Minnesota Health Care Programs

Eligibility Policy Manual

This document provides information about additions and revisions to the Minnesota Department of Human Service's Minnesota Health Care Programs Eligibility Policy Manual.

Manual Letter #18.4

September 1, 2018

Manual Letter #18.4

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of September 1, 2018. The effective date of new or revised policy may not be the same date the information is added to the EPM. Refer to the Summary of Changes to identify when the Minnesota Department of Human Services (DHS) implemented the policy.

I. Summary of Changes

This section of the manual letter provides a summary of newly added sections and changes made to existing sections.

A. EPM Home Page

This manual letter has been added to the EPM home page.

B. Section 1.3.1.5 MHCP Notices

This section has been updated to clarify when and where to send a closing notice when an enrollee's whereabouts are unknown.

C. Section 1.3.2.1 MHCP Change in Circumstances

This section has been updated to add language to describe the effective dates of eligibility when a change in circumstance makes a person newly eligible for MA or MinnesotaCare.

D. Section 1.3.2.5 MHCP Overpayments

This section has been updated to align MA policy with the Minnesota Rule regarding collection of overpayment cases due to agency error. This section has also been updated to replace citation Minnesota Statues, section 256B.016 with Minnesota Rules, part 9505.2215

E. Section 2.1.1.2.1.3 Third Party Liability

This section has been updated to clarify that DHS is required to pursue third party liability information during the application process for CHIP-funded MA enrollees. It is no longer optional to obtain information related to third parties for these enrollees during the application process.

F. Section 2.2.2.1 MA-FCA Basis of Eligibility

This section has been updated to clarify that for someone to be eligible for MA under a caretaker relative basis of eligibility, a parent cannot live in the home.

G. Section 2.2.3.4 MA-FCA Income Methodology

The upate to this section provides a reference to the new MAGI Fact Sheet, which is a quick reference guide to MAGI.

H. Section 2.2.3.6 MA-FCA Medical Spenddown

This section has been updated to clarify that if there is not a biological or adoptive parent in the home a stepparent may be eligible for MA with a spenddown under the caretaker relative basis of eligibility.

I. Section 2.3.3.2.7.14 MA-ABD Household Goods, Personal Effects, and Other Personal Property

This section has been updated to clarify when it is appropriate to evaluate a manufactured home or mobile home as personal property.

J. Section 2.3.5.1.2 MA-EPD Premiums and Cost Sharing

This section has been updated to clarify that an MA-EPD premium can be changed during the budget period due to a a reported change resulting in a decreased premium, law change, or increase in RSDI benefit amount when the RSDI COLA disregard ends.

K. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations

This section has been updated to add back the annuity transaction transfer date of February 8, 2006 to provide clarification and distinguish the difference between the two transfer analysis methodologies.

L. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

This section has been updated to include missing policy regarding when medical expenses are not allowed as a deduction. This section has also been updated to clarify that the Home Maintenance Allowance amount includes the Personal Needs Allowance amount in the monthly deduction.

M. Section 3.2.3.1 MinnesotaCare Health Care Coverage Barriers

This section has been updated to clarify the definition of access and enrollment in relation to the chart listing government sponsored health care coverage and their impact on MinnesotaCare eligibility.

N. Section 3.3.3 MinnesotaCare Income Methodology

This section has been updated with a reference to the new MAGI Fact Sheet, which is a quick reference guide to MAGI.

O. Appendix F Standards and Guidelines

The update to this section updated the utility, electricity, and telephone allowances, which become effective October 1, 2018.

II. Documentation of Changes

This section of the manual letter documents all changes made to an existing section. Deleted text is displayed with strikethrough formatting and newly added text is displayed with underline formatting. Links to the revised and archived versions of the section are also provided.

A. EPM Home Page

B. Section 1.3.1.5 MHCP Notices

C. Section 1.3.2.1 MHCP Change in Circumstances

D. Section 1.3.2.5 MHCP Overpayments

E. Section 2.1.1.2.1.3 Third Party Liability

F. Section 2.2.2.1 MA-FCA Basis of Eligibility

G. Section 2.2.3.4 MA-FCA Income Methodology

H. Section 2.2.3.6 MA-FCA Medical Spenddown

I. Section 2.3.3.2.7.14 MA-ABD Household Goods, Personal Effects, and Other Personal Property

J. Section 2.3.5.1.2 MA-EPD Premiums and Cost Sharing

K. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations

L. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

M. Section 3.2.3.1 MinnesotaCare Health Care Coverage Barriers

N. Section 3.3.3 MinnesotaCare Income Methodology

O. Appendix F Standards and Guidelines

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

Welcome to the Minnesota Department of Human Services (DHS) Minnesota Health Care Programs Eligibility Policy Manual (EPM). This manual contains the official DHS eligibility policies for the Minnesota Health Care Programs including Medical Assistance and MinnesotaCare. Minnesota Health Care Programs policies are based on the state and federal laws and regulations that govern the programs. See Legal Authority section for more information.

The EPM is for use by applicants, enrollees, health care eligibility workers and other interested parties. It provides accurate and timely information about policy only. The EPM does not provide procedural instructions or systems information that health care eligibility workers need to use.

Manual Letters

DHS issues periodic manual letters to announce changes in the EPM. These letters document updated sections and describe any policy changes.

MHCP EPM Manual Letter #18.1, January 1, 2018

MHCP EPM Manual Letter #18.2, April 1, 2018

MHCP EPM Manual Letter #18.3, June 1, 2018

MHCP EPM Manual Letter #18.4, September 1, 2018

2017 Manual Letters

MHCP EPM Manual Letter #17.1, April 1, 2017

MHCP EPM Manual Letter #17.2, June 1, 2017

MHCP EPM Manual Letter #17.3, August 1, 2017

MHCP EPM Manual Letter #17.4, September 1, 2017

MHCP EPM Manual Letter #17.5, December 1, 2017

2016 Manual Letters

MHCP EPM Manual Letter #16.1, June 1, 2016

MHCP EPM Manual Letter #16.2, August 1, 2016

MHCP EPM Manual Letter #16.3, September 1, 2016

MHCP EPM Manual Letter #16.4, December 1, 2016

Bulletins

DHS bulletins provide information and direction to county and tribal health and human services agencies and other DHS business partners. According to DHS policy, bulletins more than two years old are obsolete. Anyone can subscribe to the Bulletins mailing list.

A DHS Bulletin supersedes information in this manual until incorporated into this manual. The following bulletins have not yet been incorporated into the EPM:

- Bulletin #17-21-02, DHS Explains: Changes to MA Estate Recovery Resulting from CMS Approval of a Revised State Plan Amendment; and a New Statewide Funeral Expenses Policy
- Bulletin #17-21-05, DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- Bulletin #17-21-08, DHS Explains Changes to the Minnesota Health Care Programs (MHCP) Application for Medical Assistance for Long-Term Care Services (MA-LTC)
- Bulletin #18-21-03, Periodic Data Matching for Medical Assistance and MinnesotaCare
- Bulletin #18-21-04, DHS Announces the Addition of DEED Income Data for Medical Assistance and MinnesotaCare Renewals in METS
- Bulletin #18-21-05, DHS Implements Automated Reasonable Opportunity Period Functionality for Posteligibility Verifications in METS

Archives

This manual consolidates and updates eligibility policy previously found in the Health Care Programs Manual (HCPM) and Insurance Affordability Programs Manual (IAPM). Prior versions of policy from the HCPM and IAPM are available upon request.

Refer to the EPM Archive for archived sections of the EPM.

Contact Us

Direct questions about the Minnesota Health Care Programs Eligibility Policy Manual to the DHS Health Care Eligibility and Access (HCEA) Division, P.O. Box 64989, 540 Cedar Street, St. Paul, MN 55164-0989, call (888) 938-3224 or fax (651) 431-7423.

Health care eligibility workers must follow agency procedures to submit policy-related questions to HealthQuest.

Legal Authority

Many legal authorities govern Minnesota Health Care Programs, including but not limited to: Title XIX of the Social Security Act; Titles 26, 42 and 45 of the Code of Federal Regulations; and Minnesota Statutes chapters 256B and 256L. In addition, DHS has obtained waivers of certain federal regulations from the Centers for Medicare & Medicaid Services (CMS). Each topic in the EPM includes applicable legal citations at the bottom of the page.

DHS has made every effort to include all applicable statutes, laws, regulations and other presiding authorities; however, erroneous citations or omissions do not imply that there are no applicable legal citations or other presiding authorities. The EPM provides program eligibility policy and should not be construed as legal advice.

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Manual Letter #18.3, June 1, 2018

Manual Letter #18.2, April 1, 2018

Manual Letter #18.1, January 1, 2018

Manual Letter #17.5, December 1, 2017

Manual Letter #17.4, September 1, 2017

Manual Letter #17.3, August 1, 2017

Manual Letter #17.2, June 1, 2017

Manual Letter #17.1, April 1, 2017

Manual Letter #16.4, December 22, 2016

Manual Letter #16.3, September 1, 2016

Manual Letter #16.1, June 1, 2016 (Original Version)

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B. Section 1.3.1.5 MHCP Notices

Minnesota Health Care Programs

1.3.1.5 Notices

Minnesota Health Care Programs (MHCP) applicants and enrollees must receive written notice of decisions affecting their case. The notice provides eligibility information and information about how to appeal decisions if the applicant or enrollee disagrees.

Required Notices

The following notices are required:

- Approval of MHCP eligibility
- Application processing delays
- Denial of MHCP eligibility
- Ending MHCP coverage
- Change in premium
- Change in spenddown
- Change in eligibility for payment of long-term care services

Advance Notice

10-Day Advance Notice

Usually, a 10-day advance notice must be sent when taking an adverse action. Adverse actions include:

- Ending coverage
- Reducing eligibility (For example, increasing a premium or a spenddown)
- Reducing covered services

When a change in an eligibility factor is known in advance the notice may be sent earlier to allow more time to resolve any issue or questions.

Five-Day Advance Notice

Usually, a five-day advance notice is required before ending coverage, reducing eligibility, or reducing covered services if there is probable fraud as determined by a fraud investigator. See the MHCP Fraud policy for more information.

Adequate Notice

Sometimes an advance notice is not required before ending coverage, reducing eligibility, or reducing benefits. The county, tribal or state servicing agency must send an adequate notice no later than the date of action if:

- the enrollee sends a written and signed statement clearly indicating that they want coverage ended. However, if the enrollee requests cancellation orally and does not submit a written statement, a 10-day notice is required.
- the enrollee is eligible for another Minnesota Health Care Program with better benefits or less cost sharing.
- the enrollee is eligible for Medicaid (MA) in another state for the same period.
- the enrollee's whereabouts are unknown. Whereabouts unknown means ~~and~~ the post office returned ~~agency~~ mail directed to the person ~~beneficiary indicating~~ with no forwarding address, and there is no information, such as a telephone number, ~~available on~~ as an alternate way to contact the person. When the person's whereabouts are unknown, the agency must send the adequate notice of closure to the person's last known address.
- the enrollee's eligibility changes as the result of a renewal.
- the enrollee provides a signed, written statement acknowledging that the result will be reduction or closure.
- the enrollee is admitted to a city, county, state, or federal correctional and detention facility where they are ineligible for further services or coverage.

Notice Content

All notices must include the following information:

- Action taken
- The reason for the action
- Which household members the action affects
- Effective date of the action
- The legal authority for the action
- The right to appeal and instructions for filing an appeal
- In cases of an action based on a change in law, the circumstances under which a hearing will be granted

Additionally, notices for processing delays must include:

- The reason the application is not yet processed
- Anything the applicant or enrollee must do to complete the process

Additionally, notices related to MA with a spenddown must include:

- Completed income computation worksheet
- The monthly amount of the enrollee spenddown

Retroactive Notice

In some situations, neither advance nor adequate notice is required before ending coverage, reducing eligibility, or reducing covered services. Instead, a written notice is mailed the next available business day.

Notices of ending coverage, reduction of eligibility, or reduction of services may be sent after the effective dates of the action in the following situations:

- When a case opening is processed after the end of an eligibility period, such as after a six-month spenddown period, and a case is opened and closed the same day
- When a LTC spenddown must be adjusted for past months to reflect actual income or deductions
- When the spenddown type changes from a medical spenddown to an LTC spenddown
- When a enrollee's death has been verified
- When an enrollee requests retroactive MA and is denied coverage for the retroactive months

Legal Citations

Code of Federal Regulations, title 42, section 431.210

Code of Federal Regulations, title 42, section 431.211

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 431.214

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 42, section 435.918

Code of Federal Regulations, title 45, section 155.230

Code of Federal Regulations, title 45, section 155.515

Minnesota Rules, part 9505.0100

Minnesota Rules, part 9505.0125

Minnesota Statutes, section 256B.056

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C. Section 1.3.2.1 MHCP Change in Circumstances

Minnesota Health Care Programs

1.3.2.1 Change in Circumstances

Minnesota Health Care Programs (MHCP) enrollees must report changes that may affect their eligibility. County, tribal and state servicing agencies must act on reported changes. Changes that people may be required to report include, but are not limited to:

- Household composition, including household members moving in or out, births, deaths and marriages
- Household tax filing and tax dependent status
- Access to other health insurance, including Medicare
- Pregnancy
- Address
- Assets
- Income

Reporting Changes

Applicants and enrollees must report changes to their county, tribal or state servicing agency. They may report changes via:

- Phone
- Mail
- In person
- Using a renewal form

Inconsistent Information

Changes are discovered in other ways, such as:

- Changes reported by another person or agency
- Changes reported by an enrollee to another program, such as the Supplemental Nutrition Assistance Program (SNAP)
- Information reported by electronic matches
- Upcoming or potential changes that the agency has been tracking

Any of these changes may be inconsistent information. See MHCP Inconsistent Information policy for more information.

Reporting Deadline

MA, MFPP and Medicare Savings Program enrollees have 10 days to report changes to their county, tribal, or state servicing agency. MinnesotaCare enrollees have 30 days to report changes.

Eligibility Redetermination

When an MHCP enrollee reports a change in circumstances, eligibility must be redetermined with the new information.

Medical Assistance

When an MA enrollee reports a change in circumstance that maintains MA eligibility but results in a beneficial outcome, such as additional benefits or lower cost sharing, the new MA eligibility begins the first day of the month in which the change occurred.

When an MA enrollee reports a change in circumstances that maintains MA eligibility but results in an adverse outcome, such as lesser benefits or higher cost sharing, the date the new MA eligibility begins depends on when the change occurred. A 10-day advance notice is required for adverse changes. See the MHCP Notices policy for more information.

When a MA enrollee reports a change in circumstance that results in the loss of MA eligibility, MA coverage ends the last day of the month for which advance notice can be given. Generally, 10-day advance notice is required to end MA coverage. See the MHCP Notices policy for more information.

When a person enrolled in MinnesotaCare or another Insurance Affordability Program reports a change in circumstance that results in MA eligibility, MA begins the first day of the month the change was reported, if the person does not need or is not eligible for retroactive coverage. The earliest possible begin date for MA is the first day of the month three months prior to the month the change was reported.The person may be eligible for each retroactive month they meet the MA eligibility requirements and have paid or unpaid medical expenses that would be covered by MA in each month.

MinnesotaCare

When a MinnesotaCare enrollee reports a change in circumstance that maintains MinnesotaCare eligibility but results in a different premium or cost sharing amount such as a change in income, the effective date of the premium change depends on whether it is a premium decrease or premium increase. A premium decrease is effective the month after the change was reported. A premium increase is effective for the month billed with the next regular billing cycle.

When a MinnesotaCare enrollee reports a change in circumstances that result in MA eligibility, MinnesotaCare eligibility ends the day before MA eligibility begins.

When a MinnesotaCare enrollee reports a change in circumstances that results in Advance Premium Tax Credit eligibility, MinnesotaCare eligibility and coverage ends the last day of the month for which advance notice can be given. Generally, 10-day advance notice is required to end MinnesotaCare coverage. See the MHCP Notices policy for more information.

When a MinnesotaCare enrollee reports a change in circumstances that results in loss of all health care eligibility, MinnesotaCare eligibility and coverage ends the last day of the month for which advance notice can be given. Generally, 10-day advance notice is required to end MinnesotaCare coverage. See the MHCP Notices policy for more information.

When a person enrolled in MA reports a change in circumstances that results in MinnesotaCare eligibility, MInnesotaCare eligibility begins no earlier than the first day of the month following the month MA ends. When a person enrolled in another Insurance Affordability Program reports a change in circumstance that results in MinnesotaCare eligibility, the earliest possible begin date for MinnesotaCare eligibility is the month the change was reported. MinnesotaCare coverage generally begins the first day of the month after the month in which eligibility is approved and a first premium payment is received, if the person is required to pay a premium. The coverage begin date for a person who is not required to pay a premium is the first day of the month after the month in which eligibility is approved. See MinnesotaCare Begin and End Dates for more information and exceptions for a person added to an existing MinnesotaCare household.

Medicare Savings Programs

When a Medicare Savings Program (MSP) enrollee reports a change in circumstances that results in a change to a more beneficial MSP program, the new MSP eligibility begins the first day of the month in which the change occurred.

When a MSP enrollee reports a change in circumstances that results in a change to a less beneficial MSP program, the date the new MSP eligibility begins depends on when the change occurred. A 10-day advance notice is required for adverse changes. See the MHCP Notices policy for more information.

When a MSP enrollee reports a change in circumstances that results in the loss of MSP eligibility, MSP coverage ends the last day of the month for which advance notice can be given. Generally, 10-day notice is required to end MSP coverage. See the MHCP Notices policy for more information.

Exceptions

Changes in circumstances do not effect eligibility in the following situations:

- Income increases between renewals do not change MA for Employed Persons with Disabilities (MA-EPD) monthly premiums. MA-EPD premiums may change at each six-month renewal. See the MA-EPD Premium policy for more information.
- Changes in income, assets and household composition to not change eligibility for Refugee Medical Assistance (RMA). See the RMA chapter for more information.
- Income and household composition changes only change eligibility for the Minnesota Family Planning Program at renewal or when the person fails to report a change at renewal. See the MFPP Change in Circumstances policy for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 45, section 155.330

Minnesota Rules, part 9505.0115, subpart 1

Minnesota Statutes 256B.057

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D. Section 1.3.2.5 MHCP Overpayments

Minnesota Health Care Programs

1.3.2.5 Overpayments

Overpayments occur when an enrollees receives more Minnesota Health Care Programs (MHCP) benefits than they were entitled to as a result of fraud, theft, abuse or error on the part of the enrollee.

~~Overpayments are determined in these situations:~~

- ~~Situations in which the agency finds that enrollees received more MHCP benefits than they were entitled to because of late reporting or failure to report or disclose information~~
- ~~In conjunction with pursuit of a fraud conviction~~

Overpayments are not determined when recovery of the overpayment would be unreasonable or unfair, including but not limited to, the following circumstances:

- The overpayment is the result of agency error
- ~~When~~ The enrollee reports a change timely and the agency cannot provide advance notice
- Eligibility was determined using the enrollee's estimate of expected income and the enrollee's actual income was later found to be higher than the original estimate
- There is suspected fraud or unreported information that has not yet been verified or confirmed

The overpayment amount:

- Is the amount the health care program paid for benefits on behalf of the enrollee, either through fee-for-service claims or managed care payments, minus premiums paid for the overpayment period
- The amount MHCP paid for benefits is compared to the benefits the enrollee should have received. The overpayment amount may be reduced or eliminated if the enrollee would have been eligible for the same program under a different basis.

Overpayment Notification

People must receive written notice of overpayments using Minnesota Health Care Programs Notice of Overpayment (DHS-4939) or Notice of Medical Assistance Overpayment (DHS-4600). The notice:

- explains the reason for the overpayment,
- shows how the overpayment was computed,
- requests repayment,

- advises enrollees that further action may be taken if payment is not made, and
- Advises enrollees of their appeal rights.

Overpayment Collection

Available collection methods vary according to the program, whether the overpayment is determined to be the result of fraud, and whether the person is a current enrollee.

Voluntary Repayment

Voluntary repayment is available for all MHCPs and for both current and former enrollees. Each county, tribal or state servicing agency sets its own procedures for receiving voluntary repayments.

Revenue Recapture

Revenue recapture allows the county, tribal or state servicing agency to recover overpayments in MHCPs by intercepting income or property tax refunds and lottery winnings. Counties and DHS collections must submit requests for revenue recapture to the Commissioner of Revenue, who determines if revenue recapture is allowable under the Revenue Recapture Act, Minnesota Statutes 270A.

- Revenue recapture may be used when the individual is no longer enrolled in the MHCP for which the debt is owed. Revenue recapture may be used for an overpayment established from an agency finding based on enrollee error, an administrative appeal decision based on enrollee error, or a court determination of benefits incorrectly paid.
- Some health care overpayments may not be recoverable through revenue recapture. Recovery of overpayments for medical care is prohibited if the person's income was below certain limits at the time the benefits were received.

Civil Recovery

Civil recovery includes obtaining a judgment and pursuing repayment through methods such as garnishment or property liens. Current enrollees are protected from civil recovery while they are enrolled and for six months after enrollment ends.

- For MA, these methods are only available after a civil or criminal court judgment with a finding that benefits were incorrectly paid, with or without a finding that fraud occurred.
- For state funded health care programs, the county agency or DHS collections may use the Judgment by Operation of Law (JOL) procedures outlined in Minnesota Statutes 256.0471.

Criminal Restitution

As part of the sentence for a conviction for fraud, the court may order the person to make restitution. The court may:

- Lower the previously determined overpayment amount. order a monetary restitution for an amount less than the previously determined overpayment amount without reducing the

total overpayment. This means that the person must pay a reduced amount as a condition of probation. The county or DHS collections may pursue repayment of the remainder of the overpayment through civil recovery or revenue recapture.

- Order restitution in addition to the previously determined overpayment amount, such as fines, penalties, and accrued interest. Any added restitution is collected and retained entirely by the court or the agency that brought the fraud charge.

Legal Citations

~~(d)~~

Minnesota Rules, part 9505.0131

Minnesota Rules, part 9505.2215

Minnesota Statutes, section 256.01, subdivision 2(~~t~~s)

Minnesota Statutes, section 256.98, ~~subdivision 3~~

Minnesota Statutes, section 256.045, subdivision 10

Minnesota Statutes, section 256.0471

Minnesota Statutes, section 256B.016

Minnesota Statutes, section 270A

United States Code, title 42, section 1396b(d)

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E. Section 2.1.1.2.1.3 MA Third Party Liability

Medical Assistance

2.1.1.2.1.3 Third Party Liability

Third parties are people, entities, or programs that are, or may be, liable to pay all or part of the medical costs provided to Medical Assistance (MA) or Children Health Insurance Plan (CHIP) funded MA enrollees.

A third party may be liable to pay all or part of the medical costs provided to MA or CHIP-funded MA enrollees because these programs are ~~MA is~~ the payer of last resort, with limited exception, such as Indian Health Services. This means enrollees with third party liability (TPL) must have medical costs covered by TPL paid by those sources before MA pays claims.

A third party payer includes, but is not limited to:

- Other health care coverage, such as group health plans, COBRA continuation of group health plans, individual health plans, Medicare, and military insurance
- Medical support from absent parents
- Other sources such as automobile insurance, court judgments or settlements, workers' compensation, and fundraisers to pay for medical expenses

Other Health Care Coverage

Applicants and enrollees must cooperate with identifying sources of existing health coverage and assign rights to other health care coverage. Those who fail to cooperate with TPL requirements may be denied coverage or have their MA or CHIP-funded MA coverage ended. See the MA Cooperation policy for more information.

People must cooperate with TPL requirements by:

- Providing information to assist the Minnesota Department of Human Services (DHS) or an enrollee's managed care plan to pursue any third party liable for payment, and applying for other benefits that may help pay for their medical costs. This includes:
  - Cooperation with completing Medical Service Questionnaires (MSQs) when the person has received a service that potentially indicates a third party may be responsible
  - Giving complete information about third party health, dental, vision and long-term care insurance policies that cover MA enrollees
- Enrolling or maintaining enrollment in:
  - A group health plan that is cost effective
  - A group health plan when there is no cost for the policyholder to cover all family members enrolled in MA

MA eligibility continues for people who do not enroll in, cooperate with or assign rights to a group health plan if they cannot do so on their own behalf. See MA Cost Effective Health Insurance for more information.

- Assigning rights to DHS for medical support and payment for medical care from any third party

Enrollees do not have to cooperate with TPL requirements when they are Safe at Home (SAH) Address Confidentiality program participants and the policyholder is their probable assailant.

Medical Support

Medical support may include cash payments or health insurance coverage that a parent who does not live with their children must provide or is court-ordered to provide to meet the medical needs of their children. Parents and relative caretakers who are referred for medical support must cooperate with the county, tribal or state servicing agency as a condition of their own eligibility, unless they show good cause for non-cooperation. See MA Medical Support for more information.

Other Third Party Liability

In some situations, automobile insurance, homeowner insurance, court judgments or settlements, workers' compensation and other third parties may pay health care costs. See MA Other Third Party Liability for more information.

Legal Citations

Code of Federal Regulations, title 42, sections 433.135 to 433.154

Code of Federal Regulations, title 42, section 435.610

Federal Register, Vol.60, No.131 (July 10, 1995), page 35498

Minnesota Statutes, section 256B.042

Minnesota Statutes, section 256B.056

United States Code, title 42, section 1396a

United States Code, title 42, section 1396e

United States Code, title 42, section 1396g-1

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F. Section 2.2.2.1 MA-FCA Bases of Eligibility

Medical Assistance for Families with Children and Adults

2.2.2.1 Bases of Eligibility

Minnesota provides Medical Assistance (MA) to certain groups of people as allowed under law. These groups are referred to as a basis of eligibility. A person's basis of eligibility determines the non-financial criteria and financial methodology used to determine MA eligibility.

The following are the bases of eligibility for MA for Families with Children and Adults (MA-FCA):

- Parent:
  - Biological, natural, adoptive or step parent
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
- Caretaker Relative, including foster parents, legal guardians or others, who are:
  - A relative of a child younger than age 19, by blood, adoption, or marriage. Including:
    - Grandparents, siblings
    - First cousins, nephews, nieces, aunts or uncles and people of preceding generations as denoted by grand, great or great-great
    - ~~Stepfather,~~ ~~stepmother~~, stepbrother or stepsister
    - Spouses and former spouses of the people named above
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
  - The spouse of a caretaker relative can also use the caretaker relative basis of eligibility
- Pregnant Woman:
  - A woman who is pregnant
  - A woman within the 60 days post-partum period
- Auto Newborn: child born to a mother enrolled in MA
- Infant: child age 0 through 1
  - Children's Health Insurance Program (CHIP) funded MA may be available for infants with income between 275% and 283% FPG who are not enrolled in other health insurance.
  - A CHIP funded infant who has or gains other health insurance becomes eligible for MA as a non-CHIP funded infant
- Child age 2 through 18

- Child age 19 and 20
- Adult age 21 through 64 who:
  - Is not eligible for or enrolled in Medicare Part A or Medicare Part B
  - Is not a Supplemental Security Income (SSI) recipient
  - Is not eligible for MA under 1619 a/b
  - Is not a former SSI recipient who stopped receiving SSI when they began receiving Retirement, Survivor, Disability (RSDI) benefits from the Social Security Administration (SSA) under a deceased spouse or deceased or retired parent's earning record
  - Is not eligible for MA under the parent, caretaker relative, pregnant woman or former foster care basis of eligibility

Adults not eligible for this basis may meet the eligibility requirements for MA for People Who Are Age 65 or Older or People Who Are Blind or Have a Disability.

- Former Foster Child:
  - Was in Title IV-E or Non-IV-E foster care on 18th birthday
  - Currently younger than age 26
  - Was enrolled in MA or MinnesotaCare when foster care ended
  - Is not eligible for MA under the parent, relative caretaker, pregnant woman or child age 19 and 20 basis of eligibility

Beginning and Ending Bases of Eligibility

A person must have one of the following bases of eligibility for MA-FCA. A person whose basis of eligibility ends must be evaluated for other MA bases of eligibility before MA is closed.

Applicants who meet eligibility requirements at any time within a month are eligible for the entire month with the following exceptions:

- A person's eligibility ends on the date of death
- A person's eligibility begins the date they become a Minnesota resident
- A person's eligibility begins the date they meet their spenddown requirement

The begin and end dates for the following bases of eligibility are:

- Pregnant woman:
  - Begins the first day of the month of conception
  - Ends the last day of the month following the 60-day postpartum period

- Begin and end dates for the pregnant woman basis of eligibility are determined using information the application or enrollee attests. Verification of pregnancy is not required to establish this basis.

- Auto newborn:
  - Begins the first day of the month of birth
  - Ends the last day of the month of their first birthday
- Infant:
  - Begins the first day of the month of birth
  - Ends the last day of the month of their second birthday
- Child age 2 through 18:
  - Begins the first day of the month following their second birthday
  - Ends the last day of the month of their 19th birthday
- Child age 19 and 20:
  - Begins the first day of the month following their 19th birthday
  - Ends the last day of the month of their 21st birthday
- Parent or caretaker relative:
  - Begins the first day of the month of the birth or adoption of a child under the age of 19 or the first day of the first full month when a child younger than age of 19 moves into their home.
  - Ends the last day of the month when:
    - The only child or youngest child for whom the person is a parent or relative caretaker turns 19
    - The only child, or all children who live in the home under the age 19, leave the home and the absence is not temporary
    - The parent or caretaker relative no longer lives with a child younger than age 19
- Adults without children:
  - Begins the first day of the month following their 21st birthday
  - Ends the last day of the month prior to their 65th birthday
- Former foster child:
  - Begins no earlier than the first day of the month after the month that Medicaid for Title IV-E foster care or Non-Title IV-E ends
  - Ends the last day of the month following their 26th birthday

Multiple Bases of Eligibility

People may have more than one basis of eligibility. A person’s countable income, asset limit, cost sharing, service delivery options and benefits may differ depending on the eligibility basis used. The county, tribal or state servicing agency must allow a person with multiple bases of eligibility to have eligibility determined under the basis that best meets their needs.

Change in Basis of Eligibility for Enrollees

A change in circumstances may affect an MA enrollee's basis of eligibility. People who lose eligibility under one basis must be redetermined under another basis without interruption in their coverage. Additional information may be required to determine continued eligibility under another basis. Some changes that may affect an enrollee's basis of eligibility include, but are not limited to:

- Age
    - An auto newborn basis of eligibility ends the last day of the month in which the child turns one
    - A child basis of eligibility ends the last day of the month of the child's 21st birthday
    - An adult without children basis of eligibility ends the month before the enrollee’s 65th birthday
- Disability status
- Household Composition
- Medicare A or B. An adult without children basis of eligibility ends the month before the enrollee is eligible for or enrolled in Medicare A or B.
- Pregnancy. A pregnant basis of eligibility ends on the last day of the month in which the 60-day postpartum period ends.

If an enrollee is no longer eligible for MA under any basis, eligibility must be determined under another Minnesota Insurance Affordability Program.

Legal Citations

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 435

Code of Federal Regulations, title 42, section 457.1

Minnesota Statutes, section 256B.055

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G. Section 2.2.3.4 MA-FCA Income Methodology

Medical Assistance for Families with Children and Adults

2.2.3.4 Income Methodology

Income eligibility for Medical Assistance for Families with Children and Adults (MA-FCA) is based on current income and adjustments using the Modified Adjusted Gross Income (MAGI) methodology as follows:

- Household income includes:
  - The types of income included in Federal taxable income, including losses, minus Federal income tax adjustments
  - Nontaxable foreign earned income and housing cost of citizens or residents of the United States living abroad
  - Nontaxable interest income
  - Nontaxable Social Security and tier one railroad retirement benefits
- Household income does not include:
  - Scholarships, awards or fellowship grants used for education purposes and not for living expenses
  - Certain American Indian/Alaska Native income
- Lump sum income is counted in the month received if it is from a type of income that is included in MAGI methodology. If the lump sum is from an income type that is not included in a person's modified adjusted gross income, it is not counted.

Refer to the MAGI Fact Sheet for a quick reference guide on MAGI.

Federal Taxable Income

Federal taxable income are the different types of income that appear in the Income section of the Internal Revenue Service (IRS) form 1040, IRS form 1040-A and or IRS form 1040-EZ. Only the taxable portions of these types of income are included in the adjusted gross income.The types of losses that are reported on federal income tax returns can offset income. See the appropriate IRS form instructions for examples of federal taxable income. The general types of taxable income include the following:

- Wages, salary and tips
  - Payroll or pre-tax deductions for childcare, health insurance, retirement plans, transportation assistance and other employee benefits are not taxable and are not included in a person's adjusted gross income.

- Medicaid waiver payments received by a person who provides HCBS waiver services (personal care services, habilitation services, and other services) to an eligible person living with them are not taxable and not included in a person's adjusted gross income. See Internal Revenue Bulletin 2014-4 for more information.

  If the eligible person does not live with the person providing the HCBS waiver services, the Medicaid waiver payments are taxable and are included in the person's adjusted gross income.

- Interest
- Dividends
- Taxable refunds, credits or offsets of state and local income taxes
- Alimony received
- Business income or loss (includes self-employment)
- Capital gains or losses
- Other gains or losses
- Individual retirement account (IRA) distributions
- Pension and annuity payments
- Income or loss from rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Farm income or loss
- Unemployment compensation
- Social Security benefits
- Other income or loss
- Net operating loss, including a carryforward loss

Federal Income Tax Adjustments

The types of adjustments that appear in the Adjusted Gross Income section of the 1040 or 1040-A are subtracted from gross income to calculate the adjusted gross income. Only specific types of adjustments are allowed. See the appropriate IRS form instructions for specific information about the types of adjustments.

- Educator expenses
- Certain business expenses of reservists, performing artists and fee-basis government officials
- Health savings account
- Moving expenses
- Deductible portion of self-employment tax

- Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE) and qualified plans
- Self-employed health insurance
- Penalty on early withdrawal of savings
- Alimony paid (spousal support)
- IRA deduction
- Student loan interest
- Tuition and fees
- Domestic production activities

Scholarships, Awards or Fellowship Grants

Taxable scholarships, awards or grants used for education purposes and not for living expenses (room and board) are excluded income under the MA-FCA income methodology.

American Indian and Alaska Native Income

The following income is excluded under the MA-FCA income methodology for American Indian and Alaska Native people:

- Distributions from Alaska Native Corporations and Settlement Trusts
- Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior
- Distributions and payments from rents, leases, rights of way, royalties, usage rights or natural resource extraction and harvest from:
    - rights of ownership or possession in properties held in trust under the supervision of the Secretary of the Interior; or
    - federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources.
- Distributions resulting from real property ownership interests related to natural resources and improvements:
    - located on or near a reservation or within the most recent boundaries of a prior federal reservation, or
    - resulting from the exercise of federally protected rights relating to such real property ownership interests.
- Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom

- Student financial assistance provided under the Bureau of Indian Affairs education programs

Lump Sum Income

Under MA-FCA, lump sum income is one-time income that is not predictable. Periodic reoccurring income is not lump sum income. Lump sum income is only counted under MA-FCA if it is a type of income that is included in the calculation of modified adjusted gross income (MAGI).

Examples of lump sum income that is part of the MAGI calculation include, but are not limited to:

- Winnings (lottery, gambling)
- Alimony settlements
- Wage bonuses

Legal Citations

Code of Federal Regulations, title 42, section 435.603

Code of Federal Regulations, title 45, section 155.305

Minnesota Statutes, section 256B.057

Minnesota Statutes, section 256L.01

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H. Section 2.2.3.6 MA-FCA Medical Spenddown

Medical Assistance for Families with Children and Adults

2.2.3.6 Medical Spenddown

A spenddown is a cost-sharing approach that allows Medical Assistance (MA) eligibility for people whose income is greater than the applicable limit. Federal rules refer to this population as “medically needy.”

People can become income eligible for MA by “spending down” their excess income to the appropriate income limit. The excess income is reduced by deducting certain health care expenses.

Parents, caretaker relatives, pregnant women and children who are not eligible for MA because they are over the income limit and who have medical expenses may be eligible for MA with a spenddown. Federal law does not permit stepparents or people using an adults without children basis of eligibility to be eligible for MA with a spenddown. If there is no biological or adoptive parent in the home, a stepparent may be eligible for MA with a spenddown under the caretaker relative basis of eligibility.

Spenddown Criteria

People may be eligible for MA with a spenddown if they:

- meet all other MA eligibility criteria;
- meet the applicable asset limit;
- have a parent, caretaker relative, pregnant woman or child basis of eligibility;
- have income that exceeds the applicable MA income standard; and
- have medical expenses equal to or greater than their spenddown.

People with an age 65 or older, blind or disabled basis of eligibility must meet different criteria than those described on this page. See MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Medical Spenddown for more information.

Spenddown Types and Health Care Expenses

The policies for spenddown types, eligible health care expenses and spenddown adjustments are the same for MA for Families and Children with a Medical Spenddown and MA-ABD with a Medical Spenddown. See the following policies for details:

MA-ABD Medical Spenddowns

MA-ABD Spenddown Types

MA-ABD Health Care Expenses

Non-Financial Eligibility for MA for Families and Children with a Medical Spenddown

People enrolled in MA for Families and Children with a Medical Spenddown must meet the same responsibilities and post-eligibility requirements as enrollees in MA for Families with Children and Adults (FCA) without a spenddown:

Bases of Eligibility

This policy applies to medical spenddowns for the following people:

- Biological, natural or adoptive parent
- Caretaker relative
- Pregnant woman
- Child age birth through 20

Household Composition

Household composition and household size affects asset and income limits. People who live together and have the following relationships are considered in the household composition determination for MA for Families and Children with a Medical Spenddown.

The following people are included in the household size of an adult applicant, age 21 and older:

- Applicant
- Spouse
- Children under age 21, biological, adoptive and step-children
  - Emancipated minors are not included. An emancipated minor is a person under the age of 18 who is or was married, is on active-duty in the uniformed services, or declared emancipated by a court.
- Unborn child or children of the applicant or spouse

The following people are included in the household size of a child applicant, under age 21:

- Applicant
- Parents of applicant, including biological, natural, and adoptive parents
- Siblings under age 21, including biological, adoptive, half and step-siblings
  - Emancipated minors are not included
- Spouse
- Children of the child applicant
- Unborn child or children of the applicant, spouse or children

The following people are included in the household size of an emancipated minor:

- Applicant
- Spouse
- Children of the child applicant
- Unborn child or children of the applicant or spouse

Financial Eligibility for MA for Families and Children with a Medical Spenddown

Asset Limit

Assets are items of value that people own like bank accounts, stocks and bonds, cars and real estate. See Appendix A Types of Assets for definitions of the different types of assets.

- Children and pregnant women eligible for MA with a spenddown have no asset limit.
- Parents and caretaker relatives eligible for MA with a spenddown have the following asset limits:
  - $10,000 asset limit for a household of one
  - $20,000 for a household of two or more

Categories of Assets

Assets fall into two categories, excluded and countable.

- Excluded assets: Certain types and amounts of assets are excluded and do not count against a person's asset limit. Any assets that are not specifically excluded are countable.
- Countable assets: Countable assets are evaluated for availability and may count towards the person's asset limit.
  - Available assets: count against the asset limit
  - Unavailable assets: do not count against the asset limit

Income received in a given month is not an asset in that month. If retained beyond the month of receipt, income becomes an asset.

Excluded Assets

Excluded assets are not counted against the asset limit when establishing eligibility. Excluded assets for MA with a spenddown for a parent or caretaker relative include:

- Adoption Assistance
- Agent Orange Settlement Fund payments
- Alaska Native Claims Settlement Act (ANCSA) payments
- Blood Product Settlement payments

- Bureau of Indian Affairs (BIA) student financial aid
- Burial assets
- Cobell v. Salazar Class Action Settlement (also known as Claims Resolution Act of 2010)
- Corporation for National and Community Service (CNCS) payments
- Crime victim payments
- Disaster assistance, federal declaration
- Disaster assistance, state declaration
- Filipino Veterans Equity Compensation (FVEC) payments
- First $200,000 of household self-employment assets (net value of assets of a trade or business needed for a client to earn income). This includes self-employment assets that are temporarily not being used due to the self-employed person's illness or disability.
- Foster Care payments
- Gifts to children with life threatening conditions
- Homestead property
- Household goods and personal effects
- I-35W Bridge Collapse payment
- Individual Development Accounts (IDA)
- Interest income from Indian trust land or restricted lands
- James Zadroga 9/11 Health and Compensation Act of 2010
- Japanese-American and Aleutian Restitution payments
- Jensen Settlement Agreement Payment
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Minnesota Housing Finance Agency (MHFA) home improvement loan
- Nazi Persecution payment
- Personal property
- Public assistance appeal payments
- Radiation Exposure Compensation Act payments
- Real property
- Relocation Assistance Payments, federal
- Relocation Assistance Payments, state and local
- Retirement plans
- Ricky Ray Hemophilia Relief Act payments
- Student financial aid

- Tax refund
- Term life insurance
- Trade or business asset
- Tribal Land Settlements or Judgements
- Third Party Trusts
- Vehicles -used for employment or seeking employment, one per household member of legal driving age
- Veterans' Benefits for Educational Assistance
- Veterans' Children with Certain Birth Defects payments
- Vietnamese Commando Compensation Act payments
- Workers' compensation settlement

Countable Assets

Assets not specifically excluded are considered countable assets. Countable assets must be evaluated for availability to determine if their value counts toward the person's asset limit. Countable assets that are available count towards the person's asset limit, unavailable assets do not.

- Assets are unavailable if a person is unable to access or use them for self-support and cannot liquidate them. They include:
  - Legally unavailable assets
  - Non-homestead real property with a reasonable effort to sell
- Countable assets are not explicitly excluded from being counted against the asset limit and are available to the person.
  - Annuities
  - Continuing Care Retirement Community (CCRC) entrance fee
  - Cash Surrender Value (CSV)
  - Certificate of Deposit (CDs)
  - Home Equity
  - Interest
  - Liquid assets
  - Money market account
  - Non-homestead real property
  - Non-term life insurance policy
  - Promissory notes

- Qualified Tuition Program (QTP), also referred to as a Section 529 Plan
- Self-employment assets over the maximum excluded net value of $200,000 per household
- Trusts
- Vehicles - in excess of one per household member of legal driving age

Reducing Assets

Parents and relative caretakers who are applying for MA and have excess countable assets in the month of application must reduce those assets to be within their asset limit by the end of the processing period to be eligible.

Some acceptable ways to reduce assets for applicants who have excess assets in the application month include, but are not limited to, paying bills or other obligations such as health care expenses or purchasing assets that do not count toward the asset limit.

Applicants who are requesting MA for Long-Term Care (LTC) services may be subject to a transfer penalty if they reduce assets by giving them away without receiving adequate compensation. See MA-LTC Uncompensated Transfers for more information.

Applicants must verify that they have reduced excess countable assets by providing bank statements or other documents that show current asset amounts, but are not required to provide receipts.

Eligibility can begin back to the first day of the month of application if the applicant reduces excess assets within the applicable processing period.

Applicants who are requesting retroactive coverage and need to reduce assets have different rules from applicants not requesting retroactive coverage. Applicants requesting retroactive eligibility can only reduce assets by paying medical expenses or retroactively designate burial funds.

Income

Income is cash or in-kind benefits available to a person. Income is divided into two major categories, earned and unearned:

- Earned income is cash or in-kind benefits received in return for work or services, including employment and self-employment.
- Unearned income is cash or in-kind benefits received without being required to perform any work or service, including spousal maintenance, child support, annuities, pensions, etc.

Income is either counted or not counted. Income is not counted if it is unavailable or if it is excluded by law. Whether income is counted depends on the type of income. Income is counted in the month it is received. See Appendix B Types of Income for descriptions of each type of income.

Counted Income

- AmeriCorps State or National living allowances and other payments
- AmeriCorps-National Civilian Community Corps (AmeriCorps NCCC) living allowances and other payments
- Amount over $2,000 interest income from Indian trust land or other restricted Indian lands
- Amount over $2,000 of cash payments from tax-exempt organizations for a child with a life-threatening condition
- Annuity payments
- Blood and blood plasma sales
- Child support income
- Clergy housing allowances
- Commissions
- Compensation from an employer's vacation donation program, if paid and taxed in the same manner as the employee's usual pay
- Conservation and Youth Service Corps wages
- Court-ordered dependent care expense payments
- Disability payments that are part of the employer’s benefit package
- Experience Works wages
- Extended income support payments through the Trade Adjustment Reform Act of 2002 (TAA)
- Gifts
- Higher Education Innovative Projects wages
- Honoraria
- Hostile fire, imminent danger and combat pay
- Income from self-employment
- Income that is withheld to repay a legal debt or obligation
- Income withheld to repay a legal debt or obligation
- In-kind income if the person has the option to receive cash instead of in-kind income
- Interest and dividends received as payments
- Jury duty pay
- Lump sum income
- National and Community Service Models wages
- Net self-employment income

- Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that requires teaching, research, or other work in order to receive the aid for graduate students
- Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that does not require work to receive the aid for graduate students, after deducting allowable student expenses
- Non-Title IV of HEA and non-BIA student loans for graduate students, after deducting allowable student expenses
- Picket duty pay
- Public and private pensions
- Railroad Retirement Board (RRB) benefits
- Refugee Resettlement Program grants
- Regular cash gift income or cash gift income that exceeds $30 per three months
- Retirement, Survivor's and Disability Insurance (RSDI), except for specific exclusions
- Royalties
- Senior Aids Program wages
- Serve America wages
- Severance pay
- Sick pay based on accrued leave time
- Spousal maintenance income
- Tips
- Tribal per capita payments from gaming revenue (casino profits)
- Trust disbursements
- Unemployment insurance
- Vacation pay
- Value of in-kind gifts from tax-exempt organizations for a child with a life-threatening condition when those gifts are converted to cash
- Veteran's Administration benefits
- Vocational Rehabilitation current living expense payments
- Voluntary Resettlement Agency Matching Grant Program grants
- Wages
- Workers' Compensation
- Workforce Investment Act (WIA) earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is not a student, beyond six months per year

Excluded Income

- Agent Orange Settlement Fund payments
- All income of refugee unaccompanied minors
- American Indian tribal land settlements and judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior
- AmeriCorps Vista payments
- Assets converted to cash
- Bills paid by a third party
- Blood Product Settlement payments
- Bureau of Indian Affairs (BIA) student financial aid for undergraduate and graduate students
- Child Care and Development Block Grant Act payments
- Class action settlement agreement in Jensen et al v. Minnesota Department of Human Services, et al.
- Clinical trial participation payments
- Cobell Settlement for American Indians
- Community fundraiser income not under the control of the applicant, enrollee or a responsible relative
- Consumer Support Grant (CSG) payments
- Corporation for National and Community Service (CNCS) payments
- Costs necessary to secure the payments of unearned income, such as attorney's fees and medical fees
- Court-ordered medical support
- Coverdell Education Savings Account (ESA) payments used for educational expenses
- Crime victim payments
- Disaster assistance
- Family Support Grant (FSG) payments
- Federal Relocation Assistance
- Filipino Veterans Equity Compensation (FVEC) fund payments
- First $2,000 interest income from Indian trust land or other restricted Indian lands
- First $2,000 of cash payments from tax-exempt organizations for a child with a life-threatening condition
- First $10,000 of court-ordered Workers Compensation settlements
- Foster Care Assistance

- Gifts of cash for tuition or education
- Gifts of cash to purchase a prosthetic device not covered by health care or other insurance
- Housing and Urban Development (HUD) subsidies
- Inaccessible income such as unpaid court ordered child support
- Income excluded by the Social Security Administration to determine Supplemental Security Income (SSI) eligibility
- Income used by the Social Security Administration to determine SSI eligibility
- Income withheld to repay a prior overpayment of benefits made by the same income source
- Individual Development Accounts (IDA)
- In-kind income if the person does not have the option to receive cash
- Insurance payments not payable or available to the applicant
- Interest and dividends accrued and combined with counted assets, within the asset limit
- Irregular cash gift income of less than $30 per three months
- IV-E and State-Subsidized Adoption Assistance
- James Zadroga 9/11 Health and Compensation Act of 2010
- Japanese and Aleutian Restitution payments
- Loans – principal portion of loan payments
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Military salary reductions
- Mille Lacs Band of Ojibwa Elder Supplement Assistance Program
- Money received and spend to cover someone else’s expenses
- Nazi Persecution payments
- Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that requires teaching, research, or other work to receive the aid for undergraduate students
- Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that does not require work to receive the aid for undergraduate students
- Non-Title IV of HEA and non-BIA student loans for undergraduate students
- Payments used to reimburse a custodial parent for health insurance premiums
- Per capita distributions of all funds held in trust by the Secretary of the Interior to members of an Indian tribe
- Program participation incentive payments

- Public Assistance Payments, such as general assistance (GA), Minnesota Supplemental Aid (MSA), Minnesota Family Investment Program (MFIP), Refugee Cash Assistance (RCA), Diversionary Work Program benefits (DWP), Work Benefit Program benefits (WB)
- Radiation Exposure Compensation Act payments
- Refunds of security and utility deposits
- Reimbursements for employment and training, medical expenses and property
- Relative Custody Assistance
- Retirement, Survivor's and Disability Insurance (RSDI) for children under age 18 under the TEFRA option or receiving home and community based waiver services
- Ricky Ray Hemophilia Relief Act payments
- Student financial aid expenses for tuition, mandatory fees, course and lab fees, books, supplies and equipment required for course work, child care costs incurred while at school or in transit, transportation to and from school
- Student financial aid from a Title IV of the Higher Education Act of 1965 program for undergraduate and graduate students
- SSI
- Tax credits, rebates and refunds
- Training expenses under the Trade Adjustment Reform Act of 2002
- Veterans' Children with Certain Birth Defects payments
- Veterans' Affairs (VA) education assistance
- Vietnamese Commando Compensation Act payments
- Vocational Rehabilitation payments, except current living expense payments
- Wages and other earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is a full or part-time student and works less than 37.5 hours per week
- Workforce Investment Act (WIA) earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is a full or part-time student and works at least 37.5 hours per week
- WIA earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is not a student, six months per year
- WUV payments from the Dutch government to victims of Nazi persecution

Whose Income and Assets Counts

When calculating income and assets for a person, it is often necessary to count another person's income or assets in that determination. This is called deeming.

Income of the following people, living with the person, is deemed and counted:

- Spouse
- Parents, if the applicant is under age 21 and is not emancipated, including biological, natural and adoptive parents

The assets of the spouse, who is living with the person applying for MA, are deemed and counted.

Sponsor Deeming

Adult immigrant non-citizens who have a sponsor must have the income and assets of the sponsor deemed to them for MA with a spenddown. For MA with a spenddown, sponsor deeming only occurs for applicants using the parent or relative caretaker basis of eligibility.

The following income of the sponsor is deemed to the applicant and counted:

- Gross income
- Cash assistance received by the sponsor
- Net self-employment income

The net assets of the sponsor are deemed to the applicant and counted.

Sponsor Deeming Exceptions

Sponsor deeming does not apply to:

- Pregnant women
- Children younger than 21 years old
- People who need placement in a facility and their placement is jeopardized by the sponsor's failure or inability to provide support
- Sponsored non-citizens who have 40 qualifying work quarters

A person meeting both of the following can have a 12-month deferment of sponsor deeming, with a potential 12-month extension:

I. a battered non-citizen immigration status who is subjected to extreme cruelty and is not living with the batterer; and

II. there is a substantial connection between the need for health care coverage and the battery. There is substantial connection between the need resulting from the battery of the non-citizen or his or her children and the need for health care coverage if any of the following conditions are met:

- To enable them to become self-sufficient following separation from the abuser
- To enable escape from the abuser or the community where the abuser lives, or to ensure safety from the abuser
- Due to a loss of financial support or loss of a job due to their separation from the abuser

- Including job loss due to work absence or reduced job performance because of the abuse or cruelty or related legal proceedings, such as child support or custody disputes

- Due to a need to obtain medical attention or mental health counseling or they are disabled because of the battery or cruelty
- Because of lost housing or income, or the fear of separation from the abuser jeopardizes the ability to care for their children
- To alleviate nutritional risks or need resulting from the abuse or following the separation from the abuser
- To provide medical care during an unwanted pregnancy resulting from the abuser's sexual assault, or the relationship with the abuser. Or to care for any resulting children
- To replace medical coverage or health care services they had when living with the abuser

Income Methodology

Net income is used to determine initial and ongoing eligibility for MA for Families and Children with a Medical Spenddown. Net income is equal to gross counted income minus certain disregards and deductions including:

- Court ordered child support and arrears payments made to another household
- Work expense deductions for children age 2-20 including:
  - First $90 of earned income of a child
  - First $90 of earned income of each person whose income is deemed to the child
- Work expense deductions for pregnant women and infants based on household size using the following chart:

Household Size	Work Expense Deduction
1	$136
2	$140
3	$145
4	$149
5	$156
6	$161
7	$165
8	$170
9	$177
10	$181

each additional person	$5

- Earned income disregard of 17% of a person's gross earned income for four consecutive months
- Dependent care deduction of dependent care expenses of household members with earned income who need dependent care while at work, in transit to or from work, or not at work but in need of dependent care to maintain employment. Expenses of up to $200 per month for each dependent under age two and $175 each month for each dependent age two and older, are deducted. The dependent care deduction is not available when childcare is provided by a parent, stepparent, sibling under age 19, or when others pay for the cost of childcare.

Income Limit

People eligible for MA for Families and Children with a Medical Spenddown must spend down to the 133% federal poverty guidelines (FPG) standard.

Post Eligibility for MA for Families and Children with a Medical Spenddown

Enrollees in MA for Families and Children with a Medical Spenddown must meet the same responsibilities and post-eligibility requirements as enrollees in MA-FCA without a spenddown. See the following for more information:

MA-FCA Rights and Responsibilities

MA-FCA Post-Eligibility

Renewals

Enrollees in MA for Families and Children with a Medical Spenddown must complete an annual renewal and a six-month income renewal.

Legal Citations

Code of Federal Regulations, title 42, section 435.811

Code of Federal Regulations, title 42, section 435.831

Code of Federal Regulations, title 42, section 435.840

Minnesota Statutes, section 256B.056, subdivision 3c

Minnesota Statutes, section 256B.056, subdivision 5

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I. Section 2.3.3.2.7.14 MA-ABD Household Goods, Personal Effects, and Other Personal Property

Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability

2.3.3.2.7.14 Household Goods,~~and~~ Personal Effects, and Other Personal Property

This section discusses how personal property is evaluated. Household goods and personal effects are types of personal property. ~~This section discusses how these types of assets are evaluated~~

Household Goods

Household goods are items of personal property found in or near a home that a person uses on a regular basis or items needed by the household for maintenance, use, and occupancy of the premises as a home. Examples include furniture, clothing, jewelry, appliances, children's toys, tools and other equipment used in the home.

Household goods are an excluded asset and do not need to be verified. The exclusion for household goods does not include personal property that a person acquires or holds because of its monetary value or as an investment.

Personal Effects

Personal effects are items of personal property ordinarily worn or carried by the person, and articles otherwise having an intimate relation to the person. Personal effects include, but are not limited to, personal jewelry including wedding and engagement rings, personal care items, pets, and educational or recreational items such as books or musical instruments.

Personal effects include:

- Items of cultural or religious significance to a person, such as ceremonial attire
- Items required because of a person's physical or mental impairment, such as prosthetic devices or wheelchairs

Personal effects do not include personal property that a person acquires or holds because of its monetary value or as an investment.

Personal effects are an excluded asset and do not need to be verified.

Other Types of Personal Property

Evaluating Manufactured Homes as Personal Property

A manufactured home (including a mobile home) that is not the person's principal place of residence is evaluated as personal property if any of the following criteria are met:

- The owner of the manufactured home is a lessee of the land under the terms of a lease, or the manufactured home is located in a manufactured home park; or
- The manufactured home is not affixed to the land by a permanent foundation, is not affixed to the land like the other real property in the community, or is not installed according to the building codes and standards; or
- The manufactured home is not connected to public utilities, does not have a well and septic tank system, or is not serviced by water and sewer facilities comparable to other manufactured homes in the community.

The estimated market value of a non-homestead manufactured home that is personal property is counted as an available asset. If the manufactured home is personal property, the reasonable effort to sell exclusion does not apply.

If the owner of a non-homestead manufactured home holds title to the land on which it is situated, and none of the above criteria apply, then the manufactured home is considered real property. See Non-Homestead Real Property.

Evaluating Items Acquired or Held Because of Their Monetary Value or as Investments

Personal property that a person acquires or holds because of its monetary value or as an investment is a countable asset and not considered to be household goods or personal effects. Other personal property items include, but are not limited to, gems, jewelry and collectibles acquired or held because of its monetary value or as an investment.

The equity value of any item acquired or held because of its monetary value ~~or as an available asset~~ is counted.

A recent sales slip, an appraisal of the item, or insurance coverage can be used to verify the current market value of an item acquired or held because of its value or as an investment. If this information is not available, an estimate from a knowledgeable source, such as a local merchant, can be used to verify the current market value.

- Insurance appraisals and amounts of insurance coverage often reflect replacement value (the amount it would cost to purchase a similar item new) rather than current market value. Replacement value may not be used in lieu of current market value.

Legal Citations

Minnesota Statutes, section 256B.056, subdivision 1a

Minnesota Statues, Section 273.125, subdivision 8

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J. Section 2.3.5.1.2 MA-EPD Premiums and Cost Sharing

Medical Assistance for Employed Persons with Disabilities

2.3.5.1.2 Premiums and Cost Sharing

People enrolled in Medical Assistance for Employed Persons with Disabilities (MA-EPD) must pay monthly premiums. A premium is based upon:

1. A person's gross countable income. The minimum premium amount ~~will be~~ is $35 per month, with a sliding scale for people with gross income at or below 300% of the Federal Poverty Guidelines (FPG). If income is greater than 300% FPG, the premium ~~rate~~ is 7.5% of gross income.
2. An additional fee that is equal to 0.5% of unearned income. The fee is paid no matter how low gross income is.

The total MA-EPD premium is the combined amount.

An American Indian or Alaska Native who has provided verification of American Indian or Alaska Native status is exempt from paying a premium for MA-EPD.

An online MA-EPD premium estimator is available. A person's county or tribal servicing agency is responsible for collecting the initial MA-EPD premium. The Minnesota Department of Human Services (DHS) bills for ongoing MA-EPD premiums monthly.

MA-EPD coverage does not begin until the initial premium is paid. Applicants who request retroactive coverage must pay the premium for any retroactive months before coverage is approved for the retroactive period.

The average anticipated gross monthly countable income is used to calculate the MA-EPD premium amount for a six-month period. The actual gross monthly income is used to calculate the MA-EPD premium amount ~~during~~ for any retroactive months.

MA-EPD premiums are calculated for a six-month period. The premium amount is the same for all six months, because the premium is based on an average anticipated income. Premiums can be changed during the six-month period only in the following situations: ~~and do not change unless a reported change results in a decreased premium. Premiums are calculated at each six month renewal.~~

- A reported change results in a decreased premium
- Income guidelines change because of a change in law,
- The annual increase in FPG standards
- To include increased RSDI benefit amounts when the RSDI COLA disregard ends, effective July 1 of each year.

Premiums are recalculated at each six-month renewal.

Gross Countable Income

Gross countable income includes countable earned and unearned income of the person and anyone whose income deems to the person ~~without any disregards or deductions applied~~ . See the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Countable Income policy for more information.

Excluded Income

The MA-ABD excluded income policy applies to MA-EPD. See the MA-ABD Excluded Income policy for more information.

Deeming

Only the MA-EPD enrollee's income is counted for adults age 18 and older. No spousal income is deemed to the MA-EPD spouse. Parental income is deemed for MA-EPD applicants and enrollees younger than age 18.

Disregards and Deductions

MA-EPD enrollees do not use standard MA-ABD deductions and disregards, because premiums are calculated using the gross countable income.

The only deduction that applies to the MA-EPD income calculation is the RSDI Cost of Living Adjustments (COLA) disregard. See 2.3.3.3.2.2 MA-ABD Disregards and Deductions for more information about the RSDI COLA disregard.

Family Size

Family size is used to determine premium rates. Family size is determined for each person separately. Family size may be different for each person on an application or in a household.

For MA-EPD enrollees age 21 or older, family size includes the following, if they are living with the person:

- Enrollee
- Spouse (unless they are enrolled in MA-EPD)
- Biological or adopted children, including those who are temporarily absent
- Spouse's biological or adopted children, including those who are temporarily absent
- Unborn children of the person or their spouse

For MA-EPD enrollees under age 21, family size includes the following if they are living with the person:

- Enrollee
- Spouse (unless they are enrolled in MA-EPD)
- Biological or adoptive parents
- Stepparent, if the biological or adoptive parent also lives with the person
- Siblings (biological, adopted, or step siblings)
- Unborn children of the person, their spouse or their biological, adoptive or step parents listed above

Good Cause for Non Payment of MA-EPD Premiums

People who cannot pay their premium may request good cause. A “good cause” request is an enrollee’s request for premium relief because of circumstances outside their control. DHS is responsible for good cause determinations. When a request is approved, premiums are waived for the period necessary for the enrollee to resolve the situation preventing the enrollee from paying premiums.

Good cause is defined as circumstances beyond a person's control or that they could not reasonably foresee resulting in the enrollee being unable or failing to pay the premium.

Good cause does not include choosing to pay other household expenses instead of the premium. A person cannot request good cause for non-payment of an initial premium. Good cause can only be requested for the non-payment of subsequent premiums.

Requesting Good Cause

People must request good cause using the MA-EPD Good Case Request form (DHS-6939). The form can be submitted electronically, or printed and mailed to DHS. Enrollees needing assistance in completing the form can call Disability Hub MN at 866-333-2466.

DHS provides the person with written notice of their decision within 30 days. People may appeal a finding that good cause does not exist. See the MHCP Appeals policy for more information.

Legal Citations

Minnesota Rules, part 9506.0040, subpart 7, items B to D

Minnesota Statutes, section 256B.057, subdivision 9

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K. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations

Medical Assistance for Long-Term Care Services

2.4.1.3.4 Other Asset Transfer Considerations

This section describes if a person has received adequate compensation for transfers involving the following types of assets:

- Annuities
- Coverdell Education Savings Account
- Life Estates
- Trusts

Annuities not Evaluated under the Transfer Policy

Annuities are not evaluated under the uncompensated transfer policy in the following situations:

- The annuity is a deferred annuity in the accumulation phase. An annuity in the accumulation phase is evaluated as an available asset.
- Revocable or assignable annuities are evaluated as an available asset. See Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Annuities for information on verifying these annuities.
- The annuity is an employer sponsored retirement fund. See MA-ABD Retirement Funds and Retirement Plans for more information.
- Annuities that meet a transfer exception are not evaluated for a transfer penalty; however, any annuity that meets an exception is evaluated for availability. See MA-ABD Annuities for more information.

If an annuity is not evaluated under the transfer analysis, it is evaluated to determine whether it is an available asset or if it provides unearned income.

Annuities Evaluated under the Transfer Policy

Certain annuitized annuities purchased by or on behalf of the person requesting MA for Long-Term Care (LTC) or the person’s spouse must be evaluated to determine if an uncompensated transfer occurred within the lookback period.

There are two sets of policies for evaluating these transfers: Method 1 and Method 2. Method 2 is used to evaluate annuities that do not include all of the elements of annuities evaluated under Method 1.

The policies described below do not apply to employment-based pension plans held in the form of an annuity. See Retirement Funds.

Method 1 Transfer Analysis

An annuity is evaluated under Method 1 if it meets all of the following criteria:

- The annuity was purchased with the funds of the person requesting MA-LTC.
- The person requesting MA-LTC is a payee under the annuity contract.
- An annuity transaction occurred on or after February 8, 2006 and within the lookback period.
- The annuity is in the annuitization phase.

Annuities that meet the Method 1 transfer analysis criteria are evaluated as follows:

A. The purchase of an annuity is an uncompensated transfer unless all of the following criteria are met:
   - The annuity is a commercial annuity
   - The annuity provides for payments in equal amounts during the term of the annuity with no deferral of payments and no balloon payments
   - The annuity is actuarially sound using the life expectancy tables published by the Chief Actuary of the Social Security Administration (SSA). The current actuarial life table is found on SSA's website.

   The value of the uncompensated transfer is the total amount annuitized less any payments the person or their spouse already received.

B. The transfer of any ownership interest or payments, through a gift, assignment or sale, from an annuity to anyone other than the person requesting MA-LTC or their spouse may be an uncompensated transfer.

An uncompensated transfer occurred if ownership interest or payments the person or their spouse were entitled to receive is transferred to a third party without receiving adequate compensation. The amount of the uncompensated transfer is the cash value of the ownership interest or payments the person or their spouse was entitled to receive, as of the transfer date, after subtracting any compensation received.

Method 2 Transfer Analysis

An annuity is evaluated under Method 2 if it meets all of the following criteria:

- The annuity was purchased with the funds of the person and their spouse within the lookback period
- The person requesting MA-LTC and/or their spouse is:
  - An owner

- A payee
- An annuitant
- A combination of the above
- None of the above
    - The funds of the person and their spouse were used to purchase an annuity to benefit someone other than the person and their spouse, or someone other than the person and their spouse holds ownership of the annuity.

- If the person requesting MA-LTC is a payee under the annuity contract ~~and~~ no annuity transaction ~~has~~ occurred to the annuity on or after February 8, 2006.
- The annuity is in the annuitization phase.

Annuities that meet the Method 2 transfer analysis criteria are evaluated as follows:

A. The purchase of an annuity is an uncompensated transfer unless all of the following criteria are met:

- the annuity is a commercial annuity;
- the annuity provides for payment of principal and interest in equal monthly installments during the term of the annuity contract; and
- principal and interest payments from the annuity begin at the earliest possible date after annuitization
- the annuity is actuarially sound using the applicable actuarial life table.

The value of the uncompensated transfer is the total amount annuitized less any payments the person or their spouse already received.

C. The transfer of any ownership interest or payments, through a gift, assignment or sale, from an annuity to anyone other than the person requesting MA-LTC or their spouse may be an uncompensated transfer.

An uncompensated transfer occurred if ownership interest or payments the person or their spouse were entitled to receive is transferred to a third party without receiving adequate compensation. The amount of the uncompensated transfer is the cash value of the ownership interest or payments the person or their spouse was entitled to receive, as of the transfer date, after subtracting any compensation received.

Actuarial Soundness

An annuity is actuarially sound if the cash value, on the date it was annuitized, is less than or equal to the amount of payments the person will receive during the payee's life expectancy. If both the person and their spouse are listed as payees under the annuity contract, the person with the longest life expectancy is used to determine actuarial soundness.

The life expectancy of the person requesting or receiving MA-LTC or their spouse is determined using the actuarial life table found on the SSA website.

Any portion of the annuity that is funded with money contributed by a third party is not included in the cash value used to determine actuarial soundness.

Coverdell Education Savings Accounts Evaluated under the Transfer Policy

Funds in a Coverdell Education Savings Account (ESA) may be transferred or “rolled over” to a member of the beneficiary’s family. When a designated beneficiary “rolls over” funds in a Coverdell ESA to a family member, the rollover must be evaluated as an uncompensated transfer.

Life Estates Evaluated under the Transfer Policy

There are several instances when a life estate transfer of assets must be evaluated to determine if an uncompensated transfer occurred. See Uncompensated Transfers for more information on transfer policy. See Purchases as Transfers for more information when a person purchases a life estate interest in another person's home.

A life estate must be evaluated to determine if an uncompensated transfer occurred by the original owner of the property when:

- The life estate is established. The life estate is evaluated as a transfer at the time of a request for MA-LTC if the life estate is established prior to application and the life estate was created during the lookback period.
    - Creating the life estate and granting the remainder interest to someone other than the property owner is a transfer of real property.
    - The value of the transfer is the value of the remainder interest, less any compensation received. See MA-ABD Life Estate and Remainder Interests.
- The life estate is terminated prior to the death of the life estate owner, such as with a conditional limitation.
    - The value of this transfer is the value of the life estate interest on the date of the termination, less any compensation received. See MA-ABD Life Estate and Remainder Interests.

Trusts Evaluated under the Transfer Policy

Client Funded Trusts

If a non-excluded asset is placed in a trust, during the lookback period or while the person is receiving MA-LTC, an uncompensated transfer takes place if the grantor is no longer able to access all or a portion of the trust income or trust corpus. The amount of the uncompensated transfer is the portion of the trust income or trust corpus that is considered unavailable.

Any distributions from the trust that are not to or for the benefit of the beneficiary are an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is to or for the benefit of someone other than the beneficiary.

Special Needs Trusts

Special needs trusts are excluded assets when determining eligibility for MA. However, funds entering and leaving the trusts must be evaluated to determine if an uncompensated transfer occurred.

- The establishment, or addition to a special needs trust before the beneficiary reaches age 65 is not considered an uncompensated transfer and a penalty cannot be imposed.
- A distribution from a special needs trust that does not meet the sole benefit requirement is an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is not for the sole benefit of the trust beneficiary.
- A special needs trust cannot be added to after the beneficiary reaches age 65. Additions to the trust after the beneficiary reaches age 65 are not considered excluded assets. The value of any non-excluded assets added to the trust after the beneficiary reaches age 65 are considered available to the beneficiary.

See MA-ABD Special Needs for more information.

Pooled Trusts

Pooled trusts may be considered excluded assets when determining eligibility for MA. However, funds entering and leaving the trusts must be evaluated to determine if an uncompensated transfer occurred.

- The establishment, or addition to a pooled trust before the beneficiary reaches age 65 is not considered an uncompensated transfer and a penalty cannot be imposed.
- The establishment of a pooled trust after the beneficiary reaches age 65 is evaluated as an uncompensated transfer. The amount of the transfer is the amount for which the beneficiary has not received adequate compensation. The beneficiary must provide proof that adequate compensation was received.
- An addition to a pooled trust by a beneficiary or a beneficiary's spouse after the beneficiary reaches age 65 is evaluated as an uncompensated transfer. The amount of the uncompensated transfer is the amount for which the beneficiary has not received adequate compensation. The beneficiary must provide proof that adequate compensation was received.
- A distribution from a pooled trust that does not meet the sole benefit requirement is an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is not for the sole benefit of the trust beneficiary.

See MA-ABD Pooled Trusts for more information.

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Minnesota Statutes, section 256B.0595

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L. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

Medical Assistance for Long-Term Care Services

2.4.2.5.1 LTC Income Calculation Deductions

Certain deductions from countable gross income are allowed in the long-term care (LTC) income calculation to determine the amount a person is required to contribute toward the cost of LTC services, if any. Deductions, like income, count in the month in which they occur. Deductions must be verified at each request for Medical Assistance for Long-Term Care Services (MA-LTC), at each renewal, and when a change is reported.

A person's eligibility for MA-LTC is not denied or closed if the person does not provide required proof of a deduction. However, the deduction is not used in the LTC income calculation if it is not verified.

The following deductions are subtracted from gross countable income in the LTC income calculation in the order listed below:

1. Special Supplemental Security Income (SSI) Deduction
2. Minnesota Supplemental Aid (MSA) Deduction
3. Special Personal Allowance from earned income
4. Medicare premiums paid by the enrollee
5. Applicable LTC Needs Allowance
6. Fees paid to a guardian, conservator, or representative payee
7. Community Spouse Income Allocation
8. Family Allocation
9. Court-ordered child support
10. Court-ordered spousal maintenance
11. Health insurance premiums, co-payments and deductibles
12. Remedial Care Expense
13. Medical expenses

Special Supplemental Security Income (SSI) Deduction

Supplemental Security Income (SSI) payments received by an enrollee are deducted when the Social Security Administration (SSA) approves continued community level SSI benefits for a person who lives in a long-term care facility (LTCF) because either:

- the person is expected to live in the LTCF for less than three months and continues to maintain a home in the community; or

- the person had 1619(a) or 1619(b) status in the month prior to the first full month of LTCF residence.

Minnesota Supplemental Aid (MSA) Deduction

Minnesota Supplemental Aid (MSA) payments received by an enrollee are deducted when the state approves continued community level MSA benefits for a person who lives in an LTCF because either:

- The person is expected to live in the LTCF for less than three months and continues to maintain a home in the community; or
- The person had 1619(a) or 1619(b) status in the month prior to the first full month of the LTCF residence.

Special Personal Allowance from Earned Income

A special personal allowance from earned income are deducted for a person who is:

- certified disabled by SSA or the State Medical Review Team (SMRT);
- employed under an Individual Plan of Rehabilitation; and
- living in an LTCF.

The following deductions are applied in the order listed but cannot reduce income to less than zero:

- The first $80 of earned income
- Actual FICA tax withheld
- Actual transportation costs
- Actual employment expenses, such as tools and uniforms
- State and federal taxes if the person is not exempt from withholding

Medicare Premiums

Medicare premiums incurred by an enrollee that are not subject to payment by a third party are deducted. Medicare premiums subject to payment by a third party include Medicare premiums:

- The county, state or tribal agency reimburse to the enrollee as cost effective health insurance
- Paid through the Medicare Buy-In
- Paid through Medicare Part D Extra Help

LTC Needs Allowance

One of the following allowances is deducted:

Clothing and Personal Needs Allowance (PNA)

The Clothing and Personal Needs Allowance (PNA) is used when the enrollee is not eligible for any of the other LTC needs allowances. The PNA is adjusted each year on January 1.

Veteran's Improved Pension

A $90 veteran's improved pension is available to people who are:

- veterans but who do not have a spouse or dependent child(ren)
- the surviving spouse of a veteran who does not have a dependent child(ren)

Home Maintenance Allowance (HMA)

The Home Maintenance Allowance (HMA) is equal to 100% of the federal poverty guidelines (FPG) for a household size of one, minus the PNA. The HMA is adjusted each year on July 1. A person who is eligible for the HMA is also eligible for the PNA. The amount listed in Appendix F is a combined total of the HMA and the PNA.

The HMA is used when all of the following apply:

- the person lives in an LTCF;
- the person is expected to be discharged from the LTCF within three full calendar months from the month in which MA-LTC is requested to begin;
- the person has expenses to maintain a home (owned or rented) in the community, including room and board charges in group residential housing (GRH) or assisted living; and
- the person meets one of the following conditions:
  - The person did not live with a spouse, a child under age 21, or a person who could be claimed as a dependent of the person for federal income tax purposes at the time he or she was admitted to an LTCF.
  - The person lived with a spouse at the time he or she was admitted to an LTCF, and the person's spouse was admitted to an LTCF on the same day.

Only one spouse can receive the HMA when both spouses live in an LTCF. The HMA is used for the spouse for which it is most advantageous.

Eligibility for the HMA is based on the anticipated discharge date at the time eligibility for MA-LTC is determined. Eligibility for the HMA is not delayed to see if the person will actually be discharged on the anticipated discharge date and is not retroactively adjusted if the person lives in the LTCF for more than three full calendar months.

A person must be discharged from an LTCF for a full calendar month before the HMA may be used again.

Special Income Standard Elderly Waiver (SIS-EW) Maintenance Needs Allowance (MNA)

The Special Income Standard Elderly Waiver (SIS-EW) maintenance needs allowance (MNA) is used for people requesting Elderly Waiver (EW) services and who have income at or below the Special Income Standard (SIS). The SIS-EW MNA is updated annually in July. The SIS-EW MNA is not used for a person with income above the SIS.

When an SIS-EW enrollee moves to or from an LTCF:

- The PNA or veteran's improved pension allowance is used beginning the month following the month the SIS-EW enrollee moves into the LTCF.
- The SIS-EW MNA is used beginning the month following the month the person is discharged from the LTCF and begins receiving EW services.

Fees Paid to a Guardian, Conservator, or Representative Payee

Five percent of the enrollee's gross monthly income, up to a maximum of $100, for fees paid to a guardian, conservator or representative payee is deducted. This deduction cannot be increased over $100 even if a higher amount is allowed to be paid by SSA or a court.

Community Spouse Income Allocation

An LTC spouse may allocate a portion of their income to the community spouse when the community spouse's income is insufficient to meet their monthly maintenance needs. The community spouse income allocation is calculated by comparing the community spouse's gross monthly income to the minimum monthly allowance plus any excess shelter costs. The income allocation cannot exceed the maximum monthly allowance.

The community spouse's gross monthly income includes all earned and unearned income, including income received from income-producing assets. No exclusions, disregards or deductions apply. If the community spouse's gross monthly income is greater than or equal to the community spouse's monthly maintenance needs, the community spouse does not qualify for an income allocation. If the community spouse's gross monthly income is less than the community spouse's monthly maintenance needs, the community spouse qualifies for an income allocation.

Calculation of the Community Spouse's Shelter Costs

The community spouse's shelter costs, in excess of the basic shelter allowance, are added to the minimum monthly allowance to calculate the community spouse income allocation. Shelter costs include:

- Rent
- Mortgage payments, including principal and interest
- Real estate taxes
- Homeowner's or renter's insurance

- Required maintenance charges for a cooperative or condominium
- Utility allowance

The amount of a shelter expense is based on the full amount that the community spouse must pay. Shelter expenses do not include charges for services received by a person who resides in a residential living arrangement. An itemized statement of monthly charges to identify the amount the community spouse must pay for rent or any other shelter expense is required.

Verification Requirements

A community spouse income allocation cannot be deducted unless the person, or their authorized representative, provides verification of the community spouse's income and shelter expenses at the time of the request for MA-LTC and at each renewal. The community spouse, or the community spouse's authorized representative, must report and verify changes in the income or shelter expenses of the community spouse.

When to Deduct the Community Spouse Income Allocation

The calculated community spouse income allocation is deducted when there is a community spouse at any time in a given month unless:

- There is a court order for spousal support for an amount that is greater than the calculated community spouse income allocation. When this occurs, the court ordered amount replaces the community spouse income allocation as a deduction. This only applies when a court order establishes support while the couple remains married. It does not apply to a court order in a divorce action.
- The LTC spouse does not have enough income remaining, after other allowable deductions, to allocate to the community spouse.
- Exceptional or unusual circumstances have occurred that result in a temporary financial hardship to the community spouse. In these cases, the community spouse income allocation may be temporarily increased while the community spouse takes the necessary steps to resolve the situation. The increased deduction cannot be applied if the situation is not temporary or the community spouse does not take the needed actions to resolve the situation.
- The LTC spouse can choose not to make an income allocation to the community spouse. A deduction can only be made if the income is actually made available to the community spouse.
- The community spouse chooses to accept a reduced income allocation or chooses not to accept any income allocation. The community spouse income allocation is counted as unearned income for the community spouse when determining eligibility for any Minnesota Health Care Program (MHCP). A community spouse may choose to not accept the income allocation if it will result in ineligibility for MA.

Family Allocation

A person may allocate a portion of their income to the following family members who have a calculated need:

- A minor child, who does not live with a community spouse
- The following relatives who live with a community spouse:
  - A child under age 21
  - A child age 21 or older who is claimed as a tax dependent
  - Parents who are claimed as tax dependents
  - Siblings who are claimed as tax dependents

Children Not Living with a Community Spouse

A family allocation may be made to the minor children of the person who does not live with a community spouse. The allocation is calculated by adding together the gross monthly earned and unearned income of all minor children not living with a community spouse and comparing it to 100% of the FPG for a family size equal to the number of minor children not living with the community spouse. No exclusions, disregards or deductions apply. The amount of the allocation is the difference between the gross income of the children and the applicable FPG amount. No allocation is allowed if the gross income of the children exceeds the applicable FPG standard.

Family Members Who Live with a Community Spouse

A separate family allocation may be made for each family member who lives with a community spouse. The allocation is calculated by adding together the gross monthly earned and unearned income of the family member who lives with the community spouse and subtracting it from the minimum monthly income allowance for a community spouse. No exclusions, disregards or deductions apply. No allocation is allowed if the gross income of the family member exceeds the minimum monthly income allowance for a community spouse.

Verification Requirements

The family allocation cannot be deducted unless the person, or their authorized representative, provides verification of the family member's income at the time of the request for MA-LTC and at each renewal. Changes in income for the family member must be reported and verified.

When to Deduct the Family Allocation

A family allocation is deducted in the LTC income calculation in each month that there is a family member eligible to receive an allocation. The family allocation is deducted regardless of whether it is made available to the family member if the income of the family member is verified.

A family allocation is counted as unearned income to the family member when determining eligibility for any MHCP.

Court-Ordered Child Support

Court-ordered child support that is garnished from the person's income up to a maximum of $250 per month is deducted. The garnishment can be for current child support or arrearages. The garnishment must be verified.

This deduction does not apply when a family allocation is deducted for the child for whom the court-ordered child support obligation is due unless the calculated family allocation is less than $250. The difference between the calculated family allocation and $250 may be deducted.

Court-Ordered Spousal Maintenance

Court-ordered spousal maintenance is deducted for people who reside in a long-term care facility (LTCF) when the spousal maintenance is:

- court-ordered under a judgement and decree for dissolution or marriage; and
- garnished from a source of the person's income

In addition to the spousal maintenance amount, the fees associated with the garnishment can be deducted if also garnished from the person's income.

The garnishment of the spousal maintenance and fees must be verified.

Health Insurance Premiums, Co-payments and Deductibles

The cost of health insurance premiums, co-payments and deductibles incurred by the person that are not subject to payment by MA or a third party, including Extra Help through SSA for Medicare Advantage Plan or Part D coverage or premium reimbursement through MA, are allowable deductions. Health insurance includes Medicare Advantage plans, dental and LTC insurance policies. Only the portion of the premium that reflects coverage for the person is an allowable deduction.

Remedial Care Expense

A remedial care expense deduction is an amount allowed for people who reside in a residential living arrangement or a housing with services establishment where a county agency has a GRH agreement. The amount can change twice a year, on January 1 and July 1.

Medical Expenses

Verified medical expenses incurred by the person that meet the criteria below are deductions in the LTC income calculation:

Medical expenses that are medically necessary and recognized under state law

Medically necessary expenses include medical services, supplies, devices, or equipment that are provided in any of these situations:

- In response to a life-threatening condition or pain
- To treat an injury, illness or infection
- To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition
- To care for a mother and child through the maternity period
- To provide preventive health service
- To treat a condition that could result in physical or mental disability

People are not required to provide proof of medical necessity for a medical expense provided by a medical provider, such as a pharmacist or medical facility. These services are assumed to be medically necessary.

Medical expenses that MA will not pay

Medical expenses for MA covered services that the person incurred in a month that MA will pay because the person is, or will be, approved for MA are not deductions. A medical expense incurred in a month in which the person is or will be an MA enrollee is assumed an MA covered service unless the person provides proof that it is not.

Medical expenses that are included in the daily rate that MA pays to a Skilled Nursing Facility (SNF) or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) are medical expenses that MA will pay.

Medical expenses not covered by a third party

A medical expense is not a deduction if it is subject to payment by a third party. Third parties include people, entities or benefits that are, or may be, liable to pay the expense. This includes:

- Other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system
- Automobile insurance
- Court judgments or settlements
- Workers' compensation benefits

The person must provide proof of the exact amount of the third party payment, such as an Explanation of Medical Benefits (EOMB) statement. The person can also sign a release form so the county, tribal, or state agency can contact the third party directly.

If not yet known, the amount of the medical expense that will be covered by a third party is estimated at the time of the eligibility determination so that application processing is not delayed. The LTC income calculation is adjusted for the applicable month once the actual amount of the expense is verified. If not verified before, the person must provide proof of the actual amount of estimated medical expenses that were used in the LTC income calculation at the time of their next renewal. The deduction is removed from the applicable month if proof is not provided.

The medical expense was incurred during a month in which the person is receiving MA-LTC or during any of the three months prior to the month in which the person requested MA-LTC

Deductions are allowed for verified medical expenses the person incurred during the month the person requested MA-LTC or while the person is receiving MA-LTC, regardless of whether retroactive MA coverage was requested or approved. Medical expenses incurred during a retroactive month must be unpaid as of the date of the request for MA-LTC. Medical expenses incurred during the month the person requested MA may be paid or unpaid.

Medical expenses are not allowed as a deduction when:

- The medical expense is for LTC services incurred in a month that is included in a transfer penalty period or period of ineligibility for failure to name Minnesota Department of Human Services (DHS) a remainder beneficiary of certain annuities.
- The person paid the medical expense to reduce excess assets.
- The medical expenses were incurred more than three months before the month of application associated with the current period of eligibility
- The nursing facility expenses were incurred without a required preadmission screening
- The medical expense was previously used:
  - As a deduction in an LTC income calculation. However, the amount of a medical expense that exceeds the amount of the person's income remaining after all other deductions in one month can be carried forward to future months
  - To meet a medical spenddown

The following services received by a person who lives in an LTCF are not medical expenses:

- Personal care items such as shampoo, toothpaste or dental floss that are included in the daily rate (also referred to as a "per diem rate") paid through MA
- Oral hygiene instruction
- Certain house/extended care facility call charges. A charge for a provider to travel to a person's residence is not an allowable medical expense deduction unless the provider delivers a medical service on the same day.
- A charge for a provider to travel to a person's residence is also not an allowable medical expense deduction if the LTCF pays the cost for the provider to travel to the LTCF through an agreement between the LTCF and the provider.

Notification

People who report medical expenses must be notified of the:

- Medical expenses that were not allowed as a deduction and the reason(s) why they were not allowed

- Medical expenses that were deducted in the LTC income calculation based on estimated third party payments
- Amount of the allowed medical expense deduction
- Amount of medical expenses that can be carried forward as a deduction to future months

Legal Citations

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

Minnesota Statues, section 256B.35

Minnesota Statutes, section 256I.03

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M. Section 3.2.3.1 MinnesotaCare Health Care Coverage Barriers

MinnesotaCare

3.2.3.1 Health Care Coverage Barriers

This section provides policy on whether government-sponsored health care coverage and other types of health care coverage are barriers to MinnesotaCare eligibility. For information about employer-sponsored health care coverage, refer to MinnesotaCare Employer-Sponsored Health Care Coverage.

Government-Sponsored Health Care Coverage

This chart provides a list of government-sponsored health care coverage and their impact on MinnesotaCare eligibility.

Access means the person can get the coverage but is not currently enrolled.

Enrollment means the person has the coverage.

Type of Coverage	Impact on MinnesotaCare Eligibility
Emergency Medical Assistance (EMA)	Not a barrier to MinnesotaCare
Health Care for Peace Corp Volunteers	Enrollment is a barrier to MinnesotaCare
Health insurance plans offered by AmeriCorps to its volunteers and their dependents, if recognized by CMS as MEC	Enrollment is a barrier to MinnesotaCare
Health insurance plans offered by AmeriCorps to its volunteers and their dependents, not recognized by CMS as MEC	Not a barrier to MinnesotaCare
Indian Health Services	Not a barrier to MinnesotaCare
Medicaid in another state	Enrollment is a barrier to MinnesotaCare
Medical Assistance, without a spenddown	Access or enrollment is always a barrier to MinnesotaCare
Medical Assistance, with a spenddown	Not a barrier to MinnesotaCare
Medicare Part A, if the person is not required to pay a premium	Access or enrollment is always a barrier to MinnesotaCare
Medicare Part A, if the person is required to pay a premium	Enrollment is a barrier to MinnesotaCare

	Access is not a barrier when the person must pay a premium to enroll in Medicare Part A, and chooses not to pay.
Medicare Part B	Enrollment is a barrier to MinnesotaCare
Medicare Supplement, unless the person also has access to Medicare Part A or is enrolled in Medicare Part A or Part B	Not a barrier to MinnesotaCare
Non-Appropriated Fund Health Benefits Program (NAF) of the Department of Defense	Enrollment is a barrier to MinnesotaCare
TRICARE Continued Health Care Beneift Program	Enrollment is a barrier to MinnesotaCare
TRICARE for Life	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Prime	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Prime Overseas	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Prime Remote	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Reserve Select	Enrollment is a barrier to MinnesotaCare
TRICARE Retired Reserve	Enrollment is a barrier to MinnesotaCare
TRICARE Standard and Extra	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Standard Overseas	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Transitional Assistance Management Program	Access or enrollment is always a barrier to MinnesotaCare
TRICARE US Family Health Plan	Access or enrollment is always a barrier to MinnesotaCare
TRICARE Young Adult (Prime and Standard)	Enrollment is a barrier to MinnesotaCare
Veterans Administration (VA) Civilians Health and Medical Program (CHAMPVA)	Enrollment is a barrier to MinnesotaCare
VA Spina bifida health care benefits program	Enrollment is a barrier to MinnesotaCare
VA Veterans health care plan	Enrollment is a barrier to MinnesotaCare

Other Health Care Coverage

The following chart provides a list of other health care coverage and their impact MinnesotaCare eligibility.

Type of Coverage	Impact on MinnesotaCare Eligibility
Accident insurance	Not a barrier to MinnesotaCare
Automobile medical payment insurance	Not a barrier to MinnesotaCare
Benefits for long-term care, nursing home care, home health or community care	Not a barrier to MinnesotaCare
Cancer only	Not a barrier to MinnesotaCare
Coverage for on-site medical clinics	Not a barrier to MinnesotaCare
Coverage just for specific diseases or illnesses	Not a barrier to MinnesotaCare
Coverage only for accident or disability	Not a barrier to MinnesotaCare
Credit-only insurance	Not a barrier to MinnesotaCare
Employer Sponsored COBRA	Enrollment is a barrier to MinnesotaCare. Refer to Section 3.2.3.2, MinnesotaCare Employer-Sponsored Coverage, for more information.
Employer sponsored health insurance (ESI) that does not meet both affordability and minimum value standards.	Enrollment is a barrier to MinnesotaCare. Refer to Section 3.2.3.2, MinnesotaCare Employer-Sponsored Coverage, for more information.
Employer sponsored health insurance (ESI) that meets both affordability and minimum value standards.	Access or enrollment is always a barrier to MinnesotaCare. Refer to Section 3.2.3.2, MinnesotaCare Employer-Sponsored Coverage, for more information.
Employer Sponsored Retiree Health Coverage	Enrollment is a barrier to MinnesotaCare. Refer to Section 3.2.3.2, MinnesotaCare Employer-Sponsored Coverage, for more information.
Family planning-only coverage	Not a barrier to MinnesotaCare
Grandfathered employer sponsored health plan that does not meet both affordability and minimum value standards.	Enrollment is a barrier to MinnesotaCare

Grandfathered employer sponsored health plan that meets both affordability and minimum value standards.	Access or enrollment is always a barrier to MinnesotaCare
Health care coverage offered by foreign governments and organizations, if recognized by CMS as minimum essential coverage (MEC)	Enrollment is a barrier to MinnesotaCare
Health care coverage offered by foreign governments and organizations, not recognized by CMS as MEC	Not a barrier to MinnesotaCare
Hospital indemnity or fixed indemnity insurance	Not a barrier to MinnesotaCare
Hospital only	Not a barrier to MinnesotaCare
Liability insurance	Not a barrier to MinnesotaCare
Limited scope dental or vision benefits	Not a barrier to MinnesotaCare
Long term care insurance	Not a barrier to MinnesotaCare
Other similar coverage that is secondary or incidental to other insurance benefits	Not a barrier to MinnesotaCare
Pregnancy-only coverage	Not a barrier to MinnesotaCare
Prescription drug only	Not a barrier to MinnesotaCare
Private health insurance	Enrollment is a barrier to MinnesotaCare
Qualified Health Plan – without subsidy	Enrollment is a barrier to MinnesotaCare
Self-funded student health insurance plans offered by post-secondary institutions to students and their dependents, if recognized by CMS as MEC	Enrollment is a barrier to MinnesotaCare
Self-funded student health insurance plans offered by post-secondary institutions to students and their dependents, not recognized by CMS as MEC	Not a barrier to MinnesotaCare
Supplemental coverage with no comprehensive coverage	Not a barrier to MinnesotaCare
Supplemental liability insurance coverage	Not a barrier to MinnesotaCare
Tuberculosis-only coverage	Not a barrier to MinnesotaCare
Vision only	Not a barrier to MinnesotaCare

Worker's Compensation	Not a barrier to MinnesotaCare

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N. Section 3.3.3 MinnesotaCare Income Methdology

MinnesotaCare

3.3.3 Income Methodology

Income eligibility for MinnesotaCare is based on projected annual income (PAI). PAI is the Modified Adjusted Gross Income (MAGI) that a person expects to have for a calendar year. PAI includes the MAGI a person has already received for the year as well as the MAGI the person expects to receive for the remaining months of the year. PAI also includes temporary income the person receives or expects to receive within the entire calendar year. When a person is requesting coverage for a future calendar year, PAI consists of the MAGI a person expects to receive for that future year.

An applicant or enrollee may attest to a PAI that is different from his or her current income. When a person reports a change in PAI, current income and adjustments may also change. There may be inconsistent information when the PAI a person reports conflicts with other information or documentation provided by the person or in the case file.

MAGI includes:

- The types of income included in Federal taxable income, including losses, minus Federal income tax adjustments
- Nontaxable foreign earned income and housing cost of citizens or residents of the United States living abroad
- Nontaxable interest income
- Nontaxable Social Security and tier one railroad retirement benefits

Refer to the MAGI Fact Sheet for a quick reference guide for MAGI.

Federal Taxable Income

Federal taxable income are the different types of income that appear in the Income section of the Internal Revenue Service (IRS) form 1040, IRS form 1040-A or IRS form 1040-EZ. Only the taxable portions of these types of income are included in the adjusted gross income. The types of losses that are reported on income tax returns can offset income. See the appropriate IRS form instructions for examples of federal taxable income. The general types of taxable income include the following:

- Wages, salary and tips
    - Payroll or pre-tax deductions for childcare, health insurance, retirement plans, transportation assistance and other employee benefits are not taxable and are not included in a person’s adjusted gross income.
- Interest
- Dividends

- Taxable refunds, credits or offsets of state and local income taxes
- Alimony received
- Business income or loss
- Capital gains or losses
- Other gains or losses
- Individual retirement account (IRA) distributions
- Pension and annuity payments
- Income or loss from rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Farm income or loss
- Unemployment compensation
- Social Security benefits
- Other income or loss
- Net operating loss, including carryforward loss

Federal Income Tax Adjustments

The types of adjustments that in the Adjusted Gross Income section of the 1040 or 1040-A are subtracted from gross income to calculate the adjusted gross income. Only specific types of adjustments are allowed. See the appropriate IRS form instructions for specific information about the types of adjustments.

The types of tax adjustments include:

- Educator expenses
- Certain business expenses of reservists, performing artists and fee-basis government officials
- Health savings account
- Moving expenses
- Deductible portion of self-employment tax
- Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE) and qualified plans
- Self-employed health insurance
- Penalty on early withdrawal of savings
- Alimony paid (spousal support)
- IRA deduction
- Student loan interest

- Tuition and fees
- Domestic production activities

Legal Citations

Code of Federal Regulations, title 26, section 1.36B-1

Code of Federal Regulations, title 42, section 600.5

Code of Federal Regulations, title 42, section 600.330 (b)

Minnesota Statues, section 256L.01

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O. Appendix F Standards and Guidelines

Appendix F

Standards and Guidelines

This appendix provides figures used to determine eligibility for a person, or in a specific calculation completed to determine eligibility.

Community Spouse Allowances

The Community Spouse Allowances are used when determining the long-term care (LTC) income calculation's community spouse allocation.

Basic Shelter Allowance

The Basic Shelter Allowance is used to determine if the community spouse has any excess shelter expenses.

Effective Dates	Basic Shelter Allowance
July 1, 2018 to June 30, 2019	$617
July 1, 2017, to June 30, 2018	$609

Maximum Monthly Income Allowance

The Maximum Monthly Income Allowance, along with the Minimum Monthly Income Allowance, is used to determine the community spouse's monthly maintenance needs amount.

Effective Dates	Maximum Monthly Income Allowance
January 1, 2018 to December 31, 2018	$3,090
January 1, 2017 to December 31, 2017	$3,022.50

Minimum Monthly Income Allowance

The Minimum Monthly Income Allowance, along with the Maximum Monthly Income Allowance, is used to determine the community spouse's monthly maintenance needs amount.

Effective Dates	Minimum Monthly Income Allowance
July 1, 2018 to June 30, 2019	$2,058
July 1, 2017 to June 30, 2018	$2,031

Utility Allowance

The Utility Allowance is allowed as a shelter expense if the community spouse is responsible for heating or cooling costs.

Effective Dates	Utility Allowance
October 1, ~~2017~~ 2018 to September 30, ~~2018~~ 2019	~~$556~~ 493
October 1, ~~2016~~ 2017 to September 30, ~~2017~~ 2018	~~$532~~ 556

The Electricity and Telephone Allowances are allowed as shelter expenses if the community spouse is not responsible for heating or cooling expenses, but is responsible for electricity or telephone expenses.

Effective Dates	Electricity Allowance
October 1, ~~2017~~ 2018 to September 30, ~~2018~~ 2019	~~$172~~ 126
October 1, ~~2015~~ 2017 to September 30, ~~2016~~ 2018	~~$141~~ 172

Effective Dates	Telephone Allowance
October 1, ~~2017~~ 2018 to September 30, 2018 2019	~~$41~~ 47
October 1, ~~2016~~ 2017 to September 30, ~~2017~~ 2018	~~$38~~ 41

Federal Poverty Guidelines

The federal poverty guidelines (FPG) are used to determine income eligibility for the Minnesota Health Care Programs (MHCP).

Refer to Insurance and Affordability Programs (IAPs) Income and Asset Guidelines (DHS-3461A) for the current FPG.

Home Equity Limit

The Home Equity Limit is applied only in specific situations and at certain times.

Effective Dates	Home Equity Limit
January 1, 2018 to December 31, 2018	$572,000

Effective Dates	Home Equity Limit
January 1, 2017 to December 31, 2017	$560,000

IRS Mileage Rate

The IRS mileage rate is used in many calculations to determine eligibility or reimbursement costs.

Effective Dates	IRS Mileage Rate
January 1, 2017 to December 31, 2017	53.5 cents
January 1, 2016 to December 31, 2016	54 cents

Long-Term Needs Allowances

The LTC needs allowances provide figures for needs allowances used in the LTC income calculation and for determining the community spouse or family allocation amounts.

Clothing and Personal Needs Allowance

The Clothing and Personal Needs Allowance is used when the enrollee is not eligible for any of the other LTC needs allowances.

Effective Dates	Clothing and Personal Needs Allowance
January 1, 2018 to December 31, 2018	$99
January 1, 2017 to December 31, 2017	$97

Home Maintenance Allowance

The Home Maintenance Allowance can be deducted from a person’s LTC income calculation if certain conditions are met.

Effective Dates	Home Maintenance Allowance
July 1, 2018 to June 30, 2019	$1,012
July 1, 2017 to June 30, 2018	$1,005

Special Income Standard for Elderly Waiver Maintenance Needs Allowance

The Special Income Standard for Elderly Waiver (SIS-EW) maintenance needs allowance is used in the LTC income calculation for persons who have income at or below the Special Income Standard (SIS).

Effective Dates	Maintenance Needs Allowance
July 1, 2018 to June 30, 2019	$1,003
July 1, 2017 to June 30, 2018	$990

Maximum Asset Allowance

The Maximum Asset Allowance is used for the community spouse asset allowance for an asset assessment.

Effective Dates	Minimum	Maximum
January 1, 2018 to December 31, 2018	No minimum	$123,600
January 1, 2017 to December 31, 2017	No minimum	$120,900

MinnesotaCare Premium Amounts

MinnesotaCare premiums are calculated using a sliding fee scale based on household size and annual income.

Refer to MinnesotaCare Premium Estimator Table (DHS-4139) for information about MinnesotaCare premiums. The table provides an estimate of the premium before receiving the actual bill. The premium calculated by the system and listed on the bill is the official calculation and the amount to be paid.

Pickle Disregard

The Pickle Disregard is a disregard of the Retirement, Survivors and Disability Insurance (RSDI) cost of living adjustment (COLA) amounts for Medical Assistance (MA) Method B and the Medicare Savings Programs (MSP).

Effective Date	Pickle Disregard
January 1, 2018 to December 31, 2018	1.02
January 1, 2017 to December 31, 2017	1.003

Remedial Care Expense

The Remedial Care Expense deduction amount can be used as a health care expense when meeting a spenddown or as an income deduction in an LTC income calculation.

Effective Dates	Remedial Care Expense
July 1, 2018 to December 31, 2018	$193
January 1, 2018 to June 30, 2018	$188

Roomer and Boarder Standard Amount

The Roomer and Boarder Standard income is used in calculating the amount of self-employment income a person who rents or boards another person has to add to the MA Method A income calculation.

Roomer and Boarder Standard	Amount
Roomer Amount	$71
Boarder Amount	$155
Roomer plus Boarder Amount	$226

Special Income Standard

The Special Income Standard (SIS) is used to determine certain criteria for the Elderly Waiver (EW) Program.

Effective Dates	SIS
January 1, 2018 to December 31, 2018	$2,250
January 1, 2017 to December 31, 2017	$2,205

Statewide Average Payment for Skilled Nursing Facility Care

The statewide average payment for skilled nursing facility (SAPSNF) care amount is used to determine a transfer penalty for MA. The SAPSNF is updated annually in July.

Effective Dates	SAPSNF
July 1, 2018 to June 30, 2019	$7,288
July 1, 2017 to June 30, 2018	$7,106

Student Earned Income Exclusion

The Student Earned Income Exclusion is a disregard of earned income for people who are under age 22 and regularly attending school. It is only available for MA Method B and MSP.

Effective Date	Monthly	Annual
January 1, 2018 to December 31, 2018	$1,820	$7,350
January 1, 2017 to December 31, 2017	$1,790	$7,200

Supplemental Security Income Maximum Payment Amount

These figures are the maximum benefit amounts for people eligible for Supplemental Security Income (SSI). A person's SSI benefit amount is based on the income of the person and certain responsible household members.

SSI benefit payments may be deducted from the LTC income calculation if the person qualifies for the Special SSI Deduction.

Effective Date	Individual
January 1, 2018 to December 31, 2018	$750
January 1, 2017 to December 31, 2017	$735

Effective Date	Couple
January 1, 2018 to December 31, 2018	$1,125
January 1, 2017 to December 31, 2017	$1,103

Tax Filing Income Threshold For Children and Tax Dependents

The tax filing income threshold refers to the income level at which a person must file a federal income tax return. The thresholds for tax dependents determines whether a child's or tax dependents income is counted or excluded when calculating household income for MA-FCA and MinnesotaCare eligibility.

The income threshold for tax filing varies based on the tax dependents age and marital status and whether the person is blind. If a child or tax dependent has income at or below these thresholds, his or her income will not count toward the household income for MA-FCA and MinnesotaCare eligibility.

The income threshold applies to the taxable income that a child or tax dependent is expected to receive in the tax year. Nontaxable income, such as Supplemental Security Income (SSI) and veteran's benefits, is not included in determining whether a child's or tax dependent's income is at or below the income threshold. Any nontaxable portion of a child's Social Security dependent or survivor benefits is not included.

The income thresholds for children and tax dependents are:

Tax Filing Income Threshold for Tax Dependents for the 2018 Tax Year

Marital Status	Age over 65?	Blind?	Income Type	Threshold Amount
Single	No	No	Earned Income	$6,350
Single	No	No	Unearned Income	$1,050
Single	No	No	Gross Income	Larger of $1,050 or Earned Income Reported up to $6,000 + $350
Single	Yes	No	Earned Income	$7,900
Single	Yes	No	Unearned Income	$2,600
Single	Yes	No	Gross Income	Larger of $2,600 or Earned Income Reported up to $6,000 + $1,900
Single	No	Yes	Earned Income	$7,900
Single	No	Yes	Unearned Income	$2,600
Single	No	Yes	Gross Income	Larger of $2,600 or Earned Income Reported up to $6,000 + $1,900
Single	Yes	Yes	Earned Income	$9,450
Single	Yes	Yes	Unearned Income	$4,150
Single	Yes	Yes	Gross Income	Larger of $4,150 or Earned Income Reported up to $6,000 + $3,450
Married	No	No	Earned Income	$6,350
Married	No	No	Unearned Income	$1,050
Married	No	No	Gross Income	Larger of $1,050 or Earned Income Reported up to $6,000 + $350
Married	Yes	No	Earned Income	$7,600
Married	Yes	No	Unearned Income	$2,300
Married	Yes	No	Gross Income	Larger of $2,300 or Earned Income Reported up to $6,000 + $1,600
Married	No	Yes	Earned Income	$7,600
Married	No	Yes	Unearned Income	$2,300

Married	No	Yes	Gross Income	Larger of $2,300 or Earned Income Reported up to $6,000 + $1,600
Married	Yes	Yes	Earned Income	$8,850
Married	Yes	Yes	Unearned Income	$3,550
Married	Yes	Yes	Gross Income	Larger of $3,550 or Earned Income Reported up to $6,000 + $2,850

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