State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road N
St. Paul, Minnesota 55155

September 14, 1994

Ms. Maryanne Hruby
Executive Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

Pursuant to Minnesota Statutes, section 14.131, enclosed is a statement of need and reasonableness relating to MinnesotaCare, Minnesota Rules, parts 9506.0010 to 9506.0100.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at 296-7815.

Sincerely,

Martha O'Toole

Martha O'Toole
Rules Division

Encl.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption
of the Rule of the State Department of
Human Services Governing MinnesotaCare,
Minnesota Rules, parts 9506.0010
to 9506.0100

DUAL NOTICE:

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING UNLESS 25 OR MORE PERSONS REQUEST A HEARING,
AND
NOTICE OF HEARING IF 25 OR MORE REQUESTS FOR HEARING ARE RECEIVED

Introduction. The Minnesota Department of Human Services intends to adopt a permanent rule without a public hearing following the procedures set forth in the Administrative Procedure Act, Minnesota Statutes, sections 14.22 to 14.28. If, however, 25 or more persons submit a written request for a hearing on the rule within 30 days or by October 19, 1994, a public hearing will be held on Thursday, November 3, 1994. To find out whether the rule will be adopted without a hearing or if the hearing will be held, you should contact the agency contact person after October 20, 1994 and before November 3, 1994.

Agency Contact Person. Comments or questions on the rule and written requests for a public hearing on the rule must be submitted to:

Martha N. O'Toole
Minnesota Department of Human Services
Appeals & Regulations Division
444 Lafayette Road
Saint Paul, Minnesota 55155-3816
(612) 296-7815
Fax (612) 297-3173

Subject of Rule and Statutory Authority. The proposed permanent rule governs administration of the MinnesotaCare program. The proposed permanent rule 1) establishes eligibility criteria; 2) specifies application and enrollment processes; 3) specifies covered services and when coverage begins; 4) specifies premium payments, premium due dates, and the consequences if premiums are received late or not at all; 5) coordinates the program with Medical Assistance; 6) requires an annual redetermination of eligibility and enrollee cooperation in this redetermination; 7) requires random audits to verify eligibility; 8) provides enrollee appeal procedures; 9) requires MinnesotaCare coverage to be secondary to other health coverage; 10) requires enrollee copayments; 11) specifies that

surveillance and utilization rules apply to the MinnesotaCare program. The statutory authority to adopt the rule is Minnesota Statutes, section 256.9352, subdivision 2. A copy of the proposed rule is published in the State Register and attached to this notice as mailed.

Copy of the Rule. A free copy of this rule is available upon request from the agency contact person listed above. A copy of the proposed rule may also be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Comments. You have until 4:30 p.m. on October 19, 1994, to submit written comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Your comment must be in writing and received by the agency contact person by the due date. Comment is encouraged. Your comments should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Request for a Hearing. In addition to submitting comments, you may also request that a hearing be held on the rule. Your request for a public hearing must be in writing and must be received by the agency contact person by 4:30 p.m. on October 19, 1994. Your written request for a public hearing must include your name, address and telephone number. You are encouraged to identify the portion of the proposed rule which caused your request, the reason for the request, and any changes you want made to the proposed rule. If 25 or more persons submit a written request for a hearing, a public hearing will be held unless a sufficient number withdraw their requests in writing.

Modifications. The proposed rule may be modified, either as a result of public comment or as a result of the rule hearing process. Modifications must not result in a substantial change in the proposed rule as attached and printed in the State Register and must be supported by data and views submitted to the agency or presented at the hearing. If the proposed rule affects you in any way, you are encouraged to participate in the rulemaking process.

Cancellation of Hearing. The hearing scheduled for Thursday, November 3, 1994, will be canceled if the agency does not receive requests from 25 or more persons that a hearing be held on the rule. If you requested a public hearing, the agency will notify you before the scheduled hearing whether or not the hearing will be held. You may also call Martha N. O'Toole at 612-296-7815 after October 19, 1994, to find out whether the hearing will be held.

Notice of Hearing. If 25 or more persons submit written requests for a public hearing on the rule, a hearing will be held following the procedures in Minnesota Statutes, sections 14.14 to 14.20. The hearing will be held on Thursday, November 3, 1994, in the Veteran's Administration Building, Fifth Floor, Room D, 20 West 12th Street, St. Paul, MN 55101, beginning at 9 a.m. and will continue until all interested persons have been heard. The hearing will continue, if necessary, at additional times and places as

determined during the hearing by the administrative law judge. The administrative law judge assigned to conduct the hearing is Howard L. Kaibel Jr. Judge Kaibel can be reached at the Office of Administrative Hearings, 100 Washington Square, Suite 1700, 100 Washington Avenue South, Minneapolis, Minnesota 55401-2138; telephone (612) 341-7608.

Hearing Procedure. If a hearing is held, you and all interested or affected persons including representatives of associations or other interested groups, will have an opportunity to participate. You may present your views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should relate to the proposed rule. You may also mail written material to the administrative law judge to be recorded in the hearing record for five working days after the public hearing ends. This five-day comment period may be extended for a longer period not to exceed 20 calendar days if ordered by the administrative law judge at the hearing. Comments received during this period will be available for review at the Office of Administrative Hearings. You and the agency may respond in writing within five business days after the submission period ends to any new information submitted. All written materials and responses submitted to the administrative law judge must be received at the Office of Administrative Hearing no later than 4:30 p.m. on the due date. No additional evidence may be submitted during the five-day period. This rule hearing procedure is governed by Minnesota Rules, parts 1400.0200 to 1400.1200 and Minnesota Statutes, sections 14.14 to 14.20. Questions about procedure may be directed to the administrative law judge.

Statement of Need and Reasonableness. A statement of need and reasonableness is now available from the agency contact person. This statement describes the need for and reasonableness of each provision of the proposed rule. It also includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing, if one is held. The statement may also be reviewed and copies obtained at the cost of reproduction from the Office of Administrative Hearings.

Small Business Considerations. In preparing these proposed rules, the Department considered the requirements of Minnesota Statutes, section 14.115 but determined that these rules are exempt from those requirements under the exemption for providers of medical care in section 14.115, subd. 7, clause (3).

Expenditure of Public Money by Local Public Bodies. A copy of the fiscal note is available from the agency contact person at the address and telephone number listed above. The Department estimates that the proposed rules will not result in additional state and local costs; costs associated with the MinnesotaCare program are statutorily-imposed and do not result from the proposed rules.

Impact on Agriculture Lands. The Department has determined in the review required under Minnesota Statutes, section 14.11, subd. 2

Lobbyist Registration. Minnesota Statutes, chapter 10A requires each lobbyist to register with the Ethical Practices Board. Questions regarding this requirement may be directed to the Ethical Practices Board at 1st Floor, Centennial Office Building, 658 Cedar Street, Saint Paul, Minnesota 55155; telephone (612) 296-5148.

Adoption Procedure if No Hearing. If no hearing is required, after the end of the comment period the agency may adopt the rule. The rule and supporting documents will then be submitted to the Attorney General for review as to legality and form to the extent form relates to legality. You may request to be notified of the date the rule is submitted to the Attorney General or be notified of the Attorney General's decision on the rule. If you want to be so notified, or wish to receive a copy of the adopted rule, submit your request to Martha O'Toole at the address listed above.

Adoption Procedure After the Hearing. If a hearing is held, after the close of the hearing record, the administrative law judge will issue a report on the proposed rule. You may request to be notified of the date on which the administrative law judge's report will be available, after which date the agency may not take any final action on the rule for a period of five working days. If you want to be notified about the report, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the administrative law judge. You may also request notification of the date on which the rule is adopted and filed with the Secretary of State. The agency's notice of adoption must be mailed on the same day that the rule is filed. If you want to be notified of the adoption, you may so indicate at the hearing or send a request in writing to the agency contact person at any time prior to the filing of the rule with the Secretary of State.

Date: 9/1 1994

MARIA R. GOMEZ
Commissioner

Department of Human Services

Proposed Permanent Rules Governing MinnesotaCare

Rules as Proposed (all new material)

9506.0010 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9506.0010 to 9506.0100 have the meanings given them in this part.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written application to the department for a determination of eligibility for MinnesotaCare.

Subp. 3. **Child.** "Child" means a person who is less than 18 years of age.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

Subp. 5. **Covered health services.** "Covered health services" means the services listed in Minnesota Statutes, section 256.9353, subdivisions 1 to 5.

Subp. 6. **Department.** "Department" means the Department of Human Services.

Subp. 7. **Dependent sibling.** "Dependent sibling" has the meaning given in Minnesota Statutes, section 256.9354, subdivision 1, paragraph (b).

Subp. 8. **Eligible provider.** "Eligible provider" means a health care provider who provides covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subp. 9. **Employer-subsidized health coverage.** "Employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee. Employer-subsidized health coverage includes employer contributions to Internal Revenue Code, section 125 plans.

Employer-subsidized health coverage excludes dependent

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coverage unless the employer offers dependent coverage to employees and pays at least 50 percent of the cost of dependent coverage. Employer-subsidized health coverage for children includes coverage through either parent, including a noncustodial parent.

Subp. 10. **Enrollee.** "Enrollee" means an individual who:

A. has been determined eligible by the department to receive covered health services under MinnesotaCare; and

B. has paid the required premium under part 9506.0040.

Subp. 11. **Family.** "Family" means a parent or parents and their children or guardians and their wards who are children; and dependent siblings residing in the same household. The term includes children and dependent siblings temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. Family also means an emancipated minor and an emancipated minor's spouse, spouses in households without children, and single individuals in a one-person household.

Subp. 12. **General assistance medical care.** "General assistance medical care" has the meaning given in Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 13. **Local social service agency.** "Local social service agency" means the local agency under the authority of the county welfare or human services board or county board of commissioners that is responsible for providing human services.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 15. **MinnesotaCare.** "MinnesotaCare" means the program authorized in Minnesota Statutes, sections 256.9351 to 256.9363, to promote access to appropriate covered health services to assure healthy children and adults.

Subp. 16. **Other health coverage.**

A. "Other health coverage" means:

(1) basic hospital coverage;

(2) medical-surgical or major medical coverage;

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(3) Medicare part A or part B coverage under title XVIII of the Social Security Act;

(4) supplemental Medicare coverage under Minnesota Statutes, sections 62A.31 to 62A.44;

(5) coverage through a health maintenance organization under Minnesota Statutes, chapter 62D;

(6) coverage through a health maintenance organization under Minnesota Statutes, chapter 62D, combined with Medicare benefits under title XVIII of the Social Security Act; or

(7) coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under United States Code, title 10, chapter 55, sections 1079 and 1086.

B. "Other health coverage" does not mean:

(1) medical assistance;

(2) general assistance medical care;

(3) coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256B.73;

(4) coverage under the Hennepin county assured care program; or

(5) coverage under the Group Health, Inc., community health plan.

Subp. 17. **Parent.** "Parent" means the birth, step, or adoptive mother or father of a child.

Subp. 18. **Permanent residency.** "Permanent residency" has the meaning given in Minnesota Statutes, section 256.9359.

Subp. 19. **Spend-down.** "Spend-down" means the process by which a person who has income in excess of the income standard allowed under the medical assistance program becomes eligible for medical assistance as a result of incurring medical expenses that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 20. **Third-party payer.** "Third-party payer" means a person, entity, agency, or other health coverage that has a probable obligation to pay all or part of the costs of an

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enrollee's health services.

9506.0020 ELIGIBILITY FOR MINNESOTACARE.

Subpart 1. **General eligibility requirements.** Except as provided in subparts 2, 3, and 5, an applicant or enrollee must:

A. be a permanent resident of Minnesota;

B. be ineligible for medical assistance without a spend-down, including medical assistance for pregnant women, except that an enrollee who receives inpatient hospital services may be eligible for medical assistance with or without a spend-down during the months of hospitalization;

C. not currently be covered by general assistance medical care;

D. not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins;

E. not have access to employer-subsidized health coverage during the 18 months immediately preceding the date coverage begins;

F. identify potentially liable third-party payers and assist the department in obtaining third-party payments;

G. have gross annual income that does not exceed the amounts in Minnesota Statutes, section 256.9358, subdivisions 3 and 4; and

H. comply with the family enrollment requirements in subpart 4.

Subp. 2. **Exceptions to general eligibility requirements.**

A. Subpart 1, items D and E, do not apply to an applicant who is terminated from medical assistance, general assistance medical care, or coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan if the department receives a MinnesotaCare application before the last day of the month following the month in which termination occurred.

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B. Subpart 1, item E, does not apply under the following circumstances:

(1) if the employer-subsidized health coverage was lost for reasons that would not disqualify the applicant from receiving reemployment benefits under Minnesota Statutes, section 268.09, and the applicant has not had access to employer-subsidized health coverage since the loss; or

(2) to children of an individual whose employer-subsidized coverage was lost for reasons that disqualify the individual for reemployment benefits if the children have not had access to employer-subsidized coverage since the disqualifying event.

Subp. 3. **Children in families with income at or below 150 percent of the federal poverty guidelines.** A child in a family with income at or below 150 percent of the federal poverty guidelines is eligible for MinnesotaCare from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old if the child:

A. meets the requirements under subpart 1, items A to C and F to H; and

B. is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitem (1), (2), or (3) applies:

(1) the child lacks coverage in two or more of the areas listed in units (a) to (e):

(a) basic hospital coverage;

(b) medical-surgical coverage;

(c) major medical coverage;

(d) dental coverage;

(e) vision coverage;

(2) coverage requires a deductible of $100 or more per person per year; or

(3) a child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

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Subp. 4. **Family enrollment.** Families must comply with items A to F.

A. Parents who enroll must enroll all eligible children and dependent siblings.

B. Children and dependent siblings may be enrolled without parents enrolling, unless other insurance is available.

C. If one parent in a household enrolls, both parents in the household must enroll, unless other insurance is available.

D. If one child in a family is enrolled, all children in the family must be enrolled, unless other insurance is available.

E. If one spouse in a household is enrolled, the other spouse in the household must enroll, unless other insurance is available.

F. Except as provided in item B, families cannot enroll only certain uninsured members.

Subp. 5. **Continuous eligibility.** An enrollee remains eligible for MinnesotaCare regardless of age or the presence or absence of children in the household as long as the enrollee:

A. maintains permanent residency in Minnesota;

B. meets all other eligibility criteria, except subpart 1, item G;

C. pays the full cost of coverage if gross annual family income after initial enrollment exceeds the limits in Minnesota Statutes, section 256.9358, subdivisions 3 and 4; and

D. is continuously enrolled in MinnesotaCare or medical assistance. To be continuously enrolled, an enrollee's reapplication must be received by the department before the last day of the first calendar month following the date of notice of termination of coverage from MinnesotaCare or medical assistance.

9506.0030 APPLICATION; ENROLLMENT; COVERAGE.

Subpart 1. **Application sources.** Applicants may apply directly to the commissioner or through appropriate referral sources.

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A. Appropriate referral sources include but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices defined in Minnesota Statutes, section 145A.02; WIC program sites under United States Code, title 42, section 1786.

B. Referral sources that accept applications from applicants must send applications to the department within five working days after receipt.

Subp. 2. **Necessary information for eligibility determination.**

A. Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for medical assistance, including:

(1) social security number;

(2) proof of permanent residency; the signature of an applicant on the application attesting to permanent residency meets the affidavit requirement under Minnesota Statutes, section 256.9359, subdivision 4, clause (3);

(3) household composition;

(4) availability of other health coverage, including access to employer-subsidized health coverage;

(5) gross annual family income; and

(6) any additional information needed by the commissioner to determine or verify eligibility.

B. If the commissioner determines an applicant may be ineligible for MinnesotaCare because employer-subsidized coverage was lost for reasons that would disqualify the applicant from receiving reemployment benefits under Minnesota Statutes, section 268.09, the commissioner shall refer the applicant to the department of economic security for a determination whether the applicant would have been disqualified.

Subp. 3. **Eligibility determination deadline.** Except during the four months after the dates on which adult individuals and families without children become eligible for

MinnesotaCare, the commissioner shall determine an applicant's eligibility within 30 days after a complete application is received by the department.

Subp. 4. **Enrollment and beginning of coverage.** The date of enrollment and the date coverage begins are determined as follows:

A. An applicant is enrolled in MinnesotaCare on the date the following are completed:

(1) a complete application is received by the department and the applicant is determined eligible under part 9506.0020; and

(2) the initial premium payment under part 9506.0040 is received by the department.

B. Coverage begins the first day of the calendar month following the date of enrollment, except:

(1) coverage for eligible newborns in an enrolled family begins immediately from the moment of birth;

(2) coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the date of placement for the purpose of adoption;

(3) coverage for other new members of an enrolled family begins the first day of the month following the month in which the new member's eligibility is determined and the first premium payment is received; and

(4) coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

9506.0040 PREMIUM PAYMENTS.

Subpart 1. **Premium payments.** Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is the total of the following:

A. $4 per month for each child in a family whose family income is at or below 150 percent of federal poverty guidelines; and

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B. for any family member not included under item A, a premium calculated under Minnesota Statutes, section 256.9358.

A premium payment table and an explanation of the table is available upon request from the department.

Subp. 2. **Gross annual family income.** "Gross annual family income" means the total income of all family members determined according to items A to C:

A. the income of self-employed persons, as defined in Minnesota Statutes, section 256.9351, subdivision 4;

B. the income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, calculated by determining:

(1) income in the four calendar months immediately preceding the month of application for MinnesotaCare, multiplied by three to reflect a 12-month period; or

(2) if the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under subitem (1), total income for the past 12 months; and

C. the following unearned income received in the four calendar months immediately preceding the month of application, multiplied by three to reflect a 12-month period:

(1) supplemental security income under title XVI of the Social Security Act;

(2) social security benefits;

(3) veterans' administration benefits;

(4) railroad retirement benefits;

(5) unemployment benefits;

(6) workers' compensation benefits;

(7) child support;

(8) spousal maintenance or support payments; and

(9) income from any other source, including interest, dividends, and rent.

Applicants and enrollees must report to the department any

changes from the amounts reported in items A to C that exceed $50 per month. Changes may be reported as a percentage increase or decrease. Gross annual family income will be recalculated by projecting the adjusted income for 12 months.

Subp. 3. **Premiums paid monthly, quarterly, or annually.** Applicants and enrollees may choose to pay premiums on a monthly, quarterly, or annual basis and may change payment schedules at the time a premium is due.

Subp. 4. **Billing notices.** The department shall mail premium payment billing notices as follows:

A. for monthly premiums, by the first day of the month preceding the month for which coverage will be provided;

B. for quarterly premiums, by the first day of the month preceding the first month of the quarter for which coverage will be provided; and

C. for annual premiums, by the first day of the month preceding the first month of the year for which coverage will be provided.

Subp. 5. **Premium payment dates.** Premium payments are due as follows:

A. An initial premium must be received by the department within four months after the date on the applicant's first premium notice.

B. Subsequent premiums must be received by the department as follows:

(1) monthly premiums by the 15th of the month preceding the month for which the premium is paid;

(2) quarterly premiums by the 15th of the month preceding the first month of the quarter for which the premium is paid; and

(3) annual premiums by the 15th of the month preceding the first month of the year for which the premium is paid.

Subp. 6. **Disenrollment.** The commissioner shall disenroll enrollees who fail to pay the required premium when due. MinnesotaCare coverage terminates the last day of the calendar

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month following the due date specified in subpart 5 unless the premium is received by the termination date.

Subp. 7. **Reenrollment.** An enrollee disenrolled for failure to pay the required premium may reenroll as provided in items A to D.

A. The enrollee:

(1) may not reenroll until four calendar months after the date coverage terminates, unless the person demonstrates good cause for nonpayment; and

(2) must comply with parts 9506.0010 to 9506.0100 and pay the unpaid premium for any month in which coverage was provided.

B. Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

C. Good cause for nonpayment means, generally, circumstances beyond an enrollee's control or that were not reasonably foreseeable that excuse an enrollee's failure to pay the required premium when due, including circumstances such as:

(1) because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;

(2) the enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available;

(3) the enrollee does not receive a regular source of income on which the enrollee has relied to pay the required premium.

D. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the person to demonstrate good cause.

Subp. 8. **Premium payment adjustments.** The commissioner shall adjust enrollees' premium payments upon receipt of the audit information required under part 9506.0060, subparts 1 to 4. Adjustments to premium payments are effective on the first day of the month following issuance of an adjusted premium invoice.

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9506.0050 COORDINATION OF MINNESOTACARE AND MEDICAL ASSISTANCE.

Subpart 1. **Referral of applicants and enrollees potentially eligible for medical assistance to local social service agency.** The commissioner shall refer applicants and enrollees who are potentially eligible for medical assistance without a spend-down to the local social service agency. The commissioner shall determine potential eligibility by considering:

A. age;

B. household income or assets;

C. pregnancy;

D. illness, injury, or incapacity indicating a disability;

E. household composition; and

F. employment status of household members.

Subp. 2. **Enrollment of applicants and enrollees potentially eligible for medical assistance.**

A. If an applicant who is potentially eligible for medical assistance without a spend-down meets the other conditions of eligibility for MinnesotaCare, the commissioner shall enroll the applicant in MinnesotaCare upon receipt of the initial premium payment.

B. An applicant or enrollee who is potentially eligible for medical assistance without a spend-down may continue to be covered by MinnesotaCare until determined eligible for medical assistance, provided:

(1) the applicant:

(a) applies for medical assistance within 60 days from the date MinnesotaCare coverage begins; and

(b) cooperates with the local social service agency in determining eligibility for medical assistance; or

(2) the enrollee:

(a) applies for medical assistance within 60 days after the first day of the month following the month of referral to the local social service agency; and

(b) cooperates with the local social service

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agency in determining eligibility for medical assistance.

C. An applicant who is determined eligible for medical assistance without a spend-down may be eligible for a refund of the applicant's MinnesotaCare premium payments, depending on family size.

Subp. 3. **Coordination of coverage for hospital inpatient services under MinnesotaCare and medical assistance.** Coverage for inpatient hospital services for enrollees shall be coordinated between MinnesotaCare and medical assistance as provided in this subpart.

A. The commissioner shall notify enrollees who have received inpatient hospital services and who are determined to have a basis of eligibility for medical assistance, in writing, that an application for medical assistance must be completed.

B. By the last day of the third month following the inpatient hospital admission, an enrollee who has received written notice under item A must apply for medical assistance and must cooperate with the local social service agency in determining eligibility for medical assistance.

C. If an enrollee is determined eligible for medical assistance with a spend-down:

(1) the enrollee is covered by medical assistance during the months of inpatient hospitalization;

(2) the enrollee must pay the MinnesotaCare premium, spend-down amounts that exceed the $10,000 annual benefit limit for adults, and the cost of services not covered by MinnesotaCare or medical assistance during any month in which inpatient hospital services are provided;

(3) the enrollee is not responsible for any hospital payments reduced under Minnesota Statutes, section 256.9353, subdivision 3, paragraph (c);

(4) MinnesotaCare shall pay the enrollee's spend-down for inpatient hospital services up to the $10,000 annual benefit limit for adults; and

(5) medical assistance shall pay the enrollee's inpatient hospital costs above spend-down amounts.

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D. An enrollee who is not eligible for medical assistance may:

(1) remain enrolled in MinnesotaCare; and

(2) unless the enrollee is a child, pay ten percent of the hospitalization charge, up to an annual maximum of $1,000 per person or $3,000 per family, and any hospitalization charges that exceed the $10,000 annual limit on MinnesotaCare benefits for inpatient hospital services.

An enrollee who is not eligible for medical assistance may be eligible for retroactive general assistance medical care under Minnesota Statutes, section 256D.03, subdivision 3, paragraph (b).

Subp. 4. **Disenrollment.**

A. The commissioner shall disenroll an enrollee and the enrollee's family when the enrollee fails to apply for medical assistance or cooperate with determining eligibility, as required under subparts 2 and 3. MinnesotaCare coverage terminates the last day of the calendar month following the month in which the medical assistance application was due.

B. An enrollee, and the enrollee's family, if disenrolled for failure to comply with subpart 2, may reenroll after cooperating with the medical assistance eligibility determination and being determined ineligible for medical assistance without a spend-down.

C. An enrollee, and the enrollee's family, if disenrolled for refusal to comply with subpart 3, item B, may not reenroll.

D. The commissioner shall disenroll an enrollee who is determined eligible for medical assistance without a spend-down. MinnesotaCare coverage terminates the last day of the calendar month in which the department receives notice of the enrollee's medical assistance eligibility.

9506.0060 QUALITY CONTROL.

Subpart 1. **Annual redetermination required.** The commissioner shall annually redetermine continued MinnesotaCare

eligibility for each enrollee.

Subp. 2. **Enrollee cooperation with annual redetermination.** Enrollees must annually provide the information needed to redetermine eligibility before the anniversary date of initial eligibility. The anniversary date of initial eligibility is the yearly recurrence of the first day of the month following the date of enrollment in MinnesotaCare.

Subp. 3. **Changes.** Enrollees must report to the department any changes in the following:

A. address;

B. household composition;

C. employment status;

D. a change of more than $50 per month of gross income;

E. availability of other health coverage;

F. onset of disability or change in disability; or

G. anticipation of legal action to collect money for an accident or an injury, or benefits available due to an accident or injury.

Subp. 4. **Random audits.** The commissioner shall perform audits of randomly selected enrollees to verify enrollees' gross annual family income and MinnesotaCare eligibility. Enrollees being audited must provide additional income and eligibility information, including:

A. federal income tax returns;

B. federal W2 forms;

C. employment check stubs;

D. family composition;

E. residency;

F. length of time without health insurance;

G. access to employer-subsidized coverage; and

H. any additional information necessary to determine income and eligibility.

Subp. 5. **Disenrollment.** The commissioner shall disenroll enrollees who refuse to provide information required under subparts 2 to 4. MinnesotaCare coverage will terminate the last

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day of the calendar month in which notice of cancellation is sent. Persons may reenroll after complying with this part and being determined eligible for MinnesotaCare.

9506.0070 APPEALS.

Subpart 1. **Notice.** The commissioner shall follow the notification procedures in chapter 9505 and Minnesota Statutes, chapter 256B, if the commissioner denies, suspends, reduces, or terminates MinnesotaCare eligibility or covered health services. The commissioner shall mail the person a written notice that describes the action, the reason for the action, and the person's right to appeal the action according to Minnesota Statutes, section 256.045.

Subp. 2. **Appeal process.** An applicant or enrollee aggrieved by a determination or action of the commissioner may appeal the determination or action according to Minnesota Statutes, section 256.045. An applicant or enrollee must submit a written request for a hearing to the department within 30 days after receipt of the written notice of the determination or action, except that a person has 90 days to submit a written request upon showing good cause why the request was not submitted within 30 days.

9506.0080 COVERED HEALTH SERVICES.

Subpart 1. **Covered health services.** Health services covered by MinnesotaCare include the services listed in Minnesota Statutes, section 256.9353.

Subp. 2. **Inpatient hospital services.**

A. Enrollees are covered for medically necessary inpatient hospital services including acute care services, mental health services, and chemical dependency services.

B. MinnesotaCare benefits for inpatient hospital services for adult enrollees are limited to $10,000 per calendar year. No benefit limit for inpatient hospital services applies to children.

C. To be reimbursed under MinnesotaCare for inpatient hospital services provided to enrollees, eligible providers must

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comply with:

(1) parts 9500.1090 to 9500.1140 and Minnesota Statutes, sections 256.9685, 256.9686, 256.969, and 256.9695, governing inpatient hospital payment rates for medical assistance;

(2) parts 9505.0170 and 9505.0475 and Minnesota Statutes, section 256.9353, subdivisions 1 to 5, establishing standards for services covered by medical assistance;

(3) parts 9505.5000 to 9505.5030 and Minnesota Statutes, section 256B.0625, subdivision 25, requiring prior authorization for certain services; and

(4) parts 9505.0540 and 9505.5035 to 9505.5105, governing second surgical opinions.

Subp. 3. **Hospital admission certification.** Inpatient hospital admissions of enrollees, including admission of a pregnant woman that results in the delivery of a newborn or a stillbirth or an admission where the principal diagnosis or procedure is an inpatient dental procedure, must be certified in accordance with the medical assistance certification criteria in parts 9505.0500 to 9505.0540, except for admissions:

A. approved under Medicare; or

B. authorized under parts 9530.6600 to 9530.6655.

Subp. 4. **Cost avoidance.** The commissioner shall use cost avoidance techniques to ensure benefit coordination for enrollees, including items A to C.

A. MinnesotaCare coverage for covered health services is secondary to other health coverage for which enrollees are eligible, except for coverage under the consolidated chemical dependency treatment fund.

B. Coverage by all potential third-party payers must be exhausted before MinnesotaCare payment for covered health services will be made. An eligible provider must attempt to collect payment from potential third-party payers before billing the department for a covered health service.

C. Private accident and health care coverage must be used according to the rules of the specific health plan.

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MinnesotaCare shall not pay for services that would have been covered by the primary health coverage if the applicable rules of that health coverage had been followed.

Subp. 5. **Lien.** When the department provides, pays for, or becomes liable for covered health services, the department has a lien for the cost of care upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence necessitating payment for covered health services. All liens under this subpart are governed by Minnesota Statutes, section 256.015.

9506.0090 COPAYMENTS AND ELIGIBLE PROVIDER REIMBURSEMENT.

Subpart 1. **Copayments required.** Adult enrollees must pay eligible providers the copayments required under Minnesota Statutes, section 256.9353, subdivision 7.

Subp. 2. **Reimbursement for covered health services.** Covered health services are reimbursed at the same rate and subject to the same conditions established for medical assistance, except:

A. federally qualified health centers, rural health clinics, and Indian health facility services are reimbursed as provided in Minnesota Statutes, section 256.9362, subdivision 2; and

B. inpatient hospital services are reimbursed as provided in Minnesota Statutes, section 256.9362, subdivisions 3 to 6.

Subp. 3. **Copayments not paid.** The commissioner shall reimburse an eligible provider at the full medical assistance rate minus any applicable copayments regardless of whether the eligible provider collects copayments from enrollees who are ineligible for medical assistance.

Subp. 4. **Commissioner's access to enrollee medical records.** Eligible providers must provide the commissioner access to enrollees' personal medical records to monitor compliance with parts 9506.0010 to 9506.0100 and to identify fraud, theft, or abuse by providers of health services through MinnesotaCare.

9506.0100 SURVEILLANCE AND UTILIZATION REVIEW.

Parts 9505.2160 to 9505.2245 apply to the MinnesotaCare program.

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Governing MinnesotaCare

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9506

The attached rules are approved for
publication in the State Register

Paul M Marinac

Paul M. Marinac
Deputy Revisor

Mary Kennedy
MN Dept. of Health
717 Delaware St. SE
INTER-OFFICE

Kathleen Murphy Mattner
3829

Sandy Burge
3829

Kathy McDonough
3848

Connie J. Cobb
3829

Nancy Dagg
3829

Senator Linda Berglin
G-9 Capitol
INTER-OFFICE

Rep. Lee Greenfield
375 State Office Building
INTER-OFFICE

Dr. Albert V. DeLeon
Council on Asian Pacific Minnesotans
205 Aurora Ave. #100
INTER-OFFICE

Katie Cavanor
Senate Counsel & Research
G-17 Capitol
INTER-OFFICE

Kristen J. Libby
MN Dept. of Finance
Centennial Office Building
INTER-OFFICE

Mamie Wertz
MN Dept. of Jobs and Training
390 N. Robert St.
INTER-OFFICE

Donna J. Petersen
Services for Children w/Handicaps
Maternal & Child Health Division
MN Dept. of Health
717 Delaware St. SE INTER-OFFICE

Randy Chun
House Research
600 State Office Building
INTER-OFFICE

Lester Kachinske
Aitkin County Family Service Agency

Linda Ewan
Anoka County Human Services Division

Nancy Obradovich
Itasca County Human Services

George French
Stevens County Social Services

Dick Williams
Isanti County Human Services

MARY HUOT
SMRLS
300 MINNESOTA BLDG
46 E 4TH ST
SAINT PAUL MN 55101

DR CAROLYN J MCKAY
AMERICAN ACADEMY OF PEDIATRICS
2221 HILLSIDE AVE
SAINT PAUL MN 55108

SUSAN CASTELLANO
CHILDRENS DEFENSE FUND
550 RICE ST #104
SAINT PAUL MN 55103

GRETCHEN MUSICANT
MN NURSES ASSOC
1295 BANDANA BLVD N
SAINT PAUL MN 55104

SUZANNE VEENHUIS
MN MEDICAL ASSOC
3433 BROADWAY ST SE #300
MINNEAPOLIS MN 55413-1761

TARRYL CLARK
SAINT CLOUD AREA LEGAL SERVICES
P O BOX 886
SAINT CLOUD MN 56302

FRAN CHERVENAK
LEGAL AID SOCIETY
430 FIRST AVE N #300
MINNEAPOLIS MN 55401-1780

Mavis Habte
Hennepin County Elderly & Disabled Adults
Ramar Bldg., 111 East Franklin

MAUREEN OCONNELL
LEGAL SERVICES ADVOCACY PROJECT
734 MINNESOTA BLDG
46 E 4TH ST
SAINT PAUL MN 55101

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICES PERMANENT RULES GOVERNING MINNESOTACARE

MINNESOTA DEPARTMENT OF HUMAN SERVICES

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

The proposed permanent rule is authorized by Minnesota Statutes, section 256.9352, subd. 2, which requires the commissioner of human services to adopt rules to administer the "health right plan," subsequently renamed "MinnesotaCare." The commissioner was also authorized to adopt emergency rules, effective for 720 days, governing initial implementation of "health right" (section 256.9352, subd. 4). An emergency rule [Minnesota Rules, parts 9506.0010 to 9506.0110 (Emergency)] was approved by the Office of the Attorney General on December 19, 1992; became effective December 28, 1992; and was published in the State Register January 19, 1993. The emergency rule expires December 18, 1994.

HISTORY

In 1992 the Minnesota Legislature enacted the HealthRight Act (Laws 1992, chapter 549), a comprehensive health care reform initiative with the goal of providing all Minnesotans access to high quality health care. The Act established a new subsidized health care coverage program for the uninsured, as well as insurance reforms and other strategies to address health care costs, quality and access. A cigarette tax and a tax on health care providers were imposed to finance the program

The health care coverage program, subsequently named "MinnesotaCare," expanded and replaced the existing Children's Health Plan, a program created in 1987 to provide health care coverage for low income children. MinnesotaCare provides comprehensive health coverage for children and more limited benefits for adults, including copayments and limited inpatient hospital coverage for adults. To be eligible, an individual or family must be without health coverage for at least 4 months and without access to employer-subsidized coverage within the previous 18 months. As originally enacted, a phase-in period of expanding eligibility for the program was established: October 1992, families of children currently enrolled in the Children's Health Plan; January 1993, all families with children; July 1, 1994, single adults and families without children.

Initially, children with family income at or below 185 percent of the federal poverty guidelines paid a $25 enrollment fee. Families with children with a gross income under 275 percent of the federal poverty guidelines paid a sliding scale premium based on household income, family size and number of family members covered by MinnesotaCare. Amendments in 1993 (Laws 1993, chapter 345) changed the premium amount for children formerly enrolled in the Children's Health Plan to $48 annually per child in families with incomes not exceeding 150 percent of federal poverty guidelines and applied the sliding scale premium to families with incomes over 150 percent of federal poverty guidelines; the premium amount was increased as well. Persons with incomes exceeding the income limits cannot enroll; however, enrollees whose incomes

exceed the limits after initial enrollment may remain enrolled but must pay the full, unsubsidized premium amount.

The 1993 amendments also provided for "bridging the gap" between MinnesotaCare and medical assistance: persons potentially eligible for medical assistance may enroll in MinnesotaCare for a limited period while they apply for medical assistance. Hospitalized enrollees must apply for medical assistance within three months of hospital admission or face permanent disenrollment of the enrollee's family as well as the enrollee.

In 1994, due to budget constraints, the Legislature delayed full expansion of the program to single adults and families without children. This group is eligible beginning October 1, 1994, if gross family income is less than 125 percent of federal poverty guidelines. All single adults and families without children who meet statutory income limits become eligible for enrollment October 1, 1995. (Laws 1994, chapter 625, article 13, section 2.)

MinnesotaCare is administered by the Department of Human Services, which is responsible for processing applications and determining eligibility, reimbursing providers, monitoring spending, and developing administrative rules. County social service agencies are responsible for determining medical assistance eligiblity for MinnesotaCare applicants and enrollees who are potentially eligible for medical assistance.

On Monday, June 28, 1993 at 17 State Register 3416, the department published a Notice of Solicitation of Outside Information or Opinions. A second Notice of Solicitation of Outside Information or Opinions was published June 27, 1994 at 18 S.R. 2758, seeking additional advice on providing health services to enrollees through managed care health plans. However, the department is not proposing the provision of managed care in this rule but rather as a future amendment.

An Advisory Committee was convened to advise the department on the proposed rule. The Committee met on October 20, 1993; February 1, 1994; May 31, 1994; and July 7, 1994. Committee members provided comments and suggestions at the meetings, in writing, and in conversations with department staff. The proposed rule reflects input received from the Committee. Advisory Committee members are listed on Attachment 1.

SPECIFIC RULE PROVISIONS

The above-entitled rule is affirmatively presented by the Department in the following narrative in accordance with the provisions of the Minnesota Administrative Procedures Act, Minnesota Statutes, chapter 14, and the rules of the Attorney General's Office.

9506.0100 **DEFINITIONS**

Subpart 1. **Scope.** This subpart is necessary to inform persons reading the rule that certain terms used in the rule have the specific meaning given them in this part. It is reasonable to clarify that the defined terms have a particular meaning notwithstanding other possible interpretations.

Subpart 2. **Applicant.** This definition is necessary because the term is used throughout the rule to identify persons who apply for MinnesotaCare coverage but are not yet enrolled in and covered by the program. The definition is reasonable because it describes persons who have completed a written application pending a determination of eligibility.

Subpart 3. **Child.** This definition is necessary because the MinnesotaCare statute distinguishes between children and adults in terms of eligibility, premium amounts, and coverage. The definition is reasonable because it is consistent with Minnesota Statutes that define a minor as a person under 18 years of age. [See Minnesota Statutes, sections 256.9354; 518.54, subd. 2; and 645.45, clause (14).]

Subpart 4. **Commissioner.** This definition is necessary to identify in this rule the state agency commissioner with responsibility for administering MinnesotaCare. The definition is reasonable because it is consistent with Minnesota Statutes, section 256.9351, subd. 2. It is reasonable to include "the commissioner's designated representative" because the commissioner cannot personally perform all the tasks for which she is responsible and which are therefore delegated to another. Minnesota Statutes, section 15.06, subd. 6, clause (1) authorizes the commissioner to delegate statutory powers and duties.

Subpart 5. **Covered health services.** This definition is necessary to identify in rule the health services covered by MinnesotaCare. It is reasonable to simply reference Minnesota Statutes, section 256.9353, which sets out those services, because of the length and complexity of the statutory authorization.

Subpart 6. **Department.** It is necessary to define this term because it is used throughout the rule. The definition is reasonable because it identifies the state agency referred to, i.e. the agency charged with responsibility for administration of MinnesotaCare. The term "MinnesotaCare" also broadly refers to the program of healthcare reform that involves several state agencies (Health and Commerce as well as Human Services), and it is necessary to identify the specific agency referred to in this rule.

Subpart 7. **Dependent sibling.** This definition is necessary because the term is given a specific meaning in the MinnesotaCare statute, and particular eligibility and enrollment criteria apply when there are "dependent siblings" within a household. It is reasonable, for rule brevity, to reference the specific definition in Minnesota Statutes, section 256.9354 subd. 1, paragraph (b) rather than duplicate the statute.

Subpart 8. **Eligible provider.** This definition is necessary because it is a term used in the rule and has a specific meaning in Minnesota Statutes, section 256.9351, subd. 3, i.e. referring only to medical assistance providers. It is reasonable to repeat the statutory definition here so that persons consulting the rule are aware of the specific statutory meaning.

Subpart 9. **Employer-subsidized health coverage.** This definition is necessary because one condition of eligibility for MinnesotaCare is that the family or individual does not have access to employer-subsidized health coverage within 18 months of applying for MinnesotaCare. This definition is reasonable because it is consistent with Minnesota Statutes, section 256.9357, subd. 2, which defines employer-subsidized coverage as coverage "for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage...." It is reasonable to clarify, consistent with the statute, that dependent coverage is excluded unless offered by an employer who contributes at least 50 percent of the cost and that children may have employer-subsidized coverage through either parent, including a noncustodial parent.

Subpart 10. **Enrollee.** This definition is necessary to identify the individuals whose health services will be paid for by MinnesotaCare, distinct from applicants or persons not eligible to enroll. It is reasonable to define an enrollee as one who has been found eligible and who has paid the required premium, consistent with Minnesota Statutes, section 256.9356, subd. 3, which

requires premium payment before enrollment is complete and to maintain eligibility.

Subpart 11. **Family.** This definition is necessary because MinnesotaCare is a program of health care coverage under which eligibility and premium amounts are tied to family composition and income.

This definition is reasonable because it initially describes the most common understanding of the term, i.e. parent & child. It is reasonable to include guardians and wards because, under Minnesota Statutes, section 525.619, the guardian of a minor has the powers and responsibilities of a parent. Because minor wards, like minor children living with parents, may not have access to health care coverage, defining guardians and wards as "family" ensures potential MinnesotaCare eligibility and is consistent with the purpose of MinnesotaCare to promote access and assure healthy children and adults. Minor wards and guardians have been covered under the emergency rule.

It is reasonable to specify dependent siblings in the same household, because Minnesota Statutes, section 256.9354 applies specific eligibility requirements to households that include children and dependent siblings. It is reasonable to clarify that temporary absence from the household does not exclude a child or dependent sibling from the family, to ensure continuous coverage and access to services; coverage of temporarily absent children is consistent with other health insurance policies and public assistance programs.

It is reasonable to include emancipated minors and their spouses because it would be inconsistent with the purpose of MinnesotaCare, an expansion of the original Children's Health Plan, to exclude children simply because they live independently from their parents.

It is reasonable to clarify that spouses without children are included, because Minnesota Statutes, section 256.9354, subd. 1(c) permits continuous enrollment of certain individuals whether or not children remain in the household; further, it is reasonable to include both spouses as "family" for purposes of calculating "family income" in determining eligibility and premium amounts.

It is reasonable to include single individuals living alone in the definition of "family" because single individuals will eventually become eligible for coverage and income eligibility is based on "family" income; in the case of single persons, "family" income will be the income of the single individual.

Subpart 12. **General assistance medical care.** This definition is necessary because general assistance medical care is another publicly-funded program of health coverage for low-income persons. Individuals may be eligible for coverage under both programs, although Minnesota Statutes, section 256.9354, subd. 7 prohibits simultaneous coverage under both. It is reasonable, for comprehensiveness and accuracy, to define the program by citing its governing statute.

Subpart 13. **Local social service agency.** This definition is necessary because a condition of eligibility for MinnesotaCare is ineligibility for medical assistance; under Minnesota Statutes, section 256B.05, the county agencies administer medical assistance, including determining eligibility. This definition is reasonable because it describes the different county boards under which the 87 county agencies operate.

Subpart 14. **Medical assistance.** This definition is necessary because coverage under MinnesotaCare is coordinated with eligibility for and coverage under the medical assistance program. It is reasonable, for brevity and accuracy, to cite the statute governing the medical assistance program.

Subpart 15. **MinnesotaCare.** This definition is necessary because the term is used throughout the rule and because this program must be distinguished from the broad legislative program of health care reform that goes under the same name. It is reasonable, for accuracy and brevity, to reference the statute sections governing the MinnesotaCare program.

Subpart 16. **Other health coverage.** This definition is necessary because the term is used throughout the rule. Eligibility for MinnesotaCare is conditioned upon nonavailability of other health care coverage. This definition is reasonable because it encompasses the available types of insurance or coverage that are not state-funded: private hospitalization and medical insurance, health maintenance coverage, and federally-funded Medicare and CHAMPUS insurance.

It is reasonable to exclude from the definition medical assistance, other state-funded health programs, and the other listed programs because coverage under these programs in the 4 months prior to application is not a disqualification when determining whether an applicant is insured in the four months prior to application. (See Minnesota Statutes, section 256.9357, subd. 3.)

Subpart 17. **Parent.** This definition is necessary because under Minnesota Statutes, section 256.9354, eligibility for MinnesotaCare depends on inclusion in an eligible group. Until October 1, 1994, only children and families with children are eligible for MinnesotaCare. (See Minnesota Statutes, section 256.9354, subd. 5.) It is necessary to define "parent" in order to define "family." It is reasonable to include birth parents, stepparents and adoptive parents to ensure the common parent-child relationships are eligible for family coverage, consistent with the goal of MinnesotaCare to promote access to health care services.

Subpart 18. **Permanent residency.** This definition is necessary because Minnesota Statutes, section 256.9359 requires families and individuals to be permanent residents of Minnesota in order to be eligible for MinnesotaCare. It is reasonable, for brevity and accuracy, to define the term by reference to the statute, which defines a permanent resident for purposes of MinnesotaCare eligibility at some length.

Subpart 19. **Spend-down.** This definition is necessary because the term is used throughout the rule. Minnesota Statutes, section 256.9353, subdivision 6 requires the commissioner of human services to coordinate the provision of hospital inpatient services under MinnesotaCare with eligibility for medical assistance with a spend-down. This definition is reasonable because it is the definition of "spend-down" in the medical assistance rule (part 9505.0015, subp. 44).

Subpart 20. **Third party payer.** This definition is necessary because Minnesota Statutes, section 256.9355, subdivision 3 makes MinnesotaCare benefits secondary to a plan of insurance or benefits under which an eligible person may have coverage. It is reasonable to define these primary sources of health care benefits as "third party payers" because it a term in common use. The definition is reasonable because it is the definition in the medical assistance rule (part 9505.0015, subp. 46).

9506.0020 ELIGIBILITY FOR MINNESOTACARE

Subpart 1. **General eligibility requirements.**
Minnesota Statutes, section 256.9352 requires the commissioner of human services to adopt rules to administer the MinnesotaCare program. The MinnesotaCare statutes contain various eligibility requirements. This subpart

is necessary to implement the commissioner's rule mandate and to provide in a single rule part the various eligibility criteria.

Item A is reasonable because Minnesota Statutes, section 256.9359, subdivision 2, requires that, to be eligible for MinnesotaCare, families and individuals must be permanent residents of Minnesota. Permanent residency is defined as being domiciled in the state and intending to live in the state permanently (section 256.9359, subdivision 3). Section 245.9359, subd. 4 also specifically requires that an applicant demonstrate intent to live in Minnesota permanently by showing that he or she maintains a verified address other than a place of accommodation and has continuously lived in the state for 180 days before application; and by signing an affidavit stating the applicant intends to reside permanently and did not come to the state to obtain medical coverage or treatment.

Item B is reasonable because ineligibility for medical assistance without a spend-down is a condition of MinnesotaCare eligibility. [See Minnesota Statutes, section 256.9354, subdivision 1 (children in families with income under 150 percent of the federal poverty guidelines); subdivision 4 (children, parents and dependent siblings residing in the same household); and subdivision 5 (individuals and households without children).]

It is reasonable to clarify that an enrollee who is hospitalized may be eligible for medical assistance with or without a spend-down. Because of the high cost of inpatient hospitalization, an enrollee (who was not eligible for medical assistance or only eligible with a spend-down) may soon become financially eligible for medical assistance. In order to maximize federal medical assistance dollars for inpatient hospital services, the Legislature has directed that an enrollee who may be eligible for medical assistance must apply for that program (Minnesota Statutes, section 256.9353, subd. 3).

Item C. A 1994 amendment to the MinnesotaCare statute provides that an individual may not have simultaneous coverage under MinnesotaCare and general assistance medical care. (Laws 1994, chapter 625, article 8, section 55, codified at Minnesota Statutes, section 256.9354 subd. 7). It is reasonable to include this clarification in rule because it is a condition of eligibility for MinnesotaCare.

Item D. Minnesota Statutes, section 256.9357, subdivision 3 requires families and individuals initially enrolled under section 256.9354, subdivisions 4 and 5 (i.e. children and families initially enrolled in the Children's Health Plan) to be without health coverage for at least four months prior to application to be eligible for subsidized premium payments based on a sliding scale. (Individuals and families whose income is greater than the sliding scale premium limits established under section 256.9358 are ineligible and may not enroll.) It is reasonable to compute the 4 months from the date coverage begins because, like other health insurance, MinnesotaCare coverage always begins on the first day of the month; it is administratively easier for the department to calculate 4 month timeframes on the first day of each month, rather than the application date which may be any day of the month. This method, which has been the practice of the department under the emergency rule, may slightly reduce the time an applicant is without coverage and thereby expands access to health services, a statutory goal.

Item E. Minnesota Statutes, section 256.9357, subdivision 2 requires that families or individuals must not have access to subsidized health coverage through an employer for the 18 months prior to application for MinnesotaCare, unless that coverage was lost for reasons that would not disqualify for reemployment benefits and there has been no coverage "since the layoff." It is reasonable to compute the timeframe from the date of coverage rather than application for the reason stated in item D.

Item F is reasonable because Minnesota Statutes, section 256.9354, subdivision 1a requires individuals to cooperate with the department to identify potential third-party payers. Under the statute, cooperation includes identifying third-party payers, providing relevant information to the department, and completing necessary forms.

Item G is reasonable because it is consistent with Minnesota Statutes, section 256.9358, subdivision 4, which provides that an individual or family whose gross monthly income is above the amount specified in subdivision 3 is not eligible for MinnesotaCare. (Subdivision 3 establishes a sliding scale beginning July 1, 1993, that sets required premium amounts at percentages of gross family income.)

Item H is reasonable because it clarifies that eligibility depends on compliance with special enrollment requirements applicable to family members.

Subpart 2. **Exceptions to general eligibility requirements.** This subpart is necessary because the MinnesotaCare statute contains specific exceptions to some of the general eligibility requirements. It is reasonable to set out these exceptions in a separate subpart for the convenience of persons consulting the rule.

Item A. Minnesota Statutes, section 256.9357, subd. 3 exempts specified categories (children in families with income under 150 percent of federal poverty guidelines; children, parents and dependent siblings residing in the same household; families or individuals who apply for MinnesotaCare upon termination from MA, GAMC, or are covered under specified regional demonstration projects) from the requirement of at least four months of no health coverage prior to application.

It is reasonable to exempt these same groups from both item D and item E of subp. 1 because, according to the Legislative Commission on Health Care Access, that was the legislature's intention. A regional demonstration project in St. Louis county, which was in operation at the time the MinnesotaCare statute was passed, used employer-subsidized coverage as a base. In 1992 the Commission orally responded that the intent of the legislation was to exempt both groups from both the 4-month and 18-month requirements. The department will request a clarifying statutory amendment in 1995.

This policy makes sense from an administrative point of view: if a child is receiving medical assistance, the child is required to take advantage of other available insurance, including employer-subsidized insurance. It would be inconsistent to preclude the child from enrolling directly in MinnesotaCare from medical assistance because employer-subsidized insurance had been available several months previously. This policy has been followed under the emergency rule (those programs are excluded from the definition of "other health coverage"; see part 9506.0010, subp. 20, item B [Emergency]).

Item B is reasonable because it is consistent with Minnesota Statutes, section 256.9357, subd. 2, and because it is reasonable, for the convenience of persons consulting the rule, to specifically set out the exemptions from the general requirement of no access to employer-subsidized health coverage for 18 months.

Subpart 3. **Children in families with income at or below 150 percent of the federal poverty guidelines.** This subpart is necessary to implement in rule the special statutory eligibility provisions affecting children ages one through seventeen from families with incomes that do not exceed 150 percent of the federal poverty guidelines.

Item A is reasonable because it reiterates the general statutory eligibility requirements applicable to this group: permanent residency (section 256.9359, subd. 2); ineligibility for medical assistance (section 256.9354, subd. 1); not currently covered by general assistance medical care (section 256.9354, subd. 7); cooperation in identifying third-party payers (256.9354, subd. 1a); compliance with family enrollment requirements (section 256.9354, subd. 1, para. b).

Item B is reasonable because Minnesota Statutes, section 256.9354, subdivision 1 identifies "eligible persons" as children between one and 18, from families with incomes under 150 percent of federal poverty guidelines "who are not otherwise insured for the covered services." It is necessary to define the statutory phrase because the phrase is vague and has been subject to varying interpretation. Whether an individual has other health coverage for a health service covered under MinnesotaCare has been an issue in appeals brought under the emergency rule.

Subitems (1) to (3) state the criteria utilized in administering the Children's Health Plan and MinnesotaCare over the past five years. These criteria represent a balance between the goal of MinnesotaCare to promote access to health services and the commissioner's statutory mandate under section 256.9352, subd. 3, to manage spending for the program and make adjustments necessary to limit expenditures to available revenues.

(1) It is reasonable to require that the child lack health coverage in at least two of the listed areas because most comprehensive health plans cover basic hospital or medical-surgical or major medical expenses. However, many plans do not cover dental expenses, and requiring coverage to be lacking in two areas ensures that MinnesotaCare does not become a program of supplemental dental insurance.

(2) Requiring an annual deductible of over $100 per person to be considered uninsured is reasonable, because anecdotal evidence indicated deductible amounts over $100 impeded access to health care in families under the federal poverty guidelines. While the Children's Health Plan was in effect, $100 was the amount of deductible. Currently, under MinnesotaCare a child has to pay $48 per year in order to obtain a $100 benefit.

(3) It is reasonable to consider a child uninsured if a child is not covered by insurance for a particular diagnosis, because this is consistent with the goal of promoting access to health services to assure healthy children. In such cases, MinnesotaCare only covers the costs of the uncovered illness; 3rd-party payer provisions apply for other services so that MinnesotaCare costs are kept down.

Subpart 4. **Family enrollment.**
This subpart is necessary to assure that those consulting the rule are aware of special statutory eligibility and enrollment requirements applicable to members of the same family. Items A to F are reasonable because they are consistent with the enrollment requirements in Minnesota Statutes, section 256.9354, subdivision 1, paragraph (b).

Subpart 5. **Continuous eligibility.**
This subpart is necessary because the MinnesotaCare statute specifically provides for ongoing eligibility once an applicant is enrolled in MinnesotaCare. It is reasonable to include these various provisions in one subpart, to ensure persons consulting the rule are aware of these provisions.

Items A, B and D are reasonable because these items are consistent with Minnesota Statutes, section 256.9354, subdivision 1, paragraph (c) and

subdivision 3, which provide that individuals initially enrolled in MinnesotaCare continue to be eligible as long as all other eligibility criteria are met and continuous enrollment in the MinnesotaCare plan or medical assistance is maintained. It is reasonable to clarify permanent residency (item A) because that is an eligibility requirement and is specified in Minnesota Statutes, section 256.9354, subdivision 1, paragraph (c).

Item C is reasonable because it is consistent with Minnesota Statutes, section 256.9357, subdivision 1, which provides that families and individuals who initially enrolled under section 245.9354, (i.e. children from poverty-level families, and families and individuals who became eligible under the phased-in eligibility schedule), whose income increases above the sliding fee scale premium limits, may continue enrollment upon payment of the full cost of coverage.

Item D. It is reasonable to define continuous enrollment as re-enrollment in MinnesotaCare before the last day of the month following the month notice of termination of coverage from MinnesotaCare or medical assistance is sent. This allows a MinnesotaCare enrollee sufficient time to pay the required premium and submit paperwork necessary for coverage to continue. A notice of termination from medical assistance may not be received until the end of a month, and this allows a reasonable time to apply for MinnesotaCare.

9506.0030 APPLICATION; ENROLLMENT; COVERAGE.

Subpart 1. **Applications sources.**
This subpart is necessary to inform persons consulting the rule how the application process may be initiated and to explain that applications may be made directly to the department or through alternative referral sources. This is consistent with Minnesota Statutes, section 256.9355, which sets out application procedures.

Item A is reasonable, because it lists the alternative sites where applications and other MinnesotaCare information must be made available under Minnesota Statutes, section 256.9355, subdivision 1. That statute authorizes sources other than the department to accept and forward applications. The sites listed are those utilized by the department under the emergency rule. The department attempts to make application forms widely available, to promote access to coverage for health services.

Item B. It is reasonable to require these alternate sites to forward applications to the department within five working days after receipt, to ensure timely processing of applications because enrollment is strictly tied to payment of the initial premium. This time limit was recommended by the Advisory Committee. Under the emergency rule the alternate sites have not accepted initial premium payments; these sites have no way to know the amount of premium due because the department must individually calculate the premium.

Subpart 2. **Necessary information for eligibility determination.**
Item A is necessary to assure that persons consulting the rule are aware of the information applicants must provide in order to have their eligibility determined.

(1) It is reasonable to require social security numbers because Minnesota Statutes, section 256.9355, subdivision 2 requires the commissioner to use social security numbers as identifiers for program administration and to verify income.

(2) It is reasonable to require proof of permanent residency, because permanent residency is a MinnesotaCare eligibility requirement under section 256.9359, subdivision 2. Section 256.9359, subdivision 4 requires applicants

to demonstrate intent to live in the state permanently by signing an affidavit that the applicant currently resides in Minnesota, intends to reside permanently in Minnesota, and did not come to the state primarily to obtain medical coverage or treatment. It is reasonable to provide in rule that the affidavit requirement is met by signing the application form because the form contains language asking if each applicant is a permanent Minnesota resident and describing the permanent residency requirement. It is more convenient for applicants, as well as more efficient administratively, to meet the statutory affidavit requirement on the application form as opposed to requiring a separate sworn writing.

(3) and (5) It is reasonable to require household composition and gross annual family income because Minnesota Statutes, section 256.9358 provides that an individual or family whose gross monthly income is above the amount specified in statute (sliding fee based on percentage of gross family income) is ineligible for the plan. It is therefore necessary to determine household composition and income in order to determine program eligibility and premium amount.

(4) It is reasonable to require information about other available health coverage, since two conditions of eligibility are lack of coverage within the four months preceding application and unavailability of employer-subsidized insurance within eighteen months (Minnesota Statutes, section 256.9357, subdivisions 2 and 3).

(6) It is necessary to ensure that only persons who meet eligibility requirements are covered by MinnesotaCare. This subitem is necessary and reasonable not only to ensure that enrollees comply with statutory eligibility conditions but also to ensure the financial viability of the program. The commissioner is directed to administer the program, to manage spending, and to "make adjustments as necessary to ensure that expenditures remain within the limits of available revenues." (Minnesota Statutes, section 256.9352, subdivisions 2 and 3.) Further, the departments of health and human services must plan to ensure expenditures are within revenues (from the provider and HMO tax) for fiscal year 1997 (section 256.9352, subdivision 3). It is reasonable, therefore, that the commissioner be able to obtain any additional information (for example, copies of tax returns; check stubs, or verification of income from employers; verification from past employers regarding access to employer subsidized insurance)needed to verify eligibility.

Item B is reasonable, because occasionally it is uncertain whether an applicant would have qualified for reemployment compensation. This situation has usually occurred when an applicant has secured new employment since being dismissed and never applied for reemployment compensation. Because MinnesotaCare personnel are not trained or qualified to determine whether an individual would have been ineligible for reemployment compensation, it is reasonable to refer the applicant to the department of economic security, which administers the reemployment compensation program, for an answer. If the department of economic security reports that the person would not have qualified, and the applicant is found ineligible for MinnesotaCare for that reason, the person may appeal under part 9506.0070 and present evidence and argument at an appeal hearing.

Subpart 3. **Eligibility determination deadline.** This subpart is necessary to include in rule the 1994 legislative directive that the department process MinnesotaCare applications within 30 days, except for the 4-month periods after enrollment is opened to single adults and families without children (Laws 1994, chapter 625, article 13, section 3; codified at section 256.9355, subd. 4). It is reasonable to include this information for persons consulting the rule.

Subpart 4. **Enrollment and beginning of coverage.**

This subpart is necessary to set out clearly the distinction between the date when a person is actually enrolled in MinnesotaCare and the date when coverage begins. This is reasonable because of the financial ramifications to individuals of having to pay for health care during a period when the individual is not covered, since MinnesotaCare does not provide for retroactive eligibility or coverage. This subpart is also necessary to administer the program in a fiscally responsible manner.

Item A. In order to administer the program efficiently and effectively, it is reasonable to distinguish the date of enrollment and the date coverage begins. Minnesota Statutes, section 256.9355, subd. 3 distinguishes between the effective date of coverage and the month eligibility is approved and the first premium payment received (i.e. enrollment). It is reasonable to consider an applicant enrolled once eligibility has been determined and the initial premium payment received, because the applicant has thereby met all requirements for MinnesotaCare coverage. This has been the practice under the emergency rule as well.

Item B is reasonable, because it is consistent with the effective coverage dates established in Minnesota Statutes, section 256.9355, subdivision 3. The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment is received (i.e. the date of "enrollment"), with certain exceptions. Coverage for eligible newborns and newly adopted children (subitems 1 and 2) begins on the date of entry into the family. It is reasonable to clarify that "date of entry" means the moment of birth (newborns) or the date of placement within the family; these are the dates on which accident and health insurance policies covering families are required to cover newborns and newly adoptive children (Minnesota Statutes, sections 62A.042, subdivision 1 and 62A.27). Subitems 3 and 4, establishing the effective coverage dates of other new family members and hospitalized enrollees, are the dates established in Minnesota Statutes, section 256.9355, subdivision 3.

9506.0040 PREMIUM PAYMENTS.

Subpart 1. **Premium payments.**
This subpart is necessary because payment of the required premium is a condition of enrollment in MinnesotaCare (Minnesota Statutes, sections 256.9354, subdivision 4). It is reasonable to inform persons consulting the rule that, although the program is subsidized with public funds, payment of a premium is necessary.

Item A is reasonable because it sets premium amounts consistent with section 256.9356, subdivision 1 (an annual premium of $48 for enrollees eligible under section 256.9354, subdivision 1, i.e. children between 1 and 18 years of age with gross family incomes under 150% of federal poverty guidelines who are ineligible for medical assistance and not otherwise insured for the covered service).

Item B. Under Minnesota Statutes, section 256.9356, subd. 2, the commissioner must require enrollees other than children under item A to pay a premium based on a sliding scale. It is reasonable to state that the premium amount is calculated on a family income-based sliding scale which is available upon request, because Minnesota Statutes, section 256.9358, subdivisions 3 and 4 establishes a premium calculation that is both complex and specific. Because each family's premium amount must be individually calculated, it is reasonable to simply describe the sliding scale rather than repeat the formula components in rule. Further, Minnesota Statutes, section 256.9352, subd. 3 requires the commissioner to decrease premium subsidies in case program expenditures exceed estimated revenues; therefore, it is not possible to state the premium sliding scale formula conclusively in rule.

Subpart 2. **Gross annual family income.**
Because eligibility for MinnesotaCare and the amount of premium depends on gross family income, it is necessary to define gross family income in rule. (See Minnesota Statutes, sections 256.9354 and 256.9358.)

Item A. Self-employment income is specifically defined in Minnesota Statutes, section 256.9351, subdivision 4; it is reasonable to simply reference the statutory definition, for rule brevity and comprehensiveness.

Item B. Minnesota Statutes, section 256.9351, requires applicants to report the most recent financial situation if it is different from the last federal income tax form. It is reasonable to use 4-month wage income multiplied by three because Minnesota Statutes, section 256.9358, subd. 2 requires that the sliding scale be based on the enrollee's gross family income during the previous four months. Because the income of a seasonal worker in the four months immediately preceding application might present a skewed picture of annual income, it is reasonable to use twelve month income in such cases.

Item C. It is reasonable to include other unearned income, including public benefits, because the premium is based on gross family income. Including these income sources ensures a more accurate count of all income actually received by a household than simply counting earned income.

It is reasonable to require enrollees to report changes in income, as required under section 256.9351, subd. 4. Further, Minnesota Statutes, section 256.9356, subdivision 3 requires the commissioner to develop and implement procedures to require reporting income changes and to adjust premium payments based upon income changes. Reporting changes by percentages is specifically authorized under section 256.9351, subd. 4.

Subpart 3. **Premiums paid monthly, quarterly, or annually.**
This subpart is necessary to ensure persons consulting the rule are aware of the options available in scheduling premium payments. It is reasonable because it is consistent with Minnesota Statutes, section 256.9356, subd. 3, which requires calculation of premiums on a calendar month basis but payable monthly, quarterly or annually.

Subpart 4. **Billing notices.**
This subpart is necessary to inform persons consulting the rule when to expect bills for payment of premiums. It is reasonable to mail the notices in the month preceding the month coverage ends, to allow enrollees sufficient time to pay the premium before the due date. This has worked well under the emergency rule.

Subpart 5. **Premium payment dates.**
This subpart is necessary to establish in the rule the dates on which premium payments are due. This is reasonable because premium payment is required before MinnesotaCare enrollment is complete and to maintain eligibility; furthermore, the commissioner is required to disenroll enrollees for failure to pay required premiums within one calendar month after the due date (Minnesota Statutes, section 256.9356, subdivision 3).

Item A. Minnesota Statutes, section 256.9356, subd. 3 provides that the first premium payment is due upon notice from the commissioner of the amount required. It is reasonable to require applicants to pay the initial premium within 4 months after the date on the notice because this allows applicants some flexibility in timing the payment; at the same time, the 4-month limit provides reasonable assurance that the income information used to calculate the initial premium amount is current. This limit has been in effect under the emergency rule. If the initial premium is not paid within 4 months, the applicant must update income information so that the premium can be recalculated.

Item B. Under Minnesota Statutes, section 256.9356, subdivision 3, nonpayment of the premium results in disenrollment within one calendar month after the due date. It is reasonable to require enrollees to make subsequent premium payments by the 15th day of the month preceding the month of a new period of coverage, to implement the statutory requirement. This allows the department 15 days to process premiums before a new coverage period begins as well as allows sufficient time for the department to send a ten-day notice of disenrollment before coverage terminates in case of nonpayment. (If the premium is not paid by the first day of the month beginning the period for which the premium is due, the enrollee is notified in writing of the disenrollment and termination of coverage at the end of that calendar month.)

Subpart 6. **Disenrollment.**
This subpart is necessary to inform persons consulting the rule of the consequences of failure to pay the required premium. It is reasonable to terminate coverage at the end of the calendar month following the month in which payment was due for the reasons discussed in subpart 5.

Subpart 7. **Reenrollment.**
This subpart is necessary to inform persons consulting the rule of the steps necessary to reenroll in MinnesotaCare after disenrollment for failure to pay required premiums.

Item A is reasonable because it is consistent with Minnesota Statutes, section 2256.9356, subdivision 3, which provides that persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed unless the person demonstrates good cause for nonpayment. This requirement is a disincentive to enrollees intermittently leaving and rejoining the program at will, which would increase the administrative costs of the program substantially as well as lead to the risk of adverse selection (i.e. paying for coverage only when medical care is needed), which would have substantial negative financial impact on the MinnesotaCare program. This also promotes the statutory goal of increasing access to health care by ensuring consistent coverage as well as the commissioner's mandate to manage program expenditures.

It is reasonable to specify as well that, to reenroll, the individual must continue to meet eligibility and other requirements, as well as pay any unpaid premiums for months in which coverage was provided. Because the schedule of premium due dates and disenrollment does, in effect, allow a month of free coverage before coverage ends (see subparts 5 and 6), the premium for that "grace" month and for any time period during which an appeal is pending and coverage continues must be paid before reenrollment.

Item B. It is reasonable to restate in the rule, for the information of persons consulting the rule, the specific situation that does not constitute good cause contained in Minnesota Statutes, section 256.9356, subd. 3.

Item C. It is reasonable to include examples of situations that may excuse failure to pay a premium when due, thus exempting the enrollee from a 4-month disenrollment period. The situations listed are ones for which the enrollee would not be responsible for nonpayment and were recommended by the Advisory Committee. They are similar to some of the good cause for failure to complete a household report form exemptions in the AFDC rule (Minnesota Rules, part 9500.2700, subp. 6 item C).

Item D. This item is reasonable because Minnesota Statutes, section 256.9356, subd. 3 requires the enrollee to demonstrate good cause for nonpayment. This item clarifies that it is the enrollee's burden to present evidence to support his or her claim of good cause for nonpayment.

Subpart 8. **Premium payment adjustments.**

This subpart is necessary to carry out the commissioner's responsibility under Minnesota Statutes, section 256.9356, subd. 3 to annually redetermine continued eligibility and to adjust premium payments based upon changes in enrollee income. It is reasonable to simply reference part 9506.0060, because that rule part deals with eligibility redeterminations and random income audits.
It is reasonable to inform persons consulting the rule that adjusted premium amounts are effective the month following receipt of an adjusted invoice. This means that the adjusted premium amount must be paid by the 15th day of the month following the notice of adjustment, allowing the enrollee sufficent time to plan accordingly while assuring timely payment of accurate premium amounts. This has been the practice under the emergency rule.

9506.0050 COORDINATION OF MINNESOTACARE AND MEDICAL ASSISTANCE

Subpart 1. **Referral of applicants and enrolleess potentially eligible for medical assistance to local social service agency.**
This subpart is necessary to implement the 1993 legislative mandate that the commissioner refer individuals who apply for MinnesotaCare but may be eligible for medical assistance to their county social service agency for a determination of eligibility for medical assistance (Minnesota Statutes, section 256.9354, subdivision 6). Medical assistance expenditures for covered health services are reimbursed by the federal government at approximately a 50% rate. Expenditures under MinnesotaCare, on the other hand, are funded solely from state revenues. As a result, the legislature intends persons eligible for medical assistance to receive health coverage under that program rather than under MinnesotaCare.

It is reasonable to state in this rule that these referrals will be made and to set out some of the bases on which the referral decision is made, to ensure persons consulting the rule are aware of the mandate. The list of referral criteria is reasonable because these are eligibility criteria for the medical assistance progam. (See Minnesota Statutes, sections 256B.055 to 256B.062)

Subpart 2. **Enrollment of applicants and enrolleess potentially eligible for medical assistance.** The 1993 legislation permitted MinnesotaCare applicants who are potentially eligible for medical assistance to enroll in MinnesotaCare for 60 days as long as all other conditions of eligibility are met (colloquially termed "bridging the gap"). However, enrollees must cooperate with the county social service agency in determining their medical assistance eligibility during the 60 day period or be disenrolled from MinnesotaCare (Minnesota Statutes, section 256.9354, subdivision 6).

This subpart is necessary to establish in rule the temporary enrollment provisions of statute and to clarify for applicants and enrollees their responsibilities.

Item A. It is reasonable to state that the commissioner shall enroll an otherwise eligible applicant upon receipt of the initial premium, to clarify that the premium must still be paid, as required under Minnesota Statutes, section 256.9354, subd. 6 and the enrollment provisions of this rule (part 9506.0030, subpart 4).

Item B is reasonable because it informs persons consulting the rule of the statutory responsibility of applicants and enrollees to apply for medical assistance and to cooperate with the medical assistance eligibility determination. Because the statute provides for a 60 day enrollment period and because the local social service agency eligibility determination may take longer than 60 days, it is reasonable to specify a deadline by which the individual must apply for medical assistance rather than specify a date on

which MinnesotaCare coverage would end. It is reasonable to require applicants to apply for medical assistance within 60 days from the date coverage begins because this is an easily identifiable date, i.e. always the first day of the month following the date of enrollment. This is administratively efficient for the MinnesotaCare program because coverage always begins the first day of the month and terminates on the last day of the month. Further, this standardizes the maximum amount of time a noncooperating individual would be covered by MinnesotaCare (i.e. two months of coverage plus a grace period of one month following notice of termination).

Minnesota Statutes, section 256.9356, subd. 3 requires the commissioner to annually redetermine an enrollee's continued eligibility and to identify enrollees who may have become eligible for medical assistance. It may happen, during the annual review of eligibility, that an enrollee is determined potentially eligible for medical assistance, in which case a referral is made to the local social service agency. It is reasonable to require enrollees to apply for medical assistance within 60 days after the first day of the month following the month of referral because, again, it is an easily identifiable date that promotes adminstrative efficiency for the program and allows the enrollee the full 60 day enrollment period in which to apply (an action that may be as simple as submitting to the local social service agency a writing that the individual wants to apply for medical assistance).

Item C. It is reasonable to include, for the information of persons consulting the rule, the information that an applicant determined eligible for medical assistance may be eligible for refund of the MinnesotaCare premium. Under the 1995 MinnesotaCare premium table, which is adjusted for family size, a premium refund would be due if the family consists of three or more members; if the family size is less than three, a refund may be due. The Advisory Committee requested that this information be included in the rule.

Subpart 3. **Coordination of coverage for hospital inpatient services under MinnesotaCare and medical assistance.**
This subpart is necessary to implement in rule the commissioner's statutory mandate to coordinate the provision of hospital inpatient services under MinnesotaCare with enrollee eligibility under the medical assistance spend-down. (Minnesota Statutes, section 256.9353, subd. 6.) Further, section 256.9353, subdivision 3 requires that a MinnesotaCare enrollee who is hospitalized must apply for medical assistance by the last day of the third month following inpatient hospital admission.

Item A. It is reasonable to state in rule that the commissioner will notify hospitalized enrollees in writing that they must apply for medical assistance. Because the consequences of failure to comply are so severe (permanent disenrollment from the program), it is reasonable to assure enrollees are provided written notice of the requirement. However, the department relies on outside parties for notice that an enrollee has been hospitalized and does not always receive this information in a timely manner. Because medical assistance eligibility is retroactive for three months only, referrals of enrollees to medical assistance after three months from the date of hospitalization would not result in medical assistance reimbursement for their care. Therefore, the department will not issue the written notice to enrollees after three months from the month of hospitalization.

[The department relies on the hospital admission certification process for notification that an enrollee has been hospitalized. The department has a contract with Blue Cross/Blue Shield to certify inpatient hospital admissions for MA, GAMC, and MinnesotaCare enrollees. Prior to billing, hospitals must obtain certification for the inpatient admission from Blue Cross/Blue Shield which, in turn, sends verification of the certification to the hospital, physician provider, and MinnesotaCare. To promote timely certification, the Legislature in 1994 imposed a five percent payment reduction for hospital

services covered by MinnesotaCare if certification is requested more than 30 days after admission. Minnesota Statutes, section 256.9353, subd. 3, paragraph (c).]

Item B. It is reasonable to state in rule that an enrollee who has received the written notice in item A must apply for and cooperate with the local social service agency determination. This is consistent with Minnesota Statutes, section 256.9353, subdivision 3, paragraph (b), which states that enrollees "determined by the commissioner to have a basis of eligibility for medical assistance" must apply. This provision also ensures that enrollees who are unaware of the requirement are not penalized. It is reasonable not to subject enrollees to the severe penalty of permanent disenrollment without providing written notice of the requirement and an opportunity to comply.

Item C. It is reasonable to state in rule the financial obligations of an enrollee who has received inpatient hospital services and is found to be eligible for medical assistance with a spend-down. This item is consistent with Minnesota Statutes, section 256.9353, subdivision 7, which makes enrollees eligible for medical assistance with a spend-down financially responsible for spend-down amounts exceeding $10,000 (the adult annual benefit limit for inpatient hospital services).

It is reasonable to clarify, for persons consulting the rule, that an enrollee eligible for medical assistance with a spend-down is covered by medical assistance rather than MinnesotaCare during the months of hospitalization (subitem 1). It is reasonable to clarify that the MinnesotaCare premium and the costs of noncovered services during those months must continue to be paid by the enrollee (subitem 2); in addition, adult enrollees are responsible for any spend-down that exceeds $10,000, the annual benefit limit for adults. It is reasonable to clarify that the enrollee is not responsible for hospital payments reduced for failure to timely obtain certification of the admission, as provided in Minnesota Statutes, section 256.9353, subd. 3, paragraph (c), clause (2), subitem (3). It is also reasonable to clarify the portions of the hospital costs paid by MinnesotaCare (the enrollee's medical assistance spend-down amount, up to $10,000 annually) and the portions paid by medical assistance (hospital costs above the spend-down amount) (subitems 4 and 5).

Item D. It is reasonable to include, for persons consulting the rule, the information that hospitalized enrollees who are ineligible for medical assistance may remain covered by MinnesotaCare and pay required copayments and charges over the adult benefit limit. Subitems 1 and 2 are consistent with Minnesota Statutes, section 256.9353, subdivisions 7, which requires adult enrollees to pay ten percent of inpatient hospitalization charges, subject to an annual maximum copayment of $1,000 per individual and $3,000 per family; and subdivision 3, which imposes an annual inpatient hospital benefit limit of $10,000 for adults.

It is reasonable to include, for the information of persons consulting the rule, the option of applying for general assistance medical care (and paying any required spend-down), which may be more beneficial financially than utilizing MinnesotaCare coverage and paying up to ten percent of the hospitalization costs. The department will send letters to affected enrollees informing them of this option.

Subpart 4. **Disenrollment.**
This subpart is necessary because the MinnesotaCare statute establishes disenrollment sanctions for persons who do not, if required, apply for medical assistance and cooperate with the local social service agency eligibility determination.

Item A. It is reasonable to clarify that applicants or enrollees who fail to apply for or cooperate with the medical assistance eligiblity determination,

and their families, will be disenrolled. This is required under Minnesota Statutes, sections 256.9354, subdivision 6 and 256.9353, subdivision 3, paragraph (b). It is reasonable to clarify in rule when coverage terminates for persons disenrolled under this item: at the end of the month following the month in which the medical assistance application was due. For purposes of efficient administration of the program, all coverage begins or ends on the first day of a calendar month; therefore, it is reasonable to end coverage under this item on the last day of the month. That time frame is consistent with section 256.9354, subdivision 6, which requires enrollees and their family members who fail to apply and cooperate within the 60-day enrollment period to be disenrolled within one calendar month; and section 256.9353, subd. 3, paragraph (b), which requires application and cooperation by the last day of the third month following hospital admission or be disenrolled within one calendar month.

Item B. It is reasonable to clarify that persons disenrolled under subpart 2 may reenroll, after cooperating with the eligibility determination and being found ineligible for medical assistance. This is consistent with the statutory goal of promoting access to health care services.

Item C. Because the sanction under Minnesota Statutes, section 256.9353, subdivision 3, paragraph (b) for failure by hospitalized enrollees to apply for or cooperate with medical assistance is severe, it is reasonable to state the penalty in rule (i.e. that enrollees and their families may not reenroll).

Item D. It is reasonable to clarify that an enrollee who is determined eligible for medical assistance without a spend-down must be disenrolled from MinnesotaCare and receive health coverage through the medical assistance program. This is consistent with Minnesota Statutes, section 256.9354, which conditions eligiblity for MinnesotaCare on ineligiblity for medical assistance. It is reasonable to terminate coverage on the last day of the month in which the local social service agency notifies the department of the enrollee's eligibility for medical assistance, for purposes of administrative efficiency (see discussion above).

9506.0060 QUALITY CONTROL

Subpart 1. **Annual redetermination required.**
This subpart is necessary and reasonable to notify enrollees and others consulting the rule that eligibility for MinnesotaCare must be redetermined on an annual basis, as required under Minnesota Statutes, section 256.9356, subdivision 3.

Subpart 2. **Enrollee cooperation with annual redetermination.**
This subpart is necessary to carry out the commissioner's responsibility to annually redetermine eligibility. It is reasonable to require enrollees to provide the information needed to make an accurate redetermination. In order to perform the redeterminations on an orderly and efficient schedule, it is reasonable to require submission of necessary information before the eligibility anniversary date, defined as the first day of the month following the date of approved eligibility. Further, this allows consistent 12-month program income projections.

Subpart 3. **Changes.**
This subpart is necessary to enable the commissioner to carry out her responsibility under Minnesota Statutes, section 256.9356, subdivision 3, to develop and implement procedures to require enrollees to report changes in income. The data required under items A to G are reasonable because each is an item that may affect eligibility (permanent residency, item A; family income, items B to D; availability of other coverage or third-party payers, items E to G).

Subpart 4. **Random audits.**
This subpart is necessary to carry out the commissioner's statutory responsibility to perform random audits to verify reported income and eligibility (Minnesota Statutes, section 256.9355, subdivision 2). The information items listed are reasonable because each is an item that may affect income (items A to D) or eligibility (item D, family composition; item E, permanent residency; availability of other health insurance, items F and G).

Subpart 5. **Disenrollment.**
This subpart is necessary to carry out the commissioner's statutory responsibility to administer the program, which "provide(s) covered health services for **eligible** persons (emphasis added)." (Minnesota Statutes, section 256.9352, subd. 2). Further, the commissioner must determine applicant and enrollee eligibility (sections 256.9355, subd. 2 and 256.9356, subd. 3). It is reasonable, therefore, that persons who refuse to cooperate in determining their eligibility for MinnesotaCare be disenrolled from the program. For purposes of administrative ease and efficiency, it is reasonable to terminate coverage on the last day of the month in which notice of cancellation is sent, since termination of coverage for any other reason ends on the last day of the month.
Because there is no specific statutory prohibition against reenrollment for failure to cooperate with quality control (unlike other situations, e.g. failure to cooperate with the medical assistance eligibility determination) and because it is consistent with the statutory goal of promoting access to health services, it is reasonable to allow reenrollment after the former enrollee complies with this part and is determined otherwise eligible.

9506.0070 APPEALS.

Subpart 1. **Notice.**
This subpart is necessary to implement the commissioner's statutory mandate to provide notice of determinations or actions negatively affecting eligibility or covered services. Minnesota Statutes, section 256.9361 requires the commissioner to "provide notification according to the laws and rules governing the medical assistance program" if the commissioner "suspends, reduces, or terminates eligibility for the health right plan or services provided under the health right plan...." It is reasonable, for rule accuracy and brevity as well as for the information of interested persons, to reference the medical assistance statute and rule because these are the procedures the commissioner must follow. It is reasonable to specify the elements that must be included in the notice under part 9505.0125, so that persons consulting this rule or receiving a notice are fully aware of the initial information they are entitled to receive.

Subpart 2. **Appeal process.**
This subpart is necessary to inform persons consulting the rule of the procedures that must be followed to appeal a determination or action of the commissioner. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256.9361, which establishes a right to appeal according to section 256.045. It is reasonable, for rule accuracy and brevity as well as to avoid any confusion about the proper procedure, to simply reference section 256.045. It is reasonable as well to restate the appeal deadlines in section 256.045 to ensure persons are immediately aware of the important jurisdictional time frames in that statute.

9306.0080 COVERED HEALTH SERVICES.

Subpart 1. **Covered health services.**

This subpart is necessary to clarify in rule that only the health services specified in statute will be paid for under MinnesotaCare. It is reasonable to include this for the information of enrollees and providers. It is reasonable to simply cite the statutory section listing those services for the sake of rule brevity and accuracy and because the services covered may be changed by the legislature (as occurred between 1992 and 1993). (See Minnesota Statutes, section 256.9353, subdivisions 1 to 5.)

Subpart 2. **Inpatient hospital services.**
This subpart is necessary to set out in rule, for the convenience of persons consulting the rule, the inpatient hospital services covered under MinnesotaCare.

Item A. It is reasonable to state that medically-necessary inpatient hospital services services are covered, consistent with Minnesota Statutes, section 256.9353, subd. 3 (a). It is reasonable as well to clarify that inpatient hospital mental health and residential chemical dependency services are covered, as coverage of these service was specifically added during the 1993 legislative session and these are services that medical assistance often will not cover (for example, medical assistance limits coverage for treatment in "institutions for mental disease" for persons with mental illness; see 42 C.F.R., section 435.1008 and part 440, subpart A).

Item B. It is reasonable to specifically state, for the information of enrollees, providers, and others consulting the rule, that inpatient hospital benefits for adult enrollees are limited to $10,000 annually. This benefit limit is established under Minnesota Statutes, section 256.9353, subd. 3, paragraph (a).

Item C. Under Minnesota Statutes, section 256.9362, subd. 1, payments by MinnesotaCare to providers must be at the same rates and conditions established for medical assistance, with specified exceptions. It is reasonable, therefore, to list in rule the applicable medical assistance statutes and rules that will apply in reimbursing eligible providers for inpatient hospital services provided enrollees. These include the statutes and rules governing inpatient hospital payment rates, standards for services, prior authorization for certain services, and second surgical opinions.

Subpart 3. **Hospital admission certification.**
This subpart is necessary because Minnesota Statutes, section 256.9353, subd. 3, para. (c) requires admissions for inpatient hospital services covered under section 256.9362, subd. 3 (establishing hospital payment rates and adult copay responsibilities) to be certified as medically necessary in accordance with Minnesota's medical assistance rules. It is reasonable to include that information for persons consulting this rule.

It is reasonable as well to clarify that the certification criteria apply to admissions of pregnant women and for inpatient dental procedures, because these admissions do not require certification under medical assistance rules. It is reasonable to clarify that Medicare-approved admissions and admissions under rules govering chemical dependency care for persons receiving public assistance are not required to be certified, consistent with Minnesota Statutes, section 256.9353, subd. 3, paragraph (c), clause (1).

Subpart 4. **Cost avoidance.**
This subpart is necessary to implement Minnesota Statutes, section 256.9355, subdivision 3, which provides that benefits under [MinnesotaCare] are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and requires the commissioner to use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons.

Item A. It is reasonable to inform persons consulting the rule that MinnesotaCare reimbursement is secondary to other sources of payment, except for coverage under the consolidated chemical dependency treatment fund. That exception is noted because MinnesotaCare is a primary source of coverage for persons eligible for chemical dependency fund services under Minnesota Statutes, chapter 254B (though secondary to other sources of coverage for chemical dependency services). (See Minnesota Statutes, section 256.9353, subd. 2.)

Item B. To carry out the requirements of Minnesota Statutes, section 256.9355, subd. 3, it is reasonable to state in rule that coverage by other payers must be exhausted before MinnesotaCare will reimburse for health care. Requiring providers to attempt collection from potential third party payers before billing the department is administratively efficient for the department and results in substantial cost-savings (because the program is not paying providers up front and later collecting from third-party payers).

Item C. It is reasonable to state in rule that private accident and health insurance requirements must be followed and that MinnesotaCare will not pay for services that are not being reimbursed because applicable rules were not followed. This requirement is consistent with the statutory mandate that MinnesotaCare be a secondary source of coverage. This requirement is also a reasonable method of carrying out the commissioner's administrative responsibilities, including implementing the legislative policy of containing MinnesotaCare expenditures within revenues (see Minnesota Statutes, section 256.9352, subdivision 3).

Subpart 5. **Lien.**
This subpart is necessary and reasonable to ensure that persons consulting the rule are aware that under Minnesota Statutes, section 256.9353, subdivision 8, the department has a lien, subject to section 256.015, for the costs of health services covered by MinnesotaCare upon an enrollee's cause of action arising out of the occurrence that necessitated the care.

9506.0090 COPAYMENTS AND ELIGIBLE PROVIDER REIMBURSEMENT.

Subpart 1. **Copayments required.**
This subpart is necessary to assure that enrollees and eligible providers are aware that copayments may be required under MinnesotaCare. It is reasonable, for rule brevity and comprehensiveness, to simply cite the statutory section that establishes copayment amounts and responsibilities.

Subpart 2. **Reimbursement for covered health services.**
This subpart is necessary to inform providers of covered health services of the amount of reimbursement available from MinnesotaCare. Items A and B are consistent with Minnesota Statutes, section 256.9362, subdivision 1, which mandates payments to providers under MinnesotaCare at the same rates established for medical assistance, with exceptions for (item B) certain providers (federally qualified health centers, rural health clinics, and Indian health service facilities, that are paid according to a complex formula that may result in higher or lower payments than MinnesotaCare) and for (item C) inpatient hospital services.

Subpart 3. **Copayments not paid.**
This subpart is necessary to ensure that enrollees and providers are aware that the copayments required under MinnesotaCare are the responsibility of the enrollee and will not be paid by MinnesotaCare even if an enrollee's failure to pay results in reimbursement to the provider at less than the full medical assistance rate. This is reasonable because copayments are required of the enrollee under the MinnesotaCare statute (see discussion under subpart 1).

Subpart 4. **Commissioner's access to enrollee medical records.** This subpart is necessary for the commissioner to carry out her statutory responsibility under Minnesota Statutes, section 256.9352, subd. 2 to administer the MinnesotaCare plan. This subpart is reasonable because provider payments under MinnesotaCare are subject to the same conditions established for medical assistance. Under Minnesota Statutes, section 256B.064, subdivision 1a, medical assistance providers must allow the department access during regular business hours to all records necessary to disclose the extent of services provided.

PART 9506.0100 SURVEILLANCE & UTILIZATION REVIEW.

This part is necessary to apply the surveillance and review functions of the department to the MinnesotaCare program. It would not be reasonable or responsible to operate the MinnesotaCare program without some monitoring and review. It is reasonable to utilize those surveillance and review functions already in place and adequate to meet the needs of the department and enrollees. Utilizing established functions is both cost-effective and administratively efficient.

SMALL BUSINESS CONSIDERATIONS

In preparing these rules the Department considered the requirements of Minnesota Statutes, section 14.115 but believes that any impact on small business falls within the exemptions in section 14.115, subd. 7, clause (3) for providers of medical care.

AGRICULTURAL LAND

Because the proposed rule does not have a direct and substantial adverse impact on agricultural land in Minnesota, Minnesota Statutes, section 14.11. subd. 2 is not applicable.

EXPERT WITNESSES

If this rule is heard in public hearing, the Department does not intend to have outside expert witnesses testify on its behalf.

Dated: 9/1/94

MARIA R. GOMEZ
Commissioner