verification include:

-
- > A Request for Verification of Employer Insurance (DHS-3348) completed and signed by the employer or union.
 - > Documents from an employer that show what health insurance is offered and how much the employer and employee pay for it. Open enrollment materials will often have this information. Employee handbooks or new employee orientation papers may also have this information: or
 - > A written statement from the employer or union that provides information necessary to determine whether the employee and dependents have access to ESI.

Example:

Jack applies for MinnesotaCare for himself and his family on April 3. Jack answers “no” to the employer-offered health insurance question on the application. Jack is employed. His wife is self-employed. Income verification has not been submitted with the application. The worker pends Jack and his family for Incomplete Application, noting that income and insurance verification are needed. See MMIS User Manual, MinnesotaCare Section, Reference Codes, Pending Codes, for information on correct MMIS codes.

The worker requests income verification and includes a Request for Verification of Employer Insurance (DHS-3348) and a note to Jack that he may submit open enrollment or other health insurance documents from his employer or give the verification form to his employer to complete. Jack faxes copies of his pay stubs and tax forms as income verification and provides the employer completed Request for Verification of Employer Insurance (DHS-3348). The ESI verification indicates that Jack and his dependents do not have access to ESI through his employer:

The family meets all income and eligibility requirements for MinnesotaCare. Approve the case as pending awaiting payment. If Jack submits income verification but does not submit the verification form or copies of his open enrollment materials or other employer documentation, continue the pending status for ESI. MMIS will automatically deny the application in 60 days.

Do not contact the employer or union without written consent from the applicant or enrollee to verify access to ESI.

Submit a HealthQuest if the employer refuses to provide ESI verification.

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VERIFICATION OF ESI

0910.11.01

MA/GAMC:

No provisions.

MinnesotaCare:

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

MA and GAMC:

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

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

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

METHOD A:

Allow a flat rate deduction for each roomer/boarder:

- < Roomer: \$71 per month.
- < Boarder: \$152 effective 10/01/2005
\$149 effective 10/01/2004
\$141 effective 10/01/2003
- < Roomer **plus** boarder:
\$223 effective 10/01/2005
\$220 effective 10/01/2004
\$212 effective 10/01/2003

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

METHOD B:

Allow the following expenses for a roomer/boarder:

ROOMER/BOARDER INCOME

0911.09.03.17

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

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

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ALLOCATIONS--COMMUNITY SPOUSE

0912.05.25.03

MinnesotaCare:

No provisions.

MA:

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

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

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

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

2. Determine the monthly total of these shelter expenses for the community spouse:
 - < Rent or mortgage payments.
 - < Real estate taxes.
 - < Homeowner's or renter's insurance.
 - < Required maintenance charges for a cooperative or condominium.
 - < A utility allowance. Use [\\$305 effective 03/01/2006 \(previously \\$262\)](#) for residences billed for heating and/or cooling. For residences not billed for heating or cooling, allow \$75 for electricity and \$25 for phone service. Reduce the utility allowance by the amount of any utility expenses included in a required cooperative or condominium maintenance charge.
3. Subtract \$482 beginning 7-1-05 (\$469 from 7-1-04 through 6-30-05) from the total of expenses in step 3. The result is the excess shelter allowance.

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4. Add \$1,604 beginning 7-1-05 (\$1,562 from 7-1-04 through 6-30-05) to the excess shelter allowance. The result, up to a limit of \$2,489 (\$2,378 from 1-1-05 through 12-31-05), is the maximum monthly income allowance to the community spouse.

If there is a court order for support in excess of \$2,489 (\$2,378 from 1-1-05 through 12-31-05), use the court-ordered figure as the maximum amount.

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

EXAMPLE:

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

Determine Leo's maximum allocation as follows:

1. Determine Leo's total gross monthly income by adding the RSDI amount of \$700, the pension amount of \$300, and \$50 per month interest (\$600 divided by 12). Total monthly income is \$1,050.
2. Determine Leo's monthly shelter expenses by adding rent of \$400, utility allowance of \$262, and \$25 per month (\$300 divided by 12) for renter's insurance. Total shelter expenses are \$687.
3. Subtract \$482 from \$687. The result, \$205, is the excess shelter amount.
4. Add \$205 to \$1,604. The result, \$1,809, is the maximum monthly allocation amount.
5. Subtract Leo's monthly income of \$1,050 from \$1,809. The result, \$759, is the actual allocation amount. Allow this amount in Norma's

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LTC budget. See §0913.13 (Long Term Care Spenddown Calculation).

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

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

- < Meet a spenddown using the allocated income.
- OR
- < Request a decrease or end to the allocation. This will increase the LTCF spouse's monthly LTC spenddown.

GAMC:

No provisions.

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

MinnesotaCare:

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

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

Enrollees may pay premiums by check, money order, automatic withdrawal, payroll deduction, or through the tax refund premium payment plan. Enrollees also have the option of making check or credit card payments via the DHS web site.

See §0913.02 (Premium Payment Options). DHS collects and posts all initial and ongoing payments regardless of the household's choice of enrollment site. If you receive a premium at the county agency in error, forward it to DHS-MinnesotaCare, attn. Cashier, PO Box 64834, St. Paul, MN 55164-0834. Return initial premium payments received with applications to the applicants. Inform applicants that they will receive a First Premium Notice if their applications are approved.

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

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

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

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

EXAMPLE:

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

Take action to change the premium amount:

- < At the time of the annual renewal if the household's income or household size has changed. See §0905 (Reviews and Renewals) and §0915.07 (Change in Income).
- < At any time the household reports a change in income that results in a lower premium amount. See §0915.07 (Change in Income).
- < When the household size changes. See §0915.03 (Adding a Person to the Household) and §0915.05 (Removing a Person From the Household).
- < When household member is removed from coverage.
- < The income guidelines change because of a change in law or the annual update of the federal poverty guidelines.

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

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

MA:

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

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

Take action to change the premium amount:

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

Exception:

If an IEVS match results in an increase in the MA-EPD premium, apply the increased premium amount for the next available month. See 0916.21.03 (MA Overpayments from IEVS Matches).

GAMC:

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

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

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

1. Redetermine eligibility for MA for the following month.
 - > If MA eligibility exists, approve MAXIS results and enter eligibility information in MMIS. Add the following worker comments to the approval notice:

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

DHS – Special Recovery Unit
MA-EPD Good Cause
PO Box 64995
St. Paul, MN 55164-0995”

Or it can be faxed to (651) 431-7431.
 - > If MA eligibility does not exist, close MA-EPD on MAXIS on STAT/PACT using reason code A3 (Refused/Failed Required Info) and end eligibility in MMIS. Add the same worker comments to the closing notice.
2. Notify SRU via MAXIS E-mail that the enrollee’s MA-EPD is being closed and to discontinue billing. Include the enrollee’s name, PMI number and effective date of closure. SRU will not discontinue billing without an E-mail.
 - > If DHS approves good cause for late payment, DHS will send a copy of the approval letter and/or a MAXIS E-mail. Enrollees who have been granted good cause and set up a payment plan will continue to appear on the MA-EPD Overdue Premiums Report. Do not close these enrollees for late payment unless instructed

to do so by DHS.

- > In some cases, enrollees may pay premiums after the overdue report is generated. If an enrollee reports the premium was paid, verify the payment with SRU. Do not end coverage. Reopen MA-EPD if it has been closed.

EXAMPLE:

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

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

Exception:

If an IEVS match results in an increase in the MA-EPD premium, apply the increased premium amount for the next available month. See 0916.21.03 (MA Overpayments from IEVS Matches).

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

- > Use actual income received in any retroactive months
- > Anticipate income for current and future months by multiplying biweekly income by 2.16 and weekly income by 4.3.

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

EXAMPLE:

John works part time at a convenience store and is paid weekly. He is also a member of his town's council, for which he receives payment quarterly, or twice

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MA-EPD PREMIUMS: ONGOING

0913.01.03.03

in a 6-month period. Average the council income over the 6-month period and combine it with the convenience store income to arrive at a consistent monthly premium.

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

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

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

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

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

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

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

GAMC:

No provisions.

MinnesotaCare:

People may pay premiums by:

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

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

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

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

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

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

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

OR

-Checking account. Enrollees will need to enter the bank routing number and checking account number.

Online payments made by 5:00 PM on a business day will be credited that day. Online payments made after 5:00 PM on a business day or on weekends

and holidays will be credited the next business day.

MA:

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

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

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

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

- < Credit card--Visa or MasterCard.
- < Bank debit card with a VISA logo.

To pay by credit or debit card, instruct clients to call 651-431-3355 or 1-888-234-1321.

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

GAMC:

No provisions.

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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
PrimeWest Health Systems
South Country Health Alliance

- > People eligible with all spenddown types except institutional spenddowns.

Note: People that are on Long Term Care (LTC) spenddown are not excluded from managed care. For enrollees with a waiver obligation refer to the SIS EW criteria below. **Applicants who have a medical spenddown or a combination LTC/medical spenddown may not enroll in MSHO.**

See 0914.03.27 (Minnesota Disability Health Options – MnDHO) for information on people with spenddowns who may voluntarily enroll.

- > Undocumented and non-immigrant non-citizen recipients who only receive emergency MA (EMA). See §0907.29 (Medical Emergency Programs).
- > People under age 65 who are eligible for MA due to blindness or disability as determined by SSA or the State Medical Review Team (SMRT). See §0907.21.05 (MA/Medicare Supplement Basis: Blindness) and §0907.21.07 (MA/Medicare Supplement Basis: Disability). This includes people with blindness or disabilities who receive services under the CAC, CADI, MR/RC and TBI waivers who meet the above criteria. See §0907.23 (MA Waiver Programs). Blind or disabled individuals under 65 who have a Method A basis of eligibility may choose to voluntarily enroll in managed care.
- > People who are terminally ill with a medical prognosis of 6 MONTHS OR LESS to live and who, at the time of notification of mandatory health plan enrollment, have a permanent relationship with a primary physician who is not part of any available managed care health plan.
- > People who are enrolled in the SIS EW program with gross incomes greater than the maintenance needs allowance but less than or equal to the Special Income Standard. These people may enroll in managed care voluntarily. SIS EW enrollees with incomes less than the maintenance needs allowance must enroll in managed care.
- > People eligible for QMB, SLMB, QWD, or QI only (eligibility types BQ, BS, BW, DS, DQ, DW, EQ, ES, 1B, 1D, 1E, 2B, 2D, and 2E). See §0907.21.09 (MA Basis: Medicare Supplement Programs).

- > People who, at the time of notification of mandatory enrollment in managed care, meet ALL the following:
 - Have a communicable disease.
 - Have a prognosis of a terminal illness (may exceed 6 months) because of the communicable disease.
 - The disease and prognosis are verified by a written statement from a licensed physician based on a current medical examination.
 - Currently have a primary physician who is not a participating provider in an available managed care health plan.
 - The physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient stopping recommended medication or other health services.

- > Children who are identified to DHS as having severe emotional disturbance (SED) and who are eligible to receive MA-covered mental health case management services.

Children receiving IV-E or state adoption assistance.

SED and adoption assistance children may enroll voluntarily. See §0914.03.03.03 (Managed Care Voluntary Enrollment).

- > Adults who are identified to DHS as having serious and persistent mental illness (SPMI) and who are eligible to receive MA-covered mental health case management services.

These adults may enroll voluntarily if they have a Method A basis of eligibility. 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

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MANAGED CARE EXCLUSIONS

0914.03.03

enrolled in an individual non-Medicare health plan determined to be cost-effective.

Also exclude the following groups from enrollment in GAMC managed care:

- > GAMC recipients eligible for Medicare benefits.
- > GAMC recipients living in nursing facilities.
- > GAMC recipients in the GAMC Hospital Only (GHO) Program.

MinnesotaCare:

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) if they have a Method A basis of eligibility.
- > **People with an LTC spenddown may enroll in MSHO. People with a medical spenddown are not eligible to enroll in 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, **Carver**, Dakota, Hennepin, Ramsey, **Scott** or **Washington** counties. These people may voluntarily enroll in Minnesota Disability Health Options **for people with physical disabilities (MnDHO-PD)**. See §0914.03.27 (Minnesota Disability Health Options (MnDHO-PD)).
- > **People age 18 through 64 who are determined by the county to have mental retardation or a related condition, who reside in Carver, Hennepin or Scott counties and are currently receiving residential habilitative services in a Mount Olivet Rolling Acres (MORA) owned ICF/MR or a MORA-managed**

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MANAGED CARE VOLUNTARY ENROLLMENT

0914.03.03.03

foster home, or receiving residential habilitative services from MORA in their own homes are eligible to enroll. These people may voluntarily enroll in Minnesota Disability Health Options – Developmental Disabilities (MnDHO- DD).

- > 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:

No provisions.

MA:

Minnesota Senior Health Options (MSHO) is a project to serve people who are age 65 and over and who are eligible for Medicare Part A and B. MSHO integrates primary, acute, long term care services for people who enroll in the option. Federal waivers allow DHS to purchase both Medicare and Medicaid (MA) services in the same contract and to serve people with both community and long term care spenddowns in the demonstration. MSHO enrollment is voluntary.

People who are eligible for MA may enroll in MSHO if they:

> Are age 65 or over.

AND

> Are eligible for Medicare Part A and Part B or who do not have Medicare.

AND

> Live in a participating **MSHO** county. **Effective 01/01/06, those counties not participating in MSHO are: Beltrami, Clearwater, Hubbard and Lake of the Woods.**

AND

> Are eligible for MA without a **medical** spenddown. **Effective 06/01/05 applicants with a medical spenddown are not eligible to enroll in MSHO.**

Please Note: Current enrollees in MSHO that gain a medical spenddown or combined LTC /medical spenddown following MSHO enrollment are allowed to remain enrolled in MSHO. Their medical spenddown will be paid to DHS.

OR

> Are eligible for SIS EW with a waiver obligation (those with incomes over the maintenance needs allowance). SIS EW enrollees with waiver obligations must pay their monthly waiver obligation **OR the amount of the waiver services received, whichever is less, to the health plan. If the enrollee is moving from a medical spenddown to a waiver obligation, be sure to update MMIS to reflect the waiver obligation prior to submitting the MSHO**

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MINNESOTA SENIOR HEALTH OPTION - MSHO

0914.03.25

enrollment form. Do not add designated providers for waiver and medical spenddown types in MMIS for people enrolled in MSHO. See MMIS User Manual County Administered, Spenddowns Section.

Exception: People in hospice should be coded with the hospice provider as the designated provider.

For further information refer to DHS Bulletin 03-21-02 Minnesota Senior Health Options Serves Seniors.

GAMC:

No provisions.

MinnesotaCare

Act on all income increases and decreases reported between renewals, including those that increase monthly premiums.

EXAMPLE:

Susan calls in November to report that she began receiving child support payments of \$125 per month in June. She did not include this information on her September renewal form. Recalculate household income including the child support payment, record the new amount in MMIS to determine the new premium amount.

EXAMPLE:

Jackson reports changes in his household's employment. He received a raise, but his wife started a new job at a lower hourly rate. The combined effect of the 2 changes is decreased household income that would result in a lower premium. Enter both changes in MMIS.

MMIS will adjust the premium for the first available month when income decreases on an active case. Do not request manual adjustments.

EXAMPLE:

On May 21, Rita calls to report her husband, Karl, left the household. Karl did not have coverage, but his income was counted to determine the household's premium. Remove Karl's income and decrease the household size. MMIS will adjust the premium automatically.

If a household reports 2 income changes at the same time, act on the change to determine if the combined changes would result in an increased or a decreased premium.

EXAMPLE:

Anthony calls his worker to report that his Unemployment Insurance (UI) stopped and he began a job. The wages he reports from the job are higher than the UI and would result in an increased premium. Recalculate household income. Record the new amount in MMIS to determine the new premium amount.

M.S. 256L.07 subd. 1

Minnesota Rule 9506.0040 subp. 2c

MA/GAMC:

See §0915.03 (Adding a Person to the Household) when adding the income of a

person who moves into an existing household.

Households are required to report changes in income within 10 days of the date the change becomes known. Households who use a monthly manual spenddown must submit monthly income reports. See §0913.11 (Manual Monthly Spenddown Calculation) and §0905.07 (Monthly Reporting). All other households must submit income reports every 6 months. See §0913.07 (6-Month Spenddown Calculation), §0913.09 (Automated Monthly Spenddown Calculation), and §0905.09 (6-Month Reporting).

When you become aware of a change in household income, determine the effect of the change on the household's eligibility. If the change is reported during a certification period, recalculate eligibility for the current certification period.

For income increases:

When you become aware of an increase in income during a certification period, determine the affect on eligibility and take action immediately.

Request verification of new or increased earned income that affects eligibility. Require verification be submitted within 10 days of notification. New or increased earned income affects eligibility if it results in a change in eligibility basis, creates the need for a spenddown, or changes a spenddown amount.

Do not require verification if:

- The new or increased earned income causes ineligibility for MA; or
- The new or increased income does not affect MA eligibility

Do not require verification of an increase in unearned income if it is reported at a time other than a scheduled 6-month or annual review.

EXAMPLE:

Bridget receives MA for herself and her 2 children. Their current certification period is June-November. The household's only income is child support for the children. All household members are eligible without a spenddown. On September 5, Bridget reports that she began a job on September 1.

Redetermine eligibility for each household member for the current certification period. Count zero income for Bridget for June-August, since the children's child support is not deemed to her. Project anticipated earnings for September-November. Count child support for the children for the entire 6-

month certification period. Add Bridget's projected net earnings for September-November. Determine whether any household members are eligible for Transition Year MA. See §0907.19.11 (Transitional/Transition Year MA). If any household member has a spenddown as a result of the new calculation, determine whether the spenddown can be met with bills incurred before the current certification period or with bills incurred during the certification period that were not covered by MA.

If a household member with a spenddown cannot meet a 6-month spenddown with existing bills, determine if the person could meet a monthly spenddown based on anticipated income and bills for the remaining months in the certification period. Terminate MA effective the first month for which you can give 10-day notice for any household member who cannot meet a 6-month or monthly spenddown.

If any household members move to Transition Year MA or MA with a spenddown due to the new earned income, request verification of the new earned income to be submitted within 10 days. Cancel MA coverage with 10-day notice for household members whose eligibility was affected by the increase earned income if verification is not submitted.

For income decreases:

When you become aware of a decrease in income during a certification period, determine the effect on eligibility and take action immediately. If no one in the household has a spenddown, no action is required. Do not require verification of decreases in either earned or unearned income reported between 6-month or annual reviews.

If the household has an automated or monthly manual spenddown, recompute the spenddown beginning with the month the change occurred. See §0913.09 (Automated Monthly Spenddown Calculation) and §0913.11 (Manual Monthly Spenddown Calculation).

If any household member has a 6-month spenddown, recompute eligibility for the existing certification period. If the decreased income results in an earlier satisfaction date, change the spenddown amount and satisfaction date on MAXIS and MMIS. Send a notice to the household to notify appropriate providers to bill MA or GAMC. See §0913.07 (6-Month Spenddown Calculation) and §0913.19 (Shortened Spenddown).

EXAMPLE:

Delbert receives GAMC with a 6-month spenddown. His current certification period is January-June. He was hospitalized from January 13-16 and met his spenddown on January 14. On April 9, he reports his hours have been cut from 30 to 20 per week. The worker determines that Delbert would meet his spenddown on January 13 based on the reduction in income. Change the spenddown satisfaction date and recipient amount on MAXIS and MMIS. Notify Delbert of the change and advise him to have the hospital rebill the January 13-14 charges to GAMC. When the hospital receives payment, they will refund the difference between the old and new spenddown amounts to Delbert.

Premiums for people enrolled in Medical Assistance for Employed Persons with Disabilities (MA-EPD) are established for the full 6-month certification period. If a MA-EPD enrollee reports a change in income during the certification period, change the premium only if the income change results in a decreased premium or no premium. If the change results in an increased premium, do not take action to increase the premium until the next 6-month income review or annual recertification.

Exception:

If an IEVS match results in an increase in the MA-EPD premium, apply the increased premium amount for the next available month. See §0916.21.03 (MA Overpayments from IEVS Matches).

MinnesotaCare:

No provisions.

MA:

Review IEVS Matches for prior periods of eligibility for Medical Assistance cases. Follow current policy for all IEVS Matches. See §0916.21 (IEVS Notices) & TE02.12.10. (IEVS Wage Match: Wage Earner Discrepancy).

When an IEVS match resolution shows that an enrollee received unreported income or assets, redetermine eligibility for the affected eligibility.

Redetermine MA eligibility. Using the information from the IEVS Match, redetermine eligibility for all affected household members for the same budget period for which the IEVS Match showed the receipt of the unreported income and/or asset.

- > If the information from the match does not affect past or future eligibility, enter a detailed case note. No further action is required.
- > If the redetermination results in future ineligibility, terminate eligibility providing a 10-day notice. See §0916.11 (Timing of Notices of Adverse Action).
- > If the information results in excess assets for past months, determine the months of ineligibility based on the excess assets. If the excess assets result in future ineligibility, allow the reduction of assets according to policy. If the enrollee reduces excess assets before the effective date of termination, eligibility may continue. See §0909.29.03 (Excess Assets—Enrollees). If the assets are not reduced, terminate eligibility providing 10-day notice.
- > If the information from the IEVS Match results in ineligibility or adverse changes in past months, determine the amount of the MA overpayment.
- > If the redetermination results in a manual monthly, automated monthly, or six month spenddown; determine if the spenddown could have been met based on income and medical bills.
- > Document detailed information in case notes.

Determine the amount of MA overpayment. Request a Claims History Profile. See

MMIS User Manual, County Administered Program, Claims History Profiles, for more information.

- > If there is ineligibility for past periods, request a Claims History Profile for that timeframe using DHS-2133 or through the Program Integrity Network (PIN).
- > When Claims history information is received, determine the amount of the overpayment for the ineligibility period.
- > The claims history will list the amounts the state has paid for medical services. It will indicate payments to medical providers or payments to managed health care plans depending upon whether the enrollee was fee-for-service or enrolled in a managed care health plan.
- > If the enrollee is enrolled in a managed health care plan, the overpayment is the amount of the capitation payment regardless of whether any services have been received.

Example:

Jim is disabled and enrolled in MA-Fee-For-Service (FFS) for the periods of 1/1/05 to 6/30/05 and 7/1/05 to 12/31/05. He receives Social Security income and reports assets totaling \$2,500.

IEVS Match information: In 9/05 an IEVS match is received indicating Jim has an asset valued at \$25,000 which the worker finds was never reported. The worker sends an IEVS Difference Notice. Jim contacts the worker and provides proof that he does have an available asset valued at \$25,000 that he has owned since 1995 and forgot to report. His total countable assets going back to the first date his MA was opened total \$27,500.

Required action: The worker determines that Jim is not eligible for MA currently, in the future nor was he eligible for MA at anytime he was receiving it in the past because his assets are more than the \$3,000 limit. The worker sends a letter informing Jim he has to reduce his assets by 10/31 or his MA will close. Jim contacts the worker and states that he does not want to reduce the assets. On 10/10/05 the worker

terminates eligibility due to excess assets because the assets were not reduced. MAXIS issues a 10-day notice to terminate MA effective 10/31/05 due to excess assets.

MA overpayment calculation: The worker requests a Claims History Profile. The profile shows that MA paid \$5,200 in medical bills from 1/1/05 – 10/31/05.

The MA Overpayment is \$5,200.

The worker fills out and mails DHS 4600 to Jim requesting repayment of \$5,200.00. The worker puts a copy of the completed DHS 4600 in the case file and sends a copy to DHS. The worker enters a detailed case note in MAXIS.

Follow up information: Six days later Jim sends a check to his worker with payment of \$5,200 to repay his MA overpayment. The worker sends the check to the accounting unit with a copy of the overpayment letter that instructs them to code the repayment as a Type IV recovery. The worker enters a detailed case note in MAXIS.

Example:

John is disabled and has been enrolled in MA since 1/1/05. He has also been enrolled in a managed care health plan since he went on MA. He receives Social Security income and reports assets totaling \$2,000.

IEVS Match information: In 9/05 an IEVS match is received indicating John had stocks that were valued at \$15,000 which the worker finds he never reported. The worker sends an IEVS Difference Notice. John contacts the worker and provides proof that he did have the stocks from 1/1/05 to 6/30/05 valued at \$15,000 that he forgot to report. He provides proof that he lost the stocks when the company went bankrupt on 6/25/05. His countable assets going back to the first date his MA was opened through 6/25/05 totaled \$17,000.

Required action: The worker determines that John was not eligible for MA from 1/1/05 through 6/30/05 due to excess

assets. He continues to remain eligible for MA since he no longer has this asset and his current assets total \$2,000.

MA overpayment calculation: The worker requests a Claims History Profile. The profile shows that capitation payments were made for John from 1/1/05 through 6/30/05 totaling \$2,400.

The MA Overpayment is \$2,400.

The worker fills out and mails DHS 4600 to John requesting repayment of \$2,400. The worker puts a copy of the completed DHS 4600 in the case file and sends a copy to DHS. The worker enters a detailed case note in MAXIS.

Follow up information: Two years later John sends a check to the county with payment of \$500 to repay part of his MA overpayment. The worker sends the check to the accounting unit with a copy of the overpayment letter that instructs them to code the repayment as a Type IV recovery. The worker enters a detailed case note in MAXIS.

When the redetermination results in a spenddown, or a higher spenddown, the amount of the overpayment is whichever is the lesser of:

> The spenddown amount minus any co-payments, out of pocket medical expenses or medical expenses not used in a prior spenddown.

OR

> The amount of the capitation payment.

Example:

Mae is over age 65 and has been enrolled in MA since 06/01/05. She is enrolled in a managed care health plan. Her counted assets total \$1,300. She receives Social Security of \$620.00 a month.

IEVS Match information: In 7/05 an IEVS match was received indicating Mae received a lump sum payment of \$1,200. The

worker sends an IEVS Difference Notice. Mae contacts the worker and provides proof that she did receive the income on 7/12/05 and forgot to report it. Mae told the worker that she used the \$1,200 to buy a car on 7/18/05 and gave the worker a copy of the title.

Required action: The worker determines that Mae was not eligible for MA during the month of July due to excess income. The lump sum payment did not result in excess assets in the month after receipt.

MA overpayment calculation: The worker requests a Claims History Profile for the month of 07/05. The profile shows that a capitation payment of \$240.00 was made.

The MA Overpayment is \$240.

The worker fills out and mails DHS 4600 to Mae requesting repayment of \$240. The worker puts a copy of the completed DHS 4600 in the case file and sends a copy to DHS. The worker enters a detailed case note in MAXIS.

Follow up information: Two weeks later Mae sends a check to the county with payment of \$240 to repay the MA overpayment. The worker sends the check to the accounting unit with a copy of the overpayment letter that instructs them to code the repayment as a Type IV recovery. The worker enters a detailed case note in MAXIS.

If redetermination results in a higher spenddown, request a claims history to determine if claims were paid during the month(s) of overpayment. If no claims were paid, there is no overpayment.

When the redetermination results in a higher spenddown, the amount of the overpayment is the increased spenddown amount minus the original spenddown amount. Deduct any co-payments, out of pocket medical expenses or medical expenses not used in a prior spenddown.

Example:

Joel is 19 years old and is living on his own and employed. He was enrolled in MA with a \$100 six-month spenddown for the

period 1/1/05 – 6/30/05. John was not enrolled in a managed care health plan.

IEVS Match information: In 9/05 an IEVS match is received indicating Joel received income that he did not report in 3/05 and 4/05. The worker sends an IEVS Difference Notices to Joel. Joel provides proof to the worker that he did have another temporary job and forgot to report the income.

Required action: The worker redetermines Joel's eligibility during 1/1/05 – 6/30/05 which results in a higher six-month spenddown of \$500. Joel did not have any out-of-pocket medical expenses or copays.

MA overpayment calculation: The worker requests a Claims History Profile for the period of 02/01/05 to 6/30/05. The profile shows that MA services totaling \$1,700 were paid during this period.

The Amount of the Overpayment is \$400 (\$500 minus \$100 = \$400).

The worker fills out and sends DHS 4600 to request re-payment for the \$400.00 overpayment, puts a copy in the case file, and sends a copy to DHS. The worker enters a detailed case note in MAXIS.

If determination results in a higher MA-EPD premium, redetermine the amount of the premium based upon the information received from the IEVS match.

The overpayment amount is the redetermined premium amount minus the original premium amount. This overpayment does not affect current or future MA-EPD eligibility.

Example:

Bob is disabled and employed. He is enrolled in MA-EPD beginning 8/1/05 with a monthly premium of \$50.

IEVS Match information: In 09/05, an IEVS match is received. The report shows income that was received in 8/05 and 9/05 that was not reported.

Action required: The worker sends an IEVS Match Difference Notice. Bob provides proof of the income that he forgot to

report.

The worker redetermines Bob's eligibility for 8/05 and 9/05 which results in a higher MA-EPD premium of \$75 for each month.

MA-EPD overpayment calculation: A \$25.00 overpayment has resulted for August and a \$25.00 overpayment has resulted for September (\$75.00 {new premium amount}--\$50.00 {previous premium amount} = \$25.00 overpayment).

The worker fills out and sends DHS 4600 to request repayment of the \$50.00 overpayment and puts a copy in the case record and sends a copy to DHS. The worker enters a detailed case note in MAXIS.

Document detailed information in case notes.

To request repayment of the overpayment, complete the Notice of Medical Assistance Overpayment, form DHS 4600 and mail the form to the enrollee. Retain a copy of the Notice of Medical Assistance Overpayment for the case record. Mail or fax a copy of this form to:

HCEA -IEVS
PO Box 64989
St. Paul, MN 55164-0989
FAX number: 651-431-7446

Follow your county's current fraud procedures whenever fraud is suspected.

When repayment is received, forward all voluntary repayments to your county fiscal department for receipt along with the IEVS Notice of Medical Assistance Overpayment letter. The fiscal department should process the repayments in the same manner your county processes other recoveries, such as estate recoveries. The fiscal department should code this recovery as a TYPE IV-INELIGIBILITY-VOLUNTARY REPAYMENT.

GAMC:

No provisions.