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 #16.4

December 22, 2016

Manual Letter #16.4

This manual letter lists new and revised policy added to the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of December 22, 2016. The effective date of new or revised policy is **not** 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

Hyperlinks to the following bulletins are removed from the EPM home page because they have been incorporated into the EPM with this manual letter:

- Bulletin #16-21-04, DHS Explains Changes in the Implementation of Spousal Impoverishment Protections
- 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

Additionally, a hyperlink to this manual letter is added to the home page.

B. Section 1.4.4 Minnesota Health Care Programs (MHCP) Temporary Absence

Temporary absence was incorrectly defined as having to do with a stay in a permanent living arrangement. This information is removed.

Information relating to a temporary absence from the state is revised to include the following information:

- There is no time limit for how long a person may be temporarily absent from the state
- A person is no longer temporarily absent if the person receives Medicaid benefits from another state

C. Section 2.1.2.2.2 Medical Assistance (MA) Immigration Status

The following changes are made to this section:

- Clarification is added that a noncitizen's date of entry is not necessarily the same date they acquire a qualified immigration status. The date a person acquires a qualified immigration

status is the date used to determine the start of their five-year waiting period, if they are subject to one for MA eligibility.

- Qualified noncitizens who are U.S. veterans or on active military duty and their spouses and children are added to the list of lawfully present noncitizens who are eligible for MA without a five-year waiting period.
- In the "Qualified Immigration Statuses With a Five-Year Waiting Period" section, information is added to clarify that lawfully present noncitizens with the immigrations statuses listed are eligible for MA after a five-year waiting period if they entered the United States **after** August 22, 1996. Lawfully present noncitizens who entered the country before that date are not subject to a five-year waiting period.

D. Section 2.2.3.4 MA for Families with Children and Adults (MA-FCA) Income Methodology

The following revisions are made to this section:

- Clarification is added that income eligibility for MA-FCA is based on current income and adjustments using the Modified Adjusted Gross Income (MAGI) methodology.
- A statement indicating that nontaxable lump sum income is not counted is removed. This change is necessary because lump sum income from some nontaxable income sources, such as Social Security benefits, are counted under the MAGI methodology.

  Refer to the first bullet in the opening section to determine which types of nontaxable income are counted under the MAGI methodology.
- In the "Federal Taxable Income" and "Federal Income Tax Adjustments" sections, references to specific lines on the federal tax return were removed in favor of references to the "Income" and "Adjusted Gross Income" sections of the federal tax return. The change is made because the federal tax return form is revised yearly and may change which lines on the form refer to income and tax adjustments.
- A legal citation for Code of Federal Regulations, title 42, section 155.305, is corrected to Code of Federal Regulations, title 45, section 155.305.

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

The change to this section removes a statement that incorrectly stated that the State Medical Review Team (SMRT) does not look at a person's ability to work, and that it only reviews a person's medical condition. The statement was incorrect because SMRT does consider a person's work history when completing a disability certification.

F. Section 2.3.5 MA for Employed Persons with Disabilities

A statement is added to indicate that a person must have been certified disabled prior to age 65 to be eligible for MA-EPD.

G. Section 2.4.2.1.1 MA for Long-Term Care (MA-LTC) Services Asset Assessment

The changes to this section incorporate Bulletin #16-21-04C, Corrected #16-21-04: DHS Explains Changes in the Implementation of Spousal Impoverishment Protections, and Bulletin #16-21-08, DHS Explains Spousal Impoverishment Rules for BI, CAC, CADI, and DD Enrollees. The two bulletins addressed the requirement for DHS to implement spousal impoverishment protection rules for all Home and Community Based Services (HCBS). The change in policy became effective June 1, 2016.

This section is revised to provide information for couples who request an asset assessment, but are not applying for MA-LTC. They may do so when one spouse has or anticipates needing LTC services for 30 or more consecutive days.

To account for the revisions to the section, the title is revised to Asset Assessment for Planning Purposes.

H. Section 2.4.2.1.2 MA-LTC Community Spouse Asset Allowance

The changes to this section also incorporate Bulletin #16-21-04C and Bulletin #16-21-08.

As noted in the bulletins, the Community Spouse Asset Allowance (CSAA) is no longer determined using the minimum and maximum asset allowances. The CSAA is the maximum asset allowance allowed under federal law. The changes to this section explain how a couple's countable assets are evaluated under the new spousal impoverishment protection rules.

I. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

In the "Medical expenses not covered by a third party" subsection of the "Medical Expenses" section, policy incorrectly noted that medical expenses are not allowed when a medical expense was **not** previously used as a deduction in an LTC income calculation or to meet a medical spenddown.

This error is corrected to reflect that medical expenses are not allowed when a medical expense **was** previously used as a deduction in an LTC income calculation or to meet a medical spenddown.

J. Section 2.5.3 Emergency Medical Assistance (EMA)

Sections in the EPM related to EMA are revised to align EMA with MA eligibility rules, where applicable, and provide clearer health care eligibility information for EMA. Information deemed unnecessary is removed.

Section 2.5.3 is revised to provide information about the following:

- Who may qualify for EMA
- The requirement for a person to have a MA basis of eligibility and to meet the eligibility requirements of that basis, with the exception of immigration status
- A person may request retroactive eligibility for EMA up to three months before the month of application

K. Section 2.5.3.1.1 EMA Mandatory Verifications

The primary changes to this section are:

- Information indicating an approved care plan certification (CPC) must be verified for people renewing EMA is removed. Approved CPCs are no longer required to renew EMA eligibility.
- Medical emergency is added to the list of items people applying for EMA are not required to verify. Attestation of a medical emergency is sufficient.
- The legal citations section is updated to remove a reference to Code of Federal Regulations (CFR), title 42, section 136b, and to add references to CFR title 42, sections 435.169 and 435.350.

L. Section 2.5.3.2 EMA Non-Financial Eligibility

The primary changes to this section are:

- Policy is revised to state that EMA applicants must attest to having a medical emergency at application. Verification of the medical emergency is not required.
- Policy is revised to state that EMA enrollees must continue to meet all non-financial eligibility requirements for their basis of eligibility to remain eligible at renewal. EMA enrollees do not need to have a medical emergency to qualify for EMA at renewal.
- Clarification is added regarding EMA eligibility for certain pregnant women who do not have a lawfully present immigration status and who are ineligible for CHIP-funded MA because they have other health coverage or have excess income.
- The hyperlink to Section 2.5.3.2.1 EMA Emergency Medical Conditions is removed because the section was removed from the EPM.
- Hyperlinks to Section 2.2.2 MA-FCA Non-Financial Eligibility, Section 2.2.4.2 MA-FCA Renewals, Section 2.3.2 MA-ABD Non-Financial Eligibility, and Section 2.3.4.2 MA-ABD Renewals are added.
- Verification of immigration status is added to the list of MA non-financial eligibility policies that do not apply to EMA.

M. Section 2.5.3.2.1 EMA Emergency Medical Conditions

This section is archived because it is not to be pertinent to EMA eligibility. Attestation of medical emergency is allowed so a definition of medical emergency is no longer applicable.

N. Section 2.5.3.3 EMA Financial Eligibility

The primary change to this section adds information indicating that people who do not qualify for EMA because they are over the income limit for their basis of eligibility and who have medical expenses may be eligible for EMA with a spenddown.

O. Section 2.5.3.4 EMA Post-Eligibility

The primary changes to this section are:

- Information indicating that the earliest date of eligibility for EMA is the date the medical emergency begins is removed. As indicated in Section 2.5.3, a person may request retroactive eligibility for EMA up to three months before the month of application.
- A statement is added to indicate EMA is available for the duration of the medical emergency or until renewal is removed. EMA enrollees may renew eligibility following MA rules for their basis of eligibility.
- Information indicating EMA can only be renewed for people with an approved CPC is removed. As indicated in Section 2.5.3.2, EMA enrollees do not need to have a medical emergency to qualify for EMA at renewal.
- Information is added to clarify a person must meet the post-eligibility requirements for their basis of eligibility, including at renewal.

P. Section 2.5.3.4.1 EMA Health Care Delivery

The "Covered Services" section is revised to indicate the services covered under EMA, including additional services that may be covered as part of an approved CPC.

Q. Section 3.1.2.2 MinnesotaCare Premiums and Cost Sharing

The changes to this section incorporate Bulletin #16-21-09, DHS Provides Policy for Changes to MinnesotaCare Premium Billing. The bulletin covered changes in MinnesotaCare premium billing and payment tracking, which transitioned to the Medicaid Management Information System (MMIS) back in March 2016.

The primary changes to this section are:

- Clarification is added that the premium exemption period for military members who have completed a tour of active duty within 24 months of MinnesotaCare eligibility does not have to be 12 consecutive months. The 12-month period may be nonconsecutive.
- Policy is added to clarify when a premium increase or decrease becomes effective as a result of adding a person to an existing MinnesotaCare household that is required to pay a premium, or when an existing household member is newly determined eligible for MinnesotaCare.
- Policy is also added to clarify when a premium exemption becomes effective when a returning military member, American Indian or Alaska Native is added to the household and is determined eligible for MinnesotaCare, or when a person is added to the household and causes the household to have income below 35% of the federal poverty guidelines (FPG).
- A statement is added to indicate that there is no good cause exemption for nonpayment of a MinnesotaCare premium.

- Policy is added to clarify that enrollees can pay for coverage months that have not yet been billed. Premiums can only be refunded if the premium was paid for a future month of coverage and the agency has not yet paid a health plan.
- Policy is added to clarify that a person may have back-to-back grace months if they pay the grace month's premium by the last working day of the grace month, but do not pay the premium for a future month of coverage. The future month of coverage may be a grace month.
- Policy is added to clarify that a person approved for retroactive MA for a month in which the person had MinnesotaCare eligibility and was in a grace month must still pay the grace month premium, if it has not yet been forgiven, to reenroll in coverage.
- Policy is added to indicate that a MinnesotaCare enrollee who is currently in a grace month, or disenrolled for failure to pay premiums, follows the normal MinnesotaCare renewal process. People renewed at a higher premium must pay the grace month's premium, if it has not yet been forgiven, and the new higher premium for the future month of coverage to reinstate coverage.
- Policy is added to indicate that the grace month premium is forgiven before MinnesotaCare issues the premium bill for the fourth month of coverage after disenrollment. After the premium is forgiven, a person is only required to pay the premium for the future month of coverage to reenroll in coverage.

  The grace month premium is also forgiven for a household once a person is added to an existing household and determined eligible for MinnesotaCare, and as a result, the household is no longer required to pay a premium for coverage.

R. Section 3.2.3 MinnesotaCare Insurance Barriers

The change to this section incorporates Bulletin #16-21-10, DHS Announces 2017 Affordability Standard and Income Threshold for Tax Filing. The bulletin announced that the employer-sponsored coverage affordability standard increases to 9.69% beginning January 1, 2017. The employer-sponsored coverage affordability standard is updated in Section 3.2.3.

S. Section 3.3.3 MinnesotaCare Income Methodology

The changes to this section incorporate Bulletin #16-21-07C, Corrected #16-21-07, DHS Provides Projected Annual Income (PAI) Policy. The bulletin provided policy about PAI and how it is used to determine MinnesotaCare eligibility.

The changes add a definition of PAI and how it is calculated using MAGI. Information is also added to clarify the following:

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

Additionally, in the “Federal Taxable Income” and “Federal Income Tax Adjustments” sections, references to specific lines on the federal tax return were removed in favor of references to the “Income” and “Adjusted Gross Income” sections of the federal tax return. This change is made because the federal tax return form is revised yearly and may change which lines on the form refer to income and tax adjustments.

T. Section 3.4.1 MinnesotaCare Begin and End Dates

The changes to this section incorporate Bulletin #16-21-09, DHS Provides Policy for Changes to MinnesotaCare Premium Billing.

Clarification is added that a person determined eligible for MinnesotaCare remains eligible for the program for the remainder of the certification period, unless a change in circumstances makes the person ineligible during the certification period. A person remains eligible for MinnesotaCare even if he or she fails to pay a premium.

Additional information is added to the Coverage Begin Date section to clarify information about MinnesotaCare coverage begin dates.

U. Section 4.1.1.2 Minnesota Family Planning Program (MFPP) Mandatory Verifications

The change to this section removes a statement that incorrectly stated that a person presumptively approved for MFPP must provide verification before ongoing coverage can be approved.

V. Section 4.1.3.1 MFPP Household Composition

The changes to this section incorporate Bulletin #16-21-11, DHS Announces Changes to Income Rules for Minnesota Family Planning Program. The bulletin provided information about changes to MFPP income and household composition policy, which shifts from the Aid to Families with Dependent Children (AFDC) rules to MAGI-based rules. The changes became effective December 1, 2016.

Household composition for MFPP is no longer based on an applicant’s age. The policy in this section is now divided between household composition for presumptive eligibility and household composition for ongoing eligibility.

Household composition for presumptive eligibility includes spouses and biological, natural, and adopted children and stepchildren under the age of 19 who live with a person. For children under age 19, the household composition includes biological, natural, and adoptive parents and stepparents and biological, natural, and adoptive siblings and stepsiblings who live with the child.

Household composition for ongoing eligibility follows household composition for MA-FCA.

W. Section 4.1.3.3 MFPP Income Methodology

The changes to this section also incorporate Bulletin #16-21-11.

Similar to Section 4.1.3.1, this section is divided into sections for presumptive eligibility and ongoing eligibility. Household income for presumptive eligibility is based on a person's reported family size and income. For people over age of 21, the household income includes the person's own income and the countable income of everyone included in the person's household. For people under age 21, only their income is included.

Household income for ongoing eligibility follows the MA-FCA income methodology. For people over age 21, the household income includes the person's own income and the income of everyone in their household composition, unless specifically excluded. For people under age 21, only their income is included.

Additionally, a provision is added to apply a five percent disregard for people who have income over 200% FPG. The disregard allows these people to qualify for MFPP if their income is within 5% of 200% FPG.

X. Appendix F

One of the changes to this appendix incorporates Bulletin #16-21-04C, Corrected #16-21-04: DHS Explains Changes in the Implementation of Spousal Impoverishment Protections, and Bulletin #16-21-08, DHS Explains Spousal Impoverishment Rules for BI, CAC, CADI, and DD Enrollees.

The minimum asset allowance is no longer a factor in determining the CSAA. The CSAA refers only to the maximum amount allowed under federal law. To account for this change, the Minimum and Maximum Asset Allowances section has been changed to the Maximum Asset Allowance section. Additionally, as of June 1, 2016, the minimum asset allowance is updated to reflect no minimum standard.

The remaining changes to Appendix F incorporate annual updates to the following standards:

- Maximum Monthly Income Allowance
- Home Equity Limit
- IRS Mileage Rate
- Clothing and Personal Needs allowance
- Maximum Asset Allowance
- Pickle Disregard
- Remedial Care Expense
- Special Income Standard
- Student Earned Income Exclusion
- Supplemental Security Income (SSI) Maximum Payment Amounts

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.

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X. Appendix F Standards and Guidelines

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

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

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

Manual Letters

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

MHCP EPM Manual Letter #16.1

MHCP EPM Manual Letter #16.2

MHCP EPM Manual Letter #16.3

MHCP EPM Manual Letter #16.4

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
- ~~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 1.4.4 MHCP Temporary Absence

Minnesota Health Care Programs

1.4.4 Temporary Absence

Temporary absence refers to circumstances where one or more household members are absent from a household they share with others, but the absent members remain part of the household. ~~A temporary absence occurs when a person, after living in a permanent living arrangement for at least one full calendar month, leaves the living arrangement but intends to, and does, return to the permanent living arrangement either in that same calendar month in which the person leaves, or in the next month.~~

~~An applicant or enrollee's eligibility for Minnesota Health Care Programs (MHCP) may not be denied or terminated because of the person's temporary absence from the state. People are temporarily absent from Minnesota if they left the state for a temporary purpose and intend to return when the reason for their temporary absence ends. To be considered temporarily absent a person must have a definitive place to return to in Minnesota.~~

Reasons for the temporary absence include but are not limited to:

- School attendance or training
- Employment
- Illness or hospitalization
- Vacation
- Job search
- Military service
- Working in another state
- Natural disaster or catastrophe
- Personal or family emergency
- Visits with a non-custodial parent or other relatives

When temporarily absent for school attendance or training, the student must:

- maintain a home in Minnesota (or, for children, have a home maintained by a parent or relative caretaker); and
- return home during vacations and school breaks.

The following are some of the circumstances that are not considered a temporary absence:

- An absence of less than one calendar month

- An absence that is expected to be more than one calendar month and the person does not intend to return to the home, or does not meet a condition for temporary absence
- An absence due to incarceration for more than one calendar month
- ~~A person enters a long-term care facility (LTCF) and is expected to be absent for more than 30 consecutive days~~
- ~~Another state has determined the person is a resident of that state for any reason.~~

Temporary Absences from the State

A temporary absence includes when a person is absent from the state with the intent to return to the state when the reason for the absence ends. There is no time limit for how long a person may be temporarily absent from the state. A person is no longer considered temporarily absent from the state if they receive Medicaid benefits in another state. An applicant or enrollee's eligibility for Minnesota Health Care Programs (MHCP) may not be denied or terminated because of the person's temporary absence from the state.

Legal Citations

Code of Federal Regulations, title 20, section 416.1149

Code of Federal Regulations, title 42, section 435.403

Minnesota Statutes, section 256B.056, subdivision 1

Minnesota Statutes, section 256L.09, subdivision 4

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C. Section 2.1.2.2.2 Immigration Status

Medical Assistance

2.1.2.2.2 Immigration Status

To receive Medical Assistance (MA), applicants must be U.S. citizens, U.S. nationals or certain lawfully present noncitizens. See the MA Citizenship policy for more information.

MA Eligibility for Noncitizen Children under Age 21 and Pregnant Women

The following people are eligible for MA, regardless of their specific immigration status:

- All lawfully present noncitizen children younger than age 21
- All lawfully present noncitizen pregnant women

People granted Deferred Action for Childhood Arrivals (DACA) are not lawfully present noncitizens for the purpose of determining health care eligibility. They are not eligible for MA.

See the Appendix H Lawfully Present Noncitizens appendix for more information about lawfully present noncitizens.

MA Eligibility for Noncitizens Age 21 or Older and Not Pregnant

To be eligible for MA, lawfully present noncitizens who are age 21 or older and not pregnant must have a qualified immigration status. People with certain qualified immigration statuses must wait five years after receiving the qualified immigration status before they are eligible for MA.

The date a person enters the United States (also called date of entry) is not always the same as the date they acquire a qualified immigration status. The date of entry is used to determine eligibility for Refugee Medical Assistance for refugees who are ineligible for MA. The date a person obtains a qualified immigration status is used to determine the start of the five-year waiting period, when applicable.

Qualified Immigration Statuses Without a Five-Year Waiting Period

Lawfully present noncitizens with the following qualified immigration statuses are eligible for MA **without** a five-year waiting period:

- Afghan or Iraqi Special Immigrants
- Amerasians
- American Indian noncitizens

- Asylees, including asylees who later adjust to lawful permanent resident status
- Conditional Entrants
- Cuban/Haitian Entrants
- Qualified noncitizens who are U.S. veterans or on active military duty and their spouses and children
- Refugees, including refugees who later adjust to lawful permanent resident status
- T-Visa
- Trafficking victims
- Withholding of Removal

Qualified Immigration Statuses With a Five-Year Waiting Period

Lawfully present noncitizens with the following qualified immigration statuses who entered the United States after August 22, 1996, are eligible for MA **after** a five-year waiting period:

- Battered noncitizens
- Immigrants paroled for one year or more
- Lawful permanent residents (LPRs), except LPRs who adjusted from asylee or refugee status. LPRs who were formerly asylees or refugees are eligible for MA without a five-year wait.

MA for Noncitizens Not Otherwise Eligible for Medical Assistance

Four programs are available to certain noncitizens who are not eligible for MA because of their immigration status.

- Children's Health Insurance Program (CHIP) funded MA may be available for pregnant women who are undocumented or noncitizens not otherwise eligible for MA. Eligibility may continue through the 60–day postpartum period. CHIP-funded MA is not available to people enrolled in other health care coverage.
- People who are receiving services from the Center for Victims of Torture (CVT) may be eligible for state funded MA-CVT
- People with a medical emergency may be eligible for Emergency Medical Assistance (EMA)
- People who meet specific criteria may be eligible for federally funded Refugee Medical Assistance (RMA)

Verification

Immigration status may be verified electronically at the time of application. Applicants and enrollees whose immigration status cannot be verified electronically must provide proofs. See Immigration documentation types at HealthCare.gov for information about immigration documentation.

Eligibility is approved for applicants who meet all other eligibility criteria and attest to meeting the citizen or noncitizen eligibility requirements. A person approved for MA without verification of their immigration status has a reasonable opportunity to provide proof. A notice is sent to the enrollee to indicate they have 90 days, plus five days for mailing, from the date of the notice to provide proof. Coverage ends with a 10-day advance notice if the person fails to cooperate with the verification process.

The county, tribal or state servicing agency must help applicants and enrollees obtain required proofs.

Legal Citations

Centers for Medicare and Medicaid Services State Health Officials letter re: Individuals with Deferred Action for Childhood Arrivals (August 28, 2012), at www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf

Centers for Medicare & Medicaid Services (CMS) State Health Officials letter re: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women (July 1, 2010), at www.cms.gov/smdl/downloads/SHO10006.pdf

Children's Health Insurance Program Reauthorization Action of 2009 (CHIPRA), Public Law 111-3, Section 214

Code of Federal Regulations, title 42, section 435.406

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Minnesota Statutes, section 256B.06, subdivision 4

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193

United States Code, title 8, section 1641

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D. Section 2.2.3.4 MA-FCA Income Methodology

Medical Assistance for Families with Children and Adults

2.2.3.4 Income Methodology

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

- Household income includes:
  - The types of income included in Federal taxable income, minus Federal income tax adjustments
  - Nontaxable foreign earned income and housing cost of citizens or residents of the United States living abroad
  - Nontaxable interest income
  - Nontaxable Social Security and tier one railroad retirement benefits
- Household income does not include:
  - Scholarships, awards or fellowship grants used for education purposes and not for living expenses
  - Certain American Indian/Alaska Native income
- ~~Taxable l~~Lump sum income is counted in the month received. ~~The non-taxable portion of the lump sum income is not counted.~~

Federal Taxable Income

Federal taxable income are the different types of income that appear ~~on lines 7 through 21 on~~ in the Income section of the Internal Revenue Service (IRS) form 1040, ~~lines 7 through 15 on the~~ IRS form 1040-A and ~~line 6 on~~ or IRS form 1040-EZ. Only the taxable portions of these types of income are included in the adjusted gross income. See the appropriate IRS form instructions for examples of federal taxable income. The general types of taxable income include the following:

- Wages, salary and tips
  - Payroll or pre-tax deductions for childcare, health insurance, retirement plans, transportation assistance and other employee benefits are not taxable and are not included in a person's adjusted gross income.
- Interest
- Dividends
- Taxable refunds, credits or offsets of state and local income taxes
- Alimony received

- Business income
- Capital gains
- Other gains
- Individual retirement account (IRA) distributions
- Pension and annuity payments
- Income from rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Farm income
- Unemployment compensation
- Social Security benefits
- Other income

Federal Income Tax Adjustments

The types of adjustments that appear ~~on lines 23 through 35 on~~ in the Adjusted Gross Income section of the 1040 or ~~lines 16 through 19 on the~~ 1040-A are subtracted from gross income to calculate the adjusted gross income. Only specific types of adjustments are allowed. See the appropriate IRS form instructions for specific information about the types of adjustments.

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

Scholarships, Awards or Fellowship Grants

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

American Indian and Alaska Native Income

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

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

Lump Sum Income

Under MA-FCA, lump sum income is one-time income that is not predictable. Periodic reoccurring income is not lump sum income. Examples of lump sum income include, but are not limited to:

- Winnings (lottery, gambling)
- Insurance settlements
- Worker's Compensation settlements
- Inheritances

- Retroactive Retirements, Survivors and Disability Insurance (RSDI), Veterans Administration (VA) and unemployment insurance benefits

Legal Citations

~~Code of Federal Regulations, title 42, section 155.305~~

Code of Federal Regulations, title 42, section 435.603

Code of Federal Regulations, title 45, section 155.305

Minnesota Statutes, section 256B.057

Minnesota Statutes, section 256L.01

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E. 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 disability 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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F. Section 2.3.5 MA-EPD

2.3.5 Medical Assistance for Employed Persons with Disabilities

Medical Assistance for Employed Persons with Disabilities (MA-EPD) is a work incentive health care program that provides MA coverage to employed people with certified disabilities. A person must earn more than $65 a calendar month to be eligible for MA-EPD. A person must use the blind or disabled basis of eligibility under MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD). An MA-EPD consumer brochure (DHS-2087L) is available.

To be eligible for MA-EPD, applicants age 65 or older must have been certified disabled prior to age 65.

The following people are not eligible for MA-EPD:

- SSI recipients
- People with 1619a or 1619b status

People who are eligible for MA-EPD may also be eligible for other Minnesota Health Care Programs (MHCP). MHCPs include MA under different bases of eligibility, MinnesotaCare and Advance Premium Tax Credits. Each person's unique situation determines which MHCP is most affordable and provides the services the person needs. MA-EPD has unique financial eligibility policies that may be beneficial for people nearing age 63.

Home and Community-Based Services Waivers are available to people enrolled in MA-EPD. People must meet the general long-term care eligibility requirements. MA-EPD eligibility and premium policies apply to the person.

MA-EPD eligibility is determined using a variety of non-financial, financial and post-eligibility requirements. This subchapter includes policies that apply to MA-EPD and links to the policies that apply to all MA programs, MA-ABD, and all Minnesota Health Care Programs (MHCP) programs.

General Requirements

MA-ABD General Requirements

MA-EPD Mandatory Verifications

MA-EPD Premiums and Cost Sharing

MA-EPD Work Requirements

Non-Financial Eligibility

MA-ABD Non-Financial Eligibility

MA-EPD Living Arrangement

Financial Eligibility

MA-EPD Assets

Post-Eligibility

MA-EPD Medicare

MA-ABD Post-Eligibility

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G. Section 2.4.2.1.1 MA-LTC Asset Assessment

Medical Assistance for Long-Term Care Services

2.4.2.1.1 Asset Assessment for Planning Purposes

An asset assessment is an evaluation of assets owned individually or jointly by a married couple as of a specific date. The couple must document and provide proof of these assets.

A couple may request an asset assessment even if they are not applying for Medical Assistance for Long-Term Care Services (MA-LTC) when one spouse has or anticipates needing LTC services for 30 or more continuous days. County and tribal agencies are required to complete the assessment telling the couple which assets would count and which assets would not count if the couple had applied for MA-LTC. This will help the couple estimate how much of their assets must be spent before the LTC spouse may be eligible for MA-LTC. The Asset Assessment for Medical Assistance (MA) Payment of Long-Term Care (LTC) Services (DHS-3340) form is used to document the couple's assets when the couple is not applying for MA-LTC.

The LTC spouse, the LTC spouse's authorized representative, if applicable, and the community spouse must be notified of the results of the asset assessment.

~~An asset assessment is an evaluation of assets owned by a married couple when the long-term care (LTC) spouse requests Medical Assistance for Long-Term Care Services (MA-LTC) in a long-term care facility (LTCF) or through the Elderly Waiver (EW) program and is married to a community spouse. The asset assessment is also used in the Alternative Care (AC) eligibility determination.~~

~~The asset assessment documents all assets owned individually or jointly by the couple on the first day of the LTC spouse's first continuous period of institutionalization. The couple must document and provide proof of these assets. The asset assessment is used to calculate which assets the community spouse can keep. The amount of assets the community spouse is allowed to keep is called the Community Spouse Asset Allowance (CSAA). All of the couple's assets that do not make up the CSAA must be evaluated when determining if the LTC spouse meets the asset limit. The LTC spouse is either determined to be asset eligible for MA-LTC, or the amount of assets the LTC spouse must reduce in order to achieve asset eligibility for MA-LTC is determined.~~

~~A couple may request that the county or tribal agency complete an asset assessment even if they are not applying for MA-LTC when one spouse has or anticipates a continuous period of institutionalization. County and tribal agencies are required to complete the assessment. This will help the couple estimate how many of their assets must be spent before the LTC spouse may be eligible for MA-LTC.~~

~~When the Asset Assessment is Required~~

~~An asset assessment is required when a person, who is an LTC spouse, requests MA-LTC and all of the following conditions exist:~~

- the person is married. Separated spouses are still married; marriage only ends with divorce or the death of one spouse;
- the person resides in an LTCF and has lived, or a physician anticipates a person will live, in an LTCF for at least 30 consecutive days; or
- the person is requesting services through the EW or AC programs and has received a long-term care consultation (LTCC) that demonstrated the person requires an institutional level of care and the person has received, or a lead agency case manager anticipates the person will receive, EW or AC services for at least 30 consecutive days.

An asset assessment is not used to determine asset eligibility if an enrollee receiving MA-LTC marries a person who meets the definition of a community spouse after eligibility for MA-LTC is approved.

An asset assessment is not required as long as the person continues to receive MA-LTC. An asset assessment is required if a person has a break in LTC services and the county or tribal agency receives a new request for MA-LTC.

A couple is not required to complete a new asset assessment if the couple completed an asset assessment at another agency or in another state and the LTC spouse had a continuous 30-day period of institutionalization.

Whereabouts of the Community Spouse are Unknown

When an asset assessment is required and the LTC spouse does not know the whereabouts of the community spouse, they must make a reasonable effort to locate the community spouse.

If reasonable efforts to locate the community spouse do not succeed, eligibility for MA-LTC for the LTC spouse is possible. If the spouse cannot be located, the LTC spouse must complete the asset assessment based on the information they know about the community spouse's assets.

Asset Assessment Effective Date

The asset assessment requires an evaluation of all assets owned individually or jointly by a married couple on the LTC spouse's asset assessment effective date. The asset assessment effective date is the first day of the LTC spouse's first continuous period of institutionalization that has occurred on or after October 1, 1989.

Continuous Period of Institutionalization

A continuous period of institutionalization is a 30-day consecutive period in which:

- A person lives in an LTCF.
- A person has a documented need through an LTCC for services that would be provided by EW or AC.

- The person had a combination of services either provided in an LTCF or paid for by EW or AC.
- A person receives skilled nursing care in a swing bed in a medical hospital.

If the person is discharged from a hospital, the first day of the continuous period begins on the date the person was admitted to the hospital when the person:

- Is discharged directly from a medical hospital to an LTCF
- Received services that were paid for or would qualify for payment by the EW or AC programs immediately upon release from the medical hospital

Anticipated Continuous Period of Institutionalization

If the LTC spouse has not had a continuous period of institutionalization, one can be anticipated if the LTC spouse is likely to remain institutionalized. When the continuous period is anticipated, the determination for MA eligibility is not delayed. If the actual continuous period of institutionalization is less than 30 days, eligibility is not redetermined for months already approved. If the person does not complete the 30 days, the effective date is not valid for future determinations.

Verification of Asset Assessment Effective Date

The asset assessment effective date must be verified. A person should be assisted in obtaining supporting documentation if the asset assessment effective date cannot be verified with sources already available.

Assets Evaluated in an Asset Assessment

Countable assets, regardless of availability, are used to calculate the CSAA. The couple's assets are evaluated in the asset assessment to identify countable and excluded assets. See MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Excluded Assets and MA-ABD Countable Assets for more information.

- If the couple owns more than one vehicle, the vehicle with the lowest equity value is excluded (regardless of which spouse owns the vehicle).

The "Asset Assessment for Medical Assistance (MA) Payment of Long-Term Care (LTC) Services" (DHS-3340) form is used to document the couple's assets. The couple must provide proof of the value of their assets on the asset assessment effective date, regardless of whether the asset is excluded or unavailable.

Notification Requirements

~~The LTC spouse, the LTC spouse's authorized representative if applicable, and the community spouse must be notified of the results of the asset assessment. Any of these individuals may appeal the asset assessment results.~~

Legal Citations

Minnesota Statutes, section 256.059

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H. Section 2.4.2.1.2 MA-LTC Community Spouse Asset Allowance

Medical Assistance for Long-Term Care Services

2.4.2.1.2 Community Spouse Asset Allowance

At the time of a request for Medical Assistance for Long-Term Care Services (MA-LTC), the LTC spouse who has a community spouse must report and verify their assets. An asset evaluation is used to calculate which assets are protected for the community spouse. The assets that the community spouse is allowed to keep is called the Community Spouse Asset Allowance (CSAA).

~~An asset assessment is used to calculate which assets the community spouse can keep. This is called the Community Spouse Asset Allowance (CSAA). All assets of the couple that do not make up the CSAA are evaluated in the asset eligibility determination of the long-term care (LTC) spouse.~~

~~Once the CSAA is determined, the couple may determine which of the couple's assets will be included in the CSAA.~~ There are many factors that a couple must consider when deciding which of the couple's assets are included in the CSAA, including tax implications as well as personal factors such as the desire to retain ownership of a particular asset. The decision on how to divide the couple's assets is up to the couple. The couple can contact a tax accountant, an attorney or someone who specializes in estate planning for questions unrelated to Medical Assistance (MA) policy.

Determining the Community Spouse Asset Allowance

The CSAA ~~is based on~~ includes the couple's total countable assets~~, regardless of availability,~~ as determined by the asset evaluation ~~assessment~~. The couple must provide proof of the value of all of their assets, regardless of whether the asset is excluded or unavailable. ~~One-half of the total value of the couple's countable assets is then compared to the minimum/maximum CSAA. The CSAA is one-half of the total value of the couple's countable assets, except:~~

- ~~If the total countable assets is less than the minimum, the CSAA is the minimum.~~
- ~~If the total countable assets is greater than the maximum, the CSAA is the maximum.~~

~~The minimum/maximum amounts used are the amounts in in effect at the time of the request for MA for Long-Term Care Services (MA-LTC). The amounts are updated annually.~~

The total value of the couple's countable assets are compared to the maximum CSAA. The community spouse may keep up to the maximum asset allowance in effect on the date of the request. The maximum CSAA is updated annually.

The remaining assets that do not make up the CSAA are evaluated in an asset eligibility determination for the LTC spouse, to determine whether the LTC spouse meets the MA asset limit. If the couple's assets exceed the CSAA and the MA asset limit, the LTC spouse may have to reduce assets before MA can be approved.

An asset evaluation is not used to determine asset eligibility if an enrollee receiving MA-LTC marries a person who meets the definition of a community spouse after eligibility for MA-LTC is approved.

A new asset evaluation is required if a person has a break in LTC services of one calendar month or more and the county or tribal agency receives a new request for MA-LTC.

Whereabouts of the Community Spouse are Unknown

When an asset evaluation is required and the LTC spouse does not know the whereabouts of the community spouse, they must make a reasonable effort to locate the community spouse.

If reasonable efforts to locate the community spouse do not succeed, eligibility for MA-LTC for the LTC spouse is still possible. The LTC spouse must report assets on the application based on the information they know about the community spouse's assets.

Notification Requirements

The LTC spouse, the LTC spouse's authorized representative, if applicable, and the community spouse must be notified of the CSAA. Any of these individuals may appeal the results.

~~Redetermining the Community Spouse Asset Allowance~~

~~The LTC spouse and the community spouse will be notified that the CSAA has been redetermined if the following conditions occur:~~

- ~~It is discovered that the couple owned additional assets on the asset assessment effective date, which were not included in the assessment.~~
- ~~The asset assessment effective date was not valid because the person did not have a continuous period of institutionalization. See MA-LTC Asset Assessment for more information.~~

Increased Community Spouse Asset Allowance

The CSAA is increased beyond the maximum CSAA in the following situations:

- A court, due to a legal separation, orders an amount of the couple's assets for the community spouse that is greater than the CSAA.
- The community spouse qualifies for additional income-producing assets to meet the community spouse's monthly maintenance needs.

Additional Income-Producing Assets to Meet Community Spouse's Monthly Maintenance Needs

A community spouse may keep additional income-producing assets above the CSAA, if he or she cannot meet his or her monthly maintenance needs with the income allocated from the LTC spouse combined with his or her own income.

The couple must meet the following requirements for the community spouse to keep additional income-producing assets above the CSAA:

- The community spouse's income, combined with any income allocation from the LTC spouse, is less than the calculated monthly maintenance needs.
    - Income is not allocated to the community spouse of a person receiving Brain Injury (BI), Community Alternative Care (CAC), Community Access and Disability Inclusion (CADI) or Developmental Disability (DD) waiver services. In this instance, the increased CSAA may be available based on an income allocation of zero.
- The CSAA must already include as many income-producing assets as possible.
- The LTC spouse must make available, and the community spouse must accept, the community spouse income allocation. The couple cannot refuse to make or accept a community spouse income allocation as a way to reduce the community spouse's income in order to qualify for additional income-producing assets.
- The purchase of an income-producing asset for the benefit of the community spouse, under this provision, must occur before MA-LTC may be approved.
- The amount of assets above the CSAA is limited to an amount necessary to produce the additional income needed to meet the community spouse's monthly maintenance needs.
- Assets already producing an income cannot be used to purchase another income-producing asset, unless the asset purchased produces more income.

Transfers from the LTC Spouse to the Community Spouse

Assets considered available to the community spouse through the CSAA must be put in the community spouse's name no later than the LTC spouse's ~~first~~ next annual renewal. At the LTC spouse's ~~first~~ next annual renewal, all assets still in the name of the LTC spouse are evaluated in order to determine asset eligibility.

- Income from an asset in the LTC spouse's name is counted in the LTC income calculation even if it is income produced by an asset that is considered part of the CSAA. Therefore, it is in the best interests of the couple to transfer any income-producing asset in the name of the LTC spouse to the community spouse as soon as possible.

Transfers from the Community Spouse to the LTC Spouse

~~The community spouse must transfer ownership of assets in his or her name that are not included in the CSAA to the LTC spouse before MA-LTC eligibility may be approved.~~ Ownership of assets that are in the community spouse's name but are not included in the CSAA and do not have to be

reduced must be transferred to the LTC spouse. Transfer of ownership must be verified before MA-LTC eligibility may be approved.

Community Spouse Does Not Make Assets Available to the LTC Spouse

The community spouse must make assets owned jointly or individually in excess of the CSAA available to the LTC spouse. If the community spouse does not make those assets available, the LTC spouse may still be found eligible for MA-LTC if the LTC spouse cannot use those assets without the consent of the community spouse, and if any of the following occurs:

- the LTC spouse assigns the right to support from the community spouse to the Minnesota Department of Human Services (DHS) (this is done by signing the Minnesota Health Care Programs Application for Long-Term Care Services (DHS-3531));
- the LTC spouse is unable to assign the right to support due to a physical or mental impairment; or
- the denial of eligibility would cause an imminent threat to the LTC spouse's health and well-being.

A person whose request for a hardship waiver is denied can appeal the denial. When MA-LTC is approved under this provision, the county or tribal agency makes a referral to the county attorney's office to determine if a cause of action exists against the community spouse.

Treatment of the Community Spouse's Assets after MA-LTC Approval

Once MA-LTC has been approved, any additional assets acquired by the community spouse are not available to the LTC spouse, as long as there is no break in MA-LTC eligibility for one calendar month or more and the county or tribal agency receives a new request for MA-LTC.

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Minnesota Statutes, section 256B.0913, subdivision 12

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I. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

Medical Assistance for Long-Term Care Services

2.4.2.5.1 LTC Income Calculation Deductions

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

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

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

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

Special Supplemental Security Income (SSI) Deduction

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

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

Special Personal Allowance from Earned Income

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

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

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

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

Medicare Premiums

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

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

LTC Needs Allowance

One of the following allowances is deducted:

Clothing and Personal Needs Allowance (PNA)

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

Veteran's Improved Pension

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

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

Home Maintenance Allowance (HMA)

The Home Maintenance Allowance (HMA) is equal to 100% of the federal poverty guidelines (FPG) for a household size of one. The HMA is adjusted each year on July 1. The HMA is used when all of the following apply:

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

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

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

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

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

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

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

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

Fees Paid to a Guardian, Conservator, or Representative Payee

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

Community Spouse Income Allocation

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

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

Calculation of the Community Spouse's Shelter Costs

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

- Rent
- Mortgage payments, including principal and interest
- Real estate taxes
- Homeowner's or renter's insurance
- Required maintenance charges for a cooperative or condominium
- Utility allowance

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

Verification Requirements

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

When to Deduct the Community Spouse Income Allocation

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

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

Family Allocation

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

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

Children Not Living with a Community Spouse

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

Family Members Who Live with a Community Spouse

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

Verification Requirements

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

When to Deduct the Family Allocation

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

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

Court-Ordered Child Support

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

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

Health Insurance Premiums, Co-payments and Deductibles

The cost of health insurance premiums, co-payments and deductibles incurred by the person that are not subject to payment by MA or a third party, including Extra Help through SSA for Medicare

Advantage Plan or Part D coverage or cost-effective premium reimbursement through MA, are allowable deductions. Health insurance includes Medicare Advantage plans, dental and LTC insurance policies. Only the portion of the premium that reflects coverage for the person is an allowable deduction.

Remedial Care Expense

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

Medical Expenses

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

Medical expenses that are medically necessary and recognized under state law

A necessary medical expense is a medical service that is provided in any of these situations:

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

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

Medical expenses that MA will not pay

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

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

Medical expenses not covered by a third party

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

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

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

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

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

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

Medical expenses are not allowed as a deduction when:

- The medical expense is for LTC services incurred in a month that is included in a transfer penalty period or period of ineligibility for failure to name Minnesota Department of Human Services (DHS) a remainder beneficiary of certain annuities.
- The person paid the medical expense to reduce excess assets.
- The medical expense was ~~not~~ previously used:
  - As a deduction in an LTC income calculation. However, the amount of a medical expense that exceeds the amount of the person's income remaining after all other deductions in one month can be carried forward to future months
  - To meet a medical spenddown

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

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

Notification

People who report medical expenses must be notified of the:

- Medical expenses that were not allowed as a deduction and the reason(s) why they were not allowed
- Medical expenses that were deducted in the LTC income calculation based on estimated third party payments
- Amount of the allowed medical expense deduction
- Amount of medical expenses that can be carried forward as a deduction to future months

Legal Citations

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

Minnesota Statutes, section 256I.03

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J. Section 2.5.3 EMA

2.5.3 Emergency Medical Assistance

~~Medical Assistance (MA) eligibility is determined using a variety of non-financial, financial and post-eligibility requirements. Emergency MA (EMA) is for certain people with a medical emergency who are not otherwise eligible for MA.~~

Emergency Medical Assistance (EMA) covers emergency services for certain people who meet the financial and non-financial eligibility requirements for Medical Assistance (MA), but are not eligible due to their immigration status.

~~Noncitizens, including noncitizens granted deferred action under Deferred Action for Childhood Arrivals (DACA), who are not eligible for federally funded Medical Assistance (MA) may be eligible for Emergency Medical Assistance (EMA) if they have a medical emergency. This includes people in any of the following groups:~~

- ~~People ineligible for federally funded MA due to immigration status or date of entry who meet all other MA program requirements.~~
- ~~People with an immigration status of undocumented.~~

The following people may qualify for EMA:

- Noncitizens who do not have a lawfully present immigration status for MA eligibility, including noncitizens granted Deferred Action for Childhood Arrivals (DACA) status
- Noncitizens age 21 and older with a lawfully present immigration status who are not eligible for MA because they do not have an MA qualified immigration status or who have not resided in the United States in a qualified status for five or more years
- Sponsored noncitizens who are not eligible for MA because of their sponsors' income or assets

People enrolled in MA for people receiving services from the Center for Victims of Torture (MA-CVT) who have a medical emergency may also be eligible for EMA if they have a medical emergency. This allows the Minnesota Department of Human Services (DHS) to claim federal reimbursement for the emergency medical costs.

~~In addition to EMA requirements, a person must meet the eligibility requirements that match their basis of eligibility. People are in one of the following eligibility groups:~~

To qualify for EMA, a person must have a basis of eligibility for MA and must meet all the eligibility requirements for that basis of eligibility, with the exception of immigration status. A person's basis of eligibility determines the non-financial criteria and financial methodology used to determine EMA eligibility.

- MA for Families With Children and Adults (MA-FCA) Bases of Eligibility

- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Bases of Eligibility

People may request retroactive eligibility for EMA for up to three months before to the month of application.

This subchapter includes policies that apply to EMA and links to policies that apply to all MA programs and all Minnesota Health Care Programs (MHCP) programs.

General Requirements

MHCP Applications

EMA Mandatory Verifications

MA Responsibilities

MHCP Retroactive Eligibility

MHCP Rights

Non-Financial Eligibility

MA-ABD Bases of Eligibility

MA-ABD Non-Financial Eligibility

MA-ABD Certification of Disability

MA-FCA Bases of Eligibility

MA-FCA Non-Financial Eligibility

MA County Residency

~~EMA Emergency Medical Conditions~~

MA Living Arrangement

MHCP State Residency

MA-FCA Renewals

MA-ABD Renewals

Financial Eligibility

MA-ABD Financial Eligibility

MA-FCA Financial Eligibility

MA under the TEFRA Option

Post-Eligibility

MA Begin and End Dates

MA Benefit Recovery

MHCP Change in Circumstances

MA Cooperation

MA Cost Sharing

MHCP Fraud

EMA Health Care Delivery

MHCP Inconsistent Information

~~MA Qualifying Health Coverage~~

MA Referral for Other Benefits

MA-ABD Renewals

MA-FCA Renewals

Legal Citation

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Code of Federal Regulations, title 42, section 435.350

Code of Federal Regulations, title 42, section ~~136b~~ 440.255

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K. Section 2.5.3.1.1 EMA Mandatory Verifications

Emergency Medical Assistance

2.5.3.1.1 Mandatory Verifications

Mandatory verifications must be verified through electronic data sources or by paper proof, if electronic data sources are unsuccessful or unavailable. Self-attestation alone is not acceptable verification of mandatory verifications.

~~Medical Assistance~~ Emergency Medical Assistance (EMA) for Families with Children and Adults

People using a basis of eligibility under Medical Assistance for Families with Children and Adults (MA-FCA) must verify current income.

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

People using a basis of eligibility under Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) must verify:

- Assets
- Certification of Disability through Social Security Administration (SSA) or State Medical Review Team (SMRT) for people claiming a blind or disabled basis of eligibility
- Current income

~~Medical Assistance~~EMA with a Spenddown

People who qualify for EMA with a spenddown must also verify:

- Assets
- ~~m~~Medical expenses to meet a spenddown~~.~~

~~EMA Renewal~~

~~An approved care plan certification (CPC) must be verified for people renewing EMA under any basis of eligibility.~~

Verifications Not Required

People applying for EMA are not required to verify:

- Immigration Status
- Medical Emergency
- Social Security Number

Legal Citations

Code of Federal Regulations, title 42, section 435.139

Code of Federal Regulations, title 42, section 435.350

Code of Federal Regulations, title 42, section ~~136b~~440.255

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L. Section 2.5.3.2 EMA Non-Financial Eligibility

Emergency Medical Assistance

2.5.3.2 Non-Financial Eligibility

This subchapter provides non-financial policy information that applies to Emergency Medical Assistance (EMA). Non-financial eligibility requirements are not related to a person's income or assets.

A person must meet the non-financial eligibility requirements ~~that match~~ for their Medical Assistance (MA) basis of eligibility. ~~People are in one of the following eligibility groups:~~

- MA for Families With Children and Adults Bases of Eligibility
- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability Bases of Eligibility

EMA Medical Emergency

At application, EMA applicants must attest to having a medical emergency. Verification of the medical emergency is not required.

EMA Renewal

In order for EMA enrollees to remain eligible at renewal, they must continue to meet all non-financial eligibility requirements for their basis of eligibility, with the exception of immigration status. EMA enrollees do not need to have a medical emergency to qualify for EMA at renewal; however, coverage is limited to payment for medical emergencies or services approved through a Care Plan Certification.

EMA for Pregnant Women

Pregnant women may qualify for MA if they are lawfully present noncitizens, or CHIP-funded MA if they are not lawfully present noncitizens. EMA coverage for labor and delivery is available for certain pregnant women who are not lawfully present and who are ineligible for CHIP-funded MA because they have other health coverage or have excess income.

This subchapter includes links to the MA-ABD and MA-FCA bases of eligibility policies and links to policies that apply to all MA programs and all Minnesota Health Care Programs (MHCP).

MA-ABD Bases of Eligibility

MA-ABD Non-Financial Eligibility

MA-ABD Certification of Disability

MA-FCA Bases of Eligibility

MA-FCA Non-Financial Eligibility

MA County Residency

~~EMA Emergency Medical Conditions~~

MA Living Arrangement

MHCP State Residency

MA-FCA Renewals

MA-ABD Renewals

The following MA non-financial eligibility policies do not apply to EMA:

~~MA Citizenship and Immigration Status~~

~~Citizenship and immigration status are not an EMA eligibility requirement.~~

~~MA Social Security Number~~

- Verification of immigration status
- ~~A~~ Social Security number ~~is not required for EMA.~~

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M. Section 2.5.3.2.1 Emergency Medical Conditions

Emergency Medical Assistance

2.5.3.2.1 Emergency Medical Conditions

To be eligible for EMA a person must have an emergency medical condition that:

- Has a sudden onset of a physical or mental condition, which causes acute symptoms, including severe pain, where the absence of immediate medical attention could, reasonably, be expected to do any of the following:
  - Place the person's health in serious jeopardy
  - Cause serious impairment to bodily functions
  - Cause serious dysfunction of any bodily organ or part

When a person's emergency medical condition needs more care beyond the emergency room or hospital, the person's health care provider may submit an EMA Care Plan Certification (CPC) Request (DHS-3642) to the Minnesota Department of Human Services (DHS).

Pregnant noncitizens with an undocumented status may be eligible for MA for Families with Children and Adults (MA-FCA) from the month of conception through the 60-day postpartum period. Pregnant noncitizens with an undocumented status who do not want to apply for MA-FCA may apply for EMA for an inpatient stay related to labor and delivery.

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N. Section 2.5.3.3 EMA Financial Eligibility

Emergency Medical Assistance

2.5.3.3 Financial Eligibility

This subchapter provides financial policy information that applies to Emergency Medical Assistance (EMA). This includes eligibility factors that involve a person's income or assets.

A person must meet the financial eligibility requirements ~~that match~~ for their Medical Assistance (MA) basis of eligibility at application and renewal. However, sponsor deeming does not apply to EMA. ~~People are in one of the following eligibility groups:~~

- MA for Families With Children and Adults (MA-FCA) Bases of Eligibility
- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Bases of Eligibility

People who are not eligible for EMA because they are over the income limit for their basis of eligibility and who have medical expenses may be eligible for EMA with a spenddown.

This subchapter includes links to the MA-ABD and MA-FCA financial eligibility policies. Also included is a link to the TEFRA option for children who have a disability and household income above the income limit.

MA-FCA Financial Eligibility

MA-ABD Financial Eligibility

MA under the TEFRA Option

~~The following do not apply to EMA:~~

- ~~MA-ABD Sponsor Deeming~~
- ~~MA-FCA Sponsor Deeming~~

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O. Section 2.5.3.4 EMA Post-Eligibility

Emergency Medical Assistance

2.5.3.4 Post-Eligibility

These policies apply to Emergency Medical Assistance (EMA) enrollees.

~~The earliest date of eligibility for EMA is the date the medical emergency begins. MA is available for the duration of the medical emergency, until renewal.~~

~~EMA can only be renewed for people with an approved care plan certification (CPC).~~

A person must meet the post eligibility requirements ~~that match~~ for their Medical Assistance (MA) basis of eligibility, including at renewal. ~~People are in one of the following eligibility groups:~~

- MA for Families With Children and Adults (MA-FCA) Bases of Eligibility
- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Bases of Eligibility

This subchapter includes policies that apply to EMA and links to policies that apply to MA-ABD, MA-FCA, all MA programs and all Minnesota Health Care Programs (MHCP) programs.

MA Begin and End Dates

MA Benefit Recovery

MHCP Change in Circumstances

MA Cooperation

MA Cost Sharing

MHCP Fraud

EMA Health Care Delivery

MHCP Inconsistent Information

MA Referral for Other Benefits

MA-ABD Renewals

MA-FCA Renewals

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P. Section 2.5.3.4.1 EMA Health Care Delivery

Emergency Medical Assistance

2.5.3.4.1 Health Care Delivery

Emergency Medical Assistance (EMA) enrollees must follow guidelines for receiving medically necessary services. People who receive EMA are excluded from managed care enrollment. EMA medical services are provided via fee for service.

Fee for Service

Fee-for-service is a method of payment where the medical provider bills the Minnesota Health Care Programs (MHCP) for specific, individual services. Enrollees must use a medical provider enrolled with MHCP, except in special circumstances. A directory of enrolled providers is available online.

Covered Services

EMA covers the care and treatment of emergency medical conditions provided in an emergency department (ED) or in an inpatient hospital when the admission is the result of an ED admission. Emergency medical conditions include labor and delivery.

~~EMA does not cover preventive care, organ transplants, or home- and community-based waiver services. See the EMA section of the MHCP Provider Manual for more information on covered services.~~

In certain situations, EMA may cover additional services when a health care provider determines additional services are needed to prevent serious jeopardy to the person's health, or bodily impairment or dysfunction. EMA will cover these services only if they are part of an approved Care Plan Certification (CPC) (DHS-3642) request. The person's provider must initiate the CPC request.

See the EMA section of the MHCP Provider Manual for more information on covered services.

~~When a person's emergency medical condition needs more care beyond the emergency room or hospital, the person's health care provider may submit an EMA Care Plan Certification (CPC) Request (DHS-3642) to the Minnesota Department of Human Services (DHS). The health care provider must specifically describe the need for follow-up care and the services needed to prevent serious jeopardy to the person's health, or bodily impairment or dysfunction.~~

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Q. Section 3.1.2.2 MinnesotaCare Premiums and Cost Sharing

MinnesotaCare

3.1.2.2 Premiums and Cost Sharing

Premiums

Many MinnesotaCare enrollees must pay a monthly premium to establish and maintain coverage. The following enrollees have no premium:

- Households that include one or more military members, enrolled in MinnesotaCare, who have completed a tour of active duty within 24 months of MinnesotaCare eligibility, are exempt from paying MinnesotaCare premiums for up to 12 months, which do not have to be consecutive
- Households with one or more American Indians or Alaska Natives enrolled in MinnesotaCare
- Households with projected annual income below 35% of the Federal Poverty Guidelines (FPG)
- Children younger than 21

American Indian and Alaska Native enrollees are not required to provide proof of status to be exempt from paying MinnesotaCare premiums.

If a person is added to an existing MinnesotaCare household that is required to pay a premium, or is newly determined eligible for MinnesotaCare as an existing household member, the effective date of the resulting premium change is as follows:

- If adding the person to the MinnesotaCare household results in a premium decrease, the decrease is effective the first day of the month after the person was determined eligible.
- If adding the person to the MinnesotaCare household results in an increase in the household's premium, the increase in the overall premium is effective at the next regular billing for the household.

A household may become newly exempt from premiums when a returning military member, American Indian or Alaska Native is added to the household and is determined eligible for MinnesotaCare. A household may also become newly exempt when a person is added to the household, which causes the household to have income below 35% of the federal poverty guidelines. The effective date of the premium exemption is the first day of the month after eligibility for that person was determined.

The MinnesotaCare Premium Estimator Table (DHS-4139A) lists estimated premiums. The premium listed on a bill is the official calculation and the amount an enrollee must pay.

People who are required to pay a monthly premium must pay it to keep MinnesotaCare coverage. Ongoing MinnesotaCare premiums are due the 15th of the month, but can be paid up through noon

on the last working day of the month. Premiums should be paid on time to avoid a gap in coverage. There is no good cause exception for nonpayment of a MinnesotaCare premium.

Households may pay the premiums for coverage months that have not yet been billed. Once a household pays the MinnesotaCare premium for a particular month, the premium is refunded only if the household paid a premium for a future month of coverage for which the agency has not yet paid a health plan.

Grace Month

MinnesotaCare enrollees who do not pay their premium before the coverage month, have a one-month grace period. An enrollee will remain covered during the grace month, regardless of whether the enrollee pays the premium for that month. Coverage stops at the end of the grace month if they fail to pay their past due premium for the grace month.

A person must pay the grace month premium in full by noon on the last working day of the grace month to avoid a gap in coverage for enrollees who are required to pay a premium. People who are disenrolled from coverage because they did not pay a premium may have a gap in coverage of one month or more.

To restart coverage, the person must pay the past-due premium for the grace month, if it is not yet forgiven, and the future month's premium. Coverage begins the first day of the month after the month in which the person pays both these premiums in full.

A person may have back-to-back grace months. If the person pays the grace month premium by noon on the last working day of the grace month, but does not pay for a future month of coverage, the future month of coverage is a grace month.

A person approved for retroactive Medical Assistance (MA) for a month in which the person had MinnesotaCare eligibility and was in a grace month must still pay the grace month premium, if it has not yet been forgiven, to reenroll in coverage.

The MinnesotaCare grace month applies only to enrollees who are required to pay a MinnesotaCare premium. Household members who are not required to pay premiums, such as children under the age of 21, remain covered, regardless of whether other household members' premiums are paid.

Grace Month and Renewals

Whether a person is a MinnesotaCare enrollee who is in a grace month or was dis-enrolled for failure to pay premiums has no effect on his or her MinnesotaCare renewal process. The agency must process renewals for MinnesotaCare enrollees who have entered a grace month and people who are disenrolled for non-payment, following the same process for MinnesotaCare enrollees who are not in a grace month. Disenrollment for non-payment of a MinnesotaCare premium does not prevent or delay a person's renewal of MinnesotaCare eligibility.

People who are subject to a premium must continue paying their premiums timely during the renewal process to maintain coverage.

A person disenrolled for non-payment whose eligibility is renewed with a different monthly premium must pay the new premium amount for a future month of coverage in addition to the past due premium for the grace month, if it has not yet been forgiven, to reenroll in MinnesotaCare coverage.

The grace month and premium payment policies apply to enrollees who are required to complete a renewal form. MinnesotaCare enrollees have a January renewal month. January may be a grace month.

Premium Forgiveness

Any full or partial unpaid grace month premium, whether it is unpaid because of lack of payment or insufficient funds, is forgiven before issuing the MinnesotaCare premium bill for the fourth month of coverage after disenrollment. Premiums are forgiven even though capitation was paid for the grace month. After the grace month's premium is forgiven, a person is only required to pay a future month's premium to reenroll in coverage.

When a person is added to an existing MinnesotaCare case during a grace month, and, as a result of the person being added, the household is no longer required to pay a premium for coverage, the household is premium exempt effective the first day of the month after the change was reported. Any unpaid grace month premium for the household that is no longer required to pay a MinnesotaCare premium is forgiven once the person is added to the household and determined eligible for MinnesotaCare.

Cost Sharing

Cost sharing includes those costs a MinnesotaCare enrollee pays towards their health care. MinnesotaCare cost sharing includes deductibles, medical visit and prescription copays.

Adults age 21 or older have a:

- Monthly deductible
- Copays for non-preventative visits
- Copays for nonemergency ER visits
- Copays for eyeglasses
- Copays for prescription drugs

There is no cost sharing for mental health services.

American Indians and Alaska Natives enrolled in a federally recognized tribe are exempt from cost sharing. Verification of membership in a federally recognized tribe is required to be exempt from cost sharing. Acceptable verifications include a data match from an electronic data source or paper documentation.

Providers must serve MinnesotaCare enrollees who are not able to pay a copay or deductible at the time of the visit, however, that provider does not have to serve an enrollee again if their cost sharing is still not paid.

Legal Citations

Code of Federal Regulations, title 42, section 600.505

Code of Federal Regulations, title 42, section 600.510

Code of Federal Regulations, title 42, section 600.525

Code of Federal Regulations, title 45, section 155.350

Minnesota Statutes, section 256L.03

Minnesota Statutes, section 256L.06

Minnesota Statutes, section 256L.15

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R. Section 3.2.3 MinnesotaCare Insurance Barriers

MinnesotaCare

3.2.3 Insurance Barriers

Other Health Coverage

Other health coverage may be a barrier to MinnesotaCare eligibility.

- Access to some types of health coverage is always a barrier, even if the person is not enrolled.
- Some types of health care coverage are a barrier to MinnesotaCare only if the person is enrolled in the coverage.
- Some types of health care coverage are never a barrier to MinnesotaCare.

See Appendix C Types of Other Health Care Coverage for a list of different types of health care coverage and whether or not they are a barrier to MinnesotaCare eligibility.

Employer-Sponsored Coverage

Employer-sponsored coverage is a barrier to MinnesotaCare eligibility for an employee in the following circumstances:

- The employee has access to coverage that meets both the minimum value and affordability standards.
- The employee is enrolled in the coverage, regardless of whether it meets the minimum value or affordability standards.

Access to employer-sponsored coverage that meets both the minimum value and affordability standards is a barrier to MinnesotaCare eligibility for people even if they did not enroll in the employer-sponsored coverage at the time of the employer's open enrollment period or during a special enrollment period.

A person does not have access to employer-sponsored coverage until the first day of the first full month it is available to the person.

Minimum Value Standard for Employer-Sponsored Coverage

An employer-sponsored health plan meets the minimum value standard if it covers at least 60 percent of the total allowed costs under the plan.

Affordability Standard for Employer-Sponsored Coverage

An employer-sponsored health plan is affordable if the employee's portion of the annual premiums for employee-only coverage does not exceed 9.~~66~~69 percent of their annual household income for the tax year. The lowest-cost plan for employee-only coverage is used when determining affordability.

Employer-Sponsored Coverage for a Spouse and Dependents

Employer-sponsored coverage is a barrier to MinnesotaCare eligibility for an employee's spouse or dependents if they are enrolled in the coverage, regardless of whether the employer-sponsored coverage meets the minimum value and affordability standards.

Employer-sponsored coverage that meets both the minimum value and affordability standards for the employee is a barrier to MinnesotaCare eligibility for the following people if they have access to enroll in the coverage, regardless of whether they enroll:

- People the employee expects to claim as a tax dependent
- The employee's spouse, if either of the following are true:
  - The employee and the spouse expect to file taxes jointly
  - The employee and the spouse do not expect to file taxes jointly, but the employee expects to claim a personal exemption for the spouse. The employee expects to claim a personal exemption for the spouse when they expect to list and count the spouse on a federal income tax return.

Employer-sponsored coverage is a barrier to eligibility for these people if they did not enroll in the employer-sponsored coverage at the time of the employer's open enrollment period or during a special enrollment period.

Change in Affordability for Employer-Sponsored Coverage

If a person's employer-sponsored coverage is determined unaffordable at application, and becomes affordable at some point later in the employer-sponsored plan year, they remain eligible for MinnesotaCare for the remainder of the employer-sponsored plan year. Once the person is able to enroll in affordable employer-sponsored coverage through an open enrollment period, they are no longer eligible for MinnesotaCare.

- If a person is determined eligible for MinnesotaCare because they provide incorrect information regarding the affordability of their employer-sponsored plan at application, they can be disenrolled following 10-day advance notice requirements.
- If a person is determined eligible for MinnesotaCare because they did not update information regarding the affordability of their employer-sponsored plan at the time of their renewal, they can be disenrolled following 10-day advance notice requirements.

Voluntary Disenrollment from Employer-Sponsored Coverage

People who are ineligible for MinnesotaCare because they are enrolled in employer-sponsored coverage may qualify for MinnesotaCare if the employer-sponsored coverage does not meet

either the affordability or minimum value standard and they disenroll from the coverage. Eligibility begins the month after the employer-sponsored coverage ends.

Post-Employment Employer-Sponsored Coverage

Health insurance available to former employees and dependents of former employees, such as continuation coverage under COBRA or retiree insurance, is only a barrier to MinnesotaCare eligibility if a person is enrolled in the coverage.

Legal Citations

Code of Federal Regulations, title 26, section 1.36B-2

Code of Federal Regulations, title 26, section 1.5000A-2

Code of Federal Regulations, title 26, section 1.5000A-3

Code of Federal Regulations, title 42, section 600.305

Minnesota Statutes, section 256L.07

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S. Section 3.3.3 Income Methodology

MinnesotaCare

3.3.3 Income Methodology

~~Income eligibility for MinnesotaCare is based on projected Modified Adjusted Gross Income (MAGI) as follows:~~

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

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

MAGI includes:

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

Federal Taxable Income

Federal taxable income are the different types of income that appear ~~on lines 7 through 21 on~~ in the Income section of the Internal Revenue Service (IRS) form 1040, ~~lines 7 through 15 on the~~ IRS form 1040-A ~~and line 6 on~~ or IRS form 1040-EZ. Only the taxable portions of these types of income are included in the adjusted gross income. See the appropriate IRS form instructions for examples of federal taxable income. The general types of taxable income include the following:

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

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

Federal Income Tax Adjustments

The types of adjustments that ~~appear on lines 23 through 35 on~~ in the Adjusted Gross Income section of the 1040 ~~or lines 16 through 19 on the~~ or 1040-A are subtracted from gross income to calculate the adjusted gross income. Only specific types of adjustments are allowed. See the appropriate IRS form instructions for specific information about the types of adjustments.

The types of tax adjustments include:

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

- Student loan interest
- Tuition and fees
- Domestic production activities

Legal Citations

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

Code of Federal Regulations, title 42, section 600.5

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

Minnesota Statues, section 256L.01

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T. Section 3.4.1 MinnesotaCare Begin and End Dates

MinnesotaCare

3.4.1 Begin and End Dates

Eligibility and coverage are separate concepts for MinnesotaCare:

- Eligibility refers to when a person meets the MinnesotaCare eligibility rules.
- Coverage refers to when a person can receive MinnesotaCare benefits.

MinnesotaCare eligibility and coverage begin dates ~~are~~ can be different dates. When a person is determined eligible for MinnesotaCare, coverage can begin no earlier than the first of the month following the determination. Once a person has been determined eligible for MinnesotaCare, that person remains eligible for MinnesotaCare for the rest of the certification period, unless a change in circumstances makes the person ineligible during the certification period. A person may still be eligible for MinnesotaCare even if they fail to pay a premium. A person required to pay a premium has coverage for only those months for which a premium is paid, subject to the grace month policy.

See MinnesotaCare Premiums and Cost Sharing for more information.

MinnesotaCare eligibility and coverage end dates can be different dates as well. For example, a person can remain eligible for MinnesotaCare but have coverage end due to nonpayment of their premium.

When a MinnesotaCare enrollee received coverage for a month they were not eligible for MinnesotaCare, an overpayment may exist. See the MHCP Overpayment policy for more information.

Eligibility Begin Date

MinnesotaCare eligibility begins the first day of the month that a person meets the eligibility requirements. Eligibility can begin no earlier than the first day of the month of application. If a request for an eligibility determination does not require a new application, the eligibility begin date can begin no earlier than the first day of the month the request for coverage is received.

Generally, people who meet all eligibility requirements at any time during a month are eligible for the entire month. The eligibility begin date exceptions are:

- When a person is born, eligibility can begin no earlier than the date the person was born.
- When a person moves to Minnesota, eligibility can begin no earlier than the date the person became a Minnesota resident.

Coverage Begin Date

The coverage begin date for a person newly eligible for MinnesotaCare is the first day of the month ~~following the month the household premium payment is received~~ after the month in which eligibility is approved and a first premium payment is received, if the person is required to pay a premium.

~~If a person is exempt from premiums, coverage begins the month after the determination of eligibility.~~ The coverage begin date for a person who is not required to pay a premium is the first day of the month after eligibility is approved. This is true even if the person is a member of a household with others who are required to pay a premium.

~~If a~~ The effective date of coverage for a person who is newly eligible for MinnesotaCare in a household with existing MinnesotaCare enrollees who are subject to premium payments and have coverage, ~~coverage begins~~ is the month after the determination of eligibility.

The effective date of coverage for a person who is required to pay a premium and is added to an existing MinnesotaCare household whose members are exempt from paying a premium, or is newly determined eligible for MinnesotaCare as an existing member of a household whose other members are exempt from paying a premium, is the first day of the month after the month in which the premium is received.

There is no individual activation of MinnesotaCare coverage for premium-paying members within a household. A household must pay the entire premium due to start coverage for those members required to pay a premium.

Eligibility End Date

When a MinnesotaCare enrollee no longer meets the MinnesotaCare eligibility requirements, eligibility generally ends on the last day of the month in which the change occurred. The exceptions are:

- When a MinnesotaCare enrollee dies, eligibility ends the date the person died.
- When the change occurred too late in the month to send a 10-day advance notice, MinnesotaCare eligibility ends the last day of the month following the month in which the change occurred.
- When a MinnesotaCare enrollee becomes newly eligible for MA, MinnesotaCare eligibility ends the day before MA eligibility begins.

Coverage End Date

MinnesotaCare coverage ends if a MinnesotaCare enrollee no longer meets the eligibility requirements or fails to pay the MinnesotaCare premium.

Coverage End Date due to Ineligibility

When a MinnesotaCare enrollee no longer meets the MinnesotaCare eligibility requirements, MinnesotaCare coverage ends the last day of the month for which 10-day advance notice can be given.

Generally, 10-day advance notice is needed to end MinnesotaCare coverage. See the MHCP Notices policy for specific situations that require less than 10-day advance notice.

Coverage End Date due to Non-Payment of Premium

The monthly household premium must be paid to maintain coverage for a MinnesotaCare enrollee. See the MinnesotaCare Cost Sharing and Premiums policy for more information about the coverage end date due to nonpayment of premiums.

Households that are exempt from premiums and household members who are not required to pay premiums remain covered regardless of whether premiums are paid.

Legal Citations

Minnesota Statutes, section 256L.05

Minnesota Statutes, section 256L.15

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U. Section 4.1.1.2 MFPP Mandatory Verifications

Minnesota Family Planning Program

4.1.1.2 Mandatory Verifications

Full Eligibility

Mandatory verifications must be verified through an available electronic data source or by paper proof, if electronic data sources are unsuccessful or unavailable. The following are mandatory verifications for Minnesota Family Planning Program (MFFP) eligibility:

- Current income
- Immigration status
- Social Security number
- U.S. Citizenship

Presumptive Eligibility

Verification is not required for presumptive eligibility. ~~Verification must happen before ongoing coverage is approved.~~

Legal Citations

Minnesota Rules, parts 9505.5300 to 9505.5325

Minnesota Statutes, section 256B.78

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V. Section 4.1.3.1 MFPP Household Composition

Minnesota Family Planning Program

4.1.3.1 Household Composition

Household composition means the people included in an applicant's or enrollee's household. Household composition is used to determine household size, income and program eligibility.

Presumptive Eligibility

For Minnesota Family Planning Program (MFPP) presumptive eligibility (PE), the following people are included in a person's household composition, if they live together:

- The person
- The person's spouse
- The person's biological, natural, and adopted children and stepchildren younger than age 19
- If the person is under age 19, the following are also included:
  - Biological, natural, and adoptive parents and stepparents
  - Biological, natural, and adoptive siblings and stepsiblings younger than age 19

Ongoing Eligibility

For ongoing MFPP eligibility, household composition and family size depend on whether the person expects to be a tax filer, tax dependent, or non-tax filer for the current tax year. MFPP household composition and family size policies follow household composition and family size policies for Medical Assistance for Families with Children and Adults (MA-FCA). See MA-FCA Household Composition and Family Size for more information about household composition and family size.

A person is not required to file a federal income tax return or be claimed as a tax dependent to be eligible for MFPP. Additionally, married couples are not required to file a joint federal income tax return to be eligible.

~~Adults Age 21 and Older~~

~~Household composition for applicants age 21 and older includes the applicant, spouse, and biological, natural, adoptive and stepchildren younger than age 21 who live with the applicant. See the MHCP Temporary Absence policy for more information about household members who are temporarily living apart.~~

~~Children Younger than Age 21~~

~~Applicants younger than age 21 are considered a household size of one.~~

Legal Citations

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

Code of Federal Regulations, title 42, section 435.03

~~Minnesota Rules, parts 9505.5300 to 9505.5325~~

~~Minnesota Statutes, section 256B.78~~

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W. Section 4.1.3.3 MFPP Income Methodology

Minnesota Family Planning Program

4.1.3.3 Income Methodology

~~Income eligibility for the Minnesota Family Planning Program (MFPP) is determined as follows:~~

~~Income~~

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

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

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

~~Counted Income~~

- ~~AmeriCorps State or National living allowances and other payments~~
- ~~AmeriCorps-National Civilian Community Corps (AmeriCorps NCCC) living allowances and other payments~~
- ~~Amount over $2,000 interest income from Indian trust land or other restricted Indian lands~~
- ~~Amount over $2,000 of cash payments from tax-exempt organizations for a child with a life-threatening condition~~
- ~~Annuity payments~~
- ~~Blood and blood plasma sales~~
- ~~Child support income~~
- ~~Clergy housing allowances~~
- ~~Commissions~~
- ~~Compensation from an employer's vacation donation program, if paid and taxed in the same manner as the employee's usual pay~~
- ~~Conservation and Youth Service Corps wages~~
- ~~Court-ordered dependent care expense payments~~
- ~~Disability payments that are part of the employer’s benefit package~~

- ~~Experience Works wages~~
- ~~Extended income support payments through the Trade Adjustment Reform Act of 2002 (TAA)~~
- ~~Gifts~~
- ~~Higher Education Innovative Projects wages~~
- ~~Honoraria~~
- ~~Hostile fire, imminent danger and combat pay~~
- ~~Income from self-employment~~
- ~~Income that is withheld to repay a legal debt or obligation~~
- ~~Income withheld to repay a legal debt or obligation~~
- ~~In-kind income if the person has the option to receive cash instead of in-kind income~~
- ~~Interest and dividends received as payments~~
- ~~Jury duty pay~~
- ~~Lump sum income~~
- ~~National and Community Service Models wages~~
- ~~Net self-employment income~~
- ~~Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that requires teaching, research, or other work in order to receive the aid for graduate students~~
- ~~Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that does not require work to receive the aid for graduate students, after deducting allowable student expenses~~
- ~~Non-Title IV of HEA and non-BIA student loans for graduate students, after deducting allowable student expenses~~
- ~~Picket duty pay~~
- ~~Public and private pensions~~
- ~~Railroad Retirement Board (RRB) benefits~~
- ~~Refugee Resettlement Program grants~~
- ~~Regular cash gift income or cash gift income that exceeds $30 per three months~~
- ~~Retirement, Survivor's and Disability Insurance (RSDI), except for specific exclusions~~
- ~~Royalties~~
- ~~Senior Aids Program wages~~
- ~~Serve America wages~~
- ~~Severance pay~~

- ~~Sick pay based on accrued leave time~~
- ~~Spousal maintenance income~~
- ~~Tips~~
- ~~Tribal per capita payments from gaming revenue (casino profits)~~
- ~~Trust disbursements~~
- ~~Unemployment insurance~~
- ~~Vacation pay~~
- ~~Value of in-kind gifts from tax-exempt organizations for a child with a life-threatening condition when those gifts are converted to cash~~
- ~~Veteran's Administration benefits~~
- ~~Vocational Rehabilitation current living expense payments~~
- ~~Voluntary Resettlement Agency Matching Grant Program grants~~
- ~~Wages~~
- ~~Workers' Compensation~~
- ~~Workforce Investment Act (WIA) earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is not a student, beyond six months per year~~

~~Excluded Income~~

- ~~Agent Orange Settlement Fund payments~~
- ~~All income of refugee unaccompanied minors~~
- ~~American Indian tribal land settlements and judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior~~
- ~~AmeriCorps Vista payments~~
- ~~Assets converted to cash~~
- ~~Bills paid by a third party~~
- ~~Blood Product Settlement payments~~
- ~~Bureau of Indian Affairs (BIA) student financial aid for undergraduate and graduate students~~
- ~~Child Care and Development Block Grant Act payments~~
- ~~Class action settlement agreement in Jensen et al v. Minnesota Department of Human Services, et al.~~
- ~~Clinical trial participation payments~~
- ~~Cobell Settlement for American Indians~~

- ~~Community fundraiser income not under the control of the applicant, enrollee or a responsible relative~~
- ~~Consumer Support Grant (CSG) payments~~
- ~~Corporation for National and Community Service (CNCS) payments~~
- ~~Costs necessary to secure the payments of unearned income, such as attorney's fees and medical fees~~
- ~~Court-ordered medical support~~
- ~~Coverdell Education Savings Account (ESA) payments used for educational expenses~~
- ~~Crime victim payments~~
- ~~Disaster assistance~~
- ~~Family Support Grant (FSG) payments~~
- ~~Federal Relocation Assistance~~
- ~~Filipino Veterans Equity Compensation (FVEC) fund payments~~
- ~~First $2,000 interest income from Indian trust land or other restricted Indian lands~~
- ~~First $2,000 of cash payments from tax-exempt organizations for a child with a life-threatening condition~~
- ~~First $10,000 of court-ordered Workers Compensation settlements~~
- ~~Foster Care Assistance~~
- ~~Gifts of cash for tuition or education~~
- ~~Gifts of cash to purchase a prosthetic device not covered by health care or other insurance~~
- ~~Housing and Urban Development (HUD) subsidies~~
- ~~Inaccessible income such as unpaid court ordered child support~~
- ~~Income excluded by the Social Security Administration to determine Supplemental Security Income (SSI) eligibility~~
- ~~Income used by the Social Security Administration to determine SSI eligibility~~
- ~~Income withheld to repay a prior overpayment of benefits made by the same income source~~
- ~~Individual Development Accounts (IDA)~~
- ~~In-kind income if the person does not have the option to receive cash~~
- ~~Insurance payments not payable or available to the applicant~~
- ~~Interest and dividends accrued and combined with counted assets, within the asset limit~~
- ~~Irregular cash gift income of less than $30 per three months~~
- ~~IV-E and State-Subsidized Adoption Assistance~~
- ~~James Zadroga 9/11 Health and Compensation Act of 2010~~

- ~~Japanese and Aleutian Restitution payments~~
- ~~Loans – principal portion of loan payments~~
- ~~Low Income Home Energy Assistance Program (LIHEAP) payments~~
- ~~Military salary reductions~~
- ~~Mille Lacs Band of Ojibwa Elder Supplement Assistance Program~~
- ~~Money received and spend to cover someone else's expenses~~
- ~~Nazi Persecution payments~~
- ~~Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that requires teaching, research, or other work to receive the aid for undergraduate students~~
- ~~Non-Title IV of HEA and non-BIA grants, scholarships, fellowships and other non-loan financial aid that does not require work to receive the aid for undergraduate students~~
- ~~Non-Title IV of HEA and non-BIA student loans for undergraduate students~~
- ~~Payments used to reimburse a custodial parent for health insurance premiums~~
- ~~Per capita distributions of all funds held in trust by the Secretary of the Interior to members of an Indian tribe~~
- ~~Program participation incentive payments~~
- ~~Public Assistance Payments, such as general assistance (GA), Minnesota Supplemental Aid (MSA), Minnesota Family Investment Program (MFIP), Refugee Cash Assistance (RCA), Diversionary Work Program benefits (DWP), Work Benefit Program benefits (WB)~~
- ~~Radiation Exposure Compensation Act payments~~
- ~~Refunds of security and utility deposits~~
- ~~Reimbursements for employment and training, medical expenses and property~~
- ~~Relative Custody Assistance~~
- ~~Retirement, Survivor's and Disability Insurance (RSDI) for children under age 18 under the TEFRA option or receiving home and community based waiver services~~
- ~~Ricky Ray Hemophilia Relief Act payments~~
- ~~Student financial aid expenses for tuition, mandatory fees, course and lab fees, books, supplies and equipment required for course work, child care costs incurred while at school or in transit, transportation to and from school~~
- ~~Student financial aid from a Title IV of the Higher Education Act of 1965 program for undergraduate and graduate students~~
- ~~SSI~~
- ~~Tax credits, rebates and refunds~~
- ~~Training expenses under the Trade Adjustment Reform Act of 2002~~
- ~~Veterans' Children with Certain Birth Defects payments~~

- Veterans' Affairs (VA) education assistance
- Vietnamese Commando Compensation Act payments
- Vocational Rehabilitation payments, except current living expense payments
- Wages and other earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is a full or part-time student and works less than 37.5 hours per week
- Workforce Investment Act (WIA) earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is a full or part-time student and works at least 37.5 hours per week
- WIA earned income of a child under age 18 or 18 years old and expected to graduate by age 19, who is not a student, six months per year
- WUV payments from the Dutch government to victims of Nazi persecution

Whose Income Counts

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

The income deeming requirements used to determine eligibility for MA for Families with Children apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person.

Sponsor Deeming

Adult immigrant non-citizens who have a sponsor and are age 21 or older must have the income of the sponsor deemed to them for MFPP.

Applicants with a sponsor must have an Affidavit of Support (USCIS I-864). The county, tribal or state servicing agency sends the Sponsor Letter (DHS-3453) to the sponsor.

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

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

Sponsor Deeming Exceptions

Sponsor deeming does not apply to sponsored non-citizens who have 40 qualifying work quarters.

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

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

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

- To enable them to become self-sufficient following separation from the abuser
- To enable escape from the abuser or the community where the abuser lives, or to ensure safety from the abuser
- Due to a loss of financial support or loss of a job due to their separation from the abuser
    - Including job loss due to work absence or reduced job performance because of the abuse or cruelty or related legal proceedings, such as child support or custody disputes
- Due to a need to obtain medical attention or mental health counseling or they are disabled because of the battery or cruelty
- Because of lost housing or income, or the fear of separation from the abuser jeopardizes the ability to care for their children
- To alleviate nutritional risks or need resulting from the abuse or following the separation from the abuser
- To provide medical care during an unwanted pregnancy resulting from the abuser's sexual assault, or the relationship with the abuser. Or to care for any resulting children
- To replace medical coverage or health care services they had when living with the abuser

Presumptive Eligibility

For Minnesota Family Planning Program (MFPP) presumptive eligibility (PE), certified providers determine income eligibility based on the person's reported family size and income.

For a person age 21 or older, household income consists of the countable income of the person and everyone in their household.

For a person who is under age 21, only the person's income counts.

Ongoing Eligibility

The MFPP income methodology for ongoing eligibility follows the Medical Assistance for Families with Children and Adults (MA-FCA) income methodology. See MA-FCA Income Methodology for information about the types of income that count for MFPP.

For a person age 21 or older, household income consists of the person's own income and the income of everyone in their household composition, unless specifically excluded. See MFPP Household Composition for more information about MFPP household composition policy.

For a person who is under age 21, only the person's own income counts in determining ongoing eligibility.

Income Disregard

For both presumptive and ongoing eligibility, when a person's household income is above the 200 percent income limit, a five percent income disregard is applied. If the person's household income, minus the disregard, is within the income limit, the person qualifies for MFPP. This disregard effectively raises the income limit by five percent.

Legal Citations

~~Minnesota Rules, parts 9505.5300 – 9505.5325~~

Code of Federal Regulations, title 42, section 435.603

Minnesota Statutes, section 256B.78

~~United States Code, title 42, section 1396a~~

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X. Appendix F

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, 2017, to December 1, 2017	$3,022.50
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

Effective Dates	Minimum Monthly Income Allowance
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 – September 30, 2017	$532
October 1, 2015 – September 30, 2016	$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 – September 30, 2017	$141
October 1, 2015 – September 30, 2016	$141

Effective Dates	Telephone Allowance
October 1, 2016 – September 30, 2017	$38
October 1, 2015 – September 30, 2016	$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, 2017, to December 31, 2017	$560,000
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, 2017, to December 31, 2017	53.5 cents
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, 2017, to December 31, 2017	$97
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 Allowance~~s~~

The ~~Minimum and~~ Maximum Asset Allowance~~s are~~ is used for ~~to determine~~ the community spouse asset allowance for an asset assessment.

Effective Dates	Minimum	Maximum
January 1, 2017, to December 31, 2017	No minimum	$120,900
June 1, 2016 to December 31, 2016	No minimum	$119,220
January 1, 2016, to ~~December~~ May 31, 2016	$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, 2017, to December 31, 2017	1.003
January 1, 2016, to December 31, 2016	1

Effective Date	Pickle Disregard
~~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
January 1, 2017 to June 30, 2017	$196
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, 2017, to December 31, 2017	$2,205
January 1, 2016, to December 31, 2016	$2,199
~~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, 2017, to December 31, 2017	$1,790	$7,200
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, 2017, to December 31, 2017	$735
January 1, 2016, to December 31, 2016	$733
~~January 1, 2015, to December 31, 2015~~	~~$733~~

Effective Date	Couple
January 1, 2017, to December 31, 2017	$1,103
January 1, 2016, to December 31, 2016	$1,100
~~January 1, 2015, to December 31, 2015~~	~~$1,100~~

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