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 #17.2

June 1, 2017

Manual Letter #17.2

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of June 1, 2017. The effective date of new or revised policy may not be the same date the information is added to the EPM. Refer to the Summary of Changes to identify when the Minnesota Department of Human Services (DHS) implemented the policy.

I. Summary of Changes

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

A. EPM Home Page

A hyperlink is added to the EPM home page for this manual letter.

Bulletin #16-21-12, DHS Announces MinnesotaCare Eligibility for Deferred Action for Childhood Arrivals (DACA) Grantees, is removed from the home page because the policy in the bulletin is incorporated with this manual letter.

Hyperlinks to the following bulletins are added to the home page because they have not yet been incorporated into the EPM:

- Bulletin #17-21-05, DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- Bulletin #17-21-06, DHS Clarifies the Medical Assistance MAGI Based Income Calculation

B. Section 1.2.1 Minnesota Health Care Programs (MHCP) Application Forms

The change to this section under Request to Apply for MHCP (DHS-3417B) clarifies that this form sets the date of application and to apply the applicant must submit a complete application within 30 days of the written request.

C. Section 1.2.3 MHCP Date of Application

The change to this section under Request to Apply clarifies that if the applicant uses DHS-3417B to set the date of application a completed application must be received by the applicant within 30 days of the written request to apply.

D. Section 1.3.2.5 MHCP Overpayments

This section incorrectly added a legal citation for Code of Federal Regulations, title 42, section 1396(b). The incorrect citation was removed and replaced with a citation to United States Code, title 42, section 1396(d).

E. Section 2.1.1.2.1.3 Medical Assistance (MA) Cost Effective Insurance

The change to this section under Enrollee Responsibilities clarifies that CHIP-funded infants must have MA redetermined as non-CHIP-funded infants prior to a cost effective determination if they are enrolled in other health insurance.

F. Section 2.1.2.2.2 MA Immigration Status

The change to this section under MA Eligibility for Noncitizen Children under Age 21 and Pregnant Women has been updated to state that people granted Deferred Action For Childhood Arrivals (DACA) are not eligble for for MA as they are not lawfully present noncitizens.

G. Section 2.2.2.1 Medical Assistance for Families with Children and Adults (MA-FCA) Bases of Eligibility

This section has been updated to include that CHIP-funded MA may be available to infants who are not enrolled in other health insurance and have income between 275% and 283% FPG. It also clarifies that CHIP-funded infants who gain other health insurance must be redetermined for MA as a non-CHIP-funded infant.

H. Section 2.2.3.3 MA-FCA Income Limit

This section has been updated under Income Limits for Medical Assistance for Families with Children and Adults to include that CHIP-funded MA may be available to infants with income between 275% and 283% FPG if they are not enrolled in other health insurance.

I. Section 2.3.1.1 MA-ABD Mandatory Verifications

This section was updated under Assets to clarify that asset verification is required at application but once an asset is determined excluded it does not need to be verified at renewal. This section was also updated under Income to clarify that if a person is receiving Supplemental Security Income (SSI), only the SSI income is verified. Eligibility for SSI is accepted as verification of other income SSA considers in determining eligibility.

J. Section 2.3.3.3.2.3 MA-ABD Excluded Income

This section has been updated to clarify that SSI and all income used to determine SSI including deemer income are excluded.

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

This section has been updated under household composition and family size to clarify that parents of children who are eligble for one of the home and community based services waiver programs may need to pay a parental fee.

L. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

This section has been updated to clarify policy on court-ordered spousal maintenance deductions for people who reside in long-term care facilities.

M. Section 3.2.1.2 MinnesotaCare Lawful Presence

This section has been updated to incorporate Bulletin #16-21-12 DHS announces MinnesotaCare Eligibility for Deferred Action for Childhood Arrivals (DACA) Grantees. This section further clarifies that DHS will provide MinnesotaCare coverage to DACA grantees who meet all MinnesotaCare eligibility requirements beginning January 1, 2017.

N. Appendix F Standards and Guidelines

This section has been updated to include annual standard changes that become effective July 1, 2017. Those changes include the Basic Shelter Allowance, Community Spouse Minimum Monthly Income Allowance, Home Maintentance Allowance, SIS-EW Maintenance Needs Allowance, Remedical Care Expense, and the MA Statewide Average Payment for Skilled Nursing Home.

O. Appendix H Lawfully Present Noncitizens

This section has been updated to remove references to DACA grantees for health care eligibility determination.

II. Documentation of Changes

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

A. **EPM Home Page**

B. **Section 1.2.1 MHCP Application Forms**

C. **Section 1.2.3 MHCP Date of Application**

D. **Section 1.3.2.5 Overpayments**

E. **Section 2.1.1.2.1.3.1 Medical Assistance Cost Effective Insurance**

F. **Section 2.1.2.2.2 MA Immigration Status**

G. **Section 2.2.2.1 Bases FCA**

H. **Section 2.2.3.3 Income Limit FCA**

I. **Section 2.3.1.1 MA-ABD Mandatory Verifications**

J. **Section 2.3.3.3.2.3 MA ABD Excluded Income**

K. **Section 2.4.2.3.1 MA LTC Home and Community Based Service Waivers for People with Disabilities**

L. **Section 2.4.2.5.1 MA-LTC Income Calculation Deductions**

M. **Section 3.2.1.2 MinnesotaCare Lawful Presence**

N. **Appendix F Standards and Guidelines**

O. **Appendix H Lawfully Present Noncitizens**

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 #17.1, June 1, 2017

MHCP EPM Manual Letter #17.1, April 1, 2017

2016 Manual Letters

MHCP EPM Manual Letter #16.1, June 1, 2016

MHCP EPM Manual Letter #16.2, August 1, 2016

MHCP EPM Manual Letter #16.3, September 1, 2016

MHCP EPM Manual Letter #16.4, December 1, 2016

Bulletins

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

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

- ~~Bulletin #16-21-12, DHS Announces MinnesotaCare Eligibility for Deferred Action for Childhood Arrivals (DACA) Grantees~~

- Bulletin #16-21-13, DHS Announces Changes to Eligibility Rules for Minnesota Family Planning Program
- Bulletin #17-21-01, DHS Explains Policy and Procedures for MA Cost-Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEBAs Are Not CEHI
- Bulletin #17-21-02, DHS Explains: Changes to MA Estate Recovery Resulting from CMS Approval of a Revised State Plan Amendment; and a New Statewide Funeral Expenses Policy
- Bulletin #17-21-05 DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- Bulletin # 17-21-06 DHS Clarifies the Medical Assistance MAGI Based Income Calculation

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 1.2.1 MHCP Application Forms

Minnesota Health Care Programs

1.2.1 Application Forms

Many people may apply for Minnesota's Insurance Affordability Programs (IAP) using the MNsure online or a paper application. However, there are different application forms designed to collect the information needed based on the applicant's situation. Using the correct application form helps speed up the eligibility determination. When using a paper application form, it is important to choose the most appropriate form and to follow the instructions about where to send the form.

MNsure Online Application

A secure, web-based application is at MNsure.org. The online application for financial assistance in obtaining health care is a smart and dynamic application that asks questions based on an applicant's response to previous questions. The online application displays all required information about an applicant's rights and responsibilities. It is the preferred application for IAPs because a real-time eligibility determination may be possible.

Applicants using the MNsure online application have eligibility determined for all Minnesota Health Care Programs (MHCP) and advanced premium tax credits.

Eligibility is evaluated in the following order:

A. Medical Assistance (MA) for Families with Children and Adults (MA-FCA)

B. MinnesotaCare

C. Advanced premium tax credit (APTC)

D. Qualified health plan (QHP) without subsidy

People who are eligible for MA are not eligible for MinnesotaCare or APTC. Likewise, people who are eligible for MinnesotaCare are not eligible for APTC. Eligibility for help getting health care is not a barrier to purchasing a QHP without financial help.

Applicants who are potentially eligible for other types of MA are referred for a further eligibility determination.

MNsure Application for Health Coverage and Help Paying Costs (DHS-6696)

Applicants may use the paper version of the MNsure online application. Applicants submit DHS-6696 to their county or tribal servicing agency. It is available in English, Hmong, Russian, Somali, Spanish and Vietnamese.

Applicants using DHS-6696 must have eligibility determined for all Minnesota Health Care Programs (MHCP) and advanced premium tax credits.

Eligibility is evaluated in the following order:

A. MA-FCA

B.MinnesotaCare

C. APTC

D.QHP without subsidy

People who are eligible for MA are not eligible for MinnesotaCare or APTC. Likewise, people who are eligible for MinnesotaCare are not eligible for APTC. Eligibility for help getting health care is not a barrier to purchasing a QHP without financial help.

Applicants who are potentially eligible for other types of MA are referred for a further eligibility determination.

MHCP Application for Certain Populations (DHS-3876)

Applicants in households where everyone in the household is a member of one of the following populations use the MHCP Application for Certain Populations:

- Age 65 or older
- Applying only for Medicare Savings Program
- Child in foster care and receiving kinship assistance
- Older than 21 with no dependents and Medicare
- An adult receiving Supplemental Security Income (SSI)
- Applying for MA for Employed Persons with Disabilities (MA-EPD)

DHS-3876 is available in English, Hmong, Russian, Somali, Spanish and Vietnamese. Applicants submit DHS-3876 to their county or tribal servicing agency.

The Supplement to the MHCP Application DHS-3417 or DHS-3876 (DHS-6696B) must also be completed when a submitted DHS-3876 includes household members not listed above.

MHCP Application for Payment of Long-Term Care Services (DHS-3531)

The Application for Payment of Long-Term Care Services (DHS-3531) is for MA applicants who have a basis of eligibility other than MA-FCA and:

- live in a long-term care facility such as a (nursing home).
- live in an intermediate care facility for people with developmental disabilities.
- live in a nursing facility care in an inpatient hospital.
- request Elderly Waiver (EW) services.
- request Community Alternatives for Disabled Individuals (CADI) services.

- request Community Alternative Care (CAC) services.
- request Traumatic Brain Injury (TBI) services.
- request Developmental Disabilities Waiver (DD) services.

Applicants submit DHS-3531 to their county or tribal servicing agency. Applicants who are potentially eligible for MA-FCA are referred for a further eligibility determination.

Minnesota MA Application/Renewal Breast and Cervical Cancer (DHS-3525)

The Minnesota MA Application/Renewal Breast and Cervical Cancer form is for people who were screened by the Sage Screening Program and have breast or cervical cancer and are seeking MA coverage. Enrollees also use this form to renew eligibility for coverage. Applicants submit DHS-3525 to their county or tribal servicing agency.

Minnesota Family Planning Program Application – MFPP (DHS-4740)

This form is for applicants who are only seeking coverage under the Minnesota Family Planning Program (MFPP.) Applicants submit DHS-4740 to DHS Health Care Eligibility Operations. It is also available in Spanish.

ApplyMN

People may apply for MA payment of services in a long-term care facility (LTCF) using the online application at ApplyMN.

Application Supplements

Supplement to MNsure Application for Health Coverage and Help Paying Costs (DHS-6696A)

Applicants who submit their application through the MNsure online or paper application (DHS-6696) may need to provide additional information if their eligibility cannot be determined in the new eligibility system or if further evaluation is needed for long-term care services or Medicare Savings Program eligibility. This paper supplement gathers information, not requested on the MNsure application, needed to determine eligibility for:

- MA for People Age 65 and older, Blind or Disabled
- MA for people receiving care and rehabilitation services from the Center for Victims of Torture
- Refugee MA
- MA with a spenddown
- MA payment for long-term care facility services
- MA payment for home and community-based waiver services

- Medicare Savings Programs

DHS-6696A is available in English, Hmong, Russian, Somali, Spanish and Vietnamese. Applicants submit DHS-6696A to their county or tribal servicing agency.

Supplement to the MHCP Application DHS-3417 or DHS-3876 (DHS-6696B)

This supplement is for applicants who submit an obsolete or wrong form. The Combined Application Form (DHS-5223) dated prior to 1/14 and the Health Care Programs Application (DHS-5223) are no longer used to apply for health care. However, when an applicant submits one of these forms they can complete this short supplement instead of reapplying using a current form.

When an applicant submits the MHCP Application for Certain Populations (DHS-3876) and they do not meet the criteria to use DHS-3876, they must complete this short supplement to have an eligibility determination. This paper supplement gathers information needed to determine eligibility for:

- MA-FCA
- MinnesotaCare
- APTC
- QHP without subsidy

DHS-6696B is available in English, Hmong, Russian, Somali, Spanish and Vietnamese. Applicants submit DHS-6696B to their county or tribal servicing agency.

MHCP MA Payment for Inpatient Hospital Care for Inmates (DHS-6696G)

This form is a supplement to DHS-6696 for inmates requesting MA payment of hospital services while incarcerated. The correctional facility assists with the application. Applicants submit DHS-6696G and a completed DHS-6696 to DHS Health Care Eligibility Operations.

MHCP Individual Discharge Information Sheet (DHS-3443)

This form is a supplement for people leaving prison to help determine health care eligibility upon release. Applicants must submit DHS-3443 with a completed application; a DHS-6696, DHS-3876, DHS-5038 or DHS-3531. Applicants submit the two forms to the county or tribal servicing agency in which the applicant resided before entering the correctional system.

Other Forms

MHCP Payment of Long-Term Care Services for MA for Families with Children and Adults (DHS-3543A)

MA enrollees using the Families with Children and Adults bases of eligibility use this form to request payment for services in a long-term care facility. Enrollees submit DHS-3543A to their county or tribal servicing agency.

MHCP Request for Payment of Long-Term Care Services (DHS-3543)

MA enrollees using the People Who are Age 65 or Older, Blind or Disabled bases of eligibility use this form to request payment for services in a long-term care facility or a home and community-based waiver program. Enrollees submit DHS-3543 to their county or tribal servicing agency.

MHCP Request to Reopen MA (DHS-5038)

This form is used to request MA coverage reopen after the person was incarcerated less than a year. Applicant submit DHS-5038 to the county or tribal servicing agency in which:

- the applicant resided before entering the correctional system, or
- the applicant plans to live if the previous county of residence is unknown or the person came from another state.

MNsure Appendix A - Health Coverage from Jobs (DHS-6696D)

This form request missing information about employer subsidized health insurance availability. People can take this form to their human resources department to be filled out. It is included in DHS-6696 and the MNsure online application. Applicants submit DHS-6696D to their county or tribal servicing agency.

MNsure Application Additional Information Requested (DHS-6696F)

This form requests missing information from an incomplete DHS-6696. It includes steps three through nine of DHS-6696. Applicants submit DHS-6696F to their county or tribal servicing agency.

MNsure Application for Health Coverage and Help Paying Costs Signature Page (DHS-6696C)

This form obtains a signature from a Minnesota Health Care Programs applicant or enrollee when the person fails to sign the application or renewal. Applicants submit DHS-6696C to their county or tribal servicing agency.

Request to Apply for MHCP (DHS-3417B)

This form sets the date of application. ~~It is treated as an incomplete application and the~~ An applicant must submit a complete application within 30 days of the written request ~~by the end of the processing period~~. Applicants submit DHS-3417B to their county or tribal servicing agency.

Legal Citations

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 45, section 155.405

Code of Federal Regulations, title 45, section 155.310

Minnesota Statutes, section 256B.04

Minnesota Statutes, section 256B.08

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C. Section 1.2.3 MHCP Date of Application

Minnesota Health Care Programs

1.2.3 Date of Application

Paper Application

The date of application for health care coverage is the date a county, tribal or state servicing agency receives a request for coverage or an application for health care.

The date of application for an application completed by a certified assister is the date of the signature in Appendix C. The application date is set when the applicant signs the application in the presence of an assister, or the date the certified assistor received a signed application.

MNsure Online Application

For MNsure online applications, the date of application is the date the application is submitted electronically.

Request to Apply

A person may set the date of application for Medical Assistance (MA) by submitting a Request to Apply (DHS-3417B). A request to apply must be written and contain the name of the applicant and a way to locate the applicant. The request does not need to state the name of a program as long as it is clear the person wants health care. A request to apply does not need to be signed to set the date of application. ~~The request to apply is treated as an incomeplete application~~ The applicant must submit a complete paper application and provide information needed to determine eligibility ~~by the end of the processing period~~ within 30 days of the written request. A request to apply only sets the date of application for applicants who submit a paper application or use ApplyMN to request MA for Payment of Long-Term Care Facility services. Applicants who apply through the MNsure online application must submit the application in order to set the date of application.

Setting Date of Application - Social Security Administration Application for Extra Help

The date the Social Security Administration (SSA) transmits the Extra Help application data to the state agency is the date of application for MA. Applicants have until the end of the processing period to complete an application. Applicants who complete and submit a paper application retain the SSA date of application. The date of application for those who apply through an online application is the date the application is submitted.

Date of Application - Applicants with Limited English Proficiency

Applicants with limited English proficiency (LEP) may receive help applying through the Multilingual Referral Line (MRL) service or county agencies. The date of the first contact with either the MRL service or the county agency is the date of application for LEP applicants using paper applications. The date of application for those who apply through an online application is the date the application is submitted.

Legal Citations

Code of Federal Regulations, title 42, section 435.906

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.908

Minnesota Rules, part 9505.0015, subpart 5

Minnesota Statutes, section 256L.05

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D. Section 1.3.2.5 Overpayments

Minnesota Health Care Programs

1.3.2.5 Overpayments

Overpayments occur when enrollees receive more Minnesota Health Care Programs (MHCP) benefits than they were entitled.

Overpayments are determined in these situations:

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

Overpayments are not determined when:

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

The overpayment amount:

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

Overpayment Notification

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

- explains the reason for the overpayment,
- shows how the overpayment was computed,
- requests repayment,
- advises enrollees that further action may be taken if payment is not made, and
- advises enrollees of their appeal rights.

Overpayment Collection

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

Voluntary Repayment

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

Revenue Recapture

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

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

Civil Recovery

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

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

Criminal Restitution

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

- Lower the previously determined overpayment amount. order a monetary restitution for an amount less than the previously determined overpayment amount without reducing the total overpayment. This means that the person must pay a reduced amount as a condition

of probation. The county or DHS collections may pursue repayment of the remainder of the overpayment through civil recovery or revenue recapture.

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

Legal Citations

~~Code of Federal Regulations, title 42, section 1396 (b)~~

Minnesota Rules, part 9505.0131

Minnesota Statutes, section 256.01, subdivision 2(t)

Minnesota Statutes, section 256.98, subdivision 3

Minnesota Statutes, section 256.045, subdivision 10

Minnesota Statutes, section 256.0471

Minnesota Statutes, section 256B.016

Minnesota Statutes, section 270A

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

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E. Section 2.1.1.2.1.3.1 Medical Assistance Cost Effective Insurance

Medical Assistance

2.1.1.2.1.3.1 Cost Effective Insurance

A Medical Assistance (MA) enrollee with access to health insurance from another source may be eligible for assistance in paying the premiums, deductibles, and copays, if it is cost effective. Cost effective means that paying for the other plan would be less costly than the amount for an equivalent set of services paid for by MA.

When the other available health insurance is determined by the county, tribal or state servicing agency to be cost effective, the enrollee may receive a reimbursement for premiums paid for the policy or they may have the cost of the premium paid directly to the employer or insurance provider. The county, tribal or state servicing agency must process the reimbursement or premium payment within 30 days of receiving verification from the enrollee or employer. Only the portion of the premium payment that covers MA enrollees is reimbursed.

Cost effective coverage could include, but is not limited to, coverage through:

- Group health care coverage, including COBRA
- Individual health care coverage
- Long-term care insurance (group or individual coverage)
- Medicare

Enrollee responsibilities

MA enrollees must:

- Maintain or enroll in a group health plan, if determined to be cost effective and premiums are paid by the county, tribal or state servicing agency or if there is no cost to the enrollee.
- An MA enrollee currently enrolled in a group health plan is not required to maintain enrollment during the cost effective evaluation process.
- Adult enrollees who choose to disenroll from the group health plan during the evaluation process must reenroll in the group health plan at the earliest opportunity if the coverage is determined to be cost effective.
- Children who disenroll from the group health plan during the evaluation process must be reenrolled in the coverage the next possible month if the coverage is determined to be cost effective.
- Cooperate in determining the cost effectiveness of Medicare supplemental policies or group health care coverage. Enrollees have 10-day notice to provide information about other health

care coverage to maintain MA eligibility. MA coverage ends when the enrollee fails to cooperate.

- Enroll in cost effective Medicare or group health care coverage at the earliest possible date.
- Report when the cost effective insurance ends or changes.
- Enrollees are not required to cooperate with cost-effective coverage determinations when they are Safe at Home (SAH) Address Confidentiality program participants and the policyholder is their probable assailant.

MA enrollees who cannot enroll in cost effective group health care coverage on their own behalf, do not have MA coverage end due to non-cooperation. See the MA Cooperation policy for more information.

MA enrollees may choose to enroll in or maintain individual health care coverage that is cost effective, with premiums reimbursed or paid directly to the insurance provider. MA enrollees are not required to enroll in or maintain individual policies.

Pregnant women, eligible for Children's Health Insurance Program (CHIP) funded MA, are not required to pursue other health care coverage.

Infants who are funded under CHIP cannot have other health insurance. If a CHIP-funded infant gains access to other health insurance they are moved to MA and the cost effective information in this section will apply.

Premiums not reimbursable

The following policies are not cost effective:

- Medicare Supplements
- Medicare Part C (Medicare Advantage)
- Long-term care and hospital indemnity policies that provide cash payments for each day in a hospital or nursing facility and the MA enrollee is not currently collecting benefits

Managed care exclusions

Enrollees with cost effective private health care coverage are excluded from participation in managed care. These enrollees receive health care through fee-for-service (FFS).

Enrollees with non-cost effective private health care coverage through a Health Maintenance Organization (HMO) licensed under Minnesota Statutes §62D may enroll on a voluntary basis if they select the same MHCP managed care organization as their private HMO.

Legal Citations

Code of Federal Regulations, title 42, section 435.1015

Minnesota Rules, part 9505.0430

Minnesota Statutes, section 256B.056

Social Security Act, title 19, section 1906

United States Code, title 26, section 5000

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F. Section 2.1.2.2.2 MA 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~~ MA ~~healthcare~~ eligibility and therefore 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 or 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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G. Section 2.2.2.1 MA for Families with Childeren and Adults Bases of Eligibility

Medical Assistance for Families with Children and Adults

2.2.2.1 Bases of Eligibility

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

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

- Parent:
  - Biological, natural, adoptive or step parent
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
- Caretaker Relative:
  - A relative of a child younger than age 19, by blood, adoption, or marriage. Including:
    - First cousins, nephews, nieces, aunts or uncles and people of preceding generations as denoted by grand, great or great-great
    - Stepfather, stepmother, stepbrother or stepsister
    - Spouses and former spouses of the people named above
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
- Pregnant Woman:
  - A woman who is pregnant
  - A woman within the 60 days post-partum period
- Auto Newborn: child born to a mother enrolled in MA
- Infant: child age 0 through one year
  - Children's Health Insurance Program (CHIP) funded MA may be available for infants with income between 275% and 283% FPG who are not enrolled in other health insurance
  - A CHIP-funded infant who gains other health insurance becomes eligible for MA as a non-CHIP-funded infant
- Child age 2 through 18
- Child age 19 and 20
- Adult age 21 through 64 who:
  - Is not eligible for or enrolled in Medicare Part A or Medicare Part B

    - Is not a Supplemental Security Income (SSI) recipient
    - Is not eligible for MA under 1619 a/b
    - Is not a former SSI recipient who stopped receiving SSI when they began receiving Retirement, Survivor, Disability (RSDI) benefits from the Social Security Administration (SSA) under a deceased spouse or deceased or retired parent's earning record
    - Is not eligible for MA under the parent, caretaker relative, pregnant woman or former foster care basis of eligibility

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

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

Beginning and Ending Bases of Eligibility

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

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

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

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

- Pregnant woman:
    - Begins the first day of the month of conception
    - Ends the last day of the month following the 60-day postpartum period
- Auto newborn:
    - Begins the first day of the month of birth
    - Ends the last day of the month of their first birthday
- Infant:

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

Multiple Bases of Eligibility

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

Change in Basis of Eligibility for Enrollees

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

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

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

Legal Citations

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 435

Code of Federal Regulations, title 42, section 457.1

Minnesota Statutes, section 256B.055

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H. Section 2.2.3.3 Income Limit FCA

Medical Assistance for Families with Children and Adults

2.2.3.3 Income Limit

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

Federal Poverty Guidelines

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

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

- The basis of eligibility for Medical Assistance (MA)

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

Income Limits for Medical Assistance for Families with Children and Adults

The following income limits determine eligibility for MA -FCA:

- Pregnant women: less than or equal to 278% FPG
- Infants under 2: less than or equal to 283% FPG
  - Children's Health Insurance Program (CHIP) funded MA may be available for infants with income between 275% and 283% FPG who are not enrolled in other health insurance
- Children 2 through 18: less than or equal to 275% FPG
- Children 19 and 20: less than or equal to133% FPG
- Parent and caretaker relatives: less than or equal to 133% FPG
- Adults without children: less than or equal to 133% FPG
- Transition Year MA (TYMA) second six months: less than or equal to 185% FPG

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

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

Five Percent FPG Disregard

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

Safety Net Provision

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

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

When these situations arise, people are eligible for MA if their projected annual income is below 100% FPG using the MinnesotaCare income methodology. People whose projected annual income is equal to or greater than 100% FPG, but equal to or less than 133% FPG using the MinnesotaCare income methodology are eligible for MinnesotaCare.

Legal Citations

Code of Federal Regulations, title 42, section 435.100
Code of Federal Regulations, title 42, section 435.116
Code of Federal Regulations, title 42, section 435.118
Code of Federal Regulations, title 42, section 435.119
Code of Federal Regulations, title 42, section 435.603
Minnesota Statutes, section 256B.056

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I. Section 2.3.1.1 MA ABD Mandatory Verifications

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

2.3.1.1 Mandatory Verifications

Mandatory verifications must be verified through an available electronic data source or by paper proof, if electronic data sources are unsuccessful or unavailable. Self-attestation alone is not acceptable for eligibility requirements with mandatory verifications. Medical Assistance for People Who Are Age 65 or Older and People Who are Blind or Have a Disability (MA-ABD) has the following mandatory verifications.

- Assets
  - Verification of assets is required at application and when a new asset is reported. If an asset is determined to be excluded it does no need to be verified at renewal.
- Certification of Disability through Social Security Administration (SSA) or State Medical Review Team (SMRT) for people claiming a blind or disabled basis of eligibility
- Income
  - If a person is receiving Supplemental Security Income (SSI), only the SSI income is verified. Eligibility for SSI is accepted as verification of other income SSA considers in determining eligibility.

    Veteran's Administration (VA) Aid and Attendance benefits and VA unusual medical expense payments must be verified even if the person is receiving SSI.
- Immigration status
- Medical expenses to meet a spenddown
- Social Security Number
- U.S. Citizenship

Legal Citations

Code of Federal Regulations, title 42, section 435.407

Code of Federal Regulations, title 42, section 435.541

Code of Federal Regulations, title 42, section 435.920

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.948

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

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J. Section 2.3.3.3.2.3 MA ABD Excluded Income

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

2.3.3.3.2.3 Excluded Income

Some types of income are excluded when calculating a person's income for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) and Medicare Savings Programs (MSP). See the MSP chapter for more information. Descriptions of each type of income are located in Appendix B Income.

Excluded income includes:

- Agent Orange Settlement Fund payments
- Blood Product Settlement payments
- Child Care and Development Block Grant Act payments
- Clinical trial participation payments excluded by Supplemental Security Income (SSI). The first $2,000 a person receives during a calendar year is excluded.
- Cobell Settlement payments for American Indians for a period of 12 months beginning with the month of receipt. This exclusion applies to all household members.
- Consumer Support Grant (CSG) payments
- Corporation for National and Community Service (CNCS) payments. Payments to volunteers, including the following payments authorized under the Domestic Volunteer Services Act:
    - AmeriCorps
    - Urban Crime Prevention Program
    - Special volunteer programs under Title I
    - Demonstration Programs under Title II
    - Senior Corps:
        - Retired Senior Volunteer Program (RSVP)
        - Foster Grandparent Program
        - Senior Companion Program
- Credit life and credit disability insurance payments
- Crime victim payments
- Disaster assistance, federal payments
- Disaster assistance, state payments
- Employment and training reimbursements and allowances

- Family Support Grant (FSG) payments
- Filipino Veterans Equity Compensation Fund payment
- Gifts to Children with Life Threatening Conditions from 501(c)(3) tax-exempt corporation. This are not considered income of a parent and apply only to children who are under age 18.
    - Any in-kind gift not converted to cash is excluded.
    - Cash gifts up to $2,000 in any calendar year are excluded. The amount of total cash payments that exceed $2,000 each year are counted as an asset.
        - Multiple cash gifts in the same calendar year are added together and up to $2,000 of the total is excluded, even if none of the cash gifts exceeds $2,000 individually.
- Hostile fire pay
- Housing and Urban Development (HUD) subsidies
- Individual Development Accounts (IDA)
- In-kind income
- Interest on funds that commingle countable and excluded assets
- James Zadroga 9/11 Health and Compensation Act of 2010
- Japanese American and Aleutian Restitution payments
- Jensen Settlement Agreement payments
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Lump sum income
    - Some lump sum income that is used to pay for certain expenses is not counted, including:
        - Costs associated with getting the lump sum, such as attorney's fees
        - Any portion of the lump sum earmarked for and used to pay medical expenses not covered by insurance or any Minnesota Health Care Program (MHCP), such as a prosthetic device
        - Any portion of the lump sum recovered by the DHS Benefit Recovery Section (BRS)
        - Any portion of the lump sum earmarked for and used to pay funeral and burial costs paid upon the death of a spouse or child
    - SSI lump sum payments
        - Retroactive SSI lump sum payments are excluded as income in the month received.
        - If a person's SSI is reissued because a representative payee misuses benefits, the reissuance is excluded as income.
    - Social Security Disability Insurance (SSDI) and Veterans Affairs (VA) payment due to representative payee misuse. If a person's SSDI or Veterans Benefits for the Elderly is reissued because an individual representative payee misuses benefits, the reissuance is excluded if the original payment of the income was used to determine the eligibility.

- Medicare Part B Premium Reimbursements. This lump sum is excluded as income in the month received if the Medicare Part B premiums being reimbursed to the client were not used as an MA spenddown expense.

- Nazi Persecution payments
- Participation incentive payments
- Public assistance payments from the following programs:
  - Minnesota Family Investment Program (MFIP)
  - Diversionary Work Program (DWP)
  - General Assistance (GA)
  - General Residential Housing (GRH)
  - Minnesota Supplemental Aid (MSA)
  - Refugee Cash Assistance (RCA)
  - Title IV-E and non-Title IV-E Kinship Assistance
  - Title IV-E and non-Title IV-E Adoption Assistance
  - Foster Care Assistance
  - Mille Lacs Band of Ojibwe Elder Supplement Assistance Program
  - Supplemental Nutrition Assistance Program (SNAP)
  - SSI and all income used to determine SSI (including deemer income)

    VA Aid and Attendance benefits and VA unusual medical expense payments are not excluded, even if the person is receiving SSI.
- Radiation Exposure Compensation Trust Fund (RECTF) payments
- Refunds of rental security and utility deposits
- Reimbursements for out-of-pocket expenses incurred while performing volunteer services, jury duty or employment
- Reimbursements for medical expenses
- Reimbursements for replacement of property
- Relocation assistance payments, federal
- Ricky Ray Hemophilia Relief Fund payments
- Student financial aid. The following types of student financial aid income are excluded:
  - Student financial aid received under Title IV of the Higher Education Act, with the exception of Federal Work Study earnings which may count for Medical Assistance for Employed Persons with Disabilities (MA-EPD)
  - Student financial aid received from the Bureau of Indian Affairs (BIA), with the exception of Federal Work Study earnings which may count for MA-EPD

- Non-Title IV and non-BIA grants, scholarships, fellowships and other non-loan financial aid, if used or set aside to pay educational expenses. Refer to MA-ABD Countable Income for funds that are not used for or set aside for educational expenses.
- Distributions from a Coverdell Educational Savings Accounts (ESA) if the funds are used for educational expenses. Refer to MA-ABD Countable Income for funds that are not used for educational expenses.
- VA benefits designated as educational assistance
- Plan to Achieve Self Support (PASS) student financial aid
- Training expenses paid by the Trade Adjustment Reform Act of 2002

- Tax credits, rebates and refunds
- Third party vendor payments, which include, but are not limited to:
  - MSA or GRH payments made directly to a facility
  - Emergency payments to a utility company made by an emergency assistance program such as Emergency General Assistance (EGA)
- Tribal payments. The following types of tribal payments are excluded:
  - Tribal trust or restricted lands, individual interest: Exclude the first $2,000 received from this income source.
  - Tribal per capita payments from a tribal trust: Exclude all funds from this income source.
  - Tribal land settlements and judgments: Excluded all funds from this income source.
- Veterans' Children with Certain Birth Defects payments
- Vietnamese Commando Compensation Act payments
- Vocational Rehabilitation Payments

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

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

Medical Assistance for Long-Term Care Services

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

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

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

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

Household Composition and Family Size

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

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

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

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

Income Limits and Methodology

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

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Minnesota Statutes, section 256B.056

Minnesota Statutes, section 256B.0913

Minnesota Statutes, section 256B.092

Minnesota Statutes, section 256B.093

Minnesota Statutes, section 256B.49

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L. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

Medical Assistance for Long-Term Care Services

2.4.2.5.1 LTC Income Calculation Deductions

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

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

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

1. Special Supplemental Security Income (SSI) Deduction
2. 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. Court Ordered Spousal Maintenance
10. Health insurance premiums, co-payments and deductibles
11. Remedial Care Expense
12. 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.

Court-Ordered Spousal Maintenance

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

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

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

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

Health Insurance Premiums, Co-payments and Deductibles

The cost of health insurance premiums, co-payments and deductibles incurred by the person that are not subject to payment by MA or a third party, including Extra Help through SSA for Medicare Advantage Plan or Part D coverage or 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 previously used:
  - As a deduction in an LTC income calculation. However, the amount of a medical expense that exceeds the amount of the person's income remaining after all other deductions in one month can be carried forward to future months
  - To meet a medical spenddown

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

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

Notification

People who report medical expenses must be notified of the:

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

Legal Citations

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

Minnesota Statues, section 256B.35

Minnesota Statutes, section 256I.03

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M. Section 3.2.1.2 MinnesotaCare Lawful Presence

MinnesotaCare

3.2.1.2 Lawful Presence and DACA

To receive MinnesotaCare, applicants must be U.S. citizens, U.S. nationals, ~~or~~ certain lawfully present noncitizens or Deferred Action for Childhood Arrivals (DACA) grantees. See the MinnesotaCare Citizenship policy for more information.

Lawfully Present Noncitizens

All lawfully present noncitizens may be ~~are~~ eligible for MinnesotaCare.

People granted DACA status may be eligible for MinnesotaCare. DACA grantees are noncitizens who came to the United States as children and meet certain criteria set out by the U.S. Department of Homeland Security (USDHS). Deffered action is a use of prosecutorial discretion by the USDHS to defer removal action against a person for a period of time. DACA grantees are eligible for work authorization and may receive deferred action for a period of two years, subject to renewal.

Undocumented noncitizens are not eligible for MinnesotaCare.

Verification

Lawful presence may be verified electronically at the time of application. Applicants and enrollees whose lawful presence cannot be verified electronically must provide proofs. People who are DACA grantees must also provide proof that DACA has been approved if their status cannot be verified electronically. 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 MinnesotaCare without verification of ~~their~~ lawful presence or DACA grantee status has a reasonable opportunity to provide proof. A notice is sent to the enrollee to indicate they have 90 days, plus 5 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

Code of Federal Regulations, title 42, section 600.305

Code of Federal Regulations, title 42, section 600.5

Minnesota Statutes, section 256L.04, subdivisions 1 and 10

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N. Appendix F Standards and Guidelines

Appendix F

Standards and Guidelines

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

Community Spouse Allowances

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

Basic Shelter Allowance

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

Effective Dates	Basic Shelter Allowance
July 1, 2017 to June 30, 2018	$609
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 31, 2017	$3,022.50
January 1, 2016~~,~~ to December 31, 2016	$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, 2017 to June 30, 2018	$2,031

Effective Dates	Minimum Monthly Income Allowance
July 1, 2016 -to June 30, 2017	$2,005
~~July 1, 2015 to 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 -to September 30, 2017	$532
October 1, 2015 -to 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 -to September 30, 2017	$141
October 1, 2015 -to September 30, 2016	$141

Effective Dates	Telephone Allowance
October 1, 2016 -to September 30, 2017	$38
October 1, 2015 -to 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

IRS Mileage Rate

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

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

Long-Term Needs Allowances

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

Clothing and Personal Needs Allowance

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

Effective Dates	Clothing and Personal Needs Allowance
January 1, 2017~~,~~ to December 31, 2017	$97
January 1, 2016~~,~~ to December 31, 2016	$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, 2017 to June 30, 2018	$1,005
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, 2017 to June 30, 2018	$990
July 1, 2016, to June 30, 2017	$988
~~July 1, 2015 to June 30, 2016~~	~~$988~~

Maximum Asset Allowance

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

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

Remedial Care Expense

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

Effective Dates	Remedial Care Expense
July 1, 2017 to December 31, 2017	$186
January 1, 2017, to June 30, 2017	$196
~~July 1, 2016 - December 31, 2016~~	~~$196~~

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

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, 2017 to June 30, 2018	$7,106
July 1, 2016, to June 30, 2017	$6,280

Effective Dates	SAPSNF
~~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

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

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

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O. Appendix H Lawfully Present Noncitizens

Appendix H

Lawfully Present Noncitizens

A lawfully present noncitizen is a noncitizen who has been granted the right to enter or stay in the United States and has not violated the terms of their agreement.

> ~~**Deferred Action for Childhood Arrivals (DACA)**~~
>
> ~~For the purpose of determining health care eligibility, people granted Deffered Action for Childhood Arrivals (DACA) are not lawfully present noncitizens.~~

For eligibility information for Minnesota Health Care Programs, see the MA Immigration Status and MinnesotaCare Lawful Presence sections.

Immigration statuses that are lawfully present include, but are not limited to:

- Afghan and Iraqi Special Immigrant
- Amerasian
- Asylee, including:
  - pending applicants for asylum under the age of 14 who have had an application pending for at least 180 days, or
  - pending applicants for asylum age 14 or older who have been granted employment authorization
- Battered Noncitizen, including a child of a Battered Noncitizen
- Beneficiary of an approved visa petition with a pending application for adjustment of status
- Conditional Entrant
- Deferred Action
- Deferred Enforced Departure decision by the President of the United Sates
- Family Unity Beneficiary
- Granted an Administrative Leave
- Granted employment authorization under 8 CFR 274a.12(c). See the USCIS website for a list of employment authorized categories.
- Haitian Entrant
- Humanitarian Parolee
- Lawful Permanent Resident
- Lawful Temporary Resident

- Lawfully present in American Samoa
- Marshall Islander
- Micronesian
- Noncitizens receiving services at the Centers for Victims of Torture
- Nonimmigrant Status, including, but not limited to people with:
  - K-Visas
  - Student Visas
  - T-Visas
  - U-Visas
  - V-Visas
  - Worker Visas
- Palauan
- Refugee
- Special Immigrant Juvenile Status (SIJS), including pending applicants for SIJS
- Temporary Protected Status (TPS), including pending applicants for TPS who have been granted employment authorization
- Temporary Resident Status under 8 USC 1160 or 1255a
- Trafficking Victim
- Withholding of Removal

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 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

Code of Federal Regulations, title 42, section 435.406

Code of Federal Regulations, title 45, section 152.2

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