Minnesota Health Care Programs

Eligibility Policy Manual

Minnesota Department of **Human Services**

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 #16.3

September 1, 2016

Manual Letter #16.3

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of September 1, 2016. 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

The EPM home page is the first page a person sees when using the EPM and provides important information about manual letters and health care policy bulletins. We will update the home page with links to newly issued manual letters as well as health care policy bulletins that have not yet been incorporated into the EPM.

With this manual letter, the following have been added to the EPM home page:

- Hyperlinks to Manual Letter #16.2 (August 1, 2016) and this manual letter
- Hyperlinks to health care policy bulletins issued by the Minnesota Department of Human Services (DHS) that have not yet been incorporated into the EPM
- A hyperlink to the EPM Archive

B. Section 1.3.2.1 MHCP Change in Circumstances

The change to this section more clearly identifies which reported changes may be inconsistent information. Changes that are inconsistent information must be resolved according to policy in EPM Section 1.3.2.4 Inconsistent Information.

C. Section 2.2.3.3 Medical Assistance for Families with Children and Adults (MA-FCA) Income Limit

Previously, Section 2.2.3.3 incorrectly stated that a person would qualify for Medical Assistance (MA) under the Safety Net Provision if their income was within the applicable MA-FCA income limit using the MinnesotaCare income methodology.

The section is revised to state that people are eligible for MA under the Safety Net Provision if their projected annual income is under 100% of the federal poverty guidelines (FPG) using the MinnesotaCare income methodology. People whose projected annual income is greater than 100% FPG, but equal to or less than 133% FPG, using the MinnesotaCare income methodology are eligible for MinnesotaCare.

D. Section 2.2.4.3 MA-FCA Transition Medical Assistance (TMA) and Transition Year Medical Assistance (TYMA)

The change to this section clarifies that children under age 19 and pregnant women must have income at or below 133% FPG when they were first determined eligible for MA, **and** in three of the six months before an income increase to be eligible for TMA or TYMA.

E. Section 2.3.2.1 MA for Bases of Eligibility

The following federal regulations are added to the Legal Citations section:

- Code of Federal Regulations, title 42, section 435.522, clarifies rules regarding determination of age
- Code of Federal Regulations, title 42, section 435.541, clarifies rules regarding determinations of disability

F. Section 2.3.2.2 MA for People Who Are Age 65 or Older or People Who Are Blind or Have a Disability (MA-ABD) Certification of Disability

The following federal regulations are added to the Legal Citations section:

- Code of Federal Regulations, title 42, sections 404.1501 to 404.1599, which relate to disability determinations for Social Security Disability Insurance (SSDI)
- Code of Federal Regulations, title 42, sections 416.901 to 416.999d, which generally relate to disability determinations for Supplemental Security Income (SSI)

Additionally, the citation for Code of Federal Regulations, title 42, section 435, is revised to Code of Federal Regulations, title 42, section 435.541, which provides rules for determining disability.

G. Section 2.3.3.2.7.4 MA-ABD Real Property

The reference to Minnesota Statutes, section 507.02, is removed from the Legal Citations section because it was found not to be applicable to this section.

H. Section 2.3.3.2.7.4.3 MA-ABD Life Estates and Remainder Interests

The reference to Minnesota Statutes, section 500.11, is removed from the Legal Citations section because it was found not to be applicable to this section.

I. Section 2.3.3.2.7.11 MA-ABD Burial Contracts

The references to the following legal citations are removed from the Legal Citations section because they were found not to be applicable to this section:

- Minnesota Statutes, section 149A.97
- Minnesota Statutes, section 256B.056, subdivision 3c(a)(4)

J. Section 2.3.3.2.7.11.1 MA-ABD Burial Space Exclusion

The reference to Minnesota Statutes, section 256B.056, subdivision 3c(a)(4), is removed from the Legal Citations section because it was found not to be applicable to this section.

K. Section 2.3.3.2.7.11.2 MA-ABD Burial Fund Exclusion

The reference to Minnesota Statutes, section 256B.056, subdivision 3c(a)(4), is removed from the Legal Citations section because it was found not to be applicable to this section.

L. Section 2.3.3.2.7.12 MA-ABD Continuing Care Retirement Community Entrance Fee

United States Code, title 42, section 1396p(g), is added to the Legal Citations section because it provides policy for the treatment of entrance fees of people residing in a continuing care retirement community.

M. Section 2.3.3.2.7.13 MA-ABD Tribal Payments and Interests

United States Code, title 25, section 1407, is added to the Legal Citations section because it provides policy for the resource exemption limitation for tribal funds.

N. Section 2.3.3.3.2.2 MA-ABD Disregards and Deductions

The reference to United States Code, title 42, section 402, is removed from the Legal Citations section because it was found not to be applicable to this section.

O. Section 2.3.3.4 MA-ABD Medical Spenddowns

The reference to Code of Federal Regulations, title 42, section 435.330, is removed from the Legal Citations section because it was found not to be applicable to this section.

The following federal regulations are added to the Legal Citations section because they provide policy for medical spenddown income and resource standards:

- 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

P. Section 2.3.3.4.2 MA-ABD Health Care Expenses

The reference to Code of Federal Regulations, title 42, section 435.931, is corrected to be Code of Federal Regulations, title 42, section 435.831, which addresses income eligibility.

Q. Section 2.3.4.2 MA-ABD Renewals

The change to this section adds information about which MA-ABD enrollees are exempt from six-month income renewals.

R. Section 2.4.2.3.1 MA-LTC Home and Community-Based Services Waivers for People with Disabilities

Minnesota Statutes, section 256B.0913, is added to the Legal Citations section because it provides policy for the Alternative Care program.

S. Section 2.4.2.5 MA-LTC Income Calculations

The reference to Code of Federal Regulations, title 42, section 435.725, is removed from the Legal Citations section because it was found not to be applicable to this section.

T. Section 4.2.3.1 MSP Assets

The references to the following legal citations are removed from the Legal Citations section because they were found not to be applicable to this section:

- Minnesota Statutes, section 256B.056, subdivision 1a
- Minnesota Statutes, section 256B.056, subdivision 3
- United States Code, title 42, section 1382b

U. Section 4.2.3.2 MSP Household Composition and Family Size

The references to the following legal citations are removed from the Legal Citations section because they were found not to be applicable to this section:

- Code of Federal Regulations, title 42, part 435.602
- Minnesota Statutes, section 256.01

V. Appendix F Standards and Guidelines

Appendix F incorrectly indicated that the Electricity Allowance was $150.00, when it should have been $141. The standard was updated to correctly reflect an amount of $141 for the period of October 1, 2015, to September 30, 2016. The Electricity Allowance remains this amount for the period of October 1, 2016, to September 30, 2017.

This appendix is also updated to reflect that the Utility Allowance is increasing to $532 effective October 1, 2016. The Telephone Allowance remains $38.

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 1.3.2.1 MHCP Change in Circumstances

C. Section 2.2.3.3 MA-FCA Income Limit

D. Section 2.2.4.3 MA-FCA TMA and TYMA

E. Section 2.3.2.1 MA-ABD Bases of Eligibility

F. Section 2.3.2.2 MA-ABD Certification of Disability

G. Section 2.3.3.2.7.4 MA-ABD Real Property

H. Section 2.3.3.2.7.4.3 MA-ABD Life Estates and Remainder Interests

I. Section 2.3.3.2.7.11 MA-ABD Burial Contracts

J. Section 2.3.3.2.7.11.1 MA-ABD Burial Space Exclusion

K. Section 2.3.3.2.7.11.2 MA-ABD Burial Fund Exclusion

L. Section 2.3.3.2.7.12 MA-ABD Continuing Care Retirement Community Entrance Fee

M. Section 2.3.3.2.7.13 MA-ABD Tribal Payments and Interests

N. Section 2.3.3.3.2.2 MA-ABD Disregards and Deductions

O. Section 2.3.3.4 MA-ABD Medical Spenddowns

P. Section 2.3.3.4.2 MA-ABD Health Care Expenses

Q. Section 2.3.4.2 MA-ABD Renewals

R. Section 2.4.2.3.1 MA-LTC Home and Community-Based Services Waivers for People with Disabilities

S. Section 2.4.2.5 MA-LTC Income Calculations

T. Section 4.2.3.1 MSP Assets

U. Section 4.2.3.2 MSP Household Composition and Family Size

V. 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 (MA) 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 #16.1

MHCP EPM Manual Letter #16.2

MHCP EPM Manual Letter #16.3

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 #16-21-04, DHS Explains Changes in the Implementation of Spousal Impoverishment Protections
- Bulletin #16-21-06, DHS Provides Policy for 2016 Legislative Changes to MA and MinnesotaCare

  Note that the parts of this bulletin pertaining to MA Estate Recovery and MinnesotaCare have been implemented into the EPM. The remaining parts of the bulletin will be implemented in a future manual letter.
- Bulletin #16-21-07, DHS Provides Projected Annual Income (PAI) Policy

- Bulletin #16-21-08, DHS Explains Spousal Impoverishment Rules for BI, CAC, CADI, and DD Enrollees

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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B. Section 1.3.2.1 MHCP Changes 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

~~Applicants and enrollees must reconcile inconsistent information with their county, tribal or state servicing agency.~~ 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.

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 results 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.

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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C. Section 2.2.3.3 MA-FCA Income Limit

Medical Assistance for Families with Children and Adults

2.2.3.3 Income Limit

To be eligible for Medical Assistance for Families with Children and Adults (MA-FCA) a person's income must be less than or equal to the applicable income limit. Income limits are based on federal poverty guidelines.

Federal Poverty Guidelines

The U.S. Department of Health and Human Services (HHS) issues federal poverty guidelines (FPG) each year. New guidelines are used beginning each July 1.

These guidelines determine income eligibility for MA-FCA. A person's applicable income limit is based on many factors, including, but not limited to:

- The basis of eligibility for Medical Assistance (MA)

  The number of people included in the family size
- Whether the person has a medical spenddown for MA

Income Limits for Medical Assistance for Families with Children and Adults

The following income limits determine eligibility for MA -FCA:

- Pregnant women: less than or equal to 278% FPG
- Infants under 2: less than or equal to 283% FPG
- Children 2 through 18: less than or equal to 275% FPG
- Children 19 and 20: less than or equal to133% FPG
- Parent and caretaker relatives: less than or equal to 133% FPG
- Adults without children: less than or equal to 133% FPG
- Transition Year MA (TYMA) second six months: less than or equal to 185% FPG

Auto newborns and former foster children younger than age 26 have no income limit.

See the Minnesota Health Care Programs Income and Asset Guidelines (DHS-3461A) for more information regarding family size and income limits.

Five Percent FPG Disregard

When the person's income is above the income limit, an income disregard equal to 5% FPG is applied. When the person's income, minus the disregard, is within the income limit, they qualify for MA-FCA. This disregard effectively raises the MA-FCA income limits by 5%.

Safety Net Provision

In certain situations, a person's income may be greater than his or her income standard for MA – FCA and be less than the MinnesotaCare income standard due to differences in how income is calculated for each program. This results in ineligibility for both programs. This may occur when:

- A lump sum is counted in the month received under the MA-FCA income methodology, but counted as annual income using the MinnesotaCare income methodology.
- Sponsor income is counted in the household income using the MA-FCA income methodology, but not counted in the MinnesotaCare income methodology.
- A child younger than age of 19 has income greater than the MA-FCA income limit, but has projected annual income less than 100% FPG for MinnesotaCare eligibility. This can happen because MA-FCA and MinnesotaCare have different household composition and family size policies.
- Current income is used in the MA-FCA income methodology, but projected annual income is used for the MinnesotaCare income methodology.

When these situations arise, people are eligible for MA if their projected annual income is below 100% FPG using the modified adjusted gross income (MAGI) income methodology. People whose projected annual income is equal to or greater than 100% FPG, but equal to or less than 133% FPG, using the MAGI income methodology are eligible for MinnesotaCare ~~the person's income is recalculated using the MinnesotaCare income methodology and compared to the applicable MA-FCA income limit. If the person's income is within the applicable MA-FCA income limit, they are eligible for MA~~.

Legal Citations

Code of Federal Regulations, title 42, section 435.100

Code of Federal Regulations, title 42, section 435.116

Code of Federal Regulations, title 42, section 435.118

Code of Federal Regulations, title 42, section 435.119

Code of Federal Regulations, title 42, section 435.603

Minnesota Statutes, section 256B.056

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D. Section 2.2.4.3 MA-FCA TMA and TYMA

Medical Assistance for Families with Children and Adults

2.2.4.3 Transitional Medical Assistance and Transition Year Medical Assistance

Some Medical Assistance for Families with Children and Adults (MA-FCA) enrollees may extend their MA coverage under Transitional MA (TMA) or Transition Year MA (TYMA) after they are no longer considered MA eligible.

TMA may provide up to four months of additional coverage to people who become ineligible for MA-FCA due to increased spousal support (alimony).

TYMA may provide up to 12 months of additional coverage to people who become ineligible for MA-FCA due to increased earned income including income from a parent or relative caretaker who returns to the household. The 12 months consists of two periods of six months each, which have different eligibility and reporting requirements. There are more eligibility and reporting requirements during the second six-month period than during the first six-month period.

No application is required for TMA/TYMA. People who lose MA due to increased income or spousal support automatically qualify for TMA/TYMA if they meet other requirements.

Eligibility Requirements

To be eligible for either TMA or TYMA, the person must:

- Be a birth, natural, step or adoptive parent or relative caretaker, a child under age 19, or a pregnant woman.
- Have had MA-FCA coverage in at least three of the six months before the income increase. Re-evaluation of eligibility and reverification for any of the three of the six months before the income increase are not required.
- Live in a household that includes a child age 18 or younger.
- Lose eligibility for MA-FCA because of increased spousal support (TMA) or increased earnings (TYMA).

Children under age 19 and pregnant women are eligible for TMA or TYMA if they were at or below 133% FPG when they were first determined MA eligible, and in three of the six months before the income increase. TMA or TYMA eligibility begins after their income increases above 133% FPG and runs concurrently while they remain eligible under the child or pregnant women MA basis. TMA or TYMA coverage is available for children under age 19 and pregnant women for any remaining TMA or TYMA months after their income increases above the child or pregnant women income standards.

TMA and TYMA are not available for:

- Enrollees whose MA coverage ends because they did not verify earned income are not eligible for TYMA.
- Parents or relative caretakers who are convicted of MA fraud for any of the six months before the start of the TMA/TYMA period or for any month of TMA/TYMA.

Enrollees who are determined eligible for TMA/TYMA are exempt from annual renewals for the duration of the TMA/TYMA eligibility.

Second Six-Month Extension of TYMA

To continue to receive TYMA beyond the first six months, the household must meet several additional requirements:

- Receive TYMA for the entire first six-month period.
- Complete quarterly reports in third, sixth, and ninth month of TYMA eligibility. Enrollees can provide income and childcare information in writing or by phone.
- Have gross earned income at or below 185% FPG calculated by averaging the family's gross monthly earnings minus costs for childcare necessary for the employment of the caretaker relative for the immediately preceding 3-month period. Sponsor deeming does not apply to TYMA. See the MA-FCA Sponsor Deeming policy for more information.
- Have a parent or relative caretaker in the household with earned income unless there is good cause for the lack of earnings. Good cause for a lack of earnings during the second six-month extension of TYMA includes, but is not limited to, involuntary loss of employment and illness.

First Quarterly Report

A TYMA enrollee must receive a Transition Year Medical Assistance First Quarterly Report (DHS-2975A) at the end of the third month of TYMA eligibility. The family must report to the agency the family's gross monthly earnings and the family's costs for childcare, which is the cost necessary for the employment of the parent or caretaker relative, in each of the first three months. The report is due on the 21st day of the fourth month of the initial six-month period. Paper proof of childcare costs is not required.

If the TYMA enrollee returns the form or responds by phone indicating there is no longer a dependent child in the home, the enrollee is no longer eligible for TYMA and is closed with advanced 10-day notice.

Second and Third Quarterly Reports

TYMA enrollees must also report earnings and childcare costs for each of the previous three months by the 21st day of the seventh and 10th month of the TYMA period. Paper proof of childcare costs is not required.

Failure to Comply with Reporting Requirements

Failure to report by the 21st day of the reporting month will end the family's TYMA benefits, unless the person has established good cause for the failure to report on a timely basis. Once the person completes the reporting requirement, TYMA coverage is restored the next month and continues for the remainder of the original 12-month period, if the person's TYMA eligibility has not otherwise ended.

If the family does not comply with the reporting requirements, coverage is suspended but eligibility is not closed until the end of the 12-month period.

Fluctuating Income and Remaining TMA/TYMA Months

Enrollees with fluctuating income may move between another MA-FCA basis of eligibility and TMA or TYMA. If TMA or TYMA enrollees have an income reduction resulting in income at or under the MA-FCA income limit, they become eligible again under their previous MA-FCA basis. When this happens, TMA or TYMA ends, and any remaining TMA or TYMA months are available if income again increases beyond 133% FPG within the original 12-month period.

If people enrolled in TMA or TYMA are closed and later reapply for health care, they may be eligible of any remaining months within the original 12-month period.

If the person has had MA-FCA eligibility for three or more of the past six months, the person again may meet the eligibility criteria for a new period of TMA or TYMA eligibility.

New Household Members for TMA and TYMA

When a new member enters a household in which at least one member of the existing household is receiving TMA or TYMA, and the new member is not eligible for MA under another basis, the new member may be eligible for TMA or TYMA depending on his or her relationship to other household members who are receiving TMA or TYMA.

If an auto newborn is part of the TMA/TYMA household when the auto newborn period ends, the auto newborn is considered a new household member.

Relationship to Other Household Members

If the new household member is the birth, natural, step or adoptive parent, relative caretaker, spouse, child or stepchild of another member of the household who receives TMA or TYMA, then the new member has the same eligibility as the household members receiving TMA or TYMA.

New members who are added are eligible for TMA or TYMA effective on the first day of the first full month they are in the household. Their TMA/TYMA will continue for the same time period as the spouse or child to whose TMA/TYMA they are added. For TYMA, the new member will be subject to the same quarterly reporting schedule. For new members added during the second six months of TYMA, updated information to determine continued eligibility is required before the person is added.

Legal Citations

Minnesota Statutes, section 256B.0635, subdivision 1(b)

Minnesota Statutes, section 256B.0635, subdivision 2

Social Security Act, section 1925

Social Security Act, section 1931

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E. Section 2.3.2.1 MA-ABD Bases of Eligibility

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

2.3.2.1 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 bases of eligibility for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) are:

- People age 65 or older
- People certified blind
- People certified disabled

Beginning and Ending Bases of Eligibility

A person must have one of the following bases for MA-ABD eligibility. When an enrollee's basis of eligibility ends, they must be evaluated for other MA bases of eligibility and other health care programs before closing coverage.

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

- Adults age 65 and older:
  - Begins the first day of the month of their 65th birthday
- People certified blind or disabled:
  - Begins the first day of the month of the disability onset date as determined by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)
  - Ends the last day of the last month a person is certified disabled as determined by SSA or SMRT

The blind or disabled basis of eligibility is continued until SSA has denied two appeals of a continuing eligibility review that determined the person is no longer certified disabled.

If SSA benefits are denied solely on earnings above Substantial Gainful Activity (SGA), the blind or disabled basis of eligibility can only be continued with a disability determination from SMRT. See the MA-ABD Certification of Disability policy for more information.

Multiple Bases of Eligibility

People may have more than one basis of eligibility. A person’s countable income, asset limits, 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 are redetermined under another basis without interruption in their coverage. Additional information may be requested to determine continued eligibility under another basis. Some changes that may affect an enrollee's basis of eligibility include, but are not limited to:

- Disability certification
- Pregnancy. A pregnant basis of eligibility ends on the last day of the month in which the 60-day postpartum period ends.
- Becoming a parent or relative caretaker of a minor child

If an enrollee is no longer eligible for MA under any basis, eligibility is determined under another Minnesota Health Care Program.

Legal Citations

Code of Federal Regulations, title 42, section 435.121

Code of Federal Regulations, title 42, section 435.201

Code of Federal Regulations, title 42, section 435.230

Code of Federal Regulations, title 42, section 435.330

Code of Federal Regulations, title 42, section 435.520

Code of Federal Regulations, title 42, section 435.522

Code of Federal Regulations, title 42, section 435.530

Code of Federal Regulations, title 42, section 435.540

Code of Federal Regulations, title 42, section 435.541

Code of Federal Regulations, title 42, section 435.911

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.055

Minnesota Statutes, section 256B.057

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F. Section 2.3.2.2 MA-ABD Certification of Disability

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

2.3.2.2 Certification of Disability

Disability or blindness must be certified by the Social Security Administration (SSA) or the State Medical Review Team (SMRT). The certification process is also called a disability determination.

People receiving the following benefits may or may not be certified disabled by SSA or SMRT.

- Short-term disability
- Long-term disability
- Long-term care insurance
- Veterans' Administration (VA)
- Railroad Retirement Board (RRB)
- Worker’s Compensation

Only a SSA or SMRT certification of disability is valid for the purposes listed below.

Disability Certification for MA Eligibility

People must be certified disabled and use the disabled or blind basis of eligibility to:

- Enroll in MA for Employed Persons with Disabilities (MA-EPD)
- Use the TEFRA option. The TEFRA option for children with a disability is named after the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 that created the option. Children with a disability and household income above the MA income limit need a disability certification to use the TEFRA option.
- Receive home and community-based services through the:
    - Brain Injury (BI) waiver
    - Community Alternative Care (CAC) waiver
    - Community Access for Disability Inclusion (CADI) waiver

A disability certification is not needed for services under the Developmentally Disabled (DD) waiver. The county case manager determines if the person meets the criteria for a developmental disability.

Children turning 18 need a new disability certification under the adult standards to continue using a blind or disabled basis of eligibility.

Disability Certification for Other Reasons

Some MA enrollees get a disability certification for managed care reasons including:

- To be excluded from managed care enrollment
- To enroll in Special Needs Basic Care (SNBC), a specialized managed care plan for people age 18-64 with a certified disability

Additional reasons for needing a disability certification include:

- Community Support Grant (CSG) eligibility
- Family Support Grant (FSG) eligibility
- Aged 65 and older and establishing a pooled trust
- Establish an asset transfer penalty exception
- Creating certain trusts

State Medical Review Team Certification of Disability

SMRT completes disability determinations for people not certified disabled by SSA. SMRT certifies disability using the same criteria as the SSA, except they do not look at a person's ability to work. SMRT only reviews a person's medical condition.

Referral Process

Since the SSA disability determination process can be long, the county, tribal or state servicing agency completes a SMRT Referral for a Disability Determination (DHS-6123). The person is also referred to SSA for a disability determination and benefits.

Expedited Case Criteria

SMRT expedites the disability determination process in three situations where the person is likely to meet disability criteria:

- The person has a condition that appears on the SSA Compassionate Allowance Listing (CAL)
- The person is awaiting discharge from a facility and can be discharged immediately if MA is approved
- The person has a potentially life-threatening situation and requires immediate treatment or medication
- The person has had a MnCHOICES assessment within the past 60 days and needs services that can only be provided by a home and community-based services waiver.

Continuing Disability Review

People certified disabled by SMRT need a continuing disability review every one to seven years. Disability standards are different for children and adults, so at age 18, a child must be evaluated under the adult standards. Newborns certified disabled due to a low-birth weight must be reviewed prior to age one.

Legal Citations

Code of Federal Regulations, title 42, sections 404.1501 to 404.1599

Code of Federal Regulations, title 42, sections 416.901 to 416.999d

Code of Federal Regulations, title 42, section 435.541

Minnesota Statutes, section 256.01

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G. Section 2.3.3.2.7.4 MA-ABD Real Property

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

2.3.3.2.7.4 Real Property

Real property includes land and all buildings or immovable objects attached permanently to the land. Real property is an asset and is counted toward a person's asset limit if available and not excluded. Availability depends upon the type of real property and the person's ownership interest in it. See the following types of real property for more information.

Homestead Real Property

Non-Homestead Real Property

Life Estates and Remainder Interest

Life Estate Mortality Table

Other Property Interests

This section explains the ways in which a person can own real property.

Sole Ownership in Real Property

Sole ownership of real property means that only one person may sell, transfer, or otherwise dispose of the property. Sole ownership may be limited by conditions imposed by other interests.

Shared Ownership in Real Property

Shared ownership of real property means that two or more people own the property at the same time. Shared ownership may be limited by conditions imposed by other interests. There are three types of shared ownership:

Tenancy-in-common

Tenancy-in-common is a form of property ownership in which:

- Owners may not have the same interests in the property. This means that while two or more people each have an interest in the entire property, these interests are not necessarily equal; e.g., two joint tenants do not necessarily each own half of the property.
- Owners may sell, transfer or otherwise dispose of their share of the property without the permission of the other owner(s).

- Owners do not have survivorship rights. This means that when one tenant-in-common dies, the other tenant(s)-in-common does not automatically gain rights to the deceased owner's interest in the property.

Joint tenancy

Joint tenancy is a form of property ownership in which:

- Owners have the same interest in the property. Each owner owns all of the property and may possess all of the property.
- Owners generally may not sell, transfer or otherwise dispose of their share of the property without the permission of all other owners.
- Owners have survivorship rights. If one-joint owner dies, that owner's interest in the property passes to the other joint owner(s).

The value of a person's joint tenancy interest in real property is determined by dividing the equity value by the number of owners.

Tenancy by the entirety

Tenancy by the entirety is a form of property ownership in which:

- Owners are a married couple. Each spouse owns the entire property.
- A spouse cannot sell, transfer, or otherwise dispose of the property without the consent of the other spouse.
- Owners have survivorship rights. If one spouse dies, the other spouse becomes the sole owner of the property.

This type of real property ownership does not exist in Minnesota, but may apply to property held in another state. This form of ownership protects the property owner from debts contracted outside the marriage. Creditors of the debtor spouse may not collect against the property unless the debtor spouse becomes the sole owner.

Ownership of Homestead Property in Minnesota

In Minnesota, a spouse cannot sell, transfer, or otherwise dispose of homestead property without the consent of the other spouse. This is true regardless of whether the spouses own the homestead as tenants-in-common, as joint tenants, or if the homestead is held solely in the name of only one spouse.

Limits on Ownership

Fee simple ownership means absolute and unqualified title to real property. The owners can sell, transfer, possess, use, or otherwise dispose of their interest in the property during their lifetime

without limit or condition. Upon his or her death, property held in fee simple can pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

Less than fee simple ownership means the real property owners may have limits on their rights to sell, transfer, possess, use or otherwise dispose of their property. Two types of less than fee simple ownership are:

- Life estate. An interest in real property with the right of use or enjoyment limited to the owner's life or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law.
- Remainder interest. A life estate instrument often gives property to one person for life (life estate owner) and to one or more others (remaindermen) upon the death of the life estate owner. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

Verification of Real Property Ownership Interests

It is assumed, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. Documents that people may use to verify ownership interests include, but are not limited to:

- Deeds
- Assessment notices
- Current tax bills
- Current mortgage statements
- Report of title searches
- Wills, court records or documents which show rights of an heir to property after death of a former owner

Legal Citations

Minnesota Rules, part 9505.0015

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

~~Minnesota Statutes, section 507.02~~

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H. Section 2.3.3.2.7.4.3 MA-ABD Life Estates and Remainder Interests

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

2.3.3.2.7.4.3 Life Estates and Remainder Interests

A life estate is an ownership interest in real property. The right of ownership exists for the lifetime of the person holding it, the lives of one or more other designated persons, or one or more other specified conditions within the lifetime of the life estate owner. A life estate document specifies when the life estate terminates.

The owner(s) of a life estate is called a “life tenant” or “tenant for life.” Generally, a life estate entitles the life tenant to occupy, possess or otherwise use the property as long as he or she lives.

When the owner of property gives it to one party in the form of a life estate, and designates a second person to inherit it upon the death of the life estate owner, the second person has a remainder interest in the property and is referred to as a remainderman.

A life estate is generally created:

- When a person with property rights in real property transfers a remainder interest in the property to another and retains a life estate in the property
- When a person purchases a life estate interest in someone else’s property
- By operation of probate law

Rights and Responsibilities of the Life Estate Owner

The life estate owner:

- Has the right to occupy, possess, or otherwise use the property until the life estate is terminated
- Has the right to sell the life estate interest if not prohibited in the legal instrument establishing the life estate interest
- Is entitled to all income and profits of the life estate interest, such as rent on the property
- Cannot sell the property or the remainder interest
- Is responsible for paying the mortgage, taxes, and insurance on the property
- Is responsible for the upkeep and the repair of the property

Rights of the Remainderman

The remainderman has ownership interest in the property subject to the life estate interest. The remainderman does not have the right to occupy, possess or otherwise use the property until the life estate is terminated.

The remainderman can:

- Sell his or her interest in the property even before the life estate interest terminates, if allowed by the legal instrument establishing the life estate interest. In such cases, the life estate owner retains the life estate interest until the life estate terminates.
- Sell the entire property with the permission of the life estate owner

Life Estate Evaluation

Life estates are treated as real property. The value is not counted when the life estate interest is:

- considered homestead real property, or
- unavailable.

The proceeds from the sale of a life estate interest is counted as an asset in the month following the month of the sale, if retained:

- When the property is sold
- When the remainderman or someone else purchases the life estate interest

Determining the value of a life estate interest in real property

The value of a life estate interest in real property is the property's equity value, multiplied by the person's mortality figure based on the person's age, as determined by the Life Estate Mortality Table.

If there are two or more life estate owners, each life estate owner has a different amount of life estate interest due to differences in the owners' ages.

Remainder Interest Evaluation

Remainder interests are treated as real property and counted as an asset.

Determining the value of a remainder interest

The value of a remainder interest when a person is a remainderman is the property's equity value, multiplied by the remainderman mortality figure that corresponds to the life estate owner's age, as determined by the Life Estate Mortality Table.

When the Remainder Interest is Available to the Life Estate Owner

If a person owns both the life estate interest and the remainder interest, the life estate and remainder interests merge into full ownership of the property. The property is evaluated as a non-life estate real property.

Legal Citations

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

~~Minnesota Statutes, section 500.11~~

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I. Section 2.3.3.2.7.11 MA-ABD Burial Contracts

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

2.3.3.2.7.11 Burial Contracts

Burial contracts are contractual agreements between a consumer and a funeral provider, such as a funeral home or a cremation society. Burial agreements require that a buyer pay in advance for funeral services and items that a funeral director agrees to furnish upon the death of the buyer or other designated person.

Burial contracts are funded in a variety of ways. The burial contract and the funding source are two separate items and both must be evaluated.

The Burial Contract

In exchange for the buyer paying in advance, the funeral provider draws up a contract, itemizing burial services and/or burial space items, and noting the amount allocated towards each service and space.

- Burial space items (BSI) includes a repository used for bodily remains, as well as services performed at the burial location, and burial goods related to a person's burial site. BSIs include, but are not limited to:
  - Burial plot or site
  - Gravesite
  - Casket
  - Urn
  - Niche
  - Crypt
  - Mausoleum
  - Vault
  - Burial container (for a casket)
  - Headstone, marker or plaque
  - Engraving
  - Opening/closing of the grave
  - One-time payment for care and maintenance of the gravesite, sometimes called preservation or perpetual care

- Burial services prepare the body for burial and all services prior to burial. Burial services include, but are not limited to:
  - Transportation of the body
  - Embalming
  - Cremation
  - Flowers
  - Clothing
  - Services of the funeral director and staff

Burial contracts may be irrevocable, revocable, or a combination.

Irrevocable Burial Contracts

If a burial contract is irrevocable, the funds deposited into the agreement are unavailable and cannot be withdrawn by the person or the funeral provider until the time of need. Irrevocable burial contracts include those funded by life insurance, those funded by annuities, and those in which the person directly pays the funeral provider.

Interest earned on these contracts may be separately designated as revocable or irrevocable. If the interest is designated as irrevocable, it is unavailable. If the interest is designated as revocable, it is a counted asset.

Revocable Burial Contracts

If an agreement is revocable, the funds deposited into the agreement are available and can be withdrawn at any time. A revocable burial contract may be an excludable asset, depending on what burial costs it is intended to cover and whether any portion of the allocated funds can be excluded due to the burial space exclusion (BSE) or the burial fund exclusion (BFE).

When a revocable burial contract is a countable asset, either the amount the owner would receive if the contract was revoked, or the current market value if it is a saleable contract, is counted.

The Funding Source

A person may fund a burial contract in several ways, with the most common funding sources being liquid assets, life insurance policies, and annuity policies purchased from an insurance company. This section describes how these funding sources are evaluated.

Liquid Assets and Pre-Need Burial Agreements

Liquid assets may be designated for burial expenses. This category includes cash and bank accounts and financial instruments with a cash value, such as stocks, bonds and certificates of

deposit. If these assets are applied to the BFE, they must be kept in a separate account and designated for burial.

Pre-need burial arrangements funded by liquid assets contain the following unique provisions in Minnesota:

- A specific funeral provider draws up the contract, but state law requires freedom of choice, meaning the family may choose a funeral provider when the person dies.
- The funeral provider must place available funds into a trust for the person's burial expenses.
- If it is an irrevocable agreement, the purchaser may designate an irrevocable amount up to $2,000 for burial services. Any amount over $2,000 for services and any amount not designated as a BSI can be cashed in at any time.
- Interest earned is either revocable or irrevocable, as designated by the purchaser.
- The contract itemizes burial services separate from BSIs (generally on a Statement of Goods and Services).

Life Insurance-Funded Burials and Annuity-Funded Burials

A life insurance-funded burial (LIFB) involves a person purchasing a life insurance policy on his or her own life. Life insurance funded burial contracts are not burial insurance.

If an annuity policy is being used to fund a burial contract, it is called an annuity-funded burial (AFB) and follows LIFB policies. Otherwise, see Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Annuities for how the annuity is evaluated as an asset.

A person may assign, revocably or irrevocably, either the proceeds or ownership of an LIFB/AFB policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

- Effect of Assignment of Ownership on Burial Exclusions
  - Revocable Assignment
    - The BSE does not apply, because the funeral provider has not received any payment and no purchase of burial spaces has been made.
    - The BFE may apply. The asset value of the burial contract is equal to the cash surrender value (CSV) of the LIFB/AFB policy, subject to the $1,500 BFE.
  - Irrevocable Assignment
    - The BSE may apply, depending on the nature of the contract. See MA-ABD Burial Space Exclusion for more information. Any portion of the contract that represents the purchase of a burial space has no effect on the BFE.
    - The LIFB/AFB policy and the burial contract are not assets because the person no longer owns them. The face value (FV) of the burial funds portion of the contract

offsets the $1,500 BFE because the contract represents an irrevocable arrangement available to meet the person's burial.

- A person's estate must be named as contingent beneficiary. If a person's estate is not named as contingent beneficiary, the policy is treated as a life insurance policy, not an LIFB/AFB.

Proceeds of an LIFB/AFB policy are the FV of the policy plus any additions payable at maturity or death. This does not include dividends, CSV or interest.

- Effect of Assignment of Proceeds on Burial Exclusions
  - Revocable Assignment
    - The BSE does not apply to the CSV of the LIFB/AFB policy. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made.
    - The asset values of the burial contract is equal to the CSV of the LIFB/AFB policy. If the FV of all LIFB/AFB policies on the person's life is $1,500 or less, the CSV is excluded under the life insurance exclusion. If the FV of all policies exceeds $1,500, the CSV of the policy is treated according to the BFE.
  - Irrevocable Assignment
    - Life insurance companies generally do not permit the proceeds of a LIFB/AFB policy to be irrevocably assigned.

Dividend accumulations of a LIFB/AFB are not counted as part of the value of the policy or the burial contract. Dividend accumulations are separate assets and must be designated separately in order to qualify for the BFE. If ownership of the life insurance policy has been irrevocably assigned, absent evidence to the contrary, it is assumed that the dividend accumulations are also assigned.

Legal Citations

~~Minnesota Statutes, section 149A.97~~

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

~~Minnesota Statutes, section 256B.056, subdivision 3c(a)(4)~~

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J. Section 2.3.3.2.7.11.1 MA-ABD Burial Space Exlcusion

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

2.3.3.2.7.11.1 Burial Space Exclusion

Two separate and distinct exclusions apply to assets set aside for burial expenses. All assets set aside for burial expenses must be evaluated to determine if they may be excluded under one of the exclusions. This section discusses the Burial Space Exclusion (BSE). The Burial Fund Exclusion (BFE) will be discussed in the subsequent section.

The BSE allows burial space items to be excluded without limiting their value. Burial space items include the burial site, a repository for bodily remains, services performed at the burial site, and items related to the burial site. Only burial space items (BSI) may be excluded under the BSE. Burial services are never excluded under the BSE.

Requirements for an Asset under the BSE

An asset excluded under the BSE must meet all of the following requirements:

- Each BSI must be itemized on the burial contract.
- Each BSI must be paid in full.
- There is no limit to the value of a BSI excluded under the BSE.
- Each person is allowed one BSI serving a particular purpose.
- A married person may purchase two burial contracts allocating funds for each spouse, but cannot have one contract covering expenses for both spouses.
- When someone owns additional BSIs, a signed statement or copy of the burial contract with the name of the person for whom each BSI is intended and that person’s relationship to the buyer will be evaluated.

Assets Held for Family Members

People can exclude assets under the BSE for themselves and the following immediate family members:

- Parents, including adoptive parents
- Minor or adult children, including adoptive and stepchildren
- Siblings, including adoptive and stepsiblings
- Spouses of the above family members if they are still legally married at the time of the purchase

Assets Excluded under the BSE

The following is excluded under the BSE:

- The total value of a contract that only allocates an amount for BSIs
- The amount allocated for itemized BSIs when the contract lists both BSI and burial services

If the person cannot distinguish BSIs from burial services in the contract:

- All expenses are categorized as services and none as BSIs.
- The person may ask the funeral provider to amend the contract, distinguishing burial services from BSIs.
- The expenses under the BSE are not excluded if the contract is not amended.

The BSE is in addition to the $1,500 BFE. A burial asset is excluded under one exclusion or the other, but not simultaneously under both.

Legal Citations

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

Minnesota Statutes, ~~sub~~section 256B.056, subdivision 3d

~~Minnesota Statutes, subsection 256B.056, subdivision 3c(a)(4)~~

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K. Section 2.3.3.2.7.11.2 MA-ABD Burial Fund Exclusion

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

2.3.3.2.7.11.2 Burial Fund Exclusion

Two separate and distinct exclusions apply to assets set aside for burial expenses. All assets set aside for burial expenses must be evaluated to determine if they may be excluded under one of the exclusions. This section discusses the Burial Fund Exclusion (BFE). The Burial Space Exclusion (BSE) was discussed in the previous section.

The BFE allows a person to exclude up to $1,500 of assets for burial services. Burial services include preparing the body for burial and services that are not performed at the burial site. These assets must be clearly designated for the person or their spouse's burial, cremation, or other burial-related services; they cannot be commingled with other assets not intended for burial. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other assets not intended for burial.

Assets Held for Family Members

People can exclude assets under the BFE for themselves and the following family members:

- Spouse
  - This includes the community spouse of a person who resides in a long-term care facility (LTCF) or receives Elderly Waiver (EW) services.
  - The spouse does not have to be eligible for Minnesota Health Care Programs (MHCP).
- Dependent children who:
  - are MHCP enrollees, and
  - live with the person or the person's spouse.

Order of Assets Applied to the BFE

Each person's $1,500 exclusion is reduced in the following order:

1. The face value (FV) of any life insurance policy on the person (or spouse) if such policy is excluded under the life insurance exclusion

2. Any amount held in an irrevocable trust, an irrevocable burial contract, burial insurance, or other irrevocable arrangement for the person's (or spouse's) burial expenses, in the order purchased, except to the extent that it represents excluded burial spaces. See Medical Assistance for people Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Burial Space Exclusion for more information.

- Burial insurance is considered an irrevocable arrangement whose FV reduces the $1,500 BFE by the policy's value. However, burial insurance is not counted as an asset even if it is not applied to the BFE.

3. Liquid assets, up to $1,500, may be designated for any remaining balance of the BFE. This category includes such liquid assets as:

    - Cash and bank accounts
    - Financial instruments with a cash value, such as stocks, bonds and certificates of deposit
    - CSV of insurance policies when the total FV exceeds $1,500
    - Revocable burial contracts
    - Installment sales contracts for burial space items (BSI)
        - If the person cannot distinguish BSIs from burial services in the contract:
            - All expenses are categorized as services and none as BSIs.
            - The person may ask the funeral provider to amend the contract, distinguishing burial services from BSIs.
    - The contract amount allocated to purchases that cannot be categorized as either a burial service or a BSI, such as certified copies of the death certificate or a meal prior to the burial service.

Changes in Burial Exclusion Amounts

Once the amount of designated burial funds equals $1,500, the only additions to that amount that can be excluded under the BFE are appreciation and/or interest. Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded as income and assets if left to accumulate and become part of the burial fund.

Until $1,500 in burial funds has been designated, additional amounts can be excluded under the BFE if the person designates them for burial expenses. Interest on excluded burial funds is not included in determining if the $1,500 maximum has been reached.

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

Minnesota Statutes, ~~sub~~section 256B.056, subdivision 3d

~~Minnesota Statutes, subsection 256B.056, subdivision 3c(a)(4)~~

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L. Section 2.3.3.2.7.12 MA-ABD Continuing Care Retirement Community Entrance Fee

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

2.3.3.2.7.12 Continuing Care Retirement Community Entrance Fee

A continuing care retirement community (CCRC) entrance fee provides housing, services and nursing care, usually all in one location. This enables people to remain in a familiar setting as they grow older. Types of services provided by a CCRC include but are not limited to:

- Board
- Lodging
- Nursing services
- Medical services
- Home health care
- Other health-related services

A CCRC must be registered with the county recorder in the county where it is located. The CCRC must meet the following criteria to be registered:

- Have a written contract with a person to provide services for the life of the person or a period in excess of one year. Services and lodging provided by a CCRC do not need to be provided at the same location
- Requires an entrance fee of $100 or more
- Requires the person to pay regular periodic charges for the care provided

The following are not considered to be a CCRC:

- A facility operating solely as a nursing facility
- A facility that delivers housing without services
- A program or organization that provides services but not housing
- Services received by a person that a relative (either blood or marriage) provides

Asset Value of the CCRC Entrance Fee

The available portion of an entrance fee paid to a CCRC counts toward the person’s asset total at application or renewal.

Availability of a CCRC Entrance Fee

The availability of the CCRC entrance fee is determined by reviewing the contract specifications signed by the person.

In order to be available to the person, the entrance fee paid to a CCRC must meet all of the following conditions:

- All or a portion of the entrance fee can be refunded or used to pay for needed services if the person does not have other sufficient resources to pay for those services. Needed services may include, but are not limited to:
  - Medical care, both inpatient and outpatient
  - Home health care
  - Skilled nursing care
- The entire fee amount or the remaining portion of the fee can be refunded if the person:
  - Dies
  - Ends the contract and leaves the CCRC
- The entrance fee does not purchase ownership interest in the CCRC.

Verification Requirements

The amount of the entrance fee available to the person must be verified at application and at renewal if not previously verified or if the contract was changed. The contract between a person and the CCRC may allow for a change in the availability of an entrance fee.

Legal Citations

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

United States Code, title 42, section 1396p(g)

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M. Section 2.3.3.2.7.13 MA-ABD Tribal Payments and Interests

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

2.3.3.2.7.13 Tribal Payments and Interests

Many federal statutes provide an asset exclusion for certain interests held by and payments made to members of tribes and groups. Some statutes address interests and payments to specific tribes while others address certain types of interests and payments. This section explains how to count these interests and payments.

Individual Interests in Trust or Restricted Lands

The interests of individual tribal members in trust or restricted lands are excluded (P.L. 103-66 § 13736; 25 USC § 1408).

Per Capita Distributions of Funds Held in Trust

Per capita distributions of all funds held in trust by the Secretary of the Interior to members of an Indian tribe are excluded (P.L. 98-64).

Any local tribal funds that a tribe distributes to individual tribal members on a per capita basis, but which have not been held in trust by the Secretary of the Interior, are not excluded under this provision.

Tribal Land Settlements or Judgments

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 (P.L. 93-134; P.L. 97-458) are excluded.

Certain Assets owned by American Indians

Excluded assets for American Indians, in addition to items excluded under the general provisions, include:

- Real property that is located on Indian land, or land held in trust, subject to restriction or supervision by the Secretary of the Interior. Indian land includes:
  - A federally recognized reservation, pueblo or colony
  - Former reservations located in Oklahoma
  - Alaska Native regions established by the Alaska Native Claims Settlement Act

    - Indian allotments on or near a reservation as designated by the Bureau of Indian Affairs of the Department of the Interior
    - Property located within the most recent boundaries of a prior federal reservation
- Ownership interests in rents, leases, royalties, or usage rights related to natural resources (extraction of natural resources, harvesting timber, plants, animals, fish and shellfish)
- 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 tribal law or custom.

Alaska Native Claims Settlement Act (ANCSA) Payments

The following items received from a native corporation pursuant to Alaska Native Claims Settlement Act (ANCSA) (P.L. 100-241) are excluded:

- Cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000 per person per year
- Stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock)
- A partnership interest
- Land or an interest in land (including land received from a native corporation as a dividend or distribution on stock)
- An interest in a settlement trust

Cobell Settlement for American Indians

Cobell Settlement payments made to American Indians are excluded income in the month received and as an asset for one year from the date of receipt. Payments are excluded regardless of whether they are issued as lump sums or periodic payments.

This exclusion applies for 12 months beginning with the month of receipt and applies to all members of the household.

The verbal or written statement of a person regarding the date and amount of the excluded settlement payment are accepted.

Tribal Gaming Revenues

Per capita distributions of gaming revenues (casino profits) count as unearned income in the month received and as an asset in the following months.

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United States Code, title 25, section 1407

United States Code, title 25, section 1408

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N. Section 2.3.3.3.2.2 MA-ABD Disregards and Deductions

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

2.3.3.3.2.2 Disregards and Deductions

Disregards and deductions reduce the household income of a person under Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD). These also apply to Medicare Savings Plans (MSP). See the MSP chapter for more information.

This section provides information on disregards and deductions and the conditions that must be met to apply them.

Unearned Income Deductions

The following list are the disregards and deductions that are deducted from the specific unearned income:

- Unearned Lump Sum Income Disregard
- Child Support Disregard

The following disregards and deductions are then deducted in the specific order listed:

- Disabled Widow and Widower Disregard
- Widow and Widower Disregard
- Pickle Disregard
- Disabled Adult Child Disregard
- Retirement, Survivor, Disability Insurance (RSDI) Cost of Living Adjustment (COLA) Disregard
- Plan to Achieve Self-Support (PASS) Deduction

Earned Income Deductions

- This section provides information on the disregards and deductions that are deducted from specific earned income:
- Earned Lump Sum Income Disregard

The following disregards and deductions are then deducted in the specific order listed:

- Plan to Achieve Self-Support (PASS) Deduction
- Student Earned Income Exclusion

- Earned Income Disregard
- Impairment Related Work Expense Deduction
- Remaining Earned Income Disregard
- Blind Work Expense Deduction

Blind Work Expenses

Blind Work Expenses (BWE) that are reasonably attributable to earning income are excluded from earned income.

BWEs can be excluded if the blind person:

- is younger than age 65; or
- is age 65 or older and received Supplemental Security Income (SSI) payments due to blindness for the month before attaining age 65.

The BWEs are excluded from earned income immediately after applying:

- any portion of the MSP standard deduction which has not been deducted from unearned income; and
- all other earned income exclusions except for PASS.

Work-related items paid by a blind person may be excluded as BWE regardless of:

- any non-work benefit that may be derived from the item; or
- the item's relationship to the person's blindness.

BWEs include, but are not limited to:

- Attendant care services in the:
  - Home, if related to preparing to go to work or assistance immediately upon returning home from work
  - Process of assisting a person making the trip to and from work
  - Work setting
- Drugs and medical services which are essential to enable the person to work
- Expendable medical supplies including bandages, catheters, etc.
- Federal, State and local income taxes
- Social Security and Medicare taxes
- Service dog, including cost of dog and associated expenses

- Fees, including licenses, professional association dues, union dues, etc.
- Mandatory contributions, including pensions, disability insurance, etc.
- Meals during work hours
- Medical devices including wheelchairs, braces, etc.
- Non-medical equipment and services including child care, uniforms etc.
- Other work-related equipment and services including job coaching, vision and sensory aids, etc.
- Physical therapy
- Prosthesis
- Structural modifications to the person's home to create a work space or to allow the person to get to and from work
- Training reasonably attributable to work. General education courses are not included.
- Transportation to and from work
- Vehicle modification

The following items cannot be excluded as BWE:

- In-kind payments
- Expenses deducted under other provisions (e.g., PASS)
- Expenses which will be reimbursed
- Life maintenance expenses, including, but not limited to:
    - meals consumed outside of work hours;
    - self-care items (including items of cosmetic rather than work-related nature);
    - general educational development;
    - savings plans (e.g., Individual Retirement Accounts (IRAs) or voluntary pensions); and
    - life and health insurance premiums
- Items furnished by others that are needed in order to work (the value of such items is not income)
- Expenses claimed on a self-employment tax return

Child Support Payments Exclusion

Child support payments are unearned income to the child and one-third of the amount is excluded. Any in-kind child support is not income.

Dependent RSDI Benefit Exclusion

RSDI dependent benefits for children who receive MA under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or receive services through a Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), or Developmental Disabilities (DD) waiver are excluded.

Disabled Adult Child Disregard

The Disabled Adult Child Disregard allows for the disregard of Disabled Adult Child RSDI benefits.

To qualify for the Disabled Adult Child Disregard, a person must meet all of the following conditions:

- Is currently age 18 or older
- Became blind or disabled before reaching the age of 22
- Received SSI benefits on the basis of blindness or disability
- Lost eligibility for SSI on or after July 1, 1987, due to entitlement to RSDI Disabled Adult Child benefits, or increased RSDI Disabled Adult Child benefits based on disability, retirement or death of a parent

For people who meet the qualifications for the disregard, the Disabled Adult Child RSDI benefits are not counted.

People who receive Disabled Adult Child benefits as defined by the Social Security Administration (SSA), but do not meet the criteria above, are not eligible for the Disabled Adult Child Disregard.

Do not use the disregard on any other income, including RSDI benefits the person receives on their own account.

Disabled Widow and Widower Disregard

The Disabled Widow and Widower Disregard allows for the disregard of RSDI benefits.

To qualify for the Disabled Widow and Widower Disregard, a person must meet all of the following conditions:

- Is currently receiving either:
  - RSDI Disabled Widow or Widower benefits
  - Disabled Surviving Divorced Spouse benefits
- Is age 50 but not yet 60 and is certified disabled, or is age 60 but has not yet reached full retirement age

- Received SSI or Minnesota Supplemental Aid (MSA) benefits the month before the month they began receiving RSDI Disabled Widow or Widower or Disabled Surviving Divorced Spouse benefits
- Lost SSI or MSA eligibility on or after January 1, 1991, due to the SSI requirement to apply for and receive RSDI Disabled Widow or Widower or Disabled Surviving Divorced Spouse benefits
- Remaining income would be at or below the current SSI or MSA benefit rate if RSDI income is disregarded
- Is not entitled to Medicare Part A

Eligibility for the disregard ends the first full month a person is eligible for Medicare Part A.

Earned Income Disregard

The Earned Income Disregard allows for the disregard of a person's first $65 of earned income, including income that deems to the person.

Earned Lump Sum Income Disregard

The first $30 of irregular or infrequent earned lump sum, non-gift, income from an employer, trade or business is disregarded.

Impairment-Related Work Expense Deduction

The Impairment-Related Work Expense (IRWE) Deduction allows for the deduction of certain expenses incurred during the course of earning income. It applies to people who are certified disabled and under age 65, or people who received SSI or MSA as a disabled person the month before attaining age 65.

An IRWE is an expense for items or services that directly enable a person with a disability to work, and are incurred because of a physical or mental impairment.

IRWEs are deducted if all of the following are true:

- The severity of the impairment requires the person to purchase or rent items and services in order to work.
- The expense is reasonable.
- The person pays the cost and is not reimbursed from another source, such as Medicare or private insurance.
- One of the following occurs:

    - The person pays the expense in the month he or she receives the earned income, and the income is for work they did in the same month as using the item or service.
    - The person is working but pays the expense before receiving the earned income.

The IRWEs are excluded from earned income after applying one-half of the remaining earned income deduction. See Earned Income Disregard for more information.

IRWEs include, but are not limited to:

- Attendant care services in the:
    - Home, if related to preparing to go to work or assistance immediately upon returning home from work
    - Process of assisting a person making the trip to and from work
    - Work setting
- Drugs and medical services which are essential to enable the person to work
- Expendable medical supplies including bandages, catheters, etc.
- Service dog, including cost of dog and associated expenses
- Medical devices including wheelchairs, braces, etc.
- Non-medical equipment and services directly related to the impairment
- Other work-related equipment and services including job coaching, vision and sensory aids, etc.
- Physical therapy
- Prosthesis
- Structural modifications to the person's home to create a work space or to allow the person to get to and from work
- Training reasonably attributable to work. General education courses are not included.
- Transportation to and from work
- Vehicle modification

Expenses for a transportation method also used by people who are not disabled, such as a bus or unmodified vehicle, is not deductible.

Plan to Achieve Self Support (PASS) Deduction

The Plan to Achieve Self Support (PASS) deduction allows for the deduction of earned and unearned income set aside under an approved PASS plan. The PASS exclusion is not available for people age 65 and older, unless they were receiving SSI payments for the month before they became 65.

The plan is approved by:

- SSA for SSI recipients
- The county social service agency for:
  - MA enrollees who have a disability or are blind
  - MSA only recipients

A PASS is set initially for 18 months with a possible 18-month extension. A 48-month PASS is used only because of special educational or training requirements.

- For this deduction, the PASS must:
  - Be in writing
  - Be individually designed for the person
  - Have a feasible occupational goal
  - Explain what income will be used to meet the PASS objectives
  - Explain how the person will keep income set aside to meet PASS objectives separate from other funds
  - Set beginning and end dates for the plan

Earned and unearned income that is set aside under an approved PASS is deducted for up to 48 months, as long as the PASS continues to be approved.

- The PASS deduction ends the month after the month one of the following occurs:
  - The person does not comply with the plan
  - The person voluntarily stops participating in the plan
  - The person reaches the occupational goal of the plan
  - The plan's time limit expires and no extension is granted

When an expense qualifies as both a work expense deduction and a PASS deduction, the person must choose between them. A deduction cannot be applied twice for the same expense.

Pickle Disregard

The Pickle Disregard allows for the disregard of RSDI cost of living adjustment (COLA) amounts.

To qualify for the Pickle Disregard, a person must:

- Currently receive or is entitled to receive RSDI benefits
- Have been eligible for 1619(b) or was eligible for and received SSI, MSA or 1619(a) benefits while concurrently entitled to or receiving RSDI in any month since April 1, 1977

- Lost eligibility for SSI, MSA, 1619(a) or 1619(b) for any reason

If a person meets the above requirements, they are referred to as a “potential Pickle.” The Pickle threshold date must then be determined. A person’s Pickle threshold date is the more recent of the following two dates:

- April 1, 1977; or
- The last month the person was eligible for and received at least one of the following benefits at the same time the person received RSDI benefits or was entitled to RSDI benefits:
  - 1619a/b,
  - MSA, or
  - SSI

After determining the Pickle threshold date, the amount of the RSDI benefit the person received on the threshold date must be determined. All RSDI COLA increases received back to the Pickle threshold date are excluded.

A person who meets all of the conditions listed must have a net income, with the Pickle Disregard and all applicable earned and unearned income disregards, that is less than the current SSI payment amount. If the person’s net income is greater than the SSI payment amount, they may still receive the Pickle Disregard if their net income is less than the MSA standard.

When a person eligible for the Pickle Disregard also has a spouse or parent that is eligible for the Pickle Disregard, the disregard is applied when deeming income.

RSDI COLA Disregard

The RSDI COLA Disregard allows for the disregard of the annual RSDI COLA increase. The COLA increase amount for RSDI benefits is excluded from January 1 through June 30 of each calendar year. Beginning each July 1, all gross RSDI benefits are counted.

Remaining Earned Income Disregard

One-half of the remaining earned income is excluded.

Student Earned Income Exclusion

The student earned income exclusion allows for the limited disregard of a student’s earned income. There is a cap on how much of a student’s earned income is excluded for MA-ABD eligibility in a calendar year. The amount changes annually. See Appendix F Standards and Guidelines for the current cap amount.

To qualify for the student earned income exclusion a person must:

- Have earned income
- Be younger than age 22
- Be certified as blind or disabled by the SSA or State Medical Review Team (SMRT)
- Regularly attend school by taking one or more courses of study and attend classes:
  - in a college or university for at least eight hours per week under a semester or quarter system
  - in grades 7–12 for at least 12 hours per week
  - in a course of training to prepare for a paying job at least 15 hours per week if the course involves shop practice, or 12 hours per week if it does not involve shop practice
  - for less than the required time for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance
- A person must meet the following additional requirements in these situations:
  - Homeschooled students must:
    - be in grades 7–12, and
    - follow Minnesota home school laws
  - Homebound students must:
    - stay home because of a disability;
    - study a course or courses given by a school in grades 7–12, college, university, or government agency; and
    - have a home visitor or tutor from school who directs the studying or training.
  - Online students must:
    - study a course or courses given by a school in grades 7–12, college, university, or government agency; and
    - enroll in an online school authorized by the laws of the state in which the online school is located.

A person maintains status as a student while classes are out on a standard school break if the student attended classes regularly prior to the break and intends to resume classes regularly when school reopens.

Unearned Lump Sum Income Disregard

The first $60 of irregular or infrequent unearned lump sum income is disregarded.

Widow and Widower Disregard

The Widow and Widower's Disregard allows for the disregard of RSDI COLA increases. To qualify for the disregard, a person must:

- Currently receive RSDI
- Have filed an MA application before July 1,1988
- Has been entitled to receive RSDI continuously since December 1983
- Have been a disabled widow or widower in January 1984
- Established a right to receive RSDI benefits before age 60
- Have been eligible for SSI or MSA benefits before application of the revised actuarial reduction formula
- Lost eligibility for SSI or MSA benefits as a result of the change in the actuarial reduction formula

If a person meets the above requirements, all RSDI COLA increases effective on and after January 1, 1984 are excluded.

Legal Citations

Code of Federal Regulations, title 42, section 435.135

Code of Federal Regulations, title 42, section 435.137

~~United States Code, title 42, section 402~~

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O. Section 2.3.3.4 MA-ABD Medical Spenddowns

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

2.3.3.4 Medical Spenddowns

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

People with an aged, blind or disabled basis of eligibility, who are not eligible for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) because they are over the income limit and who have medical expenses may be eligible for MA-ABD with a spenddown.

See the MA for Families and Children Medical Spenddown policy for more information about medical spenddowns for parents, pregnant women and children.

Topics included in this section are:

MA-ABD Medical Spenddown Types

MA-ABD Health Care Expenses

MA-ABD Spenddown Standard

The spenddown standard for MA-ABD with a spenddown is:

- Before July 1, 2016: 75% FPG
- On or after July 1, 2016: 80% FPG

Legal Citations

~~Code of Federal Regulations, title 42, section 435.330~~

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 5

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P. Section 2.3.3.4.2 MA-ABD Health Care Expenses

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

2.3.3.4.2 Health Care Expenses

To be eligible for Medical Assistance (MA) with a spenddown, people may reduce excess net income by deducting allowable health care expenses that are not subject to payment by a third party.

The person, or one of the following family members, can incur the health care expenses:

- Spouse if the spouse's income is used to determine the person's eligibility
- Legal dependents if they are included in the person's family size or would have been included when the bills were incurred
- Siblings, half-siblings, and step-siblings who are included in the person's family size
- Parents or stepparents who live with the person if their income is actually used to determine the person's eligibility or they are included in the person's family size

The family members do not have to be applying or eligible for MA to use their health care expenses to meet the spenddown of the family member applying for MA with a spenddown.

Allowable Health Care Expenses to Meet a Medical Spenddown

Allowable health care expenses include:

- Paid or unpaid bills incurred in the current spenddown period
- Unpaid bills incurred before the current spenddown period

Payments from a health savings account (HSA) funded by the person are not considered third party payments.

Health care expenses incurred before the spenddown satisfaction date are not eligible for MA payment.

Types of Health Care Expenses

Allowable health care expenses are deducted from the spenddown in the following order:

1. Health insurance expenses incurred during the current six-month period. This includes:
    - Health, dental and long-term care (LTC) insurance premiums
    - Indemnity policy premiums that reimburse health care expenses

- Medicare premiums
- Medical Assistance for Employed Persons with Disabilities (MA-EPD) obligations
- Co-pays
- Deductibles, including MA family deductibles

2. Unpaid health care expenses that the person is still obligated to pay and that were incurred before the six-month period.
   - The health care expense may be:
     - An expense charged directly to the person by a medical provider
     - An expense that a medical provider has transferred for collection to a person or agency actively pursuing the collection
     - A loan payment owed to a person, financial institution, or credit company for which the loan proceeds are paid to a medical provider. Interest and service charges applied to a loan are not a health care expense.
   - The health care expense cannot have been:
     - Used to calculate a spenddown during a prior certification period, whether or not the calculation resulted in the spenddown being met. Except the expense may be used to meet another spenddown if eligibility for the entire certification period was denied.
     - An MA-covered service incurred in a prior certification period of MA
3. Non-reimbursable health care expenses that are not covered by MA, incurred during the current six-month period, including:
   - MA co-payments
   - Non-reimbursed Health Care Access Services
   - Health care expenses for dependents or financially responsible relatives who are not eligible for MA
   - A remedial care expense for people living in a residential living arrangement and there is a Group Residential Housing (GRH) agreement with the county agency
   - Alternative Care (AC) costs
   - Expenses paid by the Insurance Extension Program that pays health insurance premiums for individuals who are HIV positive
4. MA-covered services received during the current six-month period that will be paid by MA, including:
   - Waiver services received through the a home and community based services waiver
   - Personal care attendant (PCA) services
   - Targeted case management services

Reporting Health Care Expenses

People must report and verify all health care expenses used to meet a medical spenddown, except for the remedial care expense.

Legal Citations

Code of Federal Regulations, title 42, section 435.~~931~~831

Minnesota Statutes, section 256B.056, subdivision 5

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Q. Section 2.3.4.2 MA-ABD Renewals

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

2.3.4.2 Renewals

Annual Renewal

All Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) enrollees must complete an annual renewal.

Six-Month Renewal

MA-ABD enrollees with a medical spenddown must complete a six-month income renewal, with the exception of the following people: ~~.~~

- People whose only source of income is from an unvarying unearned income source that is expected to continue indefinitely. This type of income includes:
  - Retirement, Survivors, and Disability Insurance (RSDI) benefits
  - Private pensions
  - Veterans' benefits
  - Public assistance benefits, such as Minnesota Family Investment Program (MFIP), General Assistance (GA) and Minnesota Supplemental Aid (MSA).
- People whose only source of income is from an excluded income source, such as Supplemental Security Income (SSI)

Monthly Renewals

MA-ABD enrollees do not have to complete monthly renewals.

Late Renewals

A late renewal is a renewal for which either of the following is true:

- the renewal form is received before the last day of the fourth month following closure; or
- any additional information or verifications that were required are received before the last day of the fourth month following closure.

Eligibility for enrollees who do not return the renewal form, or who return the form but do not provide all the information and verifications needed to renew eligibility, is closed. However, eligibility for

enrollees who are closed for failing to renew may be redetermined without requiring a new application if the form is returned within four months of the date of closure. The original certification period and renewal date apply.

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Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256.01

Minnesota Statutes, section 256B.056

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R. Section 2.4.2.3.1 MA-LTC Home and Community-Based Waivers for People with Disabilities

Medical Assistance for Long-Term Care Services

2.4.2.3.1 Home and Community-Based Services Waivers for People with Disabilities

Home and Community-Based Services (HCBS) waivers for people with disabilities include the following HCBS waivers:

- Brain Injury (BI)
- Community Alternative Care (CAC)
- Community Access for Disability Inclusion (CADI)
- Developmental Disabilities (DD)

This section discusses rules for determining a person's household composition and family size. It also discusses the income limits and methodology used to determine income eligibility for HCBS waivers for people with disabilities.

Household Composition and Family Size

Household composition means the people included in a person's household. Household composition determines the family size. Household composition and family size are factors used to determine financial eligibility.

Household composition and family size are determined for each person separately and may be different for each person on an application or in a household.

The HCBS waiver programs allow special rules to be applied to people who are not eligible for Medical Assistance (MA) using the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) household composition and family size and deeming rules. These people are treated as a household of one, and only their income counts.

If a person enrolled in MA for Employed Persons with Disabilities (MA-EPD) requests HCBS waivers, the MA-EPD family size rules are used.

Income Limits and Methodology

The MA-ABD income limits and methodology are used to determine eligibility for MA for Long-Term Care Services (MA-LTC) through the HCBS waivers for people with disabilities. However, if the person is enrolled in MA-EPD, the MA-EPD income limits and methodology rules are used.

Legal Citations

Minnesota Statutes, section 256B.056

Minnesota Statutes, section 256B.0913

Minnesota Statutes, section 256B.092

Minnesota Statutes, section 256B.093

Minnesota Statutes, section 256B.49

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S. Section 2.4.2.5 MA-LTC Income Calculations

Medical Assistance for Long-Term Care Services

2.4.2.5 Income Calculations for Long-Term Care Services

Income Calculations

There are two income calculations used to determine what amount, if any, a person must contribute from their income toward the cost of their long-term care (LTC) services. People whose Medical Assistance (MA) eligibility is determined using an MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) basis of eligibility may have to make an income contribution toward the cost of their LTC services. People whose MA eligibility is determined using an MA for Families with Children and Adults (MA-FCA) basis of eligibility are not required to make an income contribution toward the cost of their LTC services.

The type of calculation used to determine the amount of an income contribution is either a community income calculation or an LTC income calculation.

Community Income Calculation

A community income calculation determines the amount, if any, of the income contribution for people that:

- Request home and community-based services (HCBS) through a waiver program for persons with disabilities (Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Developmental Disabilities (DD))
- Request HCBS through the Elderly Waiver (EW) program and have gross income above the Special Income Standard (SIS) but do not have a community spouse
- Are expected to reside in a long-term care facility (LTCF) for less than 30 consecutive days

A community income calculation is determined using the MA-ABD income methodology and may result in a medical spenddown. The person can use the cost of their LTC services to meet the medical spenddown, if applicable.

A community income calculation is also used for the months a person requests MA coverage prior to the month in which LTC services begin.

LTC Income Calculation

A LTC income calculation determines the amount, if any, of the income contribution for people that:

- Are expected to reside in a LTCF for at least 30 consecutive days

- An MA enrollee who is absent from an LTCF on a leave day is still considered to be residing in a LTCF.
- A Group Residential Housing (GRH), assisted living, or a non-Medicaid certified facility, is not an LTCF.

- Request EW and have income at or below the SIS
- Request EW and have income above the SIS and have a community spouse

A LTC income calculation starts with the amount of a person's countable gross income and applies certain deductions. This calculation may result in an LTC spenddown, waiver obligation or medical spenddown. The LTC income calculation determines the LTC spenddown, waiver obligation or medical spenddown, if any, based on anticipated countable gross income and deductions for each month of a six-month period. Retroactive adjustments are made for each month in the six-month period where the actual income or deductions differ from the anticipated income or deductions.

The person is responsible for payment of the amount of the LTC spenddown or waiver obligation, if any, toward the cost of their LTC services.

Countable Gross Income

The amount of a person's countable gross income is used in the LTC income calculation in the month it is received. Countable gross income is not averaged or annualized. The Retirement, Survivors, Disability Insurance (RSDI) cost-of-living adjustment (COLA) disregard is not applied in the LTC income calculation.

Countable gross income does not include the following income:

- Excluded income
- The person's spouse's income
- Sponsor income if the sponsor is the person's community spouse
- LTC insurance payments (LTC insurance payments are considered third-party liability)

Countable gross income must be verified at each request for MA-LTC, at each renewal and when a change is reported. People in an LTCF who have earned income in excess of $80 per month must use the Household Report Form (DHS-2120) to report and verify their income monthly.

Beginning and Ending the LTC Income Calculation

Once a person is found eligible for MA-LTC, the LTC income calculation begins:

- The month the person with a community spouse begins receiving LTC services

- The month following the month the person without a community spouse begins receiving LTC services

The LTC income calculation ends:

- The month the person with a community spouse stops receiving LTC services
- The month before the month the person without a community spouse stops receiving LTC services

The LTC income calculation continues through the month in which a person who lives in an LTCF or receives EW dies.

LTC Spenddown

The LTC spenddown is the amount a person must contribute toward the cost of LTC services when the person resides in an LTCF.

A person's MA eligibility cannot be closed for failure to pay the LTC spenddown to the LTCF. A county, tribal or state agency may disqualify an authorized representative who fails to pay the LTCF and assist the person in finding another authorized representative.

Interaction with Medicare Part A Payments

Medicare Part A covers care provided in an LTCF when a person is admitted to the LTCF immediately following three or more consecutive days of hospitalization. In these situations, the MA enrollee must pay the LTC spenddown or the Medicare coinsurance obligation, whichever is less.

The LTC spenddown may be collected before the Medicare payment is known. As a result, the LTCF may have received a higher LTC spenddown than the MA enrollee should have paid. The LTCF may refund the excess LTC spenddown to the MA enrollee or, with the agreement of the MA enrollee, retain the excess spenddown for payment of a past due obligation. Any amount of an LTC spenddown that is refunded to an MA enrollee is treated as follows:

- The refund is not counted as income or as an asset in the month received.
- Any amount refunded to the MA enrollee is counted as an asset beginning with the month following the month the refund is received.

If the refund results in the enrollee having excess assets, MA-LTC may be closed.

Waiver Obligation

A waiver obligation is the amount a person must contribute toward the cost of EW services when the person has income at or below the SIS.

- EW enrollees with a waiver obligation who are enrolled in a managed care plan cannot use the designated provider option.

SIS-EW enrollees who access EW services that cost less than the waiver obligation may keep the income that is not contributed to the cost of their EW services.

Medical Spenddown

A medical spenddown for a person eligible for MA-LTC is the amount the person must contribute toward the cost of LTC services.

Legal Citations

~~Code of Federal Regulations, title 42, section 435.723~~

Code of Federal Regulations, title 42, section 435.726

Code of Federal Regulations, title 42, section 435.733

Code of Federal Regulations, title 42, section 435.735

Code of Federal Regulations, title 42, section 435.832

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

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T. Section 4.2.3.1 MSP Assets

Medicare Savings Programs

4.2.3.1 Assets

Assets are items of value that people own like bank accounts, stocks and bonds, cars, and real estate. Medicare Savings Programs (MSP) follow many of the same asset eligibility policies as Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD). Specific MSP asset policies and links to the relevant MA-ABD asset policies are included.

Asset Limit

The asset limit for an MSP is determined by household composition and family size. See MSP Household Composition and Family Size policy for more information about determining household composition.

The asset limit for the MSPs are:

- Qualified Medicare Beneficiary (QMB)
  - $10,000 for a household of one
  - $18,000 for a household of two or more
- Service Limited Medicare Beneficiary (SLMB)
  - $10,000 for a household of one
  - $18,000 for a household of two or more
- Qualified Individual (QI)
  - $10,000 for a household of one
  - $18,000 for a household of two or more
- Qualified Working Disabled (QWD)
  - $4,000 for a household of one
  - $6,000 for a household of two or more

Asset Policies

All other factors in asset eligibility follow MA-ABD. See the following policies for more information.

MA-ABD Assets

MA-ABD Asset Deeming

MA-ABD Asset Evaluation

MA-ABD Countable Assets

MA-ABD Excess Assets

MA-ABD Excluded Assets

MA-ABD Unknown Assets

Legal Citations

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

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

Minnesota Statutes, section 256B.057, subdivision 3

Minnesota Statutes, section 256B.057, subdivision 4

~~United States Code, title 42, section 1382b~~

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

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

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U. Section 4.2.3.2 MSP Household Composition and Family Size

Medicare Savings Programs

4.2.3.2 Household Composition and Family Size

Household composition means the people included in a person's household. Household composition determines the family size. Household composition and family size are factors used to determine financial eligibility.

Household composition and family size are determined for each person separately, and may be different for each person on an application or in a household.

Medicare Savings Program Household Composition and Family Size

The Medicare Savings Programs (MSP) generally follow the standard Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Household Composition and Family Size policy.

Elderly Waiver Exception

An MSP applicant or enrollee receiving Elderly Waiver (EW) services is a household of one when determining MSP financial eligibility.

A spouse receiving EW services is not counted in an MSP applicant or enrollee's household composition, when the MSP applicant or enrollee is not on EW.

Legal Citations

~~Code of Federal Regulations, title 42, part 435.602~~

~~Minnesota Statutes, section 256.01~~

Minnesota Statutes, section 256B.057, subdivision 3

Minnesota Statutes, section 256B.057, subdivision 4

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V. 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, 2016, to June 30, 2017	$602
July 1, 2015, to June 30, 2016	$598

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, 2016, to December 31, 2016	$2,980.50
January 1, 2015, to December 31, 2015	$2,980.50

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, 2016 – June 30, 2017	$2,005
July 1, 2015 – June 30, 2016	$1,992

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, 2016~~5~~ – September 30, 2017~~6~~	$~~454~~532
October 1, 2015~~4~~ – September 30, 2016~~5~~	$~~450~~454

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, 2016~~5~~ – September 30, 2017~~6~~	$~~150~~141
October 1, 2015~~4~~ – September 30, 2016~~5~~	$141

Effective Dates	Telephone Allowance
October 1, 2016~~5~~ – September 30, 2017~~6~~	$38
October 1, 2015~~4~~ – September 30, 2016~~5~~	$38

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, 2016, to December 31, 2016	$552,000
January 1, 2015, to December 31, 2015	$552,000

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, 2016, to December 31, 2016	54 cents
January 1, 2015, to December 31, 2015	57.5 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, 2016, to December 31, 2016	$97
January 1, 2015, to December 31, 2015	$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, 2016, to June 30, 2017	$990
July 1, 2015, to June 30, 2016	$981

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, 2016, to June 30, 2017	$988
July 1, 2015, to June 30, 2016	$988

Minimum and Maximum Asset Allowances

The Minimum and Maximum Asset Allowances are used to determine the community spouse asset allowance for an asset assessment.

Effective Dates	Minimum	Maximum
January 1, 2016, to December 31, 2016	$33,851	$119,220
January 1, 2015, to December 31, 2015	$33,851	$119,220

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, 2016, to December 31, 2016	1
January 1, 2015, to December 31, 2015	1.017

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, 2016 – December 31, 2016	$196
January 1, 2016 – June 30, 2016	$252

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, 2015, to December 31, 2015	$2,199
January 1, 2014, to December 31, 2014	$2,163

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, 2016, to June 30, 2017	$6,280
July 1, 2015, to June 30, 2016	$6,141

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, 2016, to December 31, 2016	$1,780	$7,180
January 1, 2015, to December 31, 2015	$1,780	$7,180

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, 2016, to December 31, 2016	$733
January 1, 2015, to December 31, 2015	$733

Effective Date	Couple
January 1, 2016, to December 31, 2016	$1,100
January 1, 2015, to December 31, 2015	$1,100

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