Minnesota Eligibility Alignment Study Current Status Report

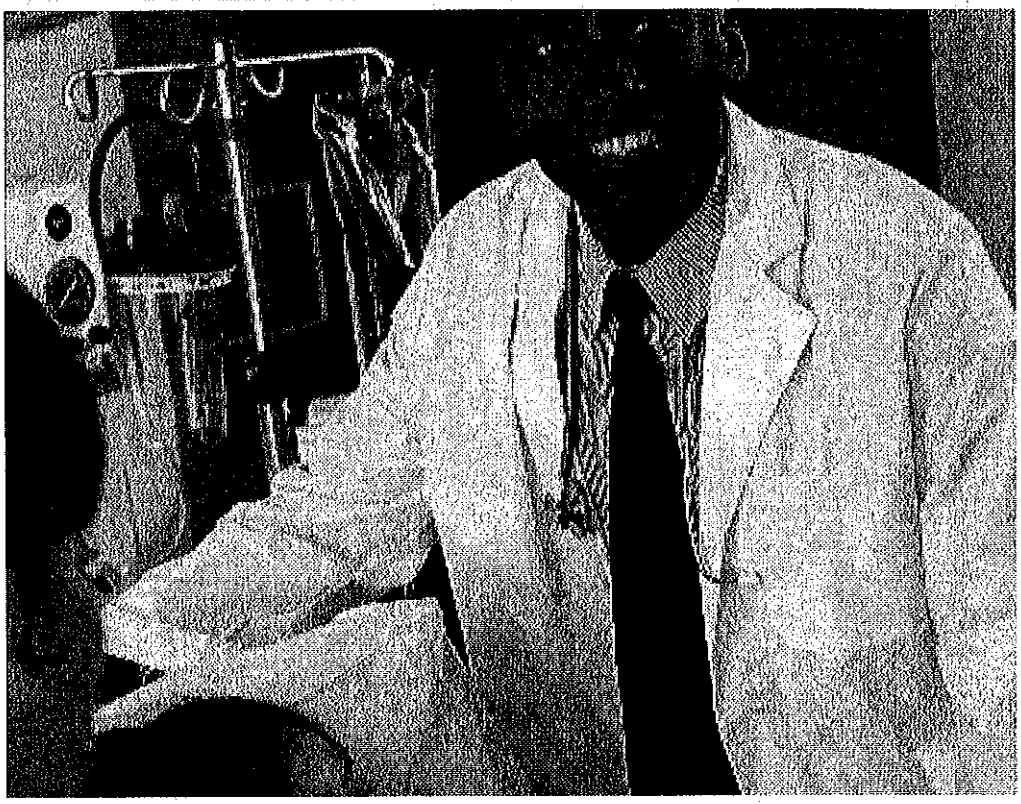
Health Care Eligibility and Access

September 2010

Legislative Report

Minnesota Department of **Human Services**

The LEWIN GROUP®



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Prepared for: Minnesota Department of Human Services

Submitted by: The Lewin Group

Date: June 15, 2010

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Introduction

Low-income families and children in the United States are served by a variety of cash, food and assistance programs, including two health programs: Medicaid and the Children's Health Insurance Program, which each provide funding for Minnesota's primary health care programs, Medical Assistance (MA) and MinnesotaCare. The major health care, cash assistance, and food programs are each administered at the state level but operate within a framework of federal rules, established for each program by different departments including the U.S. Departments of Health and Human Services, Agriculture, and Education. States have some flexibility to establish eligibility rules and processes, but the financial and categorical criteria for eligibility, as well as the acceptable processes and documentation required to establish eligibility, vary from program to program.

The result of this multitude of programs and rules is that clients face a variety of barriers to successfully enrolling (and staying enrolled) in assistance programs for which they are eligible, while states struggle to efficiently and accurately identify and enroll eligible beneficiaries. The federal government has made some efforts to relax program requirements to support greater alignment and states have developed a variety of approaches to share data, reduce administrative barriers, simplify enrollment processes from the client perspective, and support caseworkers. However, nationally 12 million individuals are eligible for public health programs but are not enrolled, including over 6 million children and 3.5 million parents.[1] In 2009, Minnesota's Department of Health, Health Economics program estimated that 61.1% of the State's 480,000 people without health insurance were potentially eligible for public health coverage based on income levels but were not enrolled.[2]

Through its two primary health care programs, MA and MinnesotaCare the Minnesota Department of Human Services (DHS) provides access to health care for nearly 650,000 individuals each month.[3] In light of the recent economic downturn, both MA and MinnesotaCare have experienced significant enrollment increases. Between 2008 and 2009, MA and MinnesotaCare enrollment grew by 5.8% and 2.9% respectively, uncharacteristically high growth rates for both programs. In previous years MA enrollment increased only 2% to 3% per year, while MinnesotaCare recently experienced negative growth rates.[4]

While public health care programs in all states struggle to find the right balance between open access to coverage and the need to ensure that only truly eligible persons are enrolled, Minnesota faces particular challenges due to the use of two programs that largely serve the same lower-income families, creating barriers, confusion, and coverage gaps.

The friction between parallel but different eligibility processes and potential duplication of effort also wastes administrative effort and creates additional burdens and costs for county and

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1 National Institute for Health Care Management Foundation, "Understanding the Uninsured," 2008.

2 Minnesota Department of Health, Health Economics Program, "Health Insurance Coverage in Minnesota, Early Results from the 2009 Minnesota Health Access Survey," February 2010.

3 Minnesota Department of Human Services, Reports and Forecasts Division, Family Self-Sufficiency and Health Care Program Statistics, September 2009.

4 Minnesota Health Care Market Chartbook, Section 5: Public Health Insurance Programs. http://tiny.cc/zizh8,1,Section 5: Public Health Insurance Programs

state eligibility workers, who must understand and apply multiple sets of eligibility rules. Previous studies have found that current staff resource levels may be insufficient to properly administer the MA and MinnesotaCare eligibility processes, due in part to the complexity of these processes.[5] However, other states have found that eligibility simplification and alignment strategies can lead to increased enrollment of eligible yet not enrolled individuals, benefiting children and families. Simplified and streamlined eligibility determination processes also result in greater accuracy and administrative savings for states and counties.[6] By reducing the barriers to enrollment, states have been able to encourage families who might otherwise be reluctant to wade through complicated applications and extensive documentation requirements to access available benefits, ultimately reducing the number of uninsured persons.

Current federal mandates that require states to maintain current Medicaid eligibility standards and methodologies also complicate possible alignment efforts. The recently enacted Patient Protection and Affordable Care Act (PPACA) includes a "maintenance of effort" provision that requires states to maintain Medicaid eligibility standards and methodologies that were in effect for adults as of March 23, 2010. This requirement remains in effect until January 1, 2014, or until the state's insurance exchange is operational, whichever is later. States must maintain Medicaid standards and methodologies for children until September 30, 2019.[7]

This paper provides an overview of the eight areas identified by Minnesota as having the greatest barriers to eligibility alignment between MA and MinnesotaCare for the State's children and families:

- Income
- Assets
- Cost of coverage
- Eligibility periods and coverage start dates
- Insurance and third party liability (TPL)
- Managed care enrollment
- Verification
- Administrative processes and the Minnesota HealthCare Connect Initiatives

Below we describe the current processes, policies, and procedures for each program in each alignment area as well as provide the federal and state statutory framework under which the State must operate, while also considering the recently enacted Patient Protection and

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[5] Minnesota Department of Human Services, "Current State Modeling and Analysis: As-Is Report," Health Care Connect Business Re-engineering Project

[6] See "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," Kaiser Family Foundation and "Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come," Mann, Rousseau, Garfield, O'Malley, Kaiser Commission of Medicaid and the Uninsured, 2002

[7] Additionally, the American Recovery and Reinvestment Act of 2009 (ARRA) contains a maintenance of effort provision that requires states to maintain Medicaid eligibility standards and methodologies that were in effect as of July 1, 2008. This provision is scheduled to expire December 31, 2010.

Affordable Care Act. We also identify the areas in which the programs overlap and where they differ. Finally, we outline the challenges that the State, counties, advocates, and clients face regarding eligibility application, renewal, and ongoing enrollment and the opportunities and challenges to alignment. This current status report will document where the programs currently do not align and serve as the basis for developing actionable eligibility alignment options for each of the areas of concern.

Project Background

In 2009, the Minnesota Legislature asked DHS to identify and present by September 15, 2010 specific opportunities for alignment between the MA and MinnesotaCare programs (2009 Minnesota Session Law, Chapter 79, Article 5, Section 77 (a)). The goal of this project is to provide DHS with analysis and options to align eligibility standards and administrative processes for children and adults who receive (or could receive) health care coverage through the MA and MinnesotaCare programs, in order to reduce client confusion, administrative barriers, and administrative costs.[8]

The State contracted with The Lewin Group in February 2010 to begin work on the eligibility alignment study. Lewin's tasks include:

- Presenting the State with a current status report on the eight alignment areas covered by the study
- Developing a report on each of the alignment areas that discusses two to three alignment options, taking into consideration the net cost to the State, potential federal regulatory issues, systems impacts, program integrity concerns, impact on clients and alignment with State cash and food programs
- Creating a final report to be presented to the Legislature that offers three overall alignment recommendations for the two programs

Lewin is reviewing publicly available information and tapping the expertise and experience of State and county staff. Specific data sources include Title XIX and Title XXI of the Social Security Act, the Code of Federal Regulations, Minnesota Statutes and Minnesota Administrative Rules, the Prepaid Medical Assistance Project Plus (PMAP+) Demonstration Waiver (including pending amendments), the State's Health Care Programs Manual (HCPM), and on-line training modules and materials provided to State and county caseworkers.

Additionally, we conducted 17 interviews with over 50 DHS staff, county eligibility workers, and advocacy organizations that work directly with clients. The interviews provided insight into current processes and challenges as well as identified areas in which to focus our alignment recommendations. We have also participated in Legislative Advisory Committee meetings. (The Legislature directed DHS to convene stakeholders to provide feedback on the eligibility alignment study as well as other state initiatives related to eligibility.) The Committee has provided initial recommendations on areas that are prime targets for alignment and will continue to provide feedback on recommended alignment options and project deliverables.

[8] For the purposes of this report, we reviewed only MA and MinnesotaCare families and children populations. We did not review other populations.

Overview of Medical Assistance and MinnesotaCare

Minnesota has two primary health care programs for families and children, MinnesotaCare and MA. Although MA is the state's official Medicaid program, both MA and MinnesotaCare receive federal funding through Medicaid and the Children's Health Insurance Program (CHIP), operating under a complicated set of federal and state statutory guidance and a "research and demonstration waiver" negotiated between the State and the federal government.

Medical Assistance

Medical Assistance provides coverage for more than 500,000 individuals each month.[9] The program, first established and implemented by the State legislature in 1966, is administered by county agencies, with statewide oversight by the Department of Human Services. Medical Assistance is funded by both the State and the federal government, with the non-federal share mostly coming from the State's Medicaid Account which is funded by the general fund, and to a lesser extent from local government contributions. The Federal Medical Assistance Percentage (FMAP) for Minnesota, the federal government's contribution to the cost of medical services, is 50% (temporarily increased by American Recovery and Reinvestment Act of 2009 (ARRA)).

The program eligibility criteria are complex and enrollees must meet both financial and categorical criteria in order to qualify.[10] That is, having low income and assets is not the only determinant of eligibility—MA eligibility is further limited to children under the age of 21, parents of dependent children, pregnant women, people who are age 65 or older, and people who have a certified disability.[11] More than half of MA program enrollees are children and families.[12]

The MA program is funded by both State and federal funds, and Title XIX of the Social Security Act provides the federal framework for the MA program. Title XIX mandates which eligibility groups must be covered, which may be covered at state option, and the income levels that apply for these respective groups. Title XIX also constrains the means by which health care coverage can be provided (e.g., fee-for-service, managed care), and governs other aspects of program administration. Title 42 of the Code of Federal Regulation (CFR), Section 435, describes additional federal policy governing eligibility in state Medicaid programs.

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[9] Minnesota Department of Human Services, Healthcare, Medical Assistance Program Overview, December 2009 http://tiny.cc/f9n5o

[10] Under federal Medicaid rules, categorical eligibility means that a person must fall into one of the statutorily recognized eligibility groups: children, pregnant women, adults in families with dependent children, people with disabilities (adults and children), persons who are blind, and older persons. In addition to fitting into one of the Medicaid eligibility groups in the State Plan, an individual also cannot have income that exceeds the income standard for the category.

[11] MA covers both parents and adult caretakers of dependent children with incomes below 100% FPG. However, for the purposes of this paper, we refer to both of these groups as "parents."

[12] The MA program also includes a small group of optional targeted low income children, specifically infants between the ages of zero and two with family income between 275% and 280% of Federal Poverty Guidelines (FPG). This is a "Medicaid expansion" group provided through Title XXI of the Social Security Act and implemented through the CHIP State Plan.

To obtain federal funds, Minnesota received approval for a Medicaid State Plan, which details program coverage rules and administrative policies. Coverage and eligibility requirements are addressed in Section 2 of the State Plan and its attachments. State funding authority is granted through Chapter 256B, Medical Assistance for Needy Persons, of the Minnesota Statutes (Minn. Stat.), which describes the State's policies (within the framework of federal rules and the State Plan). State administrative rules for MA are listed in Chapter 9505 of the Minnesota Administrative Rules. The Minnesota Health Care Programs Manual (HCPM) provides policy information for county, tribal, and State staff who determine health care eligibility. The manual is available on the Internet.

Attachment 3.1-F to the State Plan gives the State approval to require certain Medicaid beneficiaries to enroll in managed care plans to receive services. Most of the MA eligibility groups addressed in this paper (e.g., low-income parents and children, categorically needy pregnant women and infants, infants in the CHIP Medicaid expansion, and categorically needy children under age 21) are among the groups required to enroll in managed care through the State Plan, and the majority of MA clients are enrolled in managed care plans, with less than one-third of enrollees receiving care on a fee-for-service basis.[13] Exempt populations include those who have a medical spenddown or have private health insurance through a health maintenance organization (HMO). Medical Assistance clients who do not choose a managed care organization (MCO) are automatically assigned to one.

While not discussed in the report, it is important to note that some clients with a families and children basis of eligibility for MA may reside in a long-term care (LTC) facility and therefore have different eligibility rules. Differences include:

- An additional set of eligibility criteria (e.g., individuals must not have home equity of more than $500,000; must name the state as a remainder beneficiary on certain annuities)
- Use of LTC budgeting to calculate the amount of the individual's income that must be applied to the cost of care with different deductions applied
- Different asset deeming rules

MA clients may be responsible for copayments on select services up to a specified amount. However, copayments are only charged to some MA clients, such as parents. Pregnant women and children under the age of 21 are not required to pay copayments of any kind.

MinnesotaCare

Like many other states, Minnesota has obtained a research and demonstration waiver through Section 1115 of the Social Security Act, which grants it the authority to waive certain parts of Title XIX in order to test policy innovations likely to further program objectives, such as covering uninsured populations and using coordinated delivery systems. This waiver, the Pre-Paid Medical Assistance Program Plus (PMAP+), first approved in 1995, allows the State to provide coverage for certain pregnant women, infants, children, parents with income up to 275% of the FPG and to require these clients to enroll in managed care in the MinnesotaCare

[13] Ibid.

program.[14] Some of the persons meeting the eligibility criteria for the MinnesotaCare program described in the waiver are also eligible for MA under State Plan rules. Federal funds for eligible enrollees and services covered by the MinnesotaCare program are authorized through the State's 1115 PMAP+ waiver.[15]

The MinnesotaCare program began in 1992, replacing the Children's Health Plan, which was established by the State in 1987 to serve low-income children ineligible for Medicaid. Today, MinnesotaCare is jointly funded by both the State and the federal government, using Title XIX funds. The state share of MinnesotaCare is funded by a state tax on Minnesota health care providers and non-profit health plan companies. Enrollee premiums offset both federal and state costs.[16] Generally, the FMAP rate for MinnesotaCare is 50% (the Medicaid rate in the absence of the ARRA increase), as it is in MA. The State claims an additional CHIP match of 15% for expenditures relating to children in families with income above 133% FPG.[17]

State authority for the PMAP+ waiver is granted through Minn. Stat. Ch. 256L. State administrative rules for MinnesotaCare are listed in the Minnesota Administrative Rules Chapter 9506. MinnesotaCare program policy information is in the Minnesota Health Care Programs Manual (HCPM).

MinnesotaCare provides subsidized health coverage to more than 69,000 individuals in the family and children eligibility categories each month.[18] The program is administered at the State as well as in certain counties, on a volunteer basis, with statewide oversight by the Department of Human Services (DHS). MinnesotaCare serves children under the age of 21, parents, and pregnant women. There is also a state-funded MinnesotaCare program serving adults over the age of 21 without children that is not addressed in this report. Most clients are required to pay monthly premiums (based on household size, number of individuals in the household covered, and income) in order to maintain access to healthcare services.[19]

MinnesotaCare is both complementary to and an alternative to MA. Similar to the MA program, individuals must meet certain assets and income limits to be determined eligible. However, income limits are higher than those in MA. Unlike MA, a person who has health insurance coverage cannot, with some exceptions, enroll in MinnesotaCare.

All MinnesotaCare clients are required to enroll in managed care plans. The State currently contracts with eight managed care organizations to provide these services. The benefits available to pregnant women and children under the age of 21 through MinnesotaCare are

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[14] MinnesotaCare covers both parents and adult caretakers of dependent children with incomes below 275% FPG. However, for the purposes of this paper, we refer to this group as "parents."

[15] Under the CHIP maintenance of effort requirements, the State could not use its CHIP allotment for MinnesotaCare children enrolled in the 1115 PMAP+ Medicaid waiver.

[16] Minnesota House of Representatives, MinnesotaCare: An Overview. November 2009. http://tiny.cc/d3zv4

[17] Available to qualifying states under section 2105(g) of Title XXI; effective with the CHIP Reauthorization Act of February 4, 2009, states may claim the difference between Medicaid FMAP and the CHIP enhanced match on Medicaid children with income above 133% FPG.

[18] Minnesota House of Representatives, Research Department, Information Brief: MinnesotaCare, October 2009, p. 17. http://tiny.cc/n4ziw

[19] Minnesota Department of Human Services, Healthcare, MinnesotaCare Program Overview. http://tiny.cc/vpnkw

identical to the extensive benefits offered through MA, with no copayments. The benefits available through MinnesotaCare to parents are less extensive than those offered through MA, with limits on inpatient hospital, medical transportation and dental care. Copayments apply to select services for parents. Parents can be enrolled in either MinnesotaCare Basic Plus or Basic Plus Two. Figure 1 (below) provides additional information on the plans.

Figure 1. MinnesotaCare Plans for Parents

Plan	Enrollment Criteria and Limits
Basic Plus	▪ Includes parents whose total household income is over 215% FPG but less than or equal to 275% FPG (or $50,000, whichever is less) ▪ $10,000 annual limit on inpatient hospital benefits
Basic Plus Two	▪ Includes people whose household income is equal to or less than 215% FPG ▪ No annual limit on inpatient hospital benefits

Application Process and Informed Choice

Most potential opportunities for alignment addressed in this study relate to or will affect the application process. Currently, there are two ways to apply for health care coverage in Minnesota. The primary method used by children and families in Minnesota is the Health Care Programs Application, which is available through the mail per client request, on-line, in county offices, or through local advocacy/service organizations. Additionally, clients can request health care when applying for cash and food benefits via the Combined Application Form.

Counties review both the Health Care Programs Application and the Combined Application Form for MA and, in some counties, for MinnesotaCare. The State reviews the Health Care Programs Application and the Combined Application Form for MinnesotaCare only. Medical Assistance eligibility and MinnesotaCare eligibility are processed in two different computer systems. MAXIS is the eligibility system used to support the eligibility determination for MA, cash assistance, and Food Support. The MinnesotaCare program maintains eligibility information in the Medicaid Management Information System (MMIS), which is also the State's system for paying health care claims for both MA and MinnesotaCare. County caseworkers have access to both systems. The State MinnesotaCare Operations office has access to MMIS and only limited access to MAXIS.

Minnesota allows clients to specify one of two options for health care program eligibility when completing the Health Care Programs Application: whether they would like to apply for all health care programs or for MinnesotaCare only. This option is known as "informed choice" and eligibility is determined based on the option that the client requests. If the client applies for all health care programs, the Health Care Programs Application is processed by the counties, because MA is administered at the county level. If the client is not eligible for MA, the application is processed to determine MinnesotaCare by the county if the county has elected to administer MinnesotaCare. Otherwise, the application and verifications are transferred to the State MinnesotaCare Operations office for a MinnesotaCare eligibility determination. Applications that request consideration only for MinnesotaCare are processed primarily at the

State level or in those counties that administer MinnesotaCare in addition to MA. Clients can also apply through the Combined Application Form, which allows clients to indicate if they are interested in health care coverage while applying for other programs.[20]

As noted above, clients can indicate whether they would like to apply for all health care programs or only for the MinnesotaCare program. When determining eligibility for all programs, workers determine eligibility for MA first and then for MinnesotaCare if they are not eligible for MA. Minnesota's PMAP+ 1115 waiver does not require that persons found eligible for MA be enrolled in that program; if they also meet the requirements of the MinnesotaCare program, they may choose which program to enroll in. The State is required to inform clients about their choice of MA and MinnesotaCare through the application, where each program is defined.

As shown in Figure 2 below, pregnant women and infants with family income at or below 275% FPG, children ages 2 through 18 with family income at or below 150% FPG, and children 19 and 20 and parents with family income at or below 100% FPG may potentially be eligible for both MA and MinnesotaCare.

Figure 2. Income Limits for Children and Family Groups in MA and MinnesotaCare at the Time of Application

	Families and Children	
% FPG	MA	MinnesotaCare
280	Infants 0-2 280%	No coverage above 275 %
275		
250	Pregnant Women 275%	Children, Parents & Pregnant Women 275%
225		
200		
175		
150	Children 2-18 150%	
125		
100	Children 19-20 100%	
75		
50	Parents 100%	
25		
0		

The factors that affect informed choice are numerous. Examples include:

- MinnesotaCare has a monthly premium (although it is nominal for low-income children who could also be eligible for MA), but does not permit individuals with medical expenses to

[20] Combined Application Forms do not have the informed choice option and the process for determining program eligibility varies based on where the application is sent.

"spend down" to the required income limit; MA, on the other hand, has no premium requirements and does permit spenddown

- Individuals are required to apply for MA through the county human services office; individuals can apply for MinnesotaCare by submitting an application to the State office or the county human services office, which will process the application if it is a participating MinnesotaCare county or forward the application to the State if it is not

- The MA and MinnesotaCare programs both require families and children to enroll in managed care, but the benefits are different for parents under the two programs and the MCOs available under the two programs differ in some counties

While the option for informed choice gives low-income children and families in Minnesota more flexibility than similar groups have in other states, it creates additional complexity for the health care program eligibility determination process, as discussed in more detail through the remainder of this report.

Income

Income is a major eligibility criterion for all Minnesota health care programs, including MA and MinnesotaCare. The State must determine each client's income in accordance with program rules to determine whether the client meets the income thresholds for federal or state-funded medical programs. While other factors are also part of the eligibility determination, income is a key factor across all programs and the income calculation is generally the first step in determining eligibility. While not all low-income individuals are eligible for federal or state health care coverage (e.g., adults without children), income is the primary basis for determining eligibility for families and children.

Statutory and regulatory framework

Medical Assistance

Income eligibility criteria are governed by both federal and State rules. At the federal level, sections 1902, 1905, and 1920 of the Social Security Act and the related sections of the Code of Federal Regulations, Title 42 Part 435, define income eligibility thresholds (standards) for various mandatory (individuals that a participating state must cover under its Medicaid program) and optional (individuals that a participating state can choose to cover under its Medicaid program) eligibility groups. The Act allows states some flexibility in the use of income deductions and income disregards; for example, Section 1902(r)(2) of the Act gives states freedom to use less restrictive calculation methodologies in some circumstances. Title XXI of the Social Security Act authorizes states to expand Medicaid for certain additional child populations.[21]

Persons in different Medicaid eligibility groups may have different income standards. Medicaid income standards are based on the federal poverty guideline (FPG), which is updated annually to account for inflation. For example, state Medicaid programs are required to cover children under age six and pregnant women whose family income is at or below 133% FPG and children between age 6 and 19 in families with incomes at or below 100% FPG. States can choose to cover infants up to age one and pregnant women whose family income is between 133% and 185% FPG. The federal government also allows states to cover persons with higher incomes, up to certain limits.

States can also cover optional eligibility groups at higher income levels, or obtain waivers of the Medicaid rules to cover expansion populations at higher income levels. As an example, Minnesota's 1115 waiver, PMAP+, allows the State to cover one year old infants (12-23 months) at or below 275% of the FPG, using the same income methodology as non-waiver MA infants. Minnesota also allows persons with incomes above the required limit to "spend down" to a specified income level (100% FPG for children and families), by subtracting eligible incurred medical expenses from their income.

[21] In Minnesota a Title XXI-funded Medicaid expansion provides coverage for children under the age of two with family incomes between 275% and 280% of the FPG.

Minn. Stat. § 256B.055 defines eligibility categories for MA and Minn. Stat. § 256B.056 describes the income methodology for each eligibility category. Two major sections of the Medicaid State Plan address the Medicaid income rules as they apply to the MA program. Attachment 2.2 A provides specifics on the categories covered by the State and the income standards. Attachment 2.6-A describes income deductions and disregards. The State's policies regarding income as a basis of eligibility are described in detail in Chapters 20 and 21 the Minnesota Health Care Programs Manual.

MinnesotaCare

Income eligibility criteria for MinnesotaCare are governed by federal and State law. All of the federal requirements for the MinnesotaCare program are spelled out in Minnesota's PMAP+ 1115 waiver, which defines the income levels associated with the different groups made eligible through the waiver. Minn. Stat. § 256L.04 defines the populations eligible for MinnesotaCare and their associated income thresholds. Minn. Stat. § 256L.07 further defines income criteria and the impact that changes in income levels have on MinnesotaCare eligibility for various populations.

Recent Changes

Program rules have stayed fairly consistent in recent years, although there have been some changes in income standards, allowed deductions, and income exclusions. Of particular note, within the MA program the State simplified the earned income disregard for children and parents. Further, in 2001, CMS began allowing states to use unspent CHIP allotment funds to cover parents of children enrolled in Medicaid and CHIP. Minnesota applied for and received approval to move parents with household incomes of 100% to 200% FPG from Title XIX to Title XXI, for financing purposes from 2001 to 2008. However, according to the current terms of its waiver, the State now covers parents with Medicaid dollars.[22]

The State requested an amendment to its 1115 waiver on September 30, 2009, which, if approved, will change the income standards for certain MinnesotaCare groups (see Figure 3 below) and the income calculation for self-employed farmers by eliminating the farm depreciation income add-back. The waiver amendment will also allow the State to extend MA coverage for some months and then provide automatic MinnesotaCare eligibility for children who become ineligible for MA due to excess income.

[22] Families USA, "What's Next for CHIP-funded Adult Coverage?" August 2009. http://tiny.cc/pd535

Figure 3. Proposed Waiver Changes Regarding Income

Eligibility Group	Proposed Waiver Change
Children with incomes above 275% FPG	▪ Under the current waiver, children who meet certain criteria with incomes that grow to exceed 275% FPG have been permitted to remain enrolled in MinnesotaCare ▪ The 2009 changes request that all children with income above 275% FPG be permitted to enroll and remain enrolled, eliminates the requirement that children meet the MCHA criteria to retain enrollment
Caretaker adults	▪ Income limit for caretaker adults is increased to the lower of 275% FPG or $57,500/year
Children age 1through 18	▪ Coverage extension for children age one through 18 who become ineligible for MA due to excess income. Children would be eligible for two additional months of MA and be automatically eligible for MinnesotaCare until the next MinnesotaCare renewal

Current income processes and standards

Chapter 20 of the Health Care Programs Manual lists over 200 specific types of income that a client could potentially have. Certain types of income are included for both programs (e.g., wage and self-employment income), excluded from both programs (e.g., student financial aid income), or included for one program but not the other (e.g., cash assistance is counted as income in MinnesotaCare but not MA). The State uses total income on a net (for MA) or gross (for MinnesotaCare) basis to determine eligibility. More detail on the income standards for eligibility groups within each program, what income is counted, and how it is counted for each program is provided below.

Medical Assistance

Eligibility Groups and Income Standards

Families and children typically fall within one of five MA eligibility groups. For these clients, income is a key determinant of eligibility. Minnesota uses an income standard for each eligibility group based on the Federal Poverty Guidelines (FPG), which may vary by group. Some of these income levels are achieved by combining an income standard with SSA Section 1902(r)(2) income disregards. Figure 4 below summarizes the current income standards for each MA eligibility category for families and children.

Figure 4. MA Method A Income Standards for Family and Children Eligibility Groups

Income Standard	Eligibility Group
100% FPG	▪ Children ages 19-20 ▪ Parents ▪ Spenddown standard for families and children

Income Standard	Eligibility Group
150% FPG	▪ Children ages two through eighteen who do not have a spenddown
275% FPG	▪ Pregnant women who do not have a spenddown
280% FPG	▪ Children from birth through their second birthday who do not have a spenddown
No income limit	▪ Auto newborns (those born to a mother enrolled or eligible to enroll in MA at the time of birth) from birth through their first birthday

Income Methodology and Counting Income

Medical Assistance uses a methodology called "Method A" to calculate income for families and children, which was modeled after the rules of the former Aid to Families with Dependent Children (AFDC) program. Method A calculates a client's net income, which is then compared to the appropriate income standard. To determine net income, the client's gross income is determined and then appropriate deductions and disregards are applied.

MA counts both earned and unearned income to determine a client's gross income. Earned income is income that is received in exchange for work or providing a service and includes income received as an employee and self-employment income. Unearned income includes income from other sources such as rental income, interest and dividend payments, gifts, Social Security benefits, child support, unemployment insurance, and workers' compensation.

Further, MA policy distinguishes between available and unavailable income. Available income is that which the client has both a legal interest in and legal ability to access. It can include self-employment income, actual or anticipated income (income that the client is expected to receive in the six-month certification period), and varying and unvarying income (when there is a different number of pay periods in each month, when hours worked or payment received varies in each pay period, and when a client anticipates receiving less unearned income than received in the month of application). Income is unavailable if the client cannot gain access to the income. Unavailable income is not considered in the calculation.

While federal law establishes minimum income standards for mandatory eligibility groups, states are given flexibility to cover individuals at higher income levels through the use of disregards and deductions. Disregards allow states to ignore certain types of income or a certain amount or percentage of income, to effectively cover individuals at a higher FPG. Disregards are applied to certain eligibility groups. Deductions are allowed by federal law to account for work-related expenses incurred by family members applying for assistance. Minnesota has four types of deductions and one disregard applicable to children and family eligibility groups. Additional information on Minnesota's specific allowable deductions and disregards is provided in Figure 5 below.

Figure 5. MA Method A Applicable Earned Income Deductions and Disregards

Deduction/Disregard	Deduction/Disregard	Description
Work Expense Deduction	▪ Children ages 2 to 18 under 150% FPG	Subtract the first $90 of gross income from earned income of the child or earned income of each adult whose income is deemed to the child (see Chapter 21.50.45 in the HCPM)
Pregnant Woman and Infant Work Expense Deduction	▪ Pregnant woman who has income equal to or more than 275% FPG ▪ An infant with an income equal to or more than 280% FPG	Subtract the appropriate amount based on household size (see Chapter 21.50.45 in the HCPM)
MA Method A Earned Income Disregard	▪ Children ages 19 and 20 ▪ Parents ▪ Children ages 2 to 19 whose income exceeds 150% FPG (after applying the Child Work Expense Deduction) who spend down to 100% FPG ▪ Pregnant women whose income exceeds 275% FPG (after applying the Pregnant Woman and Infant Work Expense Deduction) who spend down to 100% FPG ▪ Children from birth through the month of their second birthday that are not eligible as an auto newborn whose income exceeds 280% FPG (after applying the Pregnant Woman and Infant Work Expense Deduction) who spend down to 100% FPG	Subtract 17% of the person's gross earned income for up to a maximum of four consecutive months (see Chapter 21.50.50 in the HCPM)
Dependent Care Deduction	▪ Parents with dependents either under age two or two and older ▪ Deduction is not allowed if care for the child is provided by a parent, stepparent or sibling under age 19 or when care costs are paid by child care fund or other third parties	Subtract $200 per month for each dependent under age two Subtract $175 per month for each dependent age two and older (see Chapter 21.50.60 of HCPM)

Deduction/Disregard	Deduction/Disregard	Description
Child Support Deduction	▪ Parents who pay court-ordered child support to another household	Subtract current cash payments, medical support, child care and arrearages (see Chapter 21.50.65 of HCPM)

Household Composition and Income Deeming

The federal government establishes different Federal Poverty Guidelines for different family or household sizes, as shown in Figure 6 below, as discussed in the Minnesota Health Care Programs Income and Assets Guidelines.

Figure 6. Current Federal Poverty Guideline by for Families with One to Six Members

Family Size*	Annual Guideline	Monthly Guideline
1	$10,836	$903
2	$14,580	$1,215
3	$18,324	$1,527
4	$22.068	$1,839
5	$25,812	$2,151
6	$29,556	$2,463

*Guideline continues to increase as family size increases above six

"Household composition" refers to the individuals that are included in a household for purposes of determining the appropriate income standard against which to review eligibility against, as well as to determine whose income or assets to count. In MA, household composition is determined for each individual that is applying for coverage. Generally, to be counted as a household member, individuals must be living in the household for a full calendar month.

There are different rules for adults and children when determining household composition, summarized in Figure 7 below. Please refer to Chapter 17.05 of the HCPM for additional information.

Figure 7. MA Household Composition Rules

Client	Counted Household Member
Parents or pregnant women	▪ Client ▪ Spouse ▪ Biological or adoptive children under 21 of both the client and the client's spouse ▪ Unborn child of either the client or the client's spouse

Client	Counted Household Member
Children	▪ Child ▪ Child's spouse ▪ Child's children under 18 ▪ Child's unborn child ▪ Child's adoptive, biological or stepparents (if the biological parent is also living in the house) ▪ Full, half or step siblings under 21 ▪ Unborn sibling or half-sibling with whom the child shares a biological or adoptive parent that lives in the home

The MA program determines eligibility for each individual client and must calculate household size for each client. For example, a family might consist of an unmarried woman and her two children, as well as the father of one of the children. The household size for the mother would be three: herself and both children, but not the father, as they are not married. For the child whose father does not live in the household, the household size would be three (the child, the mother, and the half-sibling). For the other child, the household size would be four (the child, both biological parents, and the half-sibling).

Therefore, a separate income calculation must be completed for each member of a household that applies for MA. In addition, in order to determine a client's income, the State must determine whose income should be counted for the individual under review. This process is referred to as "income deeming." For MA, income deeming does not necessarily follow the same rules as household composition.

Minnesota MA follows the federal Medicaid deeming rules. Generally, a spouse's income is deemed to a client and the parent's income is deemed to children under the age of 21 who are not emancipated, married, or an active duty in the uniformed services. Figure 8 below describes income that is deemed to a client as well as deeming exceptions.

Figure 8. MA Method A Income Deeming Exceptions

Deemed Income	Exception
Client's spouse	If the spouses live apart for reasons other than temporary absence
Client's parent	No exceptions
General	Do not deem income: ▪ To a parent from a child ▪ From a sibling to another sibling ▪ From a stepparent to a stepchild ▪ From a grandparent to a grandchild ▪ From a non-parent relative caretaker to a child ▪ From other people to a client who has automatic MA or other deeming exceptions

Once the appropriate income has been identified and counted for each individual client and then adjusted by the applicable deductions and disregards, it (net income) is compared to the appropriate income standard to determine if the client meets the income-related eligibility criteria.

Income Changes

Once enrolled, MA beneficiaries must provide updates on changes to income. Clients are also responsible for reporting income changes at the six month income review. Additionally, if a change in income occurs between six month income reviews, a client is required to report the changes within 10 days. Caseworkers must act on all reported changes. Changes to income can impact eligibility as well as a client's required spenddown.

MinnesotaCare

Eligibility Groups and Income Standards

Children under age 21, pregnant women, and parents of children can be eligible for federally-funded MinnesotaCare coverage. Figure 9 describes the income standards for the MinnesotaCare eligibility groups that receive federal funding.

Figure 9. MinnesotaCare Income Standards for Family and Children Eligibility Groups

Income Standard	Eligibility Group
275% FPG	▪ Children 21 and under ▪ Pregnant women ▪ Parents (not eligible if household income is greater than $50,000; September 2009 waiver request would increase the household income limit to $57,500)

While MinnesotaCare provides coverage under 275% FPG for family and children populations, the State distinguishes between subsets within the covered populations by FPG.

Income Methodology and Counting Income

MinnesotaCare typically follows the "Method A" income calculation methodology used by MA, but differs from MA in certain respects, such as using gross income to determine eligibility (with no deductions or disregards).

MinnesotaCare counts both earned and unearned income to determine a client's gross income. Earned income is income that is received in exchange for work or providing a service and includes income received as an employee and self-employment income. Unearned income includes income from other sources such as rental income, interest and dividend payments, gifts, Social Security benefits, child support, unemployment insurance, workers' compensation, and other public assistance payments.

Self-employment income or annual gross earned income for non-self-employed clients, based on wages received by the client in the last 30 days (no earlier than one calendar month prior to the date of application or renewal), is used to determine annual gross earned income, which is added to annual unearned income (i.e., income received without being required to perform any labor or service) to determine the annual gross household income. Unavailable or excluded income is not counted in the gross calculation. The client's gross income is compared to the MinnesotaCare income standards without the use of any deductions or disregards, to determine if the client is income eligible.

Household Composition and Income Deeming

For MinnesotaCare, household composition is used for determining the appropriate income standard and whose income or assets to count. Additionally, household composition, along with income and the number of family members covered, determines the family's premium amount. Household composition is based on parental and/or marital relationships and is determined the same way for the entire family. For example, two people in a household who each have a parental or marital relationship to a third household member will be in the same household, even if they do not have a parental or marital relationship with each other. The MinnesotaCare household generally includes parents, stepparents, children under the age of 21, and unborn children. For example, a family might consist of an unmarried woman and her two children, as well as the father of one of the children. The household size for all members would be four. Additional information, including exceptions, can be found in Chapter 17.10 in the HCPM.

For MinnesotaCare, income from the entire household is included in the income calculation, as income is determined on the basis of a household and not the individual. MinnesotaCare applies the "all or nothing rule" when reviewing eligibility for MinnesotaCare, meaning that, generally, all eligible members of the household must be counted and covered. Eligible members include all children in the household who do not have other health care coverage and eligible parents/spouses who do not have other health care coverage if one parent/spouse applies. Additional information on the rule and its exceptions can be found in Chapter 17.10.15 of the HCPM.

Income Changes

As with MA, clients are required to report income changes within ten days of learning of the change. Caseworkers must act on all reported changes, although they do not need to verify the change between renewals. If the change positively impacts the client (e.g., would result in a lower monthly premium), eligibility is changed to be effective the following month. If the change negatively impacts the client, the change is effective the next available month, which is the "first month for which a ten-day notice can be given." There are additional provisions for households returning to MinnesotaCare coverage after active military duty.

For certain MinnesotaCare eligibility groups, having excess income after enrollment has been established does not necessarily result in a case closure. Auto newborns remain eligible (through age one), as do pregnant women over 275% FPG until the end of the 60-day post partum period. Additionally, children under 21 who are over 275% FPG could also be eligible for continued coverage for 12 months if they meet the requirements for the Minnesota

Comprehensive Health Association (MCHA) exemption.[23] If 10% of the household's gross income is less than the comparable MCHA premium amount, the child remains enrolled in MinnesotaCare. Additional information on MinnesotaCare excess income guidelines can be found in Chapter 21.15 of the HCPM.

However, non-pregnant parents whose income exceeds 275% FPG will have their coverage closed for excess income. Coverage is closed at the end of the month following the month in which information on excess income is received, except for non-pregnant parents whose gross annual income exceeds $50,000, even if income is not over 275% FPG.[24] Coverage for this group ends the "first available month for which timely notice can be given."

Program differences and overlap

For income, there are significant areas of both overlap and difference between MA and MinnesotaCare, as shown in Figure 10.

Figure 10. MA and MinnesotaCare Differences and Overlap in Income

	Issue	MA	MinnesotaCare
Difference	Income Deeming	▪ Non-applying household member income can be deemed to a client ▪ Generally, only income from a spouse or parent is deemed to a client	▪ "All or nothing rule" o All eligible children in a household who do not have other health care coverage must enroll if one child enrolls o All eligible spouses or parents in a household who do not have other health care coverage must enroll if one spouse or parent enrolls o Parents may enroll only if the eligible children in the household who do not have other health care coverage enroll o Parents may choose not to enroll. o Eligible children may enroll regardless of whether the parents enroll ▪ Income is counted for the entire household (including those members who are not eligible or do not apply) as long as there is some parental or marital relationship between household members

[23] MCHA is a non-profit state corporation funded through State dollars and client premiums that provides health care coverage to Minnesotans who have been turned down in the private market due to preexisting conditions.

[24] The State's September 2009 waiver request would increase the household income limit to $57,500.

	Issue	MA	MinnesotaCare
	Household Composition	▪ Eligibility is determined for each individual o Adults - Count client plus spouse and biological or adoptive children o Children - Count biological and stepparents and siblings	▪ Eligibility is determined at the household level o Includes entire household including parents, stepparents children under 21 and unborn children
	Income Calculation	▪ Net income calculation - deductions and disregards allowed from gross income	▪ Gross income calculation - no deductions or disregards allowed
	Excess Income for children	▪ Excess income results in termination of coverage (unless eligible using spenddown)	▪ Children under age 21 are eligible for MHCA Exemption for excess income
Overlap	Income Standards	▪ Children under 19 with income less than 150% FPG could be eligible for both programs based on income alone ▪ Pregnant women below 275% FPG could be eligible for both programs based on income alone ▪ Parents of dependent children with income at or below 100% FPG could be eligible for both programs based on income alone	
	Excess income for auto newborns and pregnant women	▪ Both programs cover auto newborns until age one; pregnant women through 60-days post partum are covered even if excess income is reported after eligibility has been determined	

Key differences between the programs include:

Household composition and income deeming. Theoretically, each member of a family applying for MA could have a different net income due to rules around deeming of income, whereas MinnesotaCare counts the entire household's income. However, if the family is reviewed first for MA and one or more members are found not to be eligible, the eligibility worker can assess the family members not eligible for MA for eligibility for MinnesotaCare.

Income calculation. MA uses a net income calculation and MinnesotaCare uses gross income when comparing income to the income standard. Because MA allows certain disregards and deductions, one person with a certain income and many deductions might be eligible for either MA (using net income) or MinnesotaCare (using gross income), while another person with the same income and fewer deductions might only be eligible for MinnesotaCare.

Certain aspects of the calculation are also different for each program. For example, the self-employment income amount used in the income calculation is determined differently for each program. Medical Assistance self-employment income is determined in the same way for all

self-employed individuals, whereas MinnesotaCare differentiates self-employment income between non-farm self-employed and farm self-employed and determines the applicable amount differently. Medical Assistance recognizes capital gains and losses in the calculation and allows only certain business expenses to be deducted. MinnesotaCare calculates self-employment income using the adjusted gross income on the federal tax return and disallows only depreciation as a deduction. MinnesotaCare also provides more detailed information to caseworkers on where to find the information they need (i.e., which tax forms to use for different types of self-employment), with additional direction provided for those with a C-Corporation, S-Corporation and Partnerships.

Income exclusions. Income exclusions are also not the same for both programs. While there are a number of types of income that are excluded from both programs (e.g., student loan and scholarship dollars) some types of income are treated differently under the two programs (e.g., other public assistance dollars). Figure 11 shows the income types that are treated differently under both programs. The list of income sources treated the same way for both programs can be found in Appendix A.

Figure 11. Income Counted for Either MA or MinnesotaCare

	Income Type	MA	MinnesotaCare
Lump Sum Income	Awards	Count, if not a gift (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually
	Gambling Winnings	Count, if not a gift (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude only if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually
	Inheritances	Count, if not a gift (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually
	Insurance Settlements	Count (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually

	Income Type	MA	MinnesotaCare
	Irregular or Infrequent Income	Count, if not a gift (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude
	Lottery Winnings	Count, if not a gift (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude
	Prizes	Count (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually
	Retroactive Payments	Exclude retroactive SSI payment Count if: ▪ Any portion of an RSDI lump sum payment designated as dependent benefits as unearned income to the dependent in the month received ▪ Retroactive lump sum RSDI payments for clients who do not receive SSI as unearned income in the month received and an asset in the following month if retained	Exclude retroactive RSDI and SSI payments received for a previous period as income or an asset
	Winnings	Count (although certain expenses can be deducted, such as attorney fees or amount used to pay for medical expenses)	Exclude if irregular/infrequent ▪ Income is irregular if it is not possible to anticipate receiving it ▪ Income is infrequent if it is received less than annually

	Income Type	MA	MinnesotaCare
Child Income	Child Income	Exclude the earned income of a dependent child who is: ▪ Full-time or part-time student, employed less than 37.5 hours per week. ▪ WIA (Workforce Income Act) earned income full-time or part-time employed greater than or equal to 37.5 hrs/week ▪ WIA earned income of dependent child who is not student. (available for only six months per year) ▪ All earned and unearned income of Refugee Unaccompanied Minors Count unearned income of all children under age 21 Count the earned income of all other children	Exclude the earned income of children under age 19 who are full-time or part-time students Count the following unless the income is not counted or excluded under another provision: ▪ Earned income of children under age 19 who are not full-time or part-time students ▪ Earned income of children age 19 or 20 regardless of their student status ▪ Unearned income of all children under age 21
	Workforce Investment Act (WIA) Earned Income	Exclude ▪ If earnings are of dependent child who is not a student, exclusion is available only for the first six months of every year	Counted if: ▪ Earned income of children under age 19 who are not full-time or part-time students ▪ Earned income of children age 19 or 20 regardless of their student status
In-Kind Income	Clergy Housing - In Kind	Count the value only if the client has a choice of receiving cash or in-kind income (Otherwise exclude)	Exclude
	In-Kind Income	Count the value of in-kind income if the client has a choice of receiving cash or in-kind income	Exclude
Public Assistance Payments	Diversionary Work Programs (DWP)	Exclude from income payments	Count as unearned income
	Foster Care payments	Exclude from income payments	Count as unearned income if the payments are for children included in the foster parent's household

	Income Type	MA	MinnesotaCare
	General Assistance	Exclude from income payments	Count as unearned income
	Minnesota Family Investment Program (MFIP)	Exclude from income payments	Count as unearned income
	Minnesota Supplemental Aid (MSA)	Exclude from income payments	Count as unearned income
	Refugee Cash Assistance (RCA)	Exclude from income payments	Count as unearned income
Gift Income	Gifts of Cash	Count gift income if received on regular basis or gift income that exceeds $30 per calendar quarter. Otherwise, exclude	Exclude only if irregular/infrequent: Gift income is infrequent if it received less than annually. Gift income is irregular if it is not possible to anticipate receiving.
	Gifts of Cash for Tuition/Education	Exclude	Exclude only if irregular/infrequent: Gift income is infrequent if it received less than annually. Gift income is irregular if it is not possible to anticipate receiving.
	Gifts of Cash for Prosthetics	Exclude	Exclude only if irregular/infrequent: Gift income is infrequent if it received less than annually. Gift income is irregular if it is not possible to anticipate receiving.
	Gifts In-Kind	Count value only if the client has a choice of receiving cash or in-kind income	Exclude
Other Income	Interest	Exclude as income any interest from assets BUT count all other interest as unearned income	Count as unearned or earned income. Interest income counts as unearned income regardless of whether or not it comes from an asset.
	Dividends	Exclude as income any dividends from assets BUT count as income all other dividends	Count as unearned or earned income

	Income Type	MA	MinnesotaCare
	Refugee Resettlement Grants	Count if: ▪ Receive a monthly cash allowance through the Matching Grant Program ▪ Grants received from the refugee resettlement program	Count if: ▪ Receive a monthly cash allowance through the Matching Grant Program ▪ Grants received from the refugee resettlement program are not irregular or infrequent Exclude if: ▪ Grants received from the refugee resettlement program are irregular or infrequent
	Supplemental Security Income (SSI)	Exclude the following: ▪ SSI benefit ▪ All other income that SSA considers when determining SSI eligibility and benefit amount (except VA Aid and Attendance benefits, and VA unusual medical expense payments) ▪ Income the SSI program excludes, ▪ SSI payment when deeming the income of an SSI recipient to a spouse or child	Count gross amount of SSI benefits as unearned income to the household

Challenges

Minnesota—like most other states—has complicated income eligibility rules for its public health care programs. The MA and MinnesotaCare income rules vary in many different ways—what income is counted, for whom it is counted, what can be deducted or disregarded, etc.—resulting in complications for caseworkers and clients, delays, and increased potential for error. Adding to the complexity is Minnesota's unique 1115 demonstration waiver, which allows persons or families at some income levels to choose between the MA or MinnesotaCare programs (other states generally have a "bright line" threshold and persons eligible for one program cannot be eligible for the other). Specific challenges (and advantages) to alignment of income rules and processes include:

- ***Different income calculation methodologies.*** The separate income calculation methodologies and deeming requirements for the two programs create challenges for clients and county and state caseworkers. According to DHS staff, the initial intent of the gross methodology was for

the MinnesotaCare calculation process to be simpler than that for MA. However, having two similar but different sets of policies for overlapping eligibility groups makes it difficult for caseworkers to determine which coverage program may best meet a client's needs and make the most fiscal sense for the State.

- ***Overlap between eligible populations of pregnant women, parents, and children based on income.*** As noted above, clients at certain income levels (e.g., children ages 2-8 under 150% FPG, children 19-20 under 100% FPG, parents of dependent children under 100% FPG, and pregnant women under 275% FPG) can choose to enroll in either the MA or MinnesotaCare programs. Alignment of certain income calculations might make it easier to determine a person's program eligibility. However, other strategies to simplify income rules might reduce client choice by clearly assigning persons at some income levels to one program or the other.

Any changes to how income is reviewed must weigh the potential benefits of eligibility alignment and simplification against the potential issues these changes could create administratively, fiscally, and on client access to coverage.

Assets

Individual and household assets were traditionally a major eligibility criterion for public benefit programs, including welfare, food support, and medical assistance. Over time, states have been given much more flexibility in deciding whether to apply an "assets test" to certain eligibility groups, particularly pregnant women and children. Where assets are an eligibility factor, the State must determine each client's assets in accordance with program rules to determine whether the client meets the assets thresholds. For most of the groups addressed in this report, assets are not an eligibility factor.

Statutory and regulatory framework

Medical Assistance

Asset requirements are governed by both federal and State rules. At the federal level, section 1902 of the Social Security Act provides guidance on methodology, requiring that the methods used be more liberal than those for the former AFDC program, including eliminating the assets test altogether. Minn. Stat. § 256B.056 sets asset limits for parents, including assets that may or may not be included when determining eligibility. Minnesota does not have an assets test for pregnant women and children.

MinnesotaCare

As with MA, both federal and State rules govern asset requirements. The State's Prepaid MA Project Plus (PMAP+) 1115 waiver defines and sets forth asset limits and exclusions for the MinnesotaCare program. Minn. Stat. § 256L.17 defines the asset requirements for MinnesotaCare, setting a limit on total assets and related information requirements. As with MA, there are no asset-related requirements for pregnant women or children.

Recent Changes

Over the past ten years, the State reduced the asset limit from $15,000 for a household of one and $30,000 for a household of two or more to $10,000 and $20,000, respectively, for persons in both the MA and MinnesotaCare programs who are subject to an assets test.

Current assets processes and standards

Assets are a determinant of eligibility for certain groups covered by MA and MinnesotaCare. In both programs, assets are not counted for children and pregnant women, but are for parents. The State's policies regarding assets as an eligibility requirement are described in detail in Chapter 19 of Minnesota's Health Care Programs Manual.

Medical Assistance

Asset Limits and Exemptions

For family clients, Minnesota only applies the asset tests to parents. The following clients and enrollees do not have an asset limit for the MA program:

- Children under age 21, through the month of their 21st birthday. Children under age 21 do not have an asset limit regardless of whether they apply as part of a household with members age 21 or older, or if they apply separately.
- Pregnant women, regardless of age, through the end of the 60-day postpartum period.

However, assets of certain exempted persons can still be counted in determining eligibility for other household members in certain circumstances. For example, a pregnant woman's assets would be deemed to her spouse if he is also applying for MA.[25]

Parents in MA have assets limits at the time of application and through the period of enrollment. The asset limit for parents is based on household size. As parents are always in a household with two or more members, the asset standard is $20,000.

Countable Assets and Methodology

MA uses "Method A" to calculate countable assets for parents. The eligibility worker determines whether assets owned by a client or deemed to a client should be counted, excluded, or considered unavailable. Assets need only be verified for parents, as noted under Chapter 19.20 Verification Policies of the HCPM. The client's total countable assets are compared to the asset limit for the household size, which is $20,000 for parents. If the total countable assets exceed the asset limit, the person may reduce excess assets and become eligible in the same month assets are reduced. See Chapter 19.05.15 of the HCPM for a detailed description of the countable asset calculations. Figure 12 provides an overview of countable assets.

Figure 12. Countable Assets for MA Parents and Caretakers

Asset	Definition
Cash	The amount of cash reported by a client is always counted toward the client's asset total
Accounts and Securities	Ex. Savings, Checking, Money market, MHFA home-improvement loans, Certificates of Deposit (CD), Stocks, Bonds, Annuities are counted unless designated toward the burial fund exclusion(See Chapter 19.25.30 in HCPM)
Vehicles	The equity value of any vehicles is counted unless they are excluded or unavailable. Equity value is determined using the fair market value minus any encumbrances
Non-Homestead Real Property	The equity value of the non-homestead property is counted if it is legally available and the client is not making a reasonable effort to sell the property. Equity value is determined using the estimated market value minus any encumbrances
Trusts	Resources from certain trusts may be countable
Life Estates	Life estates are assessed to determine the countable value, if applicable

[25] Minnesota Department of Human Service Health Care Training: Advanced Assets. "Asset Evaluation."

For an adult client, assets from the client's spouse are considered available and are deemed to the client.

MA and MinnesotaCare exclude some assets when calculating a person's total countable assets; assets can be excluded wholly or in part. Some are excluded indefinitely, while others are excluded for only a specific period of time. Some assets are excluded only if kept separate from other sources. In general, the following assets are excluded for MA and MinnesotaCare.[26] There are additional specific payments that are considered excluded assets that can be found in Chapter 19.10 of the HCPM.

- Household and personal goods, such as pets, furniture, clothing, jewelry, appliances, and other tools and equipment used in the home
- One vehicle, used for employment or for seeking employment, for each household member of legal driving age (currently age 16 or over in the State of Minnesota)
- Homestead
- Income in the month of receipt
- Retirement accounts
- Assets owned solely by children

When determining eligibility, assets are counted toward a client's asset limit if they are available (i.e., the owner has both the legal authority and actual ability to use them or to convert them to cash) and are not specifically excluded.

Excess countable assets are a barrier to ongoing eligibility. All MA clients who have excess assets in the month of application, or any retroactive month for which they are requesting eligibility, must reduce those assets by the end of their processing period or within 45 days, whichever is later, to be eligible.[27] (See Chapter 19.35.10 of the HCPM for a detailed description of the excess asset verification process.)

MinnesotaCare

Asset Limits and Exemptions

As with MA, the only family and children eligibility categories in MinnesotaCare that have an assets tests are parents. Children under age 21 (through the month of their 21st birthday) and pregnant women (regardless of age, through the end of the 60-day postpartum period) are not subject to the assets test.

Parents in MinnesotaCare are limited in the amount of assets they can have available at the time of application and ongoing through the period of enrollment. The asset limit for the MinnesotaCare program is based on household size; household composition is determined at the household level. For parents, the asset limit is $20,000.

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[26] Minnesota Department of Human Service Health Care Training: Advanced Assets, "Asset Evaluation"
[27] Minnesota Department of Human Service Health Care Training: Advanced Assets, "Asset Reductions"

Countable Assets and Methodology

MinnesotaCare also uses "Method A" to calculate countable assets. Following a determination on whether assets owned by a client or deemed to a client are excluded, unavailable, or countable, the client's total countable assets are compared to the asset limit for the basis of eligibility and household size. See Figure 13 for a list of MinnesotaCare countable assets. If the total countable assets exceed the asset limit, the client may only be eligible starting the month after assets are reduced. Please refer to Chapter 19.05.15 of the HCPM for a detailed description of countable asset calculations.

Figure 13. Countable Assets for Parents in MinnesotaCare

Asset	Definition
Cash	The amount of cash reported by a client is always counted toward the client's asset total
Accounts and Securities	Ex. Savings, checking, money market, MHFA home-improvement loans, certificates of deposit (CD), stocks, bonds, annuities are counted unless designated toward the burial fund exclusion (See Chapter 19.25.30 in HCPM)
Vehicles	The equity value of any vehicles is counted unless they are excluded or unavailable
Non-Homestead Real Property	The equity value of the non-homestead property is counted if it is legally available
Trusts	Resources from certain trusts may be countable assets
Life Estates	Life estates are assessed to determine the countable value if applicable
Self-Employed Assets	Count the net value of self-employment assets in excess of $200,000 in the client's asset total

For an adult client, assets from the client's spouse (and the client's sponsor and sponsor's spouse if the client is a sponsored immigrant) are considered available to and are deemed to the client. Once an asset is established as a countable asset, its value is generally determined by using its equity value. However, equity value of an asset will be considered zero if the client owes more than the fair market value of the asset.

Whether an asset is counted, excluded, available or unavailable for parents depends on the type of asset. When determining eligibility, assets are counted toward a client's asset limit if they are available (e.g., assume that the value of an asset the client owns is available unless the client proves it is not, consider non-liquid personal property available even if it is for sale) and are not specifically excluded.

Excess countable assets are a barrier to ongoing MinnesotaCare eligibility. Clients with assets in excess of the applicable asset limit at the time of application are denied eligibility. Clients who report excess assets at renewal or when adding a household member will have their coverage

closed. To remain eligible, the enrollee must reduce his/her assets before the effective date of the coverage closing.

Program differences and overlap

For parents, the asset limits and exclusions are largely aligned between MA and MinnesotaCare, the exception being workers compensation settlement funds. MinnesotaCare excludes the full value of the settlements, while MA excludes only court ordered settlements up to $10,000. Specific areas of alignment and difference are listed below in Figure 14.

Figure 14. MA and MinnesotaCare Differences and Overlap in Assets

	Issue	MA	MinnesotaCare
Difference	Excluded Assets	Workers Compensation: Excludes only court-ordered settlements up to $10,000	Worker's Compensation: Excludes the full settlement amount regardless of whether or not they are court-ordered
	Excess Assets	Required to reduce assets by the end of their processing period or within 45 days, whichever is later, to be eligible	Denied eligibility at time of application
Overlap	Assets Limits	Varies ▪ $10,000 for a household of one ▪ $20,000 for a household of two or more ▪ Asset tests are not required for pregnant women and children under 21	
	Countable Assets	Method A used for calculating countable assets	
	Excluded Assets	The majority of excluded assets for MA and MinnesotaCare are aligned with one exception (see above)	

Additionally, the policies and processes associated with client reduction of assets for eligibility differ between MA and MinnesotaCare. Medical Assistance clients who have excess assets in the month of application, or any retroactive month in which they are requesting eligibility, must reduce those assets by the end of their processing period or within 45 days, whichever is later, to be eligible.

MinnesotaCare clients who have excess assets at the time of application are denied eligibility to the program. Current MinnesotaCare enrollees who report excess assets at renewal or when adding a household member will have their coverage closed. To remain eligible, the enrollee must reduce his/her assets before the effective date of the coverage closing.

Challenges

There are limited opportunities to align the assets test to children and family groups eligible for the MA and MinnesotaCare programs, as the State has already chosen to eliminate the assets test for children and pregnant women. In addition, there is already substantial alignment

among assets standards between the two programs, compared to some other aspects of eligibility. Further opportunities for alignment could include eliminating the difference in how worker's compensation is treated between to two programs and changing the policies around reduction of assets at the time of application to allow for a more seamless review of MA and MinnesotaCare eligibility. The State could also choose to eliminate the assets test for parents.

While the assets test does not apply to most of the groups addressed in this study, workers and advocates have indicated the implementation of assets policies remains challenging, in part because other programs (e.g., cash assistance, food supported) that families may jointly apply for, and which are administered on the MAXIS system, do have an assets test. Because MAXIS does not support automatic calculation of assets per the health care rules, workers often have to perform manual calculations, which have the potential for error. Additionally, county caseworkers expressed concern over difficulties in determining the value of assets when programs have different rules for how certain assets are counted. The State may wish to consider other strategies to automate the calculation of assets values for all programs for which clients face an assets test, and to further align the rules between health programs and other public programs.

Cost of Coverage

For purposes of this paper, the "cost of coverage" refers to any situation in which MA or MinnesotaCare clients are required to contribute funding to their health care coverage. Clients contribute towards their cost of coverage in a variety of ways, including premiums, copayments, and medical spenddown (a cost-sharing approach which allows people whose net income is greater than the applicable federal poverty guidelines to become eligible for the MA program). The cost of coverage for any client is based on income, program, and eligibility type. In Minnesota, different health care programs require different types of contributions. In most instances, pregnant women and children are exempt from cost sharing requirements.

Statutory and regulatory framework

Medical Assistance

Cost of coverage is addressed in both federal and state rules. At the federal level, Section 1916 of the Social Security Act limits the use of premiums, deductions, and other forms of cost sharing. Cost sharing is specifically prohibited for individuals listed in Section 1902(a)(10), including qualifying pregnant women and children. Cost sharing provisions are also addressed in Title 42 Part 447 which allows the State to require certain clients to share in the cost of their coverage to specified degrees. Section 1902(a)(10)(C)(i)(III) of the Social Security Act allows individuals to become eligible for Medicaid through a deduction of incurred medical expenses from income, or medical spenddown. Title 42 Part 435 of the Code of Federal Regulations provides guidance on the deductions of incurred medical expenses for individuals who become Medicaid eligible through a spenddown.

State Statute governs the copayments that may be charged to MA clients. Minn. Stat. § 256B.05, Minn. Stat. § 256B.063, and Minn. Stat. § 256B.0631 provide authority to the State to impose cost sharing and also define populations excluded from cost sharing, such as pregnant women and children. Pregnant women, parents, and children with income above the MA limits may achieve eligibility with a medical spenddown.

MinnesotaCare

As with MA, there are both federal and state rules governing costs associated with health coverage. At the federal level, sections 1916 and 1902(a)(14) govern the State's ability to impose cost sharing requirements. The PMAP+ 1115 waiver waives these sections and provides the State with the authority to charge MinnesotaCare populations eligible through the waiver higher premiums and cost sharing than dictated by Medicaid statute.

Minn. Stat. § 256L.15 defines the fixed and sliding scale premiums used in MinnesotaCare, which are based on income and eligibility category. State Rule 9506.0040 outlines the premium payment process, including billing notices and payment dates. MinnesotaCare premium administration is also governed by the authority found in Minn. Stat. § 256L.06.

Recent Changes

State laws have added limited cost sharing requirements for MA clients in recent years. In 2003, while copayments for certain services and populations were put in place, restrictions on such copayments were implemented in later years, such as a reduction in the monthly cap on prescription copayments from $20 to $7 for MA. In turn, the MinnesotaCare program has generally looked to implement policies that provide enrollees increased leeway in the payment of their premiums. As early as 2000, the State implemented a new reinstatement policy, allowing enrollees an additional 20 days to pay premiums.

Changes proposed to the 1115 waiver would eliminate all premiums for children under 200% FPG.

Current cost of coverage policies

Medical Assistance (MA)

Medical Assistance clients may contribute to their cost of coverage in two primary ways, through a medical spenddown, when applicable, and through copayments for selected services and populations. Medical Assistance clients are not required to pay premiums.

Spenddown

Potential clients who would otherwise be eligible for MA but exceed the income limits may become eligible for MA through a medical spenddown. In practice, the MA spenddown works similarly to an insurance deductible—a person must incur a certain amount of medical expenses before insurance coverage for subsequent expenses begins. However, for MA eligibility purposes, a person needs to incur medical expenses (or know that he or she will incur them), but does not actually have to pay out of pocket first.

Families with children are required to spend down to 100% FPG standard, which is currently $903 for a household of one. For example, a person with income of $1,400 a month (about 155% FPG) would be required to incur $497 in eligible medical expenses in order to "spend down" his or her income to the FPG threshold of $903. Figure 15 below provides examples of spenddown amounts for families and children for a household of one.

Figure 15. Spenddown Examples, Household of One

Income Level	Income Amount/Month	Spenddown Amount to Reduce Income to 100% FPG
150% FPG	$1,354	$451
200% FPG	$1,805	$902
300% FPG	$2,708	$1,805
400% FPG	$3,610	$2,707

To determine whether or not a client is eligible for the MA spenddown, workers look at a variety of factors relating to the client's income and medical expenses. The client's net income is determined for an identified "certification" period. If the client is eligible for MA with a spenddown, the eligibility worker will examine the client's medical expenses to determine what meets the spenddown requirements and the most appropriate type of spenddown to use.

There are two types of spenddowns: six month and monthly. The six month spenddown is applied when the client's net six-month income total exceeds the six-month income standard for the household size, or the client has medical expenses that equal or exceed the six-month spenddown amount. The monthly spenddown is applied when a six-month spenddown cannot be met, the six-month spenddown is not the most beneficial choice for the client, or the client can meet the spenddown in one month of the processing period with medical expenses that equal or exceed the monthly spenddown amount.

For clients who must meet a spenddown, eligibility begins on the date that the client's amount of incurred medical expenses equals or exceeds their excess income; this date is also referred to as the satisfaction date.

Additionally, clients who are eligible for a monthly spenddown may choose to prepay their spenddown to DHS. This option is known as "client option spenddown" and there are unique application and processing requirements associated with it, as detailed in Chapter 24.10.05.05 of the HCPM. Each member of a household may have a different spenddown amount, but all household members must have the same type of spenddown.

There are four groups of medical bills that can be used in the spenddown and they are applied towards the amount in a specified order. Please refer to Chapter 24.15 for detailed information on the four groups of allowable medical bills. It is also important to note that the incurred medical expenses used to show that a client has met the spenddown are not necessarily the actual expenses that will be applied to the spenddown once eligibility is approved. The MMIS claims subsystem applies medical expenses as they are received and accepted expenses vary based on the type of spenddown.

Allowable bills that may be used towards the spenddown vary by eligibility category. Parents are responsible for and may apply their own bills, their children's bills, their spouse's bills, and their spouse's children's bills (because their spouse is legally responsible for the bills) to their spenddown. Children may apply any bills that their parent/stepparent are legally responsible to pay (this includes the parent's/stepparent's bills).

The family members described above do not have to be applying or eligible for MA for the client to use their health care expenses to meet a spenddown. However, MA-eligible medical expenses of those members who have no spenddown cannot be used to meet the spenddown of other household members.

Allowable medical expenses for each person follow the MA household size rules. A bill may be used to meet other household members' spenddowns the same way one person's income is used in other household members' income calculations. One exception to the deeming rule would be using medical expenses from a person no longer in the household but whose expenses were the responsibility of someone still in the household.

Please refer to the Health Care Programs Manual, Chapter 24, Medical Spenddowns for additional information on spenddown standards, types, and related expenses.

Copayments

Medical Assistance clients may be responsible for copayments on select services up to a specified amount, as specified under the Healthcare Programs and Services section of the MN Provider Manual (see Figure 16 below). However, copayments are only charged to some MA clients, such as parents. Among others, pregnant women and clients under the age of 21 are not required to pay copayments of any kind.

Figure 16. MA Copayment Requirements

Population	Copayment	
Children under age 21	Exempt from copayments	
Pregnant women	Exempt from copayments	
Parents/Caretakers	$6	Per nonemergency visit to hospital based emergency room
	$3	Per brand-name drug prescription, subject to a $7 per month maximum
	$1	Per generic drug prescription
** Individuals with incomes at or below 100% FPG are not required to pay total monthly copayments in excess of 5% of family income		

MinnesotaCare

MinnesotaCare clients contribute towards their cost of coverage in two primary ways, through monthly premiums and copayments for certain services.

Premiums

All MinnesotaCare clients, except for qualified military members and their families, are required to pay premiums to establish and maintain coverage, as detailed in Chapter 25.05 of the HCPM.[28] Military members and their eligible family members are not required to pay premiums for 12 months if they are enrolled within 24 months of active duty.

Premium amounts vary by income level and eligibility category.

- Children at or below 150% FPG pay a fixed $4 monthly premium
- Children above 150% FPG and all adults pay a sliding scale premium

[28] ARRA exempts American Indians from most cost-sharing requirements under Medicaid and CHIP. See CMS State Medicaid Directory letter dated January 22, 2010.

The State uses three factors to calculate premium amounts: household size, income, and the number of covered people in the household. Maximum premium amounts are determined by household size. For example, the maximum amount that an individual in a household of one could be required to pay is $178 per month. However, a child who is a current enrollee whose family income exceeds the limit may continue coverage for a period of time by paying a premium of $411 per month. For households with income at or below 150% FPG and adults and minor children in the household, premiums will be a total of $4 per month for the minor children and a premium amount determined by the sliding scale for the adults.

Among the September 2009 requested changes to the PMAP+ 1115 Waiver, the State has proposed that all premiums for MinnesotaCare children at or below 200% FPG be eliminated.

The MinnesotaCare program uses a complex systems-based premium calculation program to generate premium amounts based on household size, income, and the number of people covered. The system evaluates a narrow range of family income against the number of people covered to calculate the sliding scale amounts. Please refer to the MinnesotaCare Premium Table found in Chapter 22.20 of the Minnesota HCPM for a detailed listing of related premiums. Some examples of premium amounts based on household size, income, and number of people covered are provided in Figure 17 below.

Figure 17. Sliding Scale Premium Examples for Children Above 150% FPG and All Adults

Family Size	Percent of FPG Range	Gross Monthly Income Amount Range	Total Premium Amount by Number of Person(s) Covered		
			1	2	3
3	93-96%	$1,414- 1,457	$11	$21	$32
3	189-192%	$2,881- $2,922	$44	$89	$133
3	273-275%	$4,157- $4,198 (max)	$100	$201	$301
4	93-96%	$1,703- $1,755	$13	$25	$38
4	189-192%	$3,469- $3,519	$54	$107	$161
4	273-275%	$5,007 - $5,056 (max)	$121	$242	$362

Some events (e.g., renewal, income changes, household size changes, or if a household member is removed from coverage) will trigger a change in the premium amount. Most changes to premium amounts are made automatically by MMIS but some (i.e., premium forgiveness) require the changes to be manually entered in to the system.

Premium Payment

MinnesotaCare coverage begins the month following the initial premium payment. Premiums are collected and billed on a monthly basis; most enrollees make monthly payments but some choose to pay premiums in advance for up to one year. Enrollees have four months after receiving their first notice from the State to pay their first premium and begin coverage. If no action is taken in that four month period, they must re-apply for the program.

After the initial payment is received and a case becomes active, monthly premiums are billed approximately six weeks before the first day of the coverage month. The ongoing premium is due approximately two weeks before the first day of the coverage month. The State sends an overdue premium notice containing a closure notice if payment is not received by the premium due date.

Penalties

Individuals who fail to pay their premiums or voluntarily close their MinnesotaCare coverage are ineligible to access MinnesotaCare for a period of four months unless good cause is shown. If the client appeals the four month penalty, benefits are continued at the same level the enrollee was receiving prior to the action that caused the appeal if the appeal request is received by the later of the effective date of the action or ten days after the notice mailing date.

Clients are responsible for and must pay all due premiums for coverage to continue during the appeal. Clients whose MinnesotaCare coverage is closed because of nonpayment of their premium have until the 20th day of the reinstatement month to reinstate coverage. Clients who fail to pay the premium, and are not reinstated, may apply for MA and GAMC without filing a new application. These clients are notified by DHS of their potential eligibility for MA/GAMC through the mail, including a letter that allows the client to affirm their interest in the MA or GAMC programs and prepaid return envelope. Once DHS has received the letter, it is date stamped and sent to MinnesotaCare Operations or the appropriate county or tribal agency, depending on the where the client's MinnesotaCare case was administered. The most recent MinnesotaCare application or renewal is used to determine eligibility for MA or GAMC. Please refer to Chapter 7.05.20 of the HCPM for additional information about MHCP applications after nonpayment of MinnesotaCare premiums.

There are several exceptions to these penalties. MinnesotaCare coverage cannot be canceled for pregnant women and children under the age of two for nonpayment and premiums may be forgiven in certain conditions, such as when specified in bankruptcy proceedings.

Please refer to Chapter 25.05 of the HCPM for additional information on premium payment, determinations, penalties and exceptions.

Copayments

There are several different benefit sets offered under MinnesotaCare: Expanded (for pregnant women and children), Basic Plus (for parents with incomes between 215% and 275% of the FPG), and Basic Plus Two (for parents below 215% of the FPG). The copayments for each MinnesotaCare Basic plan are the same, with the exception of charges for inpatient hospital stays. MinnesotaCare Basic Plus has a $10,000 annual limit on inpatient hospital stays. As with MA, pregnant women and clients under the age of 21 are exempt from copayments. Figure 18 provides more detail on the specific copayment requirements for each population.

Figure 18. MinnesotaCare Copayment Requirements

Population	Copayments
MinnesotaCare children	Exempt

(at or below 150% FPG)		
MinnesotaCare children (150-275% FPG)	Exempt	
MinnesotaCare pregnant women	Exempt	
MinnesotaCare parents (at or below 275% FPG)	$3	Per visit for non-preventive visit
	$6	Per visit for non-emergency room use of the emergency room
	$3	Prescription drugs
	$25	Eyeglasses
	$3	Eye exams
	$3	Diagnostics
	$3	Non-preventive family planning visit
	$3	Chiropractic
	$3	Non-preventive podiatrist visits

Program differences and overlap

Clients in Minnesota Health Care Programs can experience cost sharing in a several ways. Medical Assistance enrollees may contribute to their cost of coverage in the following ways: medical spenddown and copayments for selected services. MinnesotaCare enrollees may contribute to their cost of coverage through premium payments and copayments.

The only identified area where program requirements overlap in terms of cost of coverage is copayments. The services for which copayments are charged are similar with more cost sharing for MinnesotaCare enrollees. Services for which copayments are prohibited are also similarly structured. It is also important to note that Minnesota requires providers to provide services regardless of the client's ability to pay--they must accept any client statement of inability to pay and not require additional information. Figure 19 below provides the specific differences between MA and MinnesotaCare in regards to cost of coverage

Figure 19. MA and MinnesotaCare Differences and Overlap in Cost of Coverage

	Issue	MA	MinnesotaCare
Differences	Premiums	No premiums	Fixed and sliding scale premiums depending on income and eligibility category
	Spenddown	Clients may quality for MA through a medical spenddown	No spenddown
	Copays	Parents are charged a $3 copayment for brand name prescription drugs and $1 copayment for generic prescription	Parents are charged a $3 copayment for non-preventive visits, a $3 copayment for prescription drugs, and a $25 copayment for eyeglasses

	Issue	MA	MinnesotaCare
		drugs	
Overlap	Copays	Pregnant women and children are exempt from copays in both programs	

Challenges

The MA and MinnesotaCare programs are fundamentally different in terms of client contributions to the cost of coverage. Both programs have limited copays for some eligibility groups (primarily non-pregnant adults), but otherwise have little in common. The MA program allows persons who do not meet the income eligibility standard but who have (or expect to) incur medical bills to "spend down" to the income standard by subtracting certain incurred medical expenses from their income, but does not otherwise require clients to contribute to their cost of coverage. The MinnesotaCare program requires all clients to pay a premium (although the State has proposed eliminating the premium for children under 200% FPG) and has no opportunity for clients to spend down to meet program income standards.

Each set of rules brings its own challenges: the spenddown option, while providing an alternate door to eligibility, is complicated to administer. MinnesotaCare premiums, while straightforward, can lead to delays in coverage (a person can be determined eligible but will not receive coverage until the month after the first premium is received). Aligning the two programs by extending either policy to the other program would significantly impact enrollment and risk jeopardizing the State's "maintenance of effort" requirements. Thus, better alignment options may focus on strategies to improve caseworker and client understanding of the policies and methods to help evaluate which program is "better" from a client contribution perspective (for clients with a choice).

Eligibility periods/coverage start dates

Once a person is determined eligible for coverage, he or she is considered eligible for a certain span of time, at which point eligibility will be redetermined. However, the start date and length of the eligibility period depend on a number of factors. Coverage start dates for the MA program generally begin either the first day of the month of application or on the date all eligibility factors are met, whichever is later, or earlier if the client is eligible for retroactive coverage. The MinnesotaCare program coverage start date depends on the receipt of premium payments after all other eligibility requirements are met.

Statutory and regulatory framework

Medical Assistance

Section 1902 of the Social Security Act and 42 CFR 435.914 provide guidance relating to coverage start dates, particularly retroactive eligibility periods. Additionally, Title 42 Part 435 of the CFR sets parameters for how frequently eligibility must be determined and when certain groups may be provided with extended or presumptive eligibility. 42 CFR Part 435.916 states that Medicaid eligibility must be redetermined at least every twelve months.

Minn. Stat. § 256B.056 authorizes eligibility periods and redetermination requirements for MA, which are described in section 2.1(b)(1) of the Medicaid State Plan (retroactive eligibility) and attachment 2.6A (effective dates of eligibility, including start dates and retroactive eligibility).

MinnesotaCare

The State's PMAP+ 1115 waiver defines eligibility periods for the MinnesotaCare population.

State Rule 9506.0300 defines the process and timelines associated with eligibility and coverage determinations for MinnesotaCare. Additionally, State Rule 9506.0020 provides related administrative guidance, including requirements associated with eligibility determinations and renewal processes.

Recent Changes

The State's requested changes to the PMAP+ waiver would extend eligibility periods for some MinnesotaCare children, allowing for continued eligibility if renewal forms and related documentation are not submitted in a timely manner. Additionally, pending CMS approval, children age two through eighteen years of age enrolled in MA who become ineligible due to excess income would retain eligibility for an additional two months in order to facilitate the transition to MinnesotaCare.

State laws pertaining to eligibility periods and coverage start dates have prioritized coverage continuity and streamlined eligibility periods in recent years. Within the MA program, the six month income and assets renewal requirements were removed for clients with unvarying unearned income, no income, or whose only source of income is from an excluded source. Moreover, in 2002 eligibility periods were extended for certain pregnant women at the end of their 60-day post partum period. Significantly, the MinnesotaCare program eliminated six

month renewal periods in 2004, and had previously implemented retroactive MinnesotaCare eligibility for enrollees leaving MA coverage.

Current eligibility periods/coverage start dates policies

Medical Assistance

Different coverage start dates and eligibility periods correspond to different eligibility categories (e.g., pregnant women, children under 21 years, auto newborns, and parents) within the MA program. Coverage start dates generally begin either the first day of the month of application or the date on which all eligibility factors are met, whichever is later. Eligibility may be reassessed on an annual, six month, or monthly basis. Additionally, retroactive coverage may be requested for up to three months prior to the month of application. Coverage may be approved for some, but not all retroactive months. Figure 20 below provides details on the coverage period and renewal timeframes by eligibility group for those without a spenddown.

Please reference Chapter 03.25 of the HCPM and select the corresponding eligibility group for additional information on coverage start dates and renewal periods.

Figure 20. MA Coverage Start/End Dates and Renewal Periods by Eligibility Group

Eligibility Group	Coverage start/end	Renewal	Exceptions
Pregnant Women	▪ Start: First day of the month of conception ▪ End: Last day of the month of the 60 day postpartum period	▪ Exempt from renewal requirements through the postpartum period	▪ Pregnant women can be no more than three months retroactively eligible from the month of application (even if pregnancy began earlier) ▪ Eligibility may start mid month only if the enrollee established residency in the State mid-month and submitted a MA application during that month

Eligibility Group	Coverage start/end	Renewal	Exceptions
Children Under 21	▪ No retroactive eligibility requested: The start date is the first day of the month of application or the date that all eligibility criteria has been met, whichever is later ▪ Retroactive eligibility requested: The start date becomes the first day of the month, for up to three months prior to the month of application	▪ Annual renewal ▪ Six month income renewal	▪ Eligibility may start mid month if the enrollee established residency in the State mid-month and submitted a MA application during that month ▪ Exempt from six month income renewal if the enrollee: o Completes monthly renewals for MA, food support or cash programs o Household receives only unvarying unearned income o Sole household income source is an excluded income source o No income is reported
Auto Newborns	▪ Start: First day of the birth month ▪ End: Last day of the month of the first birthday	▪ Exempt from six month and annual renewal requirements through the month of their first birthday ▪ Eligibility is re-determined prior to the end of the auto newborn coverage period ▪ Renewal is required if no one in the household has completed a renewal within the past 12 months	

Eligibility Group	Coverage start/end	Renewal	Exceptions
Parents	▪ No retroactive eligibility requested: The start date is either the first day of the month of application or the date that all eligibility criteria has been met, whichever is later ▪ Retroactive eligibility requested: The start day becomes the first day of the month, for up to three months prior to the month of application	▪ Annual renewal ▪ Six month renewal	▪ Exempt from six month income renewal if enrollee: o Completes monthly renewals for MA, food support or cash programs o Receives only unvarying unearned income o Sole income source is an excluded income source o No income is reported ▪ Exempt from six month asset test: Enrollees who are exempt from the income test ▪ Eligibility may start mid month if the enrollee established residency in the State mid-month and submitted a MA application during that month

MinnesotaCare

Coverage Start Dates

Coverage for MinnesotaCare clients begins on the first day of the month following the month of the initial premium payment receipt. Continued coverage is contingent on the monthly receipt of premium payments. Payment must be received by noon on the last working day of the month for eligibility to begin or continue in the following month. This applies to all MinnesotaCare eligibility categories, with certain exceptions for auto newborns and pregnant women. Figure 21 below provides details on the coverage period and renewal timeframes by eligibility group.

Please refer to Chapter 3.20, MinnesotaCare of the HCPM, and select the corresponding eligibility group for additional information on coverage start dates and renewal periods.

Figure 21. MinnesotaCare Coverage Start/End Dates and Renewal Periods by Eligibility Group

Eligibility Group	Coverage start/end	Renewal	Exceptions
Pregnant Women	▪ Current enrollee coverage begins the first day of the month of conception ▪ New clients receive coverage the month following the receipt of the initial premium payment ▪ Assuming necessary eligibility criteria has been met, coverage ends on the last day of the month of the 60 day post partum period	▪ Annual renewal only	▪ Coverage may not be cancelled for pregnant women through their 60 day postpartum period either for income that grows to exceed the 275% FPG limit or as a result of failure to pay premiums
Children Under 21	▪ First day of the month following the month of the initial premium payment receipt (Assuming necessary eligibility criteria has been met)	▪ Annual renewal only	▪ Coverage may not be cancelled for children under the age of two, as a result of failure to pay premiums
Auto Newborns	▪ Start: First day of birth month ▪ End: Last day of the month of the first birthday	▪ Exempt from renewal requirements	▪ Coverage may not be cancelled for children under the age of two as a result of failure to pay premiums
Parents	▪ First day of the month following the month of the initial premium payment receipt (Assuming necessary eligibility criteria has been met)	▪ Annual renewal only	

Certain groups may receive retroactive eligibility. To be eligible for retroactive coverage, the client must have recently lost MA or GAMC coverage and applied for MinnesotaCare within 30 days of the closure, and return requested verification documents by the end of the month following the month of request. Eligibility for retroactive coverage is also contingent on whether or not the enrollee paid the initial and all of the retroactive premiums by the end of the month following the month of premium billing. The retroactive coverage is fee-for-service (FFS)

and may help pay medical expenses for the duration of time the client was between healthcare programs.

Program differences and overlap

While there is some overlap, coverage start dates, renewal periods, and retroactive eligibility policies are largely unaligned across the MA and MinnesotaCare programs. Many of the variances can be attributed to the MinnesotaCare premium payment requirements: while MA eligibility is largely dependent on the eligibility determination and verification process, MinnesotaCare must also consider timely receipt of premium payments.

Figure 22. MA and MinnesotaCare Differences and Overlap in Eligibility Periods and Coverage Start Dates

	Issue	MA	MinnesotaCare
Differences	Coverage Start Date	▪ New applicants: First day of the month of application or the date that all eligibility criteria have been met ▪ Eligibility may begin no earlier than three months prior to the month of application	▪ New applicants: First day of the month following the month of the initial premium payment receipt
	Renewal	▪ Children under 21: Potential for six month income renewal in addition to annual renewal ▪ Parents: Potential for six month income and/or asset renewal in addition to annual review ▪ Pregnant Women, Current Enrollee: Renew on last day of the month of the 60 day postpartum period ▪ Auto newborns: Renew on last day of the month of the first birthday if no one in household has completed a renewal within the past 12 months	▪ Children under 21: Annual renewal only ▪ Parents: Annual renewal only ▪ Pregnant Women, Current Enrollee: Annual renewal ▪ Auto newborns: Exempt from annual renewal requirements through the month of their first birthday; continue eligibility when the exemption ends until the next scheduled household renewal

	Issue	MA	MinnesotaCare
	Retroactive Eligibility	▪ Up to three months prior to the month of application, if all eligibility requirements are met ▪ A client may be eligible for some, but not all months in the retroactive period	▪ Client must have been previously enrolled in MA coverage, and must have applied for MinnesotaCare within 30 days of the closure ▪ Eligibility is dependent on the timely receipt of verification documents and payment of the initial and retroactive premiums by the end of the month following the month they are billed
Overlap	Coverage Start Date	▪ Newborns: First day of birth month ▪ Pregnant Women, Current Enrollee: First day of the month of conception, but no earlier than the original effective date of coverage	
	Renewal	▪ Children under 21 and Parents: Annual renewal	

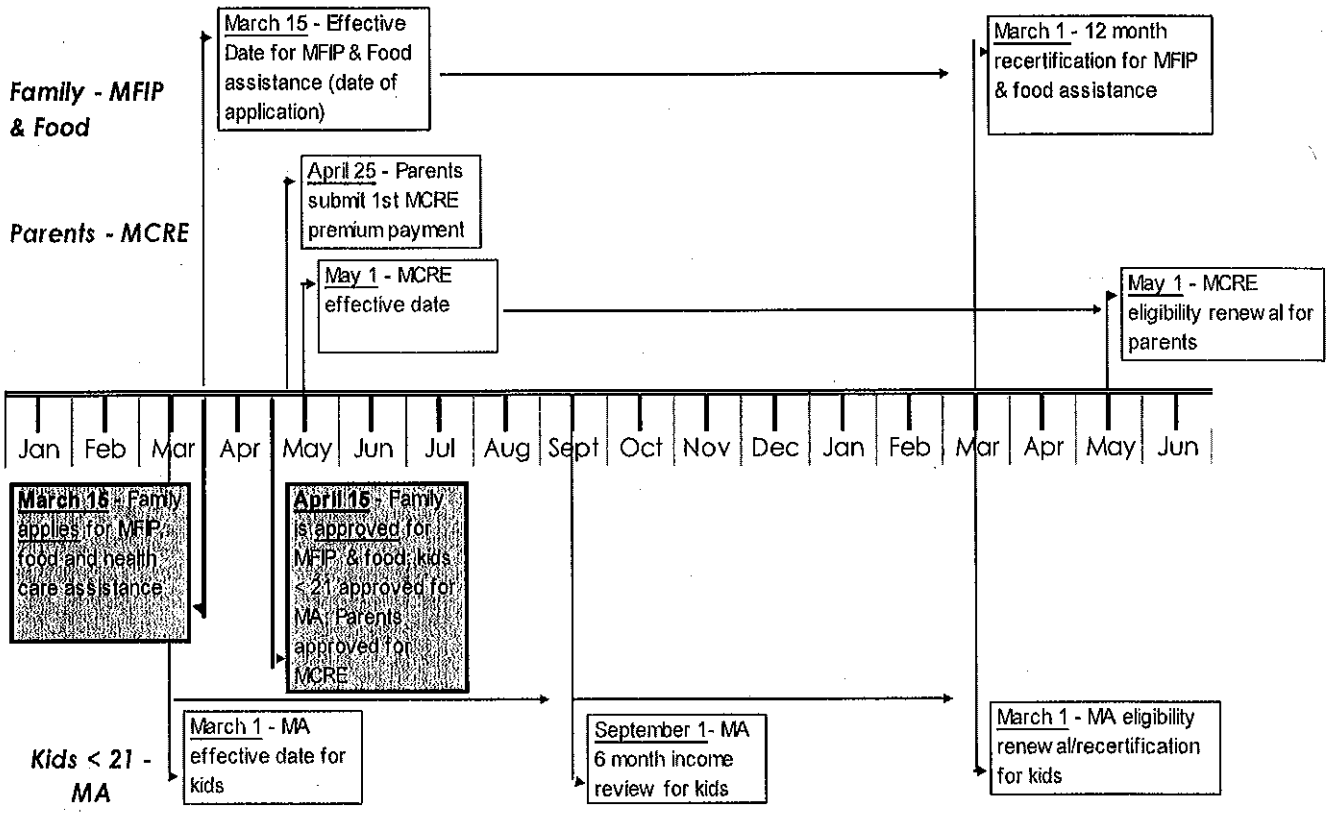
Challenges

Three key program requirements contribute to misalignment of coverage start dates and renewal dates between programs: availability of retroactive coverage for MA clients, requirement for a six month income/asset review for MA clients, and delay of coverage until receipt of premiums for MinnesotaCare clients. While for some clients these differences may be irrelevant, for families in which children are enrolled in MA and parents in MinnesotaCare or other "split cases," these timing differences can cause confusion and delay, or result in persons losing eligibility for one program or the other for failure to comply with reporting and redetermination requirements. (This is further complicated for families also eligible for cash assistance and food support, which have their own reporting and redetermination timelines that may or may not align with MA and MinnesotaCare.)

Figure 23 provides an example of the approval and renewal timeline for a family of four that was approved on April 15 for health care coverage as well as cash assistance through the Minnesota Family Investment Program (MFIP) and food support. In this scenario, the family as a whole is approved for MFIP and food support, the children who are under 21 are approved for MA, and the parents are approved for MinnesotaCare. The timeline below illustrates the eligibility *approval* date, the coverage *effective* date, and the renewal requirements in the first year of coverage for MA, MinnesotaCare, and cash and food benefits.[29, 30]

[29] MFIP eligibility is effective the date of application (*Combined Manual: Accepting and Processing Applications, §0005.12*). The certification period for MFIP is 12 months, but may be less than twelve months to align recertification dates with another program (in this example, MA). (*Combined Manual: Length of Recertification Periods, §0009.03*)

Figure 23. Example Annual Timeline for a Family Enrolled in Multiple Programs



Even in the example provided above, which shows a family receiving coverage under the most ideal circumstances (i.e., applied for everything on one date, were approved on one date, no one in the family had retroactive coverage, no one in the family was pregnant, the initial premium was paid by the last working day in April for May 1 coverage), the coverage start dates, eligibility periods and renewal requirements do not align for all programs.[31] In this example, the parents' MinnesotaCare renewal would occur after the renewal for other programs. In many instances, approval is received for one program before another (due to delays in receiving premiums, for example) or families may apply for health care coverage first and only apply for other benefits several months later. These circumstances are common and cause further challenges for both clients and caseworkers when enrolling clients and managing cases.

[30] The eligibility start dates of Minnesota's cash assistance programs are not aligned across programs. MFIP, Diversionary Work Program and General Assistance have eligibility start dates effective the date of application. Minnesota Supplemental Aid and General Residential Housing have eligibility start dates effective back to the 1st of the month of application (*Combined Manual: Accepting and Processing Applications, §0005.12).*

[31] MinesotaCare's renewal date is the last day of the twelfth month after the month the case is set to "pending awaiting payment" status. It remains unchanged from year to year as long as the case remains active without a break. In contrast, the MA renewal date is more flexible. When members of a household apply at the same time but the eligibility begin date differs, the entire household is assigned to the earliest renewal date. MA enrollees, jointly enrolled in Food Support and/or Cash Assistance, may also be able to align renewal dates, as Food Support and Cash Assistance will certify enrollees for less than the maximum time in order to coincide with another programs' review date.

The eligibility system supporting MinnesotaCare does not allow for change of the renewal period, which complicates processes for caseworkers who must ensure that clients meet their reporting and renewal deadlines in order to maintain coverage. Alignment options that allow redetermination dates to be aligned or information from one program to be used to support a subsequent reporting or renewal requirement for another program might have the greatest impact on clients and workers.

Insurance and Third Party Liability

State public assistance programs are designed to serve as the "payer of last resort" and have a variety of policies around third party liability (TPL) to ensure that the State does not pay when another insurer should be responsible. Policies regarding other health insurance (OHI) vary between Medicaid and CHIP. While Medicaid programs are encouraged to subsidize private health insurance premiums when it is cost-effective to do so (i.e., projected to be less costly than providing coverage directly), CHIP programs often explicitly exclude persons with access to OHI to prevent "crowd out," where individuals leave private insurance for lower cost public insurance.

Statutory and regulatory framework

Medical Assistance

There is a strong federal framework governing provisions relating to insurance and TPL. Sections 1902(a)(25)(G) and (H) as well as relevant sections of the CFR address some aspect of third party liability and associated requirements. Sections 1906, 1902(a)(30), and 1905(a) of the SSA define requirements associated with cost effective coverage, ensuring that premium payments for eligible clients and their family members are cost- effective.

There are several sections of Minnesota statute that address third party liability. Minn. Stat. § 256B.056 speaks to the assignment of benefits and Minn. Stat. § 256B.042 provides guidance on liens, notices, and dedicated costs.

Minnesota's election regarding the payment of medical insurance premiums by the Medicaid agency is described in Section 3.2(a)(2) of the State Plan, and Section 3.2(c) identifies Minnesota's election of the option for payment of cost-sharing obligations for eligible individuals in employer-based group health plans under section 1906 of the Social Security Act.

MinnesotaCare

From a federal perspective, statute for the CHIP program have until recently explicitly prohibited the enrollment of low-income children who have private health insurance, to prevent "crowd out," under the assumption that the relatively higher-income (compared to Medicaid) children in CHIP would be more likely to have access to private health insurance, and the federal government did not want to encourage parents or employers to drop private-sector family health care coverage. The federal model was based on crowd out provisions enacted by states such as Minnesota that had created state-funded health expansion programs prior to the creation of the federal CHIP program. The MinnesotaCare Program, when initially created in 1992, was not intended to replace employer-subsidized or private health insurance. The initial eligibility requirements stated that individuals had to be uninsured within the

previous four months and could not have had access to employer-subsidized insurance from a current employer within the previous 18 months.[32]

The PMAP+ 1115 waiver currently sets forth restrictions associated with employer-sponsored coverage. The waiver states that in order for an individual to be eligible for or enroll in MinnesotaCare, they must not have other health coverage or have had health care coverage for a period of four months prior to the date coverage is to begin. Coverage through MA or cost effective health insurance paid for by MA is not considered other health coverage.

There are also several State statutes that speak directly to third party liability and other sources of insurance. Minn. Stat. § 256L.04 requires that MinnesotaCare-eligible individuals assist the State in identifying potential third party payers. Minn. Stat. § 256L.07 defines the rules around other sources of insurance and their impact on eligibility for MinnesotaCare.

Recent Changes

In recent years, few changes have been made that impact insurance and TPL. The MA third party payer definition and private healthcare coverage definition were expanded. While MinnesotaCare underinsurance criteria have been updated, as have certain exemptions from the four month MinnesotaCare insurance barrier, few MinnesotaCare changes have occurred otherwise in the past ten years.

Proposed changes to the waiver would exempt all children with gross family incomes equal to or less than 200% of the FPG from all MinnesotaCare insurance barriers. Additionally, under the proposed changes, individuals receiving the Minnesota COBRA Premium Subsidy (a state program, enacted by the Minnesota Legislature in 2009 that is designed to supplement the federal COBRA subsidy) would not be subject to the insurance barrier after the individual is no longer receiving COBRA continuation coverage.[33]

Several changes in the new federal health reform bill may affect MA and MinnesotaCare. The new law allows states to offer premium assistance and wrap-around benefits to Medicaid clients that are offered employer-sponsored insurance if it is cost effective, starting January 1, 2014. It also requires private insurance plans to allow dependents to remain on their parent's plans until age 26, beginning in 2010. The federal government has not yet issued regulations on these new provisions, so the impact on Minnesota is unclear at this time.

Current insurance and third party liability policies

All public Minnesota health programs are required to be the payer of last resort. To ensure this, efforts to identify any third party liability (TPL) for medical costs otherwise shouldered by the MA and MinnesotaCare program are critical. The Benefit Recovery Section (BRS) of DHS assists

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[32] Minnesota Department of Health, A Profile of the MinnesotaCare Program: The First Six Years 1992-1998, November 1998.

[33] COBRA refers to Title X of the Consolidated Budget Reconciliation Act of 1985, which allows individuals who have lost employer coverage due to layoff or termination to continue receiving coverage for a certain period of time at the individual's expense.

in the coordination of benefits between the Minnesota Health Care Programs and liable third parties.

Third party liability includes, but is not limited to, other health care coverage, medical support from absent parents, and other sources of TPL such as automobile insurance, court judgments or settlements, and workers' compensation. Clients assign their rights to third party liability to DHS when they sign the Health Care Programs Application or Combined Application Form. However, potential non-healthcare coverage TPL payments are not considered "other healthcare coverage" and cannot be considered either an insurance barrier or barrier to eligibility.

Medical Assistance

Medical Assistance has no insurance barriers to eligibility, as detailed in Chapter 15.10 of the HCPM. Medical Assistance clients and enrollees may have another source of health care coverage (e.g., basic hospital, medical-surgical, HMO, vision, dental, long-term care or prescription drug coverage) and still qualify for MA benefits if they meet the other categorical and financial eligibility requirements.

Access to, or enrollment in, other health care coverage must be reported at the time of application and at renewal, and if there are any changes in access to other healthcare coverage between eligibility periods. Other health care coverage may be available from the following sources:

- **Group health care coverage:** Available to individuals who are members of a defined group, such as eligible employees and former employees of a particular employer or members of a union and their eligible dependents. Group health care coverage also includes COBRA coverage.
- **Individual health care coverage:** Includes coverage that individuals can purchase for themselves and their dependents without having to be part of a defined group
    - COBRA coverage
    - Coverage available through any of the following:
        - A non-custodial parent
        - Separated or divorced spouse
        - Parent of minor child living apart from parents
- **Coverage available through military service,** including:
    - TRICARE
    - CHAMPVA
    - Free services at veterans' clinics and hospitals

Clients who are eligible to enroll in group health care coverage are required to do so as a condition of eligibility if there is no cost to the client and the group plan is determined by MA to be Cost Effective insurance, as detailed below.

Cost Effective Insurance

Cost effective coverage includes medical, dental, or vision coverage that could reduce MA program expenses, either currently or in the future (i.e., the insurance premium is less than MA coverage costs for an equivalent set of services). When insurance is found to be cost effective, county agencies reimburse clients for the premiums or directly pay the premiums when the premiums are not used to meet a spenddown. Cost effective insurance could include, but is not limited to, group health insurance, COBRA, individual health coverage, long term care insurance, and Medicare.

If clients indicate on their application form that they may have access to other health insurance, they must fill out the Cost Effective Insurance Form and the Cost Effective Insurance Referral Form in order for the county agency to determine whether or not their coverage may qualify as cost effective. If the coverage is found cost effective, clients must enroll in the coverage to retain MA eligibility. County workers submit the information to DHS only in instances where the client indicates they are unable to use the cost effective coverage because there are no providers for that plan in the area. For more detailed information regarding cost effective insurance, please refer to the HCPM, Chapter 15.10.05.

Non-Healthcare TPL

The Benefit Recovery Section (BRS) of DHS is responsible for pursuing the collection of third party payments from non-healthcare sources such as workers compensation or auto insurance policies. If non-healthcare sources of TPL potential payments are identified, the client must be contacted to verify the TPL. If applicable, information is then entered into the appropriate operating system, and a Medical Service Questionnaire (MSQ) is sent to the client to be returned to DHS for follow up actions. If the client fails to respond, eligibility will be denied as a result of non-cooperation, unless the client is under 18 years of age.

Additionally, for a very small population of children in MA, parents may be responsible for a fee to recover part of their children's costs if they do not live with their minor children, or if their income is not considered in determining MA eligibility for their disabled children. According to DHS, the State currently has 9,000 – 10,000 open accounts involving parental fees. Depending on the circumstances, the parental fee may be assessed by either the county or DHS. Parents are not responsible for a parental fee if parental rights have been terminated, the child on MA is an emancipated minor, or the child receives state or Title IV-E adoption assistance.

Parental fees are assessed to parents whose:

- Adjusted gross income is over 100% FPG (even if they are on MA)
- Income is not deemed
- Children are eligible under TEFRA, in 24-hour care outside the home with a mental retardation diagnosis, severe emotional disturbance, or physical disability, in Regional Treatment Centers, in foster care, or otherwise not living with either parent when there is no court order for medical support

Please refer to Chapter 16.20 for additional information on parental fee assessments and determinations.

TPL Reporting

Access to, or enrollment in, other health care coverage must be reported at the time of application, and at renewal. Any changes in access to other healthcare coverage between eligibility periods must also be reported. Clients generally provide TPL information on the application at the time they apply for benefits. If information about the health insurance coverage is not provided on the application, eligibility workers may obtain it by phone, by receiving a copy of both sides of all insurance cards, or by having the household complete a Health Insurance Information Form.

MinnesotaCare

In contrast to MA, existing health insurance coverage is an explicit barrier to eligibility for MinnesotaCare. MinnesotaCare restricts enrollment based on:

- Current or prior access to Other Healthcare Insurance
- Current or prior access to Employer Subsidized Insurance (ESI)

However, there are exceptions to the health insurance coverage barriers. Children under age 21 who have household income at or below 150% FPG are exempt if determined to be "underinsured," as are children who meet the Children's Health Plan (CHP) Exception (includes children who were enrolled in CHP, the precursor to MinnesotaCare, who have had no breaks in coverage since their initial CHP enrollment). Children who are not underinsured and are not under 150% FPG are subject to the four-month rule. Please reference Chapter 15.05.15 of the HCPM for additional details on underinsurance requirements for children.

Access to Other Insurance and the Four Month Rule

Current or prior access to other health insurance is a barrier to obtaining MinnesotaCare coverage. MinnesotaCare eligibility is denied for a period of four months from the date any private, employer-based, or non-employer subsidized health insurance ends.

This Four Month Rule, "go-bare" period applies to the following health insurance policies, as addressed in Chapter 15.05.05 of the HCPM

- Basic hospital coverage
- Medical-surgical coverage
- Major medical coverage
- Health Maintenance Organization (HMO) coverage
- Medicare Supplement policies
- Minnesota Comprehensive Health Association (MCHA)
- Vision, dental, or prescription drug coverage offered as part of a comprehensive package

- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMP VA)
- Medicare Part A and Part B

Former MA enrollees with health care coverage determined cost effective by the MA program are exempt from the four-month barrier, unless they chose to keep the insurance after MA no longer considered it cost-effective. Additionally, former MA clients whose healthcare coverage costs were paid for by the enrollee in order to meet the MA spenddown requirements are also exempt. And, as noted previously, underinsured children with household incomes at or below 150% FPG and children who meet the CHP exception are not subject to any insurance barriers.

Employer Subsidized Insurance and the 18 Month Rule

Coverage offered to employees for which an employer or union pays at least 50% of the cost of coverage is considered employer-subsidized insurance (ESI). If a MinnesotaCare client has current access to ESI, regardless of whether or not they are enrolled, eligibility is denied. Moreover, if a client has had access to ESI any time in the past 18 months through a current employer they are also considered ineligible. This 18 month rule also applies to individuals who lost coverage or lost access to ESI due to a current employer terminating health coverage as an employee benefit, unless they were previously enrolled in MinnesotaCare and reapplied within six months of their MinnesotaCare termination date.

Children with household incomes at or below 150% FPG and children who meet the CHP exception are exempt from all ESI barriers. Please refer to Chapter 15.05 of the HCPM for additional information.

TPL Reporting

While TPL reporting requirements are similar between MA and MinnesotaCare, the MinnesotaCare program must also ensure information about current other health care coverage is obtained in order that DHS may pursue collection of any third party payments and the enrollee's managed care plan can coordinate benefits with the other health care coverage provider. (Some forms of healthcare coverage are not a barrier to MinnesotaCare such as dental, vision, or prescription only coverage. Please see Chapter 15.05 of the HCPM for additional information). Enrollees may provide information by answering the health care coverage questions on a health care application or renewal, or by phone. Clients must also submit documents that provide the coverage information requested on a health care application. A Health Insurance Information Form (HIIF) is required for each policy if the information on the application or renewal is incomplete

Non-Healthcare Coverage TPL

While non-healthcare coverage TPL is not considered a health insurance barrier, clients must cooperate with the TPL benefit recovery process. If non-healthcare TPL potential payments are identified, the client must be contacted to verify TPL payments. If additional information is needed, an Accident/Injury Follow-Up Request for Information form is sent to the client, and DHS is notified of the request. DHS is responsible for pursuing the collection of third party payments from sources such as workers compensation or auto insurance policies. If the client

fails to respond, eligibility will be denied as a result of non-cooperation, unless the client is under 18 years of age.

Program differences and overlap

The policies and processes governing other sources of insurance and TPL for MA and MinnesotaCare have little overlap and in the majority of circumstances, are not aligned.

Figure 24. MA and MinnesotaCare Differences and Overlap in Insurance and TPL

	Issue	MA	MinnesotaCare
Difference	Existing source of coverage	Having an existing source of health care coverage is ***not*** a barrier to eligibility for MA	Having an existing source of health care coverage is a barrier to eligibility for MinnesotaCare
	Recent health care coverage	Not a barrier	Having other healthcare coverage in the past four months is a barrier
	Employer Subsidized Insurance (ESI)	No ESI barriers	MinnesotaCare requires that all adults at any income level and children in households with income above 150% FPG do not have current access to ESI and have not had access to or participated in any ESI through a current employer for 18 months prior to enrollment in MinnesotaCare
	Parental Fees	Charged to parents of eligible children in specific circumstances	No parental fees
	Cost effective insurance	MA performs a cost effective insurance review to determine whether available insurance (whether ESI or not) is cost effective If the insurance is cost effective MA will pay the client's portion of the premium and clients are required to enroll in and maintain that coverage	MinnesotaCare does not have a similar cost effective review policy
Overlap	TPL Reporting	Both programs require clients to report any existing insurance coverage	

The only area of overlap between the MA and MinnesotaCare programs is in TPL reporting requirements at the time of application. Both programs require clients to report any existing insurance coverage; however, how existing insurance coverage affects eligibility for the two programs is drastically different.

Challenges

As with the cost of coverage, the MA and MinnesotaCare programs are fundamentally different in terms of how access to other health insurance is treated. Medical Assistance clients can have other health insurance coverage and obtain wrap-around coverage through MA, and in some cases have MA pay their premiums. For MinnesotaCare clients other than low-income children, having other health insurance or access to 50% or more employer-subsidized insurance is an explicit barrier to participation. Eliminating the insurance barriers that have been in place since the MinnesotaCare program was first developed will be a major shift in how the program is designed and operated and move it away from being a "private sector"-like option and closer to the public assistance program model. However, given the larger changes in the public and private health insurance markets that are developing in response to national health care reform, these traditional distinctions may be less relevant. Even if radical change to support alignment is not supported, other program improvements around documentation and verification of other health insurance or partial removal of the insurance barrier may greatly streamline the eligibility determination process and improve the State's ability to truly function as the payer of last resort.

Verification

Income, resources, and other information provided by clients must be verified in order to ensure that only those who meet the State's specified eligibility criteria are determined to be eligible. Some verification requirements are federally mandated, such as citizenship, immigration status, and Social Security numbers. However, States have considerable flexibility in determining what other components of eligibility must also be verified and what specific documentation can satisfy the verification requirements.

Statutory and regulatory framework

Medical Assistance

Verification criteria are governed by both federal and state rules. The federal "delinking" of cash benefits and other public programs allowed states to modify the process by which clients document and eligibility workers verify application data for Medicaid.[34] Current federal law requires states to:

- Verify citizenship (CMS has established a hierarchy of documents accepted as proof of U.S. citizenship)
- Obtain documentation of a qualified alien's immigration status (only applies to non-citizens)
- Obtain each client's signature, under penalty of perjury, that the information reported on the application is correct
- Verify client income through an automated income and eligibility verification system (IEVS).

Title 42 Part 435 of the CFR provides explicit instruction on verification requirements that must be met by the Medicaid agency when determining eligibility. Many of the requirements relate to citizenship. The CFR also provides guidance on how to manage the information used for verification, including appropriate timelines.

Minn. Stat. § 256B.056 defines verification activities for eligibility, including the requirement that pregnant women must update income and asset information and submit any required verification to continue coverage following the end of 60 day post partum. Additionally, State Rule 9505.0095 provides requirements for what may be requested of clients to verify eligibility.

MinnesotaCare

In the past, MinnesotaCare had fewer documentation requirements than MA. Following the passage of various State and federal rules over the past decade, MinnesotaCare now has similar requirements to MA. For example, beginning in 2001, all clients were required to provide their Social Security number. As of 2007, MinnesotaCare clients are required to verify citizenship status. Minn. Stat. § 256L.04 defines the requirements that an individual must meet to be

[34] CMS Letter to State Medicaid Directors, "Outreach and Enrollment," January 23, 1998. CMS Letter to State Medicaid Directors, "Application and Enrollment Simplification and Clarification of Eligibility Requirements," September 10, 1998.

eligible for MinnesotaCare, including the provision of a Social Security number, evidence of citizenship, and other required documentation.

Recent Changes

State laws surrounding verification policies have been streamlined over the past ten years, as federal verification requirements have tightened. The State mandated the use of electronic verification as the primary method of income verification. Beginning in 2001, all applicants were required to provide their Social Security number. As of 2007, MinnesotaCare enrollees are required to document their citizenship status. However, verification requirements for reported changes between the six month (for MA) and annual renewal time periods (for MA and MinnesotaCare) were removed.

Current verification policies

As outlined below in Figure 25, both MA and MinnesotaCare require verification of citizenship and identity, Social Security numbers and proof of pregnancy for most children and family eligibility categories. Additionally, verification of state residency may also be required if inconsistent information is identified. Please refer to Chapter 9.05 of the HCPM for additional information on mandatory verification policies.

Figure 25. Verification Requirements for MA and MinnesotaCare

Verification	Requirement	Process	Acceptable Documentation
Citizenship and Identity	▪ Federally mandated ▪ Exemptions: Auto newborns ▪ Exempt if previously verified	▪ Eligibility approved prior to providing citizenship documentation if all other eligibility criteria has been met, as long as documentation returned within 60 days ▪ May obtain verification on clients' behalf, through agencies such as the Minnesota Department of Health	▪ Four levels of acceptable documentation, as mandated by the Centers for Medicare and Medicaid ▪ Level one documentation is preferred. One of the following need be provided: o U.S passport, PASS card, certificate of naturalization, certificate of citizenship, State Data Exchange System match, Tribal enrollment or membership card or certificate of degree of Indian blood issued by a federally recognized Indian tribe o For documentation requirements in Level two through four reference HCPM, Chapter 11.05.05 ▪ Documentation must be provided in either original form, or as a certified copy

Verification	Requirement	Process	Acceptable Documentation
State Residency	▪ Not required unless inconsistent information is provided on the application	▪ If verification is requested due to inconsistent information, client must respond to a request for further state residency information within 10 days	▪ Examples of acceptable state residency verifications: Mail received at current address, voter registration card, valid driver's license or ID card, recent tax forms
Social Security Number	▪ Federally mandated ▪ Exemptions: Auto newborns, newly adopted children, and refusals based on religious objections ▪ Exempt if previously verified in MAXIS for MA/ MinnesotaCare	▪ SSN is verified via MAXIS SSA/DHS data exchange ▪ If the client does not have a SSN or does not know their number, they are instructed to contact the SSA and reapply. Following their application, clients must submit a receipt demonstrating proof of cooperation	▪ In instances where the client's number matches that of another client, a copy of the Social Security card is requested ▪ Otherwise, not applicable
Proof of Pregnancy	▪ Exempt if a pregnancy has already been verified through MA/MinnesotaCare or a cash assistance program	▪ May verify using the Proof of Pregnancy form or other forms of verification that state the woman is pregnant and includes the estimated date of conception. The provider's signature is not required. ▪ A release of information form may be obtained in order to contact the provider if the verification form is incomplete. ▪ If documentation is missing at the time of application, eligibility may be approved contingent on the return of the verification documents within 60 days	▪ Must be verified by a physician, registered nurse, licensed nurse midwife, certified nurse practitioner, or physician's assistant

Additionally, the State requires verification for income, assets, medical spenddown, and employer subsidized insurance (ESI). These documentation requirements are not aligned between the two healthcare programs, as outlined below.

Medical Assistance

In addition to citizenship and identity, state residency, Social Security number, and proof of pregnancy requirements, MA clients are required to verify the following, where applicable:

- Income

- Assets
- Medical spenddown

Income

There are income verification requirements for all MA eligibility categories that require enrollees have income within a specified limit. At the time of application and at subsequent renewal periods, MA enrollees must verify earned and unearned incomer received by all household members in the past 30 days. If clients are requesting retroactive eligibility, income must be verified for each retroactive month requested. If no income is claimed from any source, the client's statement is accepted if there is no conflicting information.

While the MA program does not have a set, mandated list of required verification items, it provides verification document suggestions, as shown in Figure 26 below. Verification requirements of earned income depend on the type of employment-based income, such as self or seasonally employment. Please refer to Chapter 20.10 of the HCPM for additional information on verifying income.

Figure 26. MA Income Verification Requirements Based on Income Type

Types of Income	Acceptable Verification
Traditional wage based income	▪ Paycheck stubs ▪ Employer statement ▪ Tax forms
Self-employment income	▪ Income tax forms ▪ Business financial statements or detailed records of gross receipts and expenses ▪ Business quarterly report ▪ Signed statement from business's accountant verifying projected business income or expenses
Seasonal income	▪ Recent years tax forms and W-2s ▪ 'Other documentation' reflecting the current seasonal earnings
Unearned income	▪ Award letters ▪ Copies of checks for unearned income ▪ Court orders
No income	▪ The client's statement, as provided in the application, is accepted unless there is conflicting information

If incomplete income documentation is received, at least ten days must be allowed in order for the client to respond to the request for more information, and an additional ten day notice of the proposed denial must be sent at the end of a processing period.

Certain deductions also have specific verification requirements. For example, if a client receives a child support deduction, no verification is required unless the reported amount is questionable.

Assets

Parents are the only MA eligibility category required for families and children to verify assets, which may include assets deemed from certain exempt individuals.

All countable assts and their encumbrances (legal claims against real or personal property payable when the property is sold) must be verified at both the time of application and at renewal. For applications, assets must be verified as of the first day of the month the client requests eligibility. If the net value of the assets is greater than the asset limit at application or renewal, the client must be contacted to verify whether or not any of the assets have encumbrances not already reported. Additionally, workers verify the unavailability of countable assets, the reduction of assets on medical bills for a retroactive period, and assets that are deemed to a person with an asset limit.

Common types of asset verification include, but are not limited to:

- Bank statements
- Agency-initiated verification forms
- Copies of bonds
- Stock ownership statements
- Copies of life insurance policies
- Statements from insurance companies or companies providing annuities
- Copies of burial purchase agreements
- An estimate of fair market value from a licensed dealer
- An estimate from a licensed appraiser
- Contracts

Please refer to Chapter 19.20, of the HCPM for additional information on verifying assets.

Medical Spenddown

Clients receiving coverage through one of the MA family and children eligibility categories are eligible for medical spenddown if their income exceeds their applicable income limit. To be eligible, they must spenddown to 100% FPG. Medical spenddown verification requirements may be fulfilled through one of the following:

- Copies of bills received from the provider (must be from current billing cycle)
- Copies of Explanation of Benefits from third party payers
- Direct contact with the provider

Please refer to Chapter 24.15.05 of the HCPM for additional information on verifying medical spenddown.

Verification Systems

While documentation provided by clients and enrollees to verify the eligibility factors discussed above is vital to the application review process, the Income and Eligibility Verification System (IEVS) is also available to assist counties in identifying income that was not reported or was reported incorrectly for MA verification. IEVS is a data exchange with other state and federal sources used to verify income and assets of MA applications and enrollees. The Internal Revenue Service, Social Security Administration, and the Minnesota Department of Employment and Economic Development (DEED) interface with the MAXIS system, checking clients' Social Security numbers with information from their data files and sending targeted matches of possible sources of unreported income and assets. The system is used to determine whether or not the client or enrollee has already reported the information noted in the IEVS match. If a discrepancy is identified, IEVS matches must be resolved within 45 days, unless caseworkers are waiting on information from a third party. If IEVS determines a client or enrollee ineligible, eligibility is terminated with a ten day notice.

In addition to the IEVS system check, the Providing Resources to Improve Support in Minnesota system (PRISM) is also used by MA to verify receipt of child support income. The State also participates in the Public Assistance Reporting Information System (PARIS) in order to verify state residency and prevent duplicative benefits.

MinnesotaCare

In addition to citizenship and identity, Social Security number, and proof of pregnancy requirements, clients must verify the following:

- Income
- Assets
- Employer sponsored insurance (when applicable)

Income

Income verification is required for all MinnesotaCare enrollees, with the exception of auto newborns and children under the age of 19 who are students. MinnesotaCare enrollees, as with MA, must verify earned and unearned income received by all household members 30 days before at the time of application, and at subsequent renewal periods. Verification documents requested are dependent on the type of employment and the type of income received by the client. Please refer to Chapter 20.10 of the HCPM for additional information on income verification policy.

For MinnesotaCare client, Figure 27 below provides examples of documents that serve as acceptable verification.

Figure 27. MinnesotaCare Income Verification Requirements Based on Income Type

Types of Income	Example Verification Required
Traditional wage based income	▪ Consecutive paycheck stubs from the past 30 days ▪ Employer statement o If pay stubs for income from the past 30 days are not available or if clients and enrollees are paid daily or on a varying schedule or if handwritten pay stubs are submitted or if the client or enrollee has new employment and has not yet accumulated enough pay stubs ▪ Tax forms o Do not use tax forms or W-2 forms, unless the income is from seasonal employment or self-employment
Self-employment income	▪ Federal tax forms, including all W-2s, from the most recent tax year ▪ Business records o Accept a business financial statement, detailed records of gross receipts and expenses, a business quarterly report, or a signed statement of business income and expenses only if the client states the previous year's tax forms are not available, or that they do not reflect current self-employment income
Seasonal income	▪ Previous year's Individual Tax Return if the person was seasonally employed the prior year and anticipates similar seasonal employment in the current year ▪ Pay stubs from the past 30 days to verify new seasonal employment
Unearned income	▪ Award letters ▪ Copies of checks for unearned income ▪ Court orders
No income	▪ All eligible children in a household who do not have other health care coverage must enroll if one child enrolls

If the verification on file is not within one month prior to the date of application, or if the client has had a change in hourly rate, new verification documents for applications or renewals must be requested. If clients are requesting MinnesotaCare coverage following other healthcare program coverage cancellation, new verification must also be requested in the following circumstances:

- For individuals who were enrolled in another program and were cancelled from that program: If the verification on file is not within 30 days of the date of cancellation or the date the case was transferred to MinnesotaCare Operations (whichever is earlier) new verification is requested.

- If an existing application is being used to reapply for MinnesotaCare and the verification on file is not within 30 days of the date of the new request.

Assets

Asset verification affects only MinnesotaCare parents. Verification is required only if a client reports, or information indicates, that a Continuing Care Retirement Community (CCRC) entrance fee may be available, or when a workers compensation settlement causes the client to exceed the asset limit. All other asset types do not require verification. Clients should report changes in assets between renewals; however, reported changes are not acted upon until renewal.

An award notice or settlement letter is sufficient verification of the worker compensation settlement, however, such verification is only required if the client's or enrollee's total assets exceed the MinnesotaCare asset limit. Otherwise, the client's verbal or written statement noting the settlement amount is sufficient. Please reference Chapter 19.20 of the HCPM for additional information on asset verification policy.

Employer Sponsored Insurance (ESI)

ESI verification is required when the client or enrollee indicates on his or her application, renewal, or reported employment change that the applicant or his or her parent or spouse is employed 20 or more hours per week. Verification is also required regardless of the number of hours worked if the applicant indicates on the application form that he or she has access to healthcare coverage through a current employer or union, has turned down or dropped coverage from a current employer, currently works for an employer or union that cancelled coverage in the last 18 months, or if the ESI information provided is inconsistent with documentation on file. Verification is not required for applicants and enrollees who are under age 21, employed less than 20 hours per week, or whose employment is a school-related work study program. Verification may be provided with one of the following documents:

- Employer Insurance Information Form, signed by the client and completed by either the employer or union
    - If written consent is received from the client to verify access to ESI, the eligibility worker may contact the employer on the client's behalf.
- Documents from an employer or union which provide health care coverage
- A written statement from the employer or union
- Verbal health care coverage information or confirmation from the employer or union

Clients have 30 days to provide requested documents, with eligibility pending in the interim. Eligibility will automatically be denied or closed by MMIS in 60 days for clients, or at the end of the renewal period for enrollees, if documents are not returned. Please refer to Chapter 15.05.20 of the HCPM for additional information on ESI verification policy.

Verification Systems

The State has access to several systems in order to verify components of the MinnesotaCare application. State workers have recently gained access to PRISM for the purpose of verifying child support. Additionally, they are able to access the Social Security Administration (SSA) interface of the SVES system to obtain information on Retirement Survivors Disability Insurance (RSDI) and Medicare for those clients who have previous MAXIS history. If State workers require more up-to-date information than what is available in the SSA interface, they can request an updated query.

Programs differences and overlap

While certain verification policies currently align between MA and MinnesotaCare – most notably the citizenship and identity, state residency, Social Security numbers, and proof of pregnancy requirements – there are significant variations across asset and income requirements and employer sponsored insurance.

Figure 28. MA and MinnesotaCare Differences and Overlap in Verification

	Issue	MA	MinnesotaCare
	Income: Pay Stubs	▪ If available, pay stubs over the past 30 days need not be consecutive	▪ If available, consecutive pay stubs from the past 30 days are required
	Assets	▪ Counted assets must be verified according to the first day of the month the client requests eligibility	▪ Required only if client reports that a Continuing Care Retirement Community (CCRC) entrance fee may be available, or if a workers compensation settlement causes the client to exceed asset limit
	Medical Spenddown	▪ Requires verification of each medical expense used towards the medical spenddown requirements	▪ Not applicable (medical spenddown is not an option for the MinnesotaCare program)

	Issue	MA	MinnesotaCare
	ESI	▪ ESI is not a barrier to MA eligibility. Employer-based insurance may be evaluated for potential cost effective premium payments	▪ Required when the client indicates on their application that they, their parents, or their spouse, have access to healthcare coverage through a current employer or union, that they have turned down or dropped their coverage from a current employer, if they work for employer or union that cancelled coverage in the last 18 months, or if the ESI information provided is inconsistent with documentation on file ▪ Effects only clients whose employment is not a school related work study program, are older than 21, and are employed 20 or more hours per week and have not previously reported for that employer
Overlap	Income	▪ Must verify counted earned and unearned income received 30 days before the time of application or renewal ▪ Auto newborns exempt from income requirements ▪ Similar verification documents accepted	
	SSN	▪ Federally mandated ▪ Exemptions: Auto newborns and refusals based on religious exemptions	
	State Residency	▪ Not required unless inconsistent information is provided on the application	
	Citizenship	▪ Federally mandated ▪ Exemptions: Auto newborns and newly adopted children	
	Proof of Pregnancy	▪ Must be verified by a physician, registered nurse, licensed nurse midwife, certified nurse practitioner, or physician's assistant ▪ Exemption: If a pregnancy has already been verified through another healthcare program, or a cash assistance program, verification is not required	

Challenges

According to discussions with State staff, county caseworkers and advocacy groups, verification is a major barrier to eligibility, causing clients to be denied at application or terminated at renewal when sufficient documentation cannot be provided. Verification is also a primary source of error (according to data from State quality control reviews). The challenge with verification is finding the balance between administrative burden and accountability.

The verification areas that seem to pose the most difficulties for clients and workers are ESI, citizenship, and assets. It can also be difficult to verify income within 45 days of the application for MA or within the MinnesotaCare 30-day processing period. Relying on employers to verify ESI in a timely manner can end up penalizing the client. At renewal, cases are often closed for lack of verification documentation.

MA and MinnesotaCare have experienced some program integrity issues with verification, particularly around verification of income, insurance, and citizenship and identity. According to interviews with State program integrity staff, errors were often identified due to caseworker failure to collect the appropriate documentation. For example, pregnant women might supply a verification note but it might not be signed by the appropriate type of provider. Other examples of verification errors have been found in MinnesotaCare when ESI has not been properly verified or identified at all.

Some of these errors may result from the complexity of the policies and confusion due to changes in the policies over time and remaining differences between programs. For example, comments made during county interviews suggest that some caseworkers may be verifying components where it is not required. Additionally, MinnesotaCare appears to have more specific requirements laid out in the HCPM than MA, such as with paystubs, causing caseworkers to ask clients for information that may not be needed or causing issues when a case is transferred from MA to review by MinnesotaCare. While the verifications required for MA and MinnesotaCare are similar, the slight differences contribute to the complexity of the eligibility processes.

The State's rules for verification are in place to ensure that only those who are eligible to receive coverage are enrolled. Further, the State is federally mandated to verify certain aspects of eligibility, such as citizenship. Failure to appropriately follow State and federal rules can have serious financial impacts for the State, due to expending funds on ineligible individuals as well as the potential to lose a portion of their federal funding due to errors found through federal audit reviews such as through the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs.

Managed Care Enrollment

DHS contracts with managed care organizations to provide health care services for eligible clients in MA and all clients in MinnesotaCare. The State contracts with eight MCOs to provide medical services statewide for MA and MinnesotaCare enrollees, which includes five health maintenance organizations (HMOs) and three county-based purchasing entities (CBPs). "Prepaid Minnesota Health Care Programs" (PMHCP) refers to the various prepaid health care programs in the State, including both the MA and MinnesotaCare managed care programs.

Statutory and regulatory framework

Medical Assistance

States can choose to deliver Medicaid services through a variety of managed care options as an alternative to or replacement for the fee-for-service system. Under authority provided in Section 1932 of the Social Security Act, states can require certain groups, such as healthy children and adults to enroll in a managed care plan by defining the program in the Medicaid State Plan. Attachment 3.1F of Minnesota's Medicaid State Plan permits the State to mandate the enrollment of categorically needy pregnant women and infants, infants enrolled through CHIP, categorically needy children under age 21 in AFDC-related groups, and parents, and children under Section 1931 and transitional assistance. This section of the State Plan also clearly defines those groups that are exempt from enrollment.

States can require other populations, such as disabled children and or children who are in State-subsidized foster care to enroll in managed care by obtaining a waiver of Medicaid rules under Section 1115 or Section 1915 of the SSA. In Minnesota, children receiving foster care and American Indians can enroll in managed care through the 1115 Prepaid Medical Assistance Program Plus (PMAP+) waiver.

All Medicaid managed care plans must meet federal requirements spelled out in 42 CFR Part 438, which dictates the general process for enrolling eligible individuals into managed care plans and guidelines for when a recipient must be allowed to request disenrollment. Minn. Stat. § 256B and Minnesota Administrative Rules, parts 9500.1450 to 9500.1464 address Medicaid managed care program requirements.

MinnesotaCare

Minnesota's PMAP+ waiver also mandates the enrollment of all persons covered by the MinnesotaCare program into managed care plans.

At the State level, Minn. Stat. § 256L.12 defines the managed care participating vendor and enrollee requirements. It also provides guidance on the associated financial aspects including specifics on rate setting and copayment amounts.

Minnesota Administrative Rules 9506.0200, 9506.0300, and 9506.0400 govern the prepaid MinnesotaCare program generally, including associated health plan services, payment, and other managed care health plan obligations.

Recent Changes

In July 2005, the State received approval from CMS to enroll many MA eligibility groups in managed care on a mandatory basis through a permanent Medicaid State Plan Amendment rather than a waiver, which would require periodic renewal. The groups covered by the State Plan Amendment include categorically needy pregnant women and infants, and categorically needy children under age 21 in AFDC-related groups. The State also eliminated the one month grace period for those enrolled in managed care programs who failed to comply with reporting deadlines for income renewals, eligibility renewals, or household report forms.

Current managed care enrollment policies

Medical Assistance

The Prepaid Medical Assistance Program (PMAP) refers to the capitated managed care program for MA clients. More than two-thirds of MA clients are enrolled in managed care.[35] All MA clients who must enroll in an MCO are encouraged to choose one (where multiple plans are available), although MA clients who do not choose an MCO will be automatically assigned to one. The number of plans available to MA clients varies by county; counties in Minnesota have anywhere from one to five different plans. Exempt populations include those who have a medical spenddown or have private health insurance through an HMO. While MCOs are required to provide at least all medically necessary health services that would be covered under MA, some services such as abortion services and child welfare targeted case management are "carved out" and are still covered through the fee-for-service system.

Education and Enrollment

Counties provide education and enrollment for MA managed care enrollees and mail materials to clients regarding their managed care options. Clients must be:

- Informed of their MCO options when they apply for MA
- Encouraged to select an MCO
- Required to receive their health care services through their MCO network

PMAP enrollees have 30 working days to choose a plan before they are assigned to one. Medical Assistance clients are enrolled in an MCO when their eligibility is determined for the next available month. Depending on when the recipient applies and becomes eligible, he/she may receive services through the FFS services for a short period of time. Enrollees are allowed, in specified circumstances, to change MCOs.

Allowable reasons for changing MCOs for MA include:

- Changes may be made during the annual open enrollment period or within 90 days of initial MCO enrollment each time they are enrolled in a new MCO

[35] Minnesota Department of Human Services, Medical Assistance Overview

- If the recipient has had a break of more than two full calendar months from managed care they are permitted to change MCOs if the request is made within 90 days of enrollment
- If the enrollee moves to another county or the MCO no longer provides services in the county in which the enrollee resides
- The enrollee may also request to change MCOs if they can demonstrate good cause, such as a lack of access to services

Please refer to Chapter Two of the Prepaid MHCP Manual for additional information regarding education about and enrollment in Prepaid Minnesota Health Care Programs.

MinnesotaCare

All MinnesotaCare clients are required to enroll in managed care. All counties, with the exception of Lake of the Woods County with only one plan, have two to five plans available to clients.

Education and Enrollment

MinnesotaCare eligibility is determined and entered into MMIS by either DHS or a county, if the county has opted to be a MinnesotaCare enrollment site. Managed care education for MinnesotaCare clients is completed by DHS and done through the mail. Clients must be:

- Informed of their MCO options when they apply for MinnesotaCare
- Encouraged to select an MCO
- Required to receive their health care services through their MCO network

MinnesotaCare clients are enrolled in an MCO when their eligibility is determined for the next available month. If clients fail to choose an MCO, they will be automatically assigned to one. Clients are allowed, in specified circumstances, to change MCOs.

Allowable reasons for changing MCOs for MinnesotaCare include:

- Changes may be made during the annual open enrollment period or within 90 days of initial MCO enrollment each time they are enrolled in a new MCO
- If the recipient has had a break of more than two full calendar months from managed care they are permitted to change MCOs if the request is made within 90 days of enrollment
- If the enrollee moves to another county or the MCO no longer provides services in the county in which the enrollee resides
- The enrollee may also request to change MCOs it they can demonstrate good cause, such as a lack of access to services, for the change

Program differences and overlap

A majority of clients in MA and all clients in MinnesotaCare are enrolled in managed care. The managed care plans delivering services are largely similar between the programs. The primary difference between the two programs is in the administration; MA is administered at the county level and MinnesotaCare is administered primarily by the State.

Figure 29. MA and MinnesotaCare Differences and Overlap in Managed Care

	Issue	MA	MinnesotaCare
Difference	Enrolled populations	While most MA clients are required to enroll in an MCO, there are many clients excluded from enrollment (e.g., medical spenddown)	All MinnesotaCare clients are required to receive care through an MCO
	Enrollment	The county is responsible for enrolling MA clients	The State is responsible for enrolling MinnesotaCare clients
	Consumer Education	The county is responsible for educating MA enrollees about MCO options, required to provide information sessions	The State is responsible for educating MinnesotaCare enrollees about MCO options, done by mail
	MCO Coverage	29 of 87 counties in MN do not have the same plans available for both MA and MinnesotaCare clients	
Overlap	MCO Changes	The allowable reasons for changing MCOs are uniform for both programs	
	MCO Coverage	58 of 87 counties in MN have the same plans available for both MA and MinnesotaCare clients	
	MCO Enrollment	If clients fail to choose an MCO, they will automatically be assigned to one	

MinnesotaCare requires clients to enroll in managed care and most MA enrollees participate in managed care, but there are clearly defined populations excluded from participation in MCOs who receive services on a FFS basis. Both programs enroll clients in managed care prospectively, generally beginning the first of the month following the eligibility determination (or premium receipt).

A key difference between the programs is the education and enrollment of clients. MinnesotaCare managed care education and enrollment is handled entirely at the State level, while counties are responsible for education and enrollment associated with MA.

MinnesotaCare information is only provided to clients through the mail, but some counties offer additional outreach and education to MA clients.

Finally, access to managed plans varies depending on the county. In all counties, the plans available to MA clients are the same as those available to MinnesotaCare clients. However, in 29 counties there are anywhere from one to three additional plans available for MinnesotaCare.

Please refer to Chapter Two the Prepaid MHCP Manual for additional information regarding education about enrollment in Prepaid Minnesota Health Care Programs. Please refer to the DHS Program Resources page regarding Managed Health Care Programs for additional information on MCO participation by county.

Challenges

Enrollment in a managed care plan occurs after eligibility is determined, but differences in managed care enrollment choices and processes add complication to the final step in accessing coverage. Currently, different health plans may participate in MA and MinnesotaCare in a single county, which means that families who have members enrolled in both programs could have different plans, benefits, and costs of coverage. (More likely, any family members with a choice of plans would choose the same plan as remaining family members, although this might not be the best choice for other reasons). The State administers different health plan contracts for the MA and MinnesotaCare program, balancing the risk management strategy of diversification against the benefit of streamlined contract administration and program alignment. Opportunities for significant alignment could require a change in the State's contracting strategy.

Further, the managed care enrollment process is maintained at the county level for MA clients and at the State level for MinnesotaCare, which further complicates caseworkers' ability to counsel clients of all the potential differences. Other strategies to better align managed care enrollment processes might require aligning both MA and MinnesotaCare with a third option, rather than one to the other. Regardless of decisions made regarding the managed care enrollment process itself, other potential alignments (particularly those that affect start/renewal dates) may help the State and MCOs support retention efforts.

Administrative Processes and Minnesota HealthCare Connect

In order to provide health care coverage to clients, the State must manage the immense task of administering the programs on a day-to-day basis, including the eligibility application and review process, systems issues, and communication with clients. As the MA and MinnesotaCare programs have grown in size and scope over the years, DHS has made changes to each program. However, since the programs have grown more parallel over time (in terms of populations covered and services provided), and because of increases in enrollment with corresponding increases in administrative effort, many initiatives have been undertaken to improve the process for clients and caseworkers.

Statutory and regulatory framework

Medical Assistance

Generally, the federal government does not impose many mandates on states in terms of how programs are administered on a day-to-day basis. There are specific rules that govern the timeframe for reviewing applications, documentation requirements, and the availability of program information and applications (see 42 CFR 435 Subpart J - Eligibility in the States and District of Columbia) as well as specifications for systems that pay claims and track eligibility. However, beyond these requirements, states are able to administer their programs as they see fit and design systems to meet their specific programmatic needs.

Federal law provides general methods of administration and requirements for processing applications, determining eligibility, and furnishing Medicaid.[36] These requirements include timelines for completion of the tasks and required State processes in completing the application and eligibility determination process. Minnesota State Rule 9505.0110 provides specifics on the application process and associated timelines. The PMAP+ 1115 waiver guides the process for choosing between the MA and MinnesotaCare programs, including when clients should be enrolled in a specific program.

MinnesotaCare

Administrative processes for MinnesotaCare are primarily governed by State rules and statutes. Minn. Stat. § 256L.05 provides a comprehensive outline of the requirements associated with applications, including their availability and processing time. State Rules 9506.0020 and 9506.0030 define the rules for MinnesotaCare redeterminations and the application review period.

Recent Changes

The State has made significant changes to both MA and MinnesotaCare administrative processes over the past decade. Both the Health Care Programs Application and Health Care Renewal Form were simplified, shortened, and made available online. County agencies began administering MinnesotaCare enrollment, with MinnesotaCare Operations accepting the

[36] 42 CFR 435 - Eligibility In the States, District of Columbia, the Northern Mariana Islands, and American Samoa

Combined Application Form for the first time in 2001. DHS established a new outreach strategy, increasing application availability and new application assistance, and funding a statewide informational toll-free telephone line. Additionally, the State began the Minnesota Community Application Agent (MnCAA) program in 2008.

Current administrative processes/MN HealthCare Connect initiatives

Application Structure

The primary method for applying for health care coverage in Minnesota is through the Health Care Programs Application, which is available on-line, in county offices, or through local advocacy/service organizations. Clients can also apply for the health care programs on the Combined Application Form, which is primarily for cash and food support but also allows clients to indicate if they are interested in health care coverage. Federal law requires an in-person interview for cash and food benefits so most persons using the Combined Application Form must appear at the county eligibility office. Clients can submit the Health Care Programs Application through the mail, which most choose to do.

The Health Care Programs Application provides an overview of what the application is for, what clients need to complete, where they can call with questions or for translation assistance, a list of required verifications that need to be included with the application, and the addresses for county offices and the MinnesotaCare State office. The application asks for general information (e.g., name, address, optional demographic information) as well as information needed to determine eligibility, including household composition and dependents, citizenship and residency, recent work history, income, assets and availability other health insurance. The application is eight pages long.

The first question on the Health Care Programs Application addresses informed choice. While a small piece of the application, it has a major impact on clients, processing, administration and delivery of benefits. Because the State's waiver allows for certain populations (e.g., children, families, pregnant women) to be covered under MinnesotaCare even if eligible for MA, CMS required the State to add a question to the application asking if the client wants to be considered for all health care programs or just MinnesotaCare. If a client asks to be reviewed for all health care programs, the application is to be sent to the county office where it will be reviewed based on the State's health care coverage hierarchy, with eligibility for MA being determined first and, if not eligible, then reviewed for MinnesotaCare. However, when the client chooses MinnesotaCare only, he or she is only reviewed for MinnesotaCare. (Note: If a client applies for health care on the CAF, or leaves the informed choice question blank on the application, he or she is reviewed for MA first, then MinnesotaCare).

Application Processing and Review

MA is administered at the county level, while MinnesotaCare is administered primarily at the state level. However, 48 of the State's 87 counties process MinnesotaCare applications. Of the 48 counties that process MinnesotaCare, 11 provide limited services such as initial processing, only then sending some enrolled cases to the State MinnesotaCare Operations unit for ongoing maintenance. Clients can either mail applications directly to the State or to the county. If a MinnesotaCare application is received in a county that does not process MinnesotaCare, the

application is forwarded to MinnesotaCare Operations at the State. Renewals are handled by either the entity that processed the application (e.g., if a county reviewed the initial application for MinnesotaCare, the county would also process the renewal) or by the State.

Applications for MA are statutorily required to be processed within 45 days of receipt except for pregnant women, for whom applications must be reviewed within 15 days. MinnesotaCare applications are required to be reviewed and either pended or decided within 30 days. If a client applies for MinnesotaCare and is denied for any reason, the client can reapply again for MinnesotaCare any time in the next eleven months using the same application, although verification documentation must be updated. If the client is denied for MinnesotaCare or is terminated from MinnesotaCare, the same application/renewal can be used for review by MA within 45 days. However, if a client applies for MA and is denied, the application cannot be used to reapply for MA.

For clients who want to apply for all programs in counties that do not process MinnesotaCare, the application is sent to the State MinnesotaCare Operations office if denied for MA.

Renewals

Both MA and MinnesotaCare require renewals at specific intervals. Generally for MA, there is a six-month income and assets renewal and an annual renewal which looks at income along with household composition, assets, other health insurance and other changes in circumstances that may have occurred over the previous 12 months. MinnesotaCare has only an annual renewal, which reviews the same information as MA. For both programs, pregnant women must be redetermined for continuing coverage after 60 days post-partum. MinnesotaCare pregnant women follow standard program renewal requirements. Medical Assistance pregnant women are only required to complete a renewal in certain circumstances but at the very least must have their eligibility reviewed.

The MA six-month income and asset renewal begins six months after the month of initial eligibility and is due by the eighth day of the sixth month. The case is automatically closed if the form is not received by the end of the sixth month. Clients that are no longer eligible for MA based on information provided in the six-month renewal must be reviewed for MinnesotaCare. If the county does not process MinnesotaCare, the application/renewal is forwarded to MinnesotaCare Operations for review of MinnesotaCare eligibility.

The month of the first annual renewal for MA is 12 months after the first month of the certification period. If household members have different eligibility start dates but applied at the same time, the annual renewal for the entire household is scheduled based on the household member with the earliest renewal date. Further renewals are scheduled for 12 months after the effective date of the previous renewal.

MinnesotaCare renewals must be processed by the last day of the month before the renewal month, referred to as the redetermination date. The premium amount for the first month of the new eligibility period must be received by the redetermination date. MMIS identifies the redetermination date, which is the last day of the twelfth month after the month the status of the case is set to "pending awaiting payment." Further renewals are due every subsequent twelfth month.

The MA renewal notice is sent approximately 45 days prior to when the renewal is due through a MAXIS system-generated notice. The MinnesotaCare renewal notice is sent to the client 45 days prior to the redetermination date by MMIS. If a family has members enrolled in both MA and MinnesotaCare, it will receive multiple notices. For both MA and MinnesotaCare, renewal forms received after the redetermination date (for MinnesotaCare) or after the end of the certification period (for MA) but in the renewal month are considered a new application; if the renewal is received after the renewal month, the client in most cases must submit a new application for consideration for coverage. Because coverage for MinnesotaCare clients is based on payment of premium, renewal delay could cause a break in coverage until a new application is submitted and the premium payment is received.

Minnesota Community Application Agents

In addition to the county and State application sites, Minnesota also has a program where non-profits and other agencies can work with clients in the community to support completion of applications for health care coverage. The Minnesota Community Application Agents (MnCAAs), typically organizations that already provide outreach and assistance to low-income persons, are located throughout the State. There are currently over 40 MnCAAs registered with the State, serving counties across Minnesota.

The MnCAAs are required to enter into a contract with the State and attend trainings on Minnesota Heath Care Programs. Once an organization is certified as a MnCAA, they work with individuals to assist them with the application process, including completing the application, educating them on the programs available, and assisting with collecting the required verifications. MnCAAs also track the progress of an individual's application and assist the client when additional information is needed to complete the review.

The State assists the MnCAAs by offering training, quarterly "best practice" calls, and a MnCAA resource center where MnCAA staff can go with questions. Most MnCAAs are required to send an application first to the State MnCAA center, where staff determine if the application is complete and can then forward to the county or State MinnesotaCare Operations for review. However, as MnCAAs gain more experience they are allowed to submit directly to the county or State for review. MnCAAs receive $30 per completed application for which eligibility is approved. Overall, they have a successful record of application approvals.

Systems

MA and MinnesotaCare are processed in two different systems. MAXIS is the eligibility system that is used for MA, as well for other assistance programs (e.g., food, cash). MMIS, the State's system for paying claims, also stores eligibility information for MinnesotaCare. MAXIS also creates a Personal Master Index (PMI) number for both MA and MinnesotaCare as well as the case number for MA. MMIS generates MinnesotaCare case numbers.

MAXIS is intended to automatically perform the required income and asset calculations for MA, cash assistance, and food support. However, county caseworkers must often employ multiple manual work-arounds called "fiats" to process MA applications. The use of fiats is driven by multiple factors, such as legislative changes that cannot be implemented within the time between enactment and the effective date of the change. In addition, for several years updates

were not made to MAXIS in anticipation of a new eligibility system that ultimately was not completed. Caseworkers must often use a "fiat" to enter results of the assets calculation, due to conflicts in which assets are counted for each program processed in MAXIS. A caseworker needs to "fiat" to deny eligibility because the system is not able to determine that the client is over the asset limit for MA.

For MinnesotaCare, caseworkers at the county or State must manually enter information into MMIS after completing off-line calculations. MAXIS has limited interface capabilities with MMIS, sending MMIS nightly and monthly batches of data as well transferring PMI numbers, addresses, demographic information (DOB, SSN, etc), and Medicare information in "real time." MMIS does not transmit any data to MAXIS. MMIS is also used by both programs to store TPL information, where applicable.

County caseworkers have access to both MAXIS and MMIS. MinnesotaCare Operations staff have access to MMIS and only limited access to MAXIS primarily to create a PMI for new clients.

Minnesota HealthCare Connect Initiative

The Minnesota HealthCare Connect business process re-engineering project brought the State and counties together to consider significant changes to health care eligibility and enrollment processes, and has already identified four significant process improvements. The Minnesota HealthCare Connect initiative was started in order to determine the best opportunities for minimizing State costs while maximizing current staff and system capabilities based on data analysis of current processes. The following initiatives are currently being pursued by the State via the HealthCare Connect initiative.

- **Electronic Document Management System (EDMS)**: EDMS is envisioned to be a statewide system that would allow the sharing of all public assistance client documentation (e.g., application, verification documents, etc.), allowing counties and states to have faster access to documentation necessary to determine and monitor client eligibility by reducing the need for paper transfers.

- **Enrollment broker/choice counseling**: The initiative is aimed at providing all clients of the State's health care program consistent and comprehensive information on health plans that are available. Currently, there is minimal counseling provided to enrolled clients on health plans, beyond what information is sent in the initial enrollment package. The goal of the initiative is to assist clients in choosing the health plan that that would best meet their needs.

- **Client Choice of Venue (CCV)**: CCV would allow clients to choose where and how they apply for benefits and interact with county and State staff. The initiative would include a primary center at the State for coordination and to respond to questions as well as kiosks located in the community. Clients would be allowed to apply, renew and get additional information in-person, by phone or on-line.

- **Specialized Support for Long-Term Care (LTC) Cases**: Given the complexity of LTC eligibility, the State also developed an initiative to assist county caseworkers in gaining the expertise necessary to review and manage LTC cases.

The Minnesota HeathCare Connect initiatives would greatly support alignment that would enhance both the caseworker and client experience. The EDMS, for example, would decrease processing time and improve communication between the counties and the State, by allowing documentation to be shared more easily. Additionally, the enrollment broker initiative would reduce the burden on both State and county caseworkers and would ideally result in better counseling regarding managed care options for clients, ensuring they enter the plan that would serve them best.

Programs differences and overlap

Figure 30. MA and MinnesotaCare Differences in Administrative Processes

	Issue	MA	MinnesotaCare
Differences	Application structure	▪ Client reviewed for MA if they ask to be reviewed for all programs or do not respond to informed choice questions	▪ Client can select to be reviewed for MinnesotaCare only
	Application processing and review location	▪ Applications are processed and reviewed only at the county	▪ Applications are processed primarily at the State level, and in 48 counties
	Application processing and review timeframe	▪ All applications must be processed within 45 days of receipt (except for pregnant women which must be reviewed in 15 days)	▪ All applications must be reviewed and either pended or decided within 30 days of receipt
	Denied applications	▪ Applications denied for MA for reasons other than failure to provide necessary verification documents are reviewed for MinnesotaCare by either the county or the State	▪ Applications where the client elects to be reviewed only for MinnesotaCare can be used for MA review within 45 days if the client requests that the application be reviewed for MA

	Issue	MA	MinnesotaCare
	Application lifespan	▪ Applications denied for MA or closed for MA cannot be used again	▪ If a client applies for MinnesotaCare and is denied for any reason, the client can apply again for MinnesotaCare any time in the next eleven months using the same application, although verification documentation must be updated ▪ The applications can also be used for MA review within 45 days if the client requests that the application be reviewed for MA
	12- Month Renewal Timeline	▪ The month of the first annual renewal for MA is 12 months after the first month of the certification period ▪ Further renewals are scheduled for 12 months after the effective date of the previous renewal	▪ MinnesotaCare renewals must be processed by the last day of the month before the renewal month, referred to as the redetermination date identified by MMIS ▪ MMIS identifies the redetermination date, which is the last day of the twelfth month after the month the status of the case is set to "pending awaiting payment" ▪ Further renewals are due every subsequent twelfth month
	Renewal notices	▪ The MA renewal notice is sent approximately 45 days prior to when the renewal is due through a MAXIS system-generated notice	▪ The MinnesotaCare renewal notice is sent to the client 45 days prior to the redetermination date by the MMIS system
	Systems	▪ MAXIS systems is used to process and store MA eligibility data	▪ MMIS is used to store MinnesotaCare eligibility data

Challenges

Given that historically MA and MinnesotaCare were meant to be two distinctly different programs, it is understandable why administratively there are many major differences between

the programs. However, as the two programs now serve primarily the same populations and are now, in some areas, both administered at the county level, the administrative barriers to alignment impact many stakeholders - clients, counties, the State, and MnCAAs.

Issues for clients and the MnCAAs who support them include:

- Lack of understanding as to where the application is in the process, particularly if the client is denied MA and the application is transferred to the State MinnesotaCare Operations office because the county does not review for MinnesotaCare (no single point of contact in counties or at the State for clients or MnCAAs to follow up with)
- Major impacts to the application processing timeline as information is sent between counties and the State, causing delays in enrollment and requiring clients to resubmit documentation
- Confusion over the informed choice question and other aspects of the application (e.g., questions on disabilities, defining self-employment, understanding what information is required for assets, understanding if they qualify for retroactive coverage)
- Confusion over multiple notices sent out by both MAXIS and MMIS, leaving the client unsure about what requires their immediate action

The use of multiple systems is generally difficult for caseworkers to manage given their already large workload. Changes to cases must be made in both systems, which do not always occur. Further, multiple fiats, or manual overrides in the system, must be made, creating possible program integrity issues.

While many of the current administrative challenges are driven by differences between the two major systems, the State must first address other areas in which alignment is necessary in order to lay the groundwork for a new single system that can support both programs. Until a new system is possible, the State can explore other options that might not eliminate all administrative hurdles but could reduce the burden on caseworkers and improve the process for clients and the MnCAAs that serve them.

Conclusion

While the MA and MinnesotaCare programs serve many of the same low-income children and families, differences in the eligibility rules and processes between the two programs cause confusion, delay, administrative expense, and error. The State, clients, advocates, and the federal government share concern that the complexity and overlap of the program rules make it difficult for clients to make an informed choice about the best health care coverage option. Given the growth in program enrollment during the recession—particularly among persons who had not been previously enrolled in any public health care program—and budget challenges that are contributing to eligibility processing backlogs at the counties and the State, the goal of eligibility alignment and simplification is more important than ever.

Minnesota has already implemented a variety of processes and adopted eligibility rules for State health care programs to help reduce barriers and support efficient program administration. This includes use of a common application form for MA and MinnesotaCare, eliminating the in-person interview requirement for MA, allowing counties to opt to process MinnesotaCare applications, using Minnesota Community Application Agents (MnCAA) to facilitate program enrollment, and requesting that CMS amend the terms and conditions of the State's §1115 waiver to eliminate MinnesotaCare premiums and insurance barriers for children with incomes below 200% of the FPG.

Some further alignment strategies can be implemented by the State within existing administrative rules, while others may require substantial State or federal legislative changes or federal waiver approval. Certain changes to program rules may require significant system and processes changes, while others may not. Effects on enrollment may vary depending on the magnitude and the nature of the change; some process alignments may make it easier for currently-eligible clients to obtain and maintain eligibility; other rule alignments may make additional persons newly eligible for coverage; any program improvement may create a "woodwork" effect where more people come forward to seek coverage. Finally, while it is difficult to achieve net savings through eligibility alignment (improvements in client access lead to increased medical costs that generally outweigh any administrative savings), improvements in the process that reduce per-case effort will have benefits throughout the system, supporting faster and more accurate application processing within current staffing levels.

Many of the major areas of difference (e.g., premiums, treatment of other health insurance, state/county administration) reflect fundamental distinctions that stem from the differing origins and purposes of the two programs: MA is a public assistance program originally linked to persons and families receiving cash assistance, while MinnesotaCare was developed as an alternative insurance program for low-income working families. Alignment of the programs in these areas requires not just consideration of the cost, impact on clients, and identification of required changes to the waiver or State Plan; some alignment options will require reconsidering the underlying policy goals of the program. However, the kind of substantial gains in program alignment necessary to streamline eligibility systems and processes and improve client access may demand such program-level evaluation of alignment opportunities. Comprehensive alignment strategies, which may or may not involve radical program change, will be addressed in our final paper.

It is important to note that the context for this study has changed significantly since its beginning, due to the signing of the federal health reform bill on March 23, 2010. All states, including Minnesota, must now work with the federal government over the next three years to develop insurance exchanges to (initially) serve low-income and uninsured persons, and coordinate those exchanges with existing public health programs. States will also be required to cover additional persons through their Medicaid programs, including many low-income adults who did not previously meet any categorical criteria. Both of these activities are likely to increase the identification and enrollment of additional persons already eligible for MA or MinnesotaCare (the "woodwork effect"), contributing to a potentially significant increase in program enrollment.

At the same time, the federal government has required states to demonstrate "maintenance of effort": states must ensure that the "eligibility standards, methodologies, or procedures" under the Medicaid State Plan or Medicaid waiver or demonstration programs, are not more restrictive during this period than those "in effect" on July 1, 2008. This requirement was originally a condition of receiving enhanced federal matching funds under the stimulus bill and applied only through December 31, 2010, but the health reform law now requires states to maintain their eligibility levels for Medicaid until the Secretary of Health and Human Services deems the states' new health insurance exchanges to be fully operational (anticipated to be on January 1, 2014). Furthermore, states must maintain their eligibility levels for children in both the Medicaid and CHIP programs through September 30, 2019. Federal guidance on these issues has not been finalized—and may not be within the timeframes for this study—but attention to emerging policy interpretations and potential consequences will be critical in formulating potential alignment strategies that do not run afoul of federal financing rules.

Our objective in this project is to sort through the complex set of issues that surround a program eligibility alignment effort and produce a careful recommendation of specific, actionable approaches that the State can take. We will work collaboratively with the State and its stakeholders to ensure that our analyses are grounded in fact and relevant to Minnesota's priorities.

Appendix A – Income Counted the Same for MA and MinnesotaCare

Income Source	HCPM Chapter	How Income is Treated for MA and MinnesotaCare
Availability of Income		
Credit life insurance payments	20.05	Unavailable Income → To secure eligibility, client must attempt to gain access
Credit disability insurance payments	20.05	Unavailable Income → To secure eligibility, client must attempt to gain access
AmeriCorps State and National and NCCC Payments		
AmeriCorps NCCC Pmts	20.25.70	Count
AmeriCorps State & National Pmts	20.25.70	Count
Tribal Payments		
Tribal gaming revenues	20.25.60	Count as unearned income
Tribal trusts	20.25.60	Exclude only the first $2000 a person receives each year from his or her interest in Indian trust land or other restricted Indian lands
Trusts		
Trust Disbursements	19.25.35	Count as income when: ▪ Income the client receives and later deposits into a trust ▪ Income directly deposited into a trust asset, but which is not assigned to the trust ▪ Income from the trust distributed to the client, or on behalf of the client, for his or her needs ▪ The language in the trust instrument will determine whether to count income to the trust as income to the client

Income Source	HCPM Chapter	How Income is Treated for MA and MinnesotaCare
Garnishment and Other Income Withholding		
Garnishments	20.05.05	Count, unless: ▪ Amount that is withheld from income to repay a prior overpayment of benefits made by the same income source
Overpayments	20.05.05	Count, unless: ▪ Amount that is withheld from income to repay a prior overpayment of benefits made by the same income source
Withholdings	20.05.05	Count, unless: ▪ Amount that is withheld from income to repay a prior overpayment of benefits made by the same income source
Earned and Unearned Income		
Blood & Blood Plasma Sales	20.25	Count as earned income
Clergy Housing, Reimbursements	20.25	Count as earned income
Commissions	20.25	Count as earned income
Community Service Employment Program	20.25	Count as earned income
Disability payments that are part of employer's benefit package	20.25	Count as unearned income
Employee Income	20.25	Count as earned income
Experience Work Wages	20.25	Count as earned income
Jury Duty	20.25	Count as earned income
Honoraria	20.25	Count as earned income
Housing allowances for clergy	20.25	Count as earned income
National and Community Service Act of 1990 (wages paid under)	20.25	Count as earned income
National and Community Service Models (wages paid under)	20.25	Count as earned income
Pension Payments	20.25	Count as unearned income

Income Source	HCPM Chapter	How Income is Treated for MA and MinnesotaCare
Picket Duty Pay	20.25	Count as earned income
Railway Retirement Payments	20.25	Count as unearned income
Retirement payments	20.25	Count as unearned income
Retirement Survivors and Disability Insurance (RSDI)	20.25	Count as unearned income
Royalties	20.25	Count as earned income
Salary	20.25	Count as earned income
Seasonal Employment	20.25.25	Count as earned income
Serve America Payments	20.25	Count as earned income
Senior Aide program wages	20.25	Count as earned income
Severance Pay	20.25	Count as earned income
Sick Pay	20.25	Count as earned income (if based on accrued or earned time. This is not disability benefits)
Spousal Maintenance	20.25	Count as unearned income
Tips	20.25	Count as earned income
Trade Adjustment Reform Act of 2002, employment supports	20.25	Count as unearned income
Unemployment Insurance	20.25	Count as unearned income
Vacation donation compensation	20.25	Count as earned income
Vacation pay	20.25	Count as earned income
Veterans Administration Benefits	20.25	Count as unearned income
Wages	20.25	Count as earned income
Workers Compensation	20.25	Count as unearned income
Student Financial Aid		
Fellowships	20.25.55	Exclude for undergrad students, count as unearned/earned income for grad students *This is for Non-Title IV HEA and Non-BIA grants. (Title IV grants are excluded for both undergraduate and graduate students)

Income Source	HCPM Chapter	How Income is Treated for MA and MinnesotaCare
Grants	20.25.55	*Exclude if grant is under Title IV authority * Exclude for undergraduate students, count as unearned/earned income for graduate students if grant is under non-Title IV authority
Paid internship	20.25.55	Whether counted/excluded dependent on if financial aid funding is through Title IV or not. ▪ Non-title IV excludes income for undergrads, but counts for grad students ▪ Title IV excludes income
PASS Financial Aid	20.25.55	Whether it is counted or excluded is dependent on whether or not financial aid funding is through Title IV or not or if it is through Bureau of Indian Affairs ▪ Non-title IV excludes income for undergrads, but counts for grad students ▪ Title IV excludes income
Scholarships	20.25.55	Whether it is counted or excluded is dependent on funding source
Student Financial Aid	20.25.55	Whether it is counted or excluded is dependent on funding source
Student Income	20.25.55	Whether it is counted or excluded is dependent on funding source
Workstudy	20.25.55	Whether it is counted or excluded is dependent on funding source
Other Types of Income		
Annuity Payments	19.25.30	Count as unearned income
Farm Income	20.25.20.40	Count as earned/unearned income (dependent on conditions met)

Income Source	HCPM Chapter	How Income is Treated for MA and MinnesotaCare
Fund Raisers	20.25.75	Whether or not counted or excluded as income depends on whether the funds are under the control of the client, enrollee or a responsible relative
Hostile Fire Pay	20.25.80	Count as earned income
In-home Care	20.25.20.35	Count as earned income (Clients who provide day care in their homes are considered self-employed for Minnesota Health Care Program)
Japanese Persecution, Payments to victims of	20.25.85	Count as unearned income
Make-a-Wish Gift	20.25.75	Exclude the first $2,000 of total cash payments each year & the value of in-kind gifts that are not converted to cash Count the total value of in-kind gifts converted to cash in the month they are converted (Unless asset)
Military Salary, Hostile Fire Pay	20.25.80	Count as earned income
Roomer/Boarder Income	20.25.20.30	Count as earned (self-employment) income
Self-Employment	20.25.20	Count as earned income
Gifts to Children with Life-Threatening Illnesses	20.25.75	Exclude the first $2,000 of total cash payments each year & the value of in-kind gifts that are not converted to cash. Count the total value of in-kind gifts converted to cash in the month they are converted (Unless asset)
Fund Raisers	20.25.75	Whether or not counted or excluded as income depends on whether the funds are under the control of the client, enrollee or a responsible relative