Minnesota Health Care Programs

Eligibility Policy Manual

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

Manual Letter #18.2

April 1, 2018

Manual Letter #18.2

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

I. Summary of Changes

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

A. EPM Home Page

DHS Bulletin #18-21-01, DHS Explains how to Treat ABLE Accounts in Determining MHCP eligibility has been added to the EPM home page as the policy for this bulletin has not been incorporated into the EPM yet.

DHS Bulletin #18-21-03, Periodic Data Matching for Medical Assistance and MinnesotaCare has been added to the EPM home page as the policy for this bulletin has not been incorporated into the EPM yet.

B. Section 1.2.1 MHCP Application Forms

This section has been updated to remove language instructing applicants applying for Payment of Long Term Care Facility Services to apply using the online application at ApplyMN.

C. Section 1.2.3 MHCP Date of Application

This section has been updated to remove language instructing applicants applying for Payment of Long Term Care Facility Services to apply using the online application at ApplyMN.

D. Section 1.2.6 MHCP Signature

This section has been updated to remove references to the ApplyMN online application.

E. Section 1.4 MHCP State Residency

This section has been updated to clarify existing policy that an applicant or enrollees immigration status cannot be used as a means by which to establish an inconsistency in state residency.

F. Section 2.1.2.2.1 MA Citizenship

This section has been updated to clarify that the reasonable opportunity period for applicants to provide verification of citizenship cannot be extended past the 90 plus 5 days that are allowed under the reasonable opportunity period.

G. Section 2.1.2.2.2 MA Immigration Status

This section has been updated to clarify existing policy that an applicant or enrollees immigration status cannot be used as a means by which to establish an inconsistency in state residency.

H. Section 2.1.2.5 MA Social Security Number

This section has been updated to clarify that the MA social security number process consists of both pre-eligibility and post- eligibility requirements. Additionally, it now provides guidance on how to prove an exception to having a social security number.

I. Section 2.2.2.1 MA-FCA Bases of Eligibility

The language in this section was updated to consistently refer to the age of infants as age 0 though 1.

J. Section 2.2.3.5 MA-FCA Income Verification

This section was updated to clarify that we cannot require verification or an explanation from an individual who reports no income unless there is other evidence of inconsistent information. This section was also updated to add legal citation Code of Federal Regulations, title 42, section 435.948.

K. Section 2.2.4.2 MA-FCA Renewals

This section was updated to remove incorrect policy regarding renewals and further clarifies policy regarding late renewals.

L. Section 2.3.2.2 MA-ABD Certification of Disability

This section was updated to add further clarification that a person does not need a disability basis in MA to be excluded from managed care. This section was also updated to align policy with the SMRT ISDS referral process.

M. Section 2.3.3.2.7.1 MA-ABD Liquid Assets

This section was updated to include policy on how to treat virtual currency when determining eligibility.

N. Section 2.3.3.4.1 MA-ABD Spenddown Types

This section was updated to add a missing exception to the list of people who can choose the designated provider option.

O. Section 2.3.4.2 MA-ABD Renewals

This section was updated to remove incorrect policy regarding renewals and further clarifies policy regarding late renewals.

P. Section 2.4.1 MA-LTC Eligibility Requirements

This section was updated to remove instructions directing MA LTC applicants to use the ApplyMN online application.

Q. Section 2.4.1.3 MA-LTC Uncompensated Transfers

This section was updated to clarify that a distribution of assets as directed by a court order are not considered an uncompensated transfer.

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

This section was updated to clarify that enrollees active under a IV-E foster care/kinship or adoption assistance basis of eligibility are treated differently.

S. Section 2.4.2.5 MA-LTC Income Calculations

This section was updated to clarify exceptions to what is counted as total income for an applicant or enrollee.

T. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

This section was updated to clarify what is included as an acceptable medically necessary expense.

U. Section 3.2.3.2 MinnesotaCare Employer-Sponsored Coverage

This section was revised to include the full IRS definition of minimum value as it relates to employer-sponsored coverage for MinnesotaCare.

V. Section 3.2.4 MinnesotaCare Social Security Number

This section was updated to clarify that the agency's responsibility to assist the applicant in resolving discrepancies that are preventing verification of their social security number. This section adds policy about extending the 95-day period to resolve SSN discrepancies.

W. Section 3.3.4 MinnesotaCare Income Verification

This section was updated to include missing policy on post eligibility verification for projected annual income for MinnesotaCare. Additional clarification was added regarding verifying projected annual income for someone who is newly eligible for MinnesotaCare due to a change in circumstances and clarification regarding requesting verification when no income is reported.

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 1.2.6 MHCP Signature

E. Section 1.4 MHCP State Residency

F. Section 2.1.2.2.1 MA Citizenship

G. Section 2.1.2.2.2 MA Immigration Status

H. Section 2.1.2.5 MA Social Security Number

I. Section 2.2.2.1 MA-FCA Bases of Eligibility

J. Section 2.2.3.5 MA-FCA Income Verification

K. Section 2.2.4.2 MA-FCA Renewals

L. Section 2.3.2.2 MA-ABD Disability Certification

M. Section 2.3.3.2.7.1 MA-ABD Liquid Assets

N. Section 2.3.3.4.1 MA-ABD Spenddown Types

O. Section 2.3.4.2 MA-ABD Renewals

P. Section 2.4.1 MA-LTC Eligibility Requirements

Q. Section 2.4.1.3 MA-LTC Uncompensated Transfers

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

S. Section 2.4.2.5 MA-LTC Income Calculations

T. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

U. Section 3.2.3.2 MinnesotaCare Employer-Sponsored Coverage

V. Section 3.2.4 MinnesotaCare Social Security Number

W. Section 3.3.4 MinnesotaCare Income Verification

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.

2018 Manual Letters

MHCP EPM Manual Letter #18.1, January 1, 2018

MHCP EPM Manual Letter #18.2, April 1, 2018

2017 Manual Letters

MHCP EPM Manual Letter #17.1, April 1, 2017

MHCP EPM Manual Letter #17.2, June 1, 2017

MHCP EPM Manual Letter #17.3, August 1, 2017

MHCP EPM Manual Letter #17.4, September 1, 2017

MHCP EPM Manual Letter #17.5, December 1, 2017

2016 Manual Letters

MHCP EPM Manual Letter #16.1, June 1, 2016

MHCP EPM Manual Letter #16.2, August 1, 2016

MHCP EPM Manual Letter #16.3, September 1, 2016

MHCP EPM Manual Letter #16.4, December 1, 2016

Bulletins

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

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

- Corrected Bulletin #17-21-01C, DHS Explains Policy and Procedures for MA Cost-Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEBAs Are Not CEHI
- Bulletin #17-21-05, DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- ~~Bulletin #17-21-08, DHS Explains Changes to the Minnesota Health Care Programs (MHCP) Application for Medical Assistance for Long-Term Care Services (MA-LTC)~~
- Bulletin #18-21-01 DHS Explains how to Treat ABLE Accounts when Determining MHCP eligibility
- Bulletin #18-21-03 Periodic Data Matching for Medical Assistance and MinnesotaCare

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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Previous Versions

Manual Letter #18.1 January 1, 2018

Manual Letter #17.5, December 1, 2017

Manual Letter #17.4, September 1, 2017

Manual Letter #17.3, August 1, 2017

Manual Letter #17.2, June 1, 2017

Manual Letter #17.1, April 1, 2017

Manual Letter #16.4, December 22, 2016

Manual Letter #16.3, September 1, 2016

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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:

MA-FCA
MinnesotaCare
APTC
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. An applicant must submit a complete application within 30 days of the written request. 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 applicant must submit a complete paper application and provide information needed to determine eligibility within 30 days of the written request. A request to apply only sets the date of application for applicants who later submit a paper application ~~or use ApplyMN to request MA for Payment of Long Term Care Facility Services.~~ Applicants who apply through ~~the~~ MNsure.org ~~online application~~ must submit the online 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 1.2.6 MHCP Signature

Minnesota Health Care Programs

1.2.6 Signature

Application Signature

The application filer or their authorized representative must sign the application.

- People under 18 who do not live with a parent, relative caretaker, foster parent, or legal guardian may sign an application on their own behalf. This includes both minors with and without children.

Electronic Signature

The MNsure ~~and ApplyMN~~ online application~~s~~ allow~~s~~ for an electronic signature. The electronic signature is a legally valid signature; having the same legal effect as a written signature.

People Unable to Provide Signature

People who are mentally competent but unable to sign the application due to physical or other limitations may:

- Sign electronically
- Sign a paper application by making a distinct mark, such as an X. Two witnesses must sign and date the application to verify that the person making the mark is indeed the person who is applying.

An authorized representative or a court appointed guardian or conservator must sign the application for people who are not mentally competent. An authorized representative is a person or organization authorized by an applicant or enrollee to apply for any of the health care programs and to perform the duties required to establish and maintain eligibility. See the Minnesota Health Care Programs (MHCP) Authorized Representative policy for more information.

Renewal Signature

The application filer must sign the renewal when a renewal signature is required.

A signature is required on a pre-populated renewal form. Enrollees who receive a paper renewal are required to complete, sign and return the renewal.

No signature is required for enrollees automatically renewed based on information provided through the new eligibility system.

Legal Citations

Code of Federal Regulations, title 42, section 155.230

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 42, section 435.923

Code of Federal Regulations, title 45, section 155.335

Minnesota Statutes, section 256L.05

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E. Section 1.4 MHCP State Residency

Minnesota Health Care Programs

1.4 State Residency

Minnesota Health Care Programs (MHCP) are only available to Minnesota residents.

People Age 21 or Older

- People age 21 or older are a Minnesota resident if one of the following applies.
- The person is living in Minnesota AND intends to reside in the state. This includes people without a fixed address.
- The person is living in Minnesota AND has entered the state with a job commitment or is seeking employment (whether or not currently employed).

If a person is not capable of indicating intent, the person is a Minnesota resident if they are living in Minnesota. A person is not capable of indicating intent if they meet any of the following:

- Have an I.Q. of 49 or less
- Have a mental age of seven or less
- Is determined legally incompetent by a court
- Is found incapable of indicating intent by a physician, psychologist, or other person licensed by the state in the field of intellectual disability

People Younger Than Age 21

People under age 21 who are emancipated follow the policy for people age 21 or older. Otherwise, people under age 21 are a Minnesota resident if one of the following applies.

- The person is living in Minnesota, including people without a fixed address
- The person resides with a parent or caretaker who is a Minnesota resident

Living in Minnesota

A person is living in Minnesota if they reside in the state. To reside in the state means the person has made Minnesota their home.

If a person is not physically present in Minnesota, a person is living in Minnesota if they meet a condition for temporary absence.

People visiting Minnesota, including for the purpose of obtaining medical care, do not reside in Minnesota and are not residents of the state.

Inconsistent Information Regarding State Residency

People are not required to provide proof of residency unless the person's attestation related to residency is inconsistent with other information provided by the person or known to the agency. The person may have to provide proof of residency to resolve the inconsistency.

A person's immigration status cannot be used to establish an inconsistency in state residency. Additional information about state residency can only be requested if information other than immigration status is inconsistent with attested state residency.

Examples of inconsistent information regarding state residency include, but are not limited to:

- Receipt of a Public Assistance Reporting Information System (PARIS) interstate match
- Returned mail with an out of state forwarding address
- Other information or circumstances that may yield information about state residency

Acceptable proof of state residency includes, but is not limited to:

- Correspondence showing a person receives mail at the address given
- A copy of a valid Minnesota drivers' license or ID card. A valid driver's license is a license that is not expired, suspended, revoked or canceled. The license must contain the person's current address. If the person moves, they must get a new Minnesota drivers' license within 30 days. A Minnesota driver's license is not valid if the person also possesses a driver's license issued by another state.
- The most recent federal or state tax forms showing the person's current address
- A copy of a Minnesota property tax statement
- A copy of a rental or lease agreement
- Documentation that the person came to Minnesota in response to an offer of employment
- Documentation that the person has looked for work, such as completed job applications or documentation from employers, the local job service office or temporary employment agencies
- An affidavit from a person engaged in public or private social services, legal services, law enforcement or health services that states he or she knows the person and believes the person resides in Minnesota
- For preschool, elementary and secondary school-age children, a copy of a student identification card, report card, day care receipt or other documentation of school or day care registration
- A completed Proof of Residence (DHS-6035A) form

People who are a Resident of Another State

People cannot be residents of more than one state. Generally, if another state has determined a person to be a resident of their state then they are not a Minnesota resident.

In cases where two or more states cannot resolve which state is the state of residence, the person is a resident of the state in which they are physically located.

Overlapping State Coverage

People must not receive Medical Assistance (MA) from more than one state at a time. A person who has MA coverage in another state may be eligible for MA when the person:

- Meets all other eligibility factors for a Minnesota Health Care Program,
- Has requested the other state close coverage, and
- Cannot reasonably access coverage from the other state.

Residency Rules for Certain Populations

The following groups of people have special rules for determining their state of residency:

- People, of any age, who receive a State Supplementary Payment (SSP) are residents of the state paying the SSP. SSP is a state paid supplement to federally funded Supplemental Security Income (SSI). Minnesota Supplemental Aid (MSA) is Minnesota's SSP. A person who receives MSA is a Minnesota resident. A person who receives a SSP from another state is not a Minnesota resident.
- People who receive Title IV-E or state-funded adoption assistance or foster care
- People who reside in an institution

Legal Citations

Code of Federal Regulations, title 42, section 435.403

Minnesota Statutes, section 256B.056, subdivision 1

Minnesota Statutes, section 256L.09

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F. Section 2.1.2.2.1 MA Citizenship

Medical Assistance

2.1.2.2.1 Citizenship

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

U.S. Citizen

A U.S. citizen is someone who is born in the U.S. (including U.S. territories, except for American Samoa) or who was born outside the U.S. and who either:

- Was naturalized as a U.S. citizen
- Derived citizenship through the naturalization of their parent(s)
- Derived citizenship through adoption by U.S. citizen parents, provided certain conditions are met
- Acquired citizenship at birth because he or she was born to U.S. citizen parent(s)
- Became a U.S. citizen by operation of law

U.S. National

A U.S. national is someone who is a U.S. citizen or owes permanent allegiance to the U.S. With extremely limited exceptions, all noncitizen U.S. nationals are people born in American Samoa or people born abroad with one or more American Samoan parents under certain conditions.

Verification

Citizenship may be verified electronically at the time of application. The county, tribal, or state agency must attempt and exhaust all trusted electronic sources prior to requiring paper documentation from the enrollee. A data match with the Federal Data Services Hub (FDSH) or the Social Security Administration (SSA) is the preferred method of verifying citizenship for MHCP applicants and enrollees. Only applicants and enrollees whose U.S. citizenship or U.S. national status cannot be verified electronically must provide proofs.

Eligibility must be approved for applicants who meet all other eligibility criteria and attest to meeting the citizenship eligibility requirement. A person approved for MA without verification of their citizenship status has a reasonable opportunity to work with the agency to resolve clerical discrepancies preventing electronic verification or to provide proof. A notice must be sent to the enrollee to indicate they have 90 days, plus 5 days for mailing, from the date of the notice to satisfy

the request. The 90 days plus 5 days for mailing cannot be extended for citizenship verification for MA enrollees. Coverage must end with a 10-day advance notice if the person fails to ~~cooperate~~ follow through with the verification process.

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

People who were previously enrolled in MA in another state were required to verify citizenship as a condition of eligibility for MA. As such, verification of citizenship obtained from another state's MA program is an acceptable form of verification. Proof of citizenship may be requested from the state where the client was previously enrolled in MA, if it is not available through other sources. A signed release, such as the Minnesota Department of Human Services (DHS -2243A) must be obtained from the client to contact another state's MA program agency.

Once citizenship is verified, county, tribal and state servicing agencies cannot request proof again, unless an agency possesses inconsistent information regarding a person's citizenship.

Paper Proof of Citizenship

Applicants and enrollees who must provide proof because citizenship could not be electronically verified can submit a copy of one of the following to verify U.S. citizenship:

- U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or card was issued without limitation
- Certificate of Naturalization
- Certificate of Citizenship
- Valid Minnesota Enhanced Driver's License or Enhanced Identification Card
- Documentary evidence issued by a federally recognized Native American Tribe which identifies the tribe that issued the document , identifies the individual by name, and confirms the individuals membership, enrollment or affiliation with the tribe. These documents include a tribal enrollment card, a certificate for Degree of Indian Blood; a Tribal census document; or documents on tribal letterhead, issued under the appropriate tribal official.

Applicants and enrollees can also verify citizenship by submitting a copy of one document from each of the following two lists:

- List 1
    - U.S. public birth certificate or other birth document
        - The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction.
        - For people born in Minnesota, birth records can only be obtained by sending the Minnesota Department of Health (MDH) the Minnesota Birth Record Application

form. For people that were born in another state, birth records can be obtained directly from the state of birth.

- ~~o~~ An electronic data match with a State vital statistics agency can substitute for a List 1 document. ~~Electronic Verification of Vital Events (EVVE) is a web based system that requests birth records for the purpose of verifying U.S. Citizenship for Minnesota and other participating states. Nineteen states are currently participating in the EVVE program.~~
  - ~~Note: EVVE does not verify identity, therefore an item from List 2 must still be provided with the EVVE~~
- A Certificate of Report of Birth, issued to the U.S. citizens born outside of the U.S.; or Report of Birth Abroad of a U.S. citizen
- Certification of Birth in the U.S.
- U.S. citizen ID card
- Northern Marianas Identification Card issued by the U.S. Department of Homeland Security
- American Indian card (I-872) from the U.S. Department of Homeland Security
- Final U.S. adoption papers that show the child's name and a U.S. Place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth
- Papers showing U.S. government employment before June 1, 1976
- U.S. Military Record of Service showing U.S. place of birth
- Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000
- Medical Records showing a U. S. place of birth
- Life, Health or other insurance company record showing a U. S. place of birth
- Official religious record recorded in the U.S. showing that the birth occurred in the U.S.
- School records including pre-school records, Head Start and daycare showing the child's name of U.S. place of birth
- Federal or state census record showing U.S. citizenship or U.S. place of birth
- An affidavit can be used in lieu of a List 1 proof, if citizenship cannot be verified electronically and the person does not have any List 1 documents

- List 2

  The following are accepted as proof of identity, as long as the document has a photograph or other identifying information sufficient to establish identity, including (but not limited to) name, age, sex, race, height, weight, eye color, or address:

  - State driver's license or state ID card
  - School ID card
  - U.S. Military ID card or draft record

- Military Dependent's ID Card
- U.S Coast Guard Merchant Mariner Card
- For a child under age 19:
    - School records including pre-school or daycare records
    - Clinic, doctor or hospital records
- Two other documents containing consistent information that corroborates a person's identity
- Finding of identity from a federal or State government agency
- An affidavit can be used in lieu of List 2 proof, if citizenship cannot be verified electronically and the person does not have any List 2 documents.

Exemptions from the Citizenship Verification Requirement

The following people are exempt from the U.S. citizenship verification requirement:

- People enrolled in or entitled to enroll in Medicare. The SSA has already verified citizenship and identity for these people.
- People who receive or previously received Supplemental Security Income (SSI)
- People who receive or previously received Retirement, Survivors or Disability Insurance (RSDI) benefits due to disability (also known as SSDI). This does not include people who receive RSDI retirement or survivor's insurance benefits. They are not exempt from this requirement unless they meet another condition for exemption (such as enrollment in Medicare).
- Children who receive Northstar
- Auto newborns and children previously enrolled as auto newborns

Legal Citations

Code of Federal Regulations, title 42, section 435.406

Code of Federal Regulations, title 42, section 435.407

Code of Federal Regulations, title 42, section 435.911

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

Code of Federal Regulations, title 42, section 435.956

Code of Federal Regulations, title 42, section 435.1008

Code of Federal Regulations, title 42, section 457.320

Code of Federal Regulations, title 42, section 457.380

Patient Protection and Affordable Care Act, Public Law 111-148, section 1413

Patient Protection and Affordable Care Act, Public Law 111-148, section 14141

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G. 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 MA 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 must be verified electronically. The county, tribal, or state agency must attempt and exhaust all trusted electronic sources including SAVE, prior to requiring paper documentation from the enrollee. Applicants and enrollees whose immigration status cannot be verified electronically must be provided a period of time to submit documents or resolve discrepancies to verify immigration status.

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 work with the agency to resolve clerical discrepancies preventing electronic verification or to provide proof of status for SAVE validation. 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 satisfy the request. Coverage ends with a 10-day advance notice if the person fails to follow through with the verification process.

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

Please note, verification of immigration status cannot be used to determine the individual is not a state resident. See EPM 1.4 MHCP State Residency.

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

Code of Federal Regulations, title 42, section 435.956

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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H. Section 2.1.2.5 MA Social Security Number

Medical Assistance

2.1.2.5 Social Security Number

The Minnesota Department of Human Services (DHS) uses Social Security Numbers (SSNs) to identify applicants and enrollees and to administer Minnesota Health Care Programs (MHCP). DHS matches SSNs against records in electronic data sources to identify and verify household income and size based on the most recent tax return filed by the household tax filer.

Each person requesting Medical Assistance (MA) must provide their SSN as a condition of eligibility unless they meet an exception. People who do not have SSNs and do not meet an exception must apply for an SSN. The following are exceptions:

- An applicant who refuses to obtain an SSN because of a well-established religious objection
- A noncitizen who is not eligible to receive a SSN or does not have one and may only be issued one for a valid non-work reason
- People applying for or receiving Emergency Medical Assistance (EMA), CHIP funded MA for pregnant women or MA for people receiving services from the Center for Victims of Torture(CVT)
- A child eligible for MA as an auto newborn
- A child receiving Northstar Title IV-E Foster Care or Title IV-E Kinship Assistance
- A child receiving Northstar Title IV-E Adoption Assistance
- A child receiving Title IV-E or non-Title IV-E adoption assistance under the Interstate Compact on Adoption and Medical Assistance (ICAMA)
- Refugees applying for or receiving Refugee Medical Assistance (RMA)

An agency may request but cannot require someone who is not applying for coverage to provide a SSN. If the agency requests the SSN of a non-applicant, the disclosure must:

- be voluntary,
- only be used to determine an applicant’s eligibility for a MHCP or for a purpose directly connected to administration of the State Plan, and
- include clear information on how the SSN will be used and notice to the application filer that it is voluntary.

Pre-Eligibility Verification

~~Each applicant's SSN must be verified with the Social Security Administration (SSA) unless they meet an exemption~~ If an applicant has an SSN, it must be provided prior to the MA eligibility determination. If an applicant cannot recall their SSN or if a SSN has not been issued for the applicant, and the person does not meet an exception, the county, tribal or state servicing agency must assist the applicant in:

- completing an application for a SSN, if a SSN has not been issued for the applicant, or
- contacting the SSA to confirm the applicant's SSN if one has already been issued, ~~or~~
- ~~resolving discrepancies in the case file that are preventing successful verification~~

If an applicant must apply for an SSN, proof that the person applied for an SSN is required prior to the MA eligibility determination. The proof of application is acceptable for the MA eligibility approval until the person receives the SSN. Once the SSN is received the individual must provide it to the agency. The agency must verify the newly issued number electronically.

Verifying Exceptions to having an SSN

Certain exceptions from the requirement to have or apply for an SSN must be verified prior to the MA eligibility determination.

Well-established religious objection

- A letter or other verification from a church leader that the religion is a recognized sect of division that is conscientiously opposed to applying for a SSN
- Proof of filing for a waiver with the IRS using form 4029

Non-Immigrant unable to attain SSN other than a valid non-work reason

- No further proof is needed if the agency can determine that the applicant's status is such as they cannot work in the US
- Letter from SSA or other official that the client is not eligible for a SSN except for a valid non-work reason

Other exceptions from the requirement to have or apply for an SSN do not require proof.

Post eligibility verification

SSN's must be electronically verified with the Social Security Administration (SSA).

Eligibility cannot be delayed for an otherwise eligible applicant pending the electronic verification of a SSN if one is provided at application or when newly obtained by an enrollee. ~~issuance or verification of a SSN.~~ A notice must be sent to person to inform them that they have 95 days from the date of the

notice to provide proof of their SSN or to resolve any clerical discrepancies preventing electronic verification. The agency must assist the applicant in resolving the discrepancies in the case file that are preventing successful verification. The 95-day period can be extended if the applicant is making a good faith effort to resolve the verification.

~~When a person indicates that they have applied for an SSN they must provide proof of application. The proof of application is acceptable until the person receives the SSN. The 95 day period can be extended while waiting for SSA to issue the SSN.~~

~~The newly issued or corrected SSN must be electronically verified with the SSA.~~ ~~Electronic verification is ultimately required to verify a person's SSN.~~

MA coverage ends with 10-day advance notice, if after the 95-day period the enrollee fails to ~~cooperate~~ follow through with the SSN verification process.

Legal Citations

Code of Federal Regulations, title 20, section 422.104

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.910

Code of Federal Regulations, title 42, section 435.948

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

Code of Federal Regulations, title 42, section 457.340

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I. Section 2.2.2.1 Bases of Eligibility

Medical Assistance for Families with Children and Adults

2.2.2.1 Bases of Eligibility

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

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

- Parent:
    - Biological, natural, adoptive or step parent
    - Living with a child younger than age 19
    - Has primary responsibility for the child's care
- Caretaker Relative, including foster parents, legal guardians or others, who are:
    - A relative of a child younger than age 19, by blood, adoption, or marriage. Including:
        - 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~~ 1
    - Children's Health Insurance Program (CHIP) funded MA may be available for infants with income between 275% and 283% FPG who are not enrolled in other health insurance.
    - A CHIP funded infant who has or gains other health insurance becomes eligible for MA as a non-CHIP funded infant
- Child age 2 through 18
- Child age 19 and 20
- Adult age 21 through 64 who:

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

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

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

Beginning and Ending Bases of Eligibility

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

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

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

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

- Pregnant woman:
  - Begins the first day of the month of conception
  - Ends the last day of the month following the 60-day postpartum period
  - Begin and end dates for the pregnant woman basis of eligibility are determined using information the application or enrollee attests. Verification of pregnancy is not required to establish this basis.

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

Multiple Bases of Eligibility

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

Change in Basis of Eligibility for Enrollees

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

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

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

Legal Citations

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 435

Code of Federal Regulations, title 42, section 457.1

Minnesota Statutes, section 256B.055

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J. Section 2.2.3.5 MA-FCA Income Verification

Medical Assistance for Families with Children and Adults

2.2.3.5 Income Verification

All countable income must be verified for Medical Assistance for Families with Children and Adults (MA-FCA).

A. The applicant or enrollee must attest to current monthly household income at application, renewal or when reporting a change.

B. The applicant or enrollee's attested income, adjustments and exceptions are verified using available electronic sources.

C. Income is considered verified if:

- The attested income and the electronic data both indicate income is below the applicable MA income limit or
- The attested income is at or below the MA income limit and the electronic data indicates income above the MA limit, but they are reasonably compatible.

D. If the information cannot be verified by available electronic sources, the person must provide acceptable proof within 10 days of the request by the county, tribal or state servicing agency. Acceptable proof is paper proof.

E. The county, tribal or state servicing agency must assist clients in obtaining verification. When neither the person nor the county, tribal or state servicing are able to obtain outside verification, a reasonable explanation of the discrepancy may be accepted in circumstances where paper proof is not available such as when the source of income has stopped.

MA-FCA eligibility for enrollees cooperating and attempting to obtain verification is not closed, except for when proofs are required to complete a renewal.

An individual who reports having no income is not required to provide verification or an explanation, unless electronic sources or other information the agency has indicate there is inconsistent information. See EPM 1.3.2.4 MHCP Inconsistent Information for full policy.

Income

A wide variety of paper documentation is acceptable proof of financial eligibility. Common proof includes, but is not limited to, the following:

- Pay stub or earnings statement
- Employer statement
- Tax records
- Copy of check

- Business financial records
- Bank statement
- Interest or dividend statement
- Award letter
- Proof of alimony
- Receipt or statement of rent you receive
- Proof of asset sale (Capital Gain or Loss)
- Proof or record of other taxable income
- Proof of lump sum income
- Other proof

Federal Income Tax Adjustments

Adjustments that appear on lines 23 through 35 on IRS Form 1040 or lines 16 through 19 on the IRS Form 1040-A are subtracted from gross taxable income to calculate the adjusted gross income. Only these specific types of adjustment are allowable. A copy of the last filed IRS Form 1040 or 1040A is acceptable verification for adjustments.

Applicants and enrollees who expect to have these adjustments for the current tax year can complete the appropriate form or worksheet listed below to determine the adjustment amount. These adjustments are a calculated or limited amount and the listed proof allows applicants to report anticipated adjustment accurately.

A wide variety of paper documentation is acceptable proof of financial eligibility. Common proof includes, but is not limited to, the following:

Educator expenses

- Copy of last filed IRS Form 1040 with this adjustment listed on line 23
- Copy of last filed IRS Form 1040A with this adjustment listed on line 16

Anticipated adjustment for the current tax year

- Self-attestation of a maximum of $250 for one educators or $500 if both spouses are educators

Certain business expenses of reservists, performing artists and fee-basis government officials

- Copy of last filed IRS form 1040 with this adjustment listed on line 24

Anticipated adjustment for the current tax year

- Copy of IRS Form 2106 or 2106 EZ

Health savings account

- Copy of last filed IRS Form 1040 with this adjustment listed on line 25

Anticipated adjustment for the current tax year

- Copy of IRS Form 8889

Moving expenses

- Copy of last filed IRS Form 1040 with this adjustments listed on line 26

Anticipated adjustment for the current tax year

- Copy of IRS Form 3903

Adjustment portion of self-employment tax

- Copy of last filed IRS Form 1040 with this adjustment listed on line 27

Anticipated adjustment for the current tax year

- Copy of IRS Schedule SE

Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE) and Qualified Plans

- Copy of last filed IRS Form 1040 with this adjustment listed on line 28

Anticipated adjustment for the current tax year

- Copy of adjustment worksheets from IRS Publication 560 (pages 22-24 of the 2012 publication)

Self-employed Health Insurance

- Copy of last filed IRS Form 1040 with this adjustment listed on line 29

Anticipated adjustment for the current tax year

- Copy of the “Self-Employed Health Insurance Worksheet” for line 29 of IRS Form 1040 (page 31 of the 2013 IRS 1040 Instructions)

Penalty on Early Withdrawal of Savings

- Copy of last filed IRS Form 1040 with this adjustment listed on line 30

Anticipated adjustment for the current tax year

- Copy of 1099-INT or Form 1099-OID received from the institution, which shows the amount of penalty

Alimony Paid (spousal support)

- Copy of last filed IRS Form 1040 with this adjustment listed on line 31

Anticipated adjustment for the current tax year

- Copy of court order, divorce or separation instrument indicating amount of spousal support

IRA Deduction

- Copy of last filed IRS Form 1040 with this adjustment listed on line 32
- Copy of last filed IRS Form 1040A with this adjustment listed on line 17

Anticipated adjustment for the current tax year

- Copy of IRA Deduction Worksheet, pages 34 and 35 of the 2013 IRS 1040 Instructions
- Copy of IRA Deduction Worksheet, pages 30 and 31 of the 2013 IRS 1040A Instructions

Student Loan Interest

- Copy of last filed IRS Form 1040 with this adjustment listed on line 33
- Copy of last filed IRS Form 1040A with this adjustment listed on line 18

Anticipated adjustment for the current tax year

- Copy of Student Loan Interest Deduction Worksheet, page 36 of the 2013 IRS 1040 Instructions
- Copy of Student Loan Interest Deduction Worksheet, page 32 of the 2013 1040A instructions

Tuition and Fees

- Copy of last filed IRS Form 1040 with this adjustment listed on line 34
- Copy of last filed IRS Form 1040A with this adjustment listed on line 19

Anticipated adjustment for the current tax year

- Copy of IRS Form 8917

Domestic Production Activities

- Copy of last filed IRS Form 1040 with this adjustment listed on line 35

Anticipated adjustment for the current tax year

- Copy of IRS Form 8903

Other Income Proofs

A wide variety of documentation proof is acceptable proof of financial eligibility. Common proof includes, but is not limited to, the following:

Nontaxable foreign earned income and housing cost of citizens or residents of the United States living abroad

- Tax records
- Income statement

Nontaxable interest income

- Tax records
- Bank statement

Nontaxable Social Security and tier one railroad retirement benefits

- Benefit statement
- Award letter
- SSA/RRB Form 1099

Scholarships, awards or fellowship grants used for education purposes and not for living expenses

- Proof of scholarship or grant for education purposes
- Student loan statement

Certain American Indian/Alaska Native income

- Proof of American Indian or Alaska Native income

Lump Sum income

- Proof of lump sum income

When neither the person nor the county, tribal or state servicing are able to obtain outside verification, a reasonable explanation of the discrepancy may be accepted in circumstances where paper proof is not available such as when the source of income has stopped.

Legal Citations

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 435.952

Minnesota Rules, part 9505.0095

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K. Section 2.2.4.2 MA-FCA Renewals

Medical Assistance for Families with Children and Adults

2.2.4.2 Renewals

Enrollees in Medical Assistance for Families with Children and Adults (MA-FCA) must have eligibility renewed every 12 months. Renewing eligibility means redetermining eligibility.

Annual Renewal Month

The annual renewal month is the month in which eligibility is redetermined for the next 12 months. The first annual renewal month after application is 12 months from the month of application and occurs annually thereafter as long as the enrollee remains eligible for MA.

Consent to Use Federal Tax Information

Applicants have the option when completing the application to allow the use of income data from the Internal Revenue Service to renew eligibility. Applicants choose one of six options for authorizing automatic eligibility redeterminations:

- Five years
- Four years
- Three years
- Two years
- One year
- Do not use information from my tax returns to renew my coverage

When authorized by the applicant, eligibility is redetermined using information in the case file that can be verified through electronic data sources.

Automatically Renewed MA-FCA Enrollees

Enrollees who have their eligibility automatically renewed receive a notice that includes a summary of the information used to renew their eligibility. If all of the information is correct, the enrollee does not need to do anything. If any of the information is inaccurate, the enrollee must report any corrections or changes.

Renewal Form for MA-FCA Enrollees

Enrollees whose eligibility is not automatically renewed will receive a renewal form. Enrollees must review, make any changes or updates, sign and return the renewal form to their servicing agency within 30 days from the issuance date on the renewal notice.

Late Renewals

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

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

Eligibility for enrollees who do not return the renewal form, or who return the form but do not provide all the information and verifications needed to renew eligibility, is closed. However, eligibility for enrollees who are closed for failing to renew may be redetermined without requiring a new application if the form is returned within four months of the date of closure. A late renewal is a new application. All application policies apply. ~~The original certification period and renewal date apply.~~

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.056, subdivision 7a

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L. Section 2.3.2.2 MA-ABD Certification of Disability

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

2.3.2.2 Certification of Disability

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

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

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

Medicare

- An individual does not need a disability determination if they are eligible for Medicare, and lose their RSDI benefits because they earn more than the Substantial Gainful Activity (SGA) level. These people are eligible for the Medicare extension (As long as SSA considers these people to remain disabled during the Medicare extension, they continue to meet a disabled basis for MA).

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

Disability Certification for MA Eligibility

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

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

- Community Alternative Care (CAC) waiver
- Community Access for Disability Inclusion (CADI) waiver

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

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

Disability Certification for Other Reasons

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

- To be excluded from managed care enrollment
  - A person does not have to use a disability basis of eligibility for Medical Assistance in order to be excluded from managed care enrollment
- To enroll in Special Needs Basic Care (SNBC), a specialized managed care plan for people age 18-64 with a certified disability

Additional reasons for needing a disability certification include:

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

State Medical Review Team Certification of Disability

SMRT completes disability determinations for people not certified disabled by SSA. SMRT certifies disability using the same disability criteria as the SSA.

Referral Process

SMRT referrals must be made even if the person has been referred to SSA because ~~Since~~ the SSA disability determination process can be long. The county, tribal or state servicing agency completes a SMRT Referral for a Disability Determination and submits it through ISDS. ~~(DHS-6123). The person is also referred to SSA for disability determination and benefits~~.

Expedited Case Criteria

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

- The person has a condition that appears on the SSA Compassionate Allowance Listing (CAL)
- The person is awaiting discharge from a facility and can be discharged immediately if MA is approved
- The person has a potentially life-threatening situation and requires immediate treatment or medication
- Other circumstances that may jeopardize a client's benefits. The circumstance is reviewed and accepted on a case by case basis
- ~~The person has had a MNCHOICES assessment within the past 60 days and received services that can only be paid by a home and community based services waiver.~~

Continuing Disability Review

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

Legal Citations

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

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

Code of Federal Regulations, title 42, section 435.541

Minnesota Statutes, section 256.01

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M. Section 2.3.3.2.7.1 MA-ABD Liquid Assets

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

2.3.3.2.7.1 Liquid Assets

Liquid assets include cash or any other types of assets that can be converted to cash within 20 workdays. Workdays are any days other than Saturdays, Sundays, and federal holidays. This section discusses the types of liquid assets and clarifies whether they count towards the person's asset limit.

Evaluation of Liquid Assets

The total cash value of a liquid asset is counted towards the person's asset total unless the proof provided indicates that the asset is any of the following:

- An Excluded Asset
- An Unavailable Asset
- A Jointly Owned Asset

Assumption of Liquidity

Absent evidence to the contrary, assume the following types of resources are liquid:

- Bonds
- Certificates of Deposit (CDs)
- Checking accounts
- Foreign Currency
- Guardianship accounts
    - The total value of the guardianship account the person owns or the person or someone acting on behalf of the person has a legal right to use for the person's support and maintenance is counted.
- Money market account
- Mortgages (Applicant or enrollee is the lender)
- Mutual fund shares
- Promissory notes (Applicant or enrollee is the lender)

- Savings accounts
- Stocks
- Time deposits
- Treasury Bills
- United States Savings Bonds
- Virtual currency

Assumption of Non-Liquidity

Absent evidence to the contrary, the following types of assets are assumed not to be liquid:

- Automobiles, trucks, tractors and other vehicles
- Buildings, land and other real property rights
- Household goods and personal effects
- Machinery and livestock
- Non-cash business property

Legal Citations

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

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N. Section 2.3.3.4.1 MA-ABD Medical Spenddown Types

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

2.3.3.4.1 Medical Spenddown Types

A medical spenddown is a cost-sharing approach that allows Medical Assistance (MA) eligibility for people whose income is greater than the applicable income limit. Federal rules refer to this population as “medically needy.” People can become income eligible for MA by “spending down” their excess income to the spenddown standard. The person’s excess income is reduced by the amount of certain incurred health care expenses.

There are two medical spenddown types: a six-month spenddown and a monthly spenddown.

Six-month spenddown:

A six-month spenddown is the difference between the person’s net income for a six-month period and the applicable Federal Poverty Guidelines (FPG) for a six-month period. Each household member may have a different spenddown amount depending on their net income and the FPG standard used to determine that member’s eligibility but all household members with a spenddown must use the same spenddown type.

- Household members whose eligibility is determined using a family size of one are not required to use the same spenddown type as other household members.

Allowable health care expenses are applied to the six-month spenddown in a specific order by the date the expense was incurred. The six-month spenddown must be met by the end of the application month or the date the application is processed, whichever is later.

The date on which the person has incurred medical expenses that meet or exceed the six-month spenddown is called the satisfaction date. The amount of medical expenses the enrollee is responsible to pay on the satisfaction date is called the recipient amount. MA pays for covered services beginning with the first dollar incurred above the recipient amount and for the rest of the six-month period as long as the enrollee continues to meet all eligibility requirements.

Monthly spenddown:

A monthly spenddown is the difference between the person’s net income for a one-month period and the applicable FPG standard for that month. The spenddown is determined separately for each month of a six-month period. Each household member may have a different spenddown amount depending on their net income and the FPG standard used to determine that member’s eligibility but all household members with a spenddown must use the same spenddown type.

The monthly spenddown is used when a person cannot meet a six-month spenddown or chooses a monthly spenddown. There is no satisfaction date for a monthly spenddown. MA pays for covered services beginning with the first dollar incurred above the monthly spenddown amount in each month.

- People may choose to prepay their monthly medical spenddown to the Minnesota Department of Human Services (DHS). This is called the Client Option Spenddown. The Client Option Spenddown cannot be used when the person is enrolled in Minnesota Senior Health Options (MSHO) unless the person was enrolled in MSHO before countable income increased above the applicable FPG standard.

- People, who do not meet their spenddown with incurred health care insurance premiums or the remedial care expense deduction, can choose to pay the balance of their monthly spenddown amount to the same provider each month. This is called the Designated Provider Option. People may choose the Designated Provider Option if they meet all of the following conditions:

  - They receive one of the following types of services:
    - Personal Care Attendant (PCA) services
    - Child-welfare targeted case management services
    - One of the following home and community-based waivers:
      - Brain Injury (BI)
      - Community Alternatives for Disabled Individuals (CADI)
      - Community Alternative Care (CAC)
      - Developmental Disabilities (DD)
      - Elderly Waiver (EW) ~~unless the person is enrolled in MSHO~~
        - <u>Exception: EW enrollees cannot choose the designated provider option if they are enrolled in MSHO or MSC+</u>
  - They are the only members of the MA household with a spenddown.
  - Their spenddown can be met with incurred health care expenses from one provider.

Enrollees can meet their spenddown using a provider other than the designated provider only in emergencies. Enrollees must report the emergency use within five days of incurring the expense to the county or tribal agency.

Spenddown Adjustments

Medical spenddowns may be adjusted when the person reports a change in income or medical expenses.

Legal Citations

Code of Federal Regulations, title 42, section 435.831

Minnesota Statutes, section 256B.056, subdivision 5

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O. Section 2.3.4.2 MA-ABD Renewals

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

2.3.4.2 Renewals

Annual Renewal

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

Six-Month Renewal

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

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

Monthly Renewals

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

Late Renewals

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

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

Eligibility for enrollees who do not return the renewal form, or who return the form but do not provide all the information and verifications needed to renew eligibility, is closed. However, eligibility for enrollees who are closed for failing to renew may be redetermined without requiring a new

application if the form is returned within four months of the date of closure. A late renewal is a new application. All application policies apply. ~~The original certification period and renewal date apply.~~

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P. Section 2.4.1 MA-LTC Eligibility Requirements

Medical Assistance for Long-Term Care Services

2.4.1 Eligibility Requirements

This subchapter provides general policy information that applies to Medical Assistance for Long-Term Care Services (MA-LTC).

LTC Eligibility Factors

People requesting MA-LTC must meet all of the following eligibility factors to be eligible:

- Must be eligible for MA
- Requires a nursing facility level-of-care as determined through a Long-Term Care Consultation (LTCC)
- Must have home equity at or below the home equity limit
- Must not be subject to a period of ineligibility under the uncompensated transfer rules
- Must name the state the remainder beneficiary of certain annuities

Eligibility for MA

People who request MA-LTC are required to meet all of the eligibility requirements for MA before determining if the person meets the eligibility requirements for MA-LTC. MA eligibility is determined under MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) or MA with Families with Children and Adults (FCA) basis of eligibility.

People eligible for MA with an ABD basis of eligibility are eligible MA-LTC if they meet the other LTC eligibility requirements.

People eligible for MA with an FCA basis of eligibility are only eligible to receive MA-LTC in a long-term care facility (LTCF) if they meet the other LTC eligibility requirements. They are not eligible to receive services through a home and community-based services (HCBS) waiver. If a person with a FCA basis of eligibility needs services through an HCBS waiver, the person would need to be determined eligible under one of the ABD bases of eligibility.

Minnesota Health Care Programs Applications

MA applicants who are requesting LTC services should use ~~one of~~ the following form~~s~~:

- Application for Payment of Long-Term Care Services (DHS-3531)
- ~~ApplyMN (only for people requesting LTCF services)~~

MA enrollees who are requesting LTC services should use one of the following forms:

- Minnesota Health Care Programs Request for Payment of Long-Term Care Services (DHS-3543)
- Minnesota Health Care Programs Payment of Long-Term Care Services for MA for Families with Children and Adults (DHS-3543A)

Claims for MA-LTC services cannot be paid until the enrollee is determined eligible for MA-LTC.

- If the enrollee is requesting services because of a move to an LTCF, eligibility can begin the date the enrollee moved into the LTCF or the date that all eligibility requirements for MA-LTC are met, whichever is later.
- If the enrollee is requesting services through an HCBS waiver, eligibility can begin no earlier than the date of the LTCC or the date the enrollee meets all eligibility requirements for MA-LTC, whichever is later.

Notification

People who request MA-LTC are notified of the results of the eligibility determination through either a system generated or a manual notice. ”Notice of Action for Medical Assistance (MA) Payment of Long-Term Care Services” (DHS-4915).

The lead agency assessor or case manager, or the LTCF, is notified when the person becomes eligible so that LTC services can begin.

Legal Citations

Minnesota Statutes, section 256B.056, subdivision 2a

Minnesota Statutes, section 256B.056, subdivision 11

Minnesota Statutes, section 256B.0595

Minnesota Statutes, section 256B.0911

United States Code, title 42, section 1396p

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Q. Section 2.4.1.3 MA-LTC Uncompensated Transfers

Medical Assistance for Long-Term Care Services

2.4.1.3 Uncompensated Transfers

The transfer of an asset or income without adequate compensation, known as an uncompensated transfer, may result in a period of ineligibility for Medical Assistance for Long-Term Care Services (MA-LTC). The transfer of an asset or income is assumed to be for the purpose of obtaining or maintaining eligibility for MA-LTC unless the person provides convincing evidence that proves otherwise. County, tribal, or state agency workers must only evaluate transfers that are disclosed on an application or are discovered through a fraud investigation.

The period of ineligibility that may result due to an uncompensated transfer is known as a transfer penalty, and occurs if all of the following apply:

- The transfer was made by any of the following people:
  - The person
  - The person's spouse
  - A person's authorized representative acting on behalf of the person or the person's spouse
  - A court or administrative body acting at the direction of the person or the person's spouse
  - A court or administrative body with legal authority to act in place of the person or the person's spouse
- The transfer occurred within the lookback period or while the person is receiving MA-LTC,
- The person did not receive adequate compensation, and
- No transfer penalty exception applies.

Transactions that occur outside the lookback period are not evaluated and are not subject to transfer penalties.

This section of the manual details the uncompensated transfer.

Transfer of Ownership

A transfer occurs when a person or the person's spouse gives away, sells, conveys ownership, and/or reduces control, or disposes of any asset or income or an interest in an asset or income.

Uncompensated transfers may include, but are not limited to:

- Transferring an interest in a life estate to another person

- Establishing an interest in a life estate
- Annuitizing an annuity
- Transferring assets or income into a client-funded trust
- Transferring assets or income into a special needs or pooled trust after the person turns age 65
- Assigning the right to an income stream to another person
- Reducing or eliminating ownership or control of income or assets held in common with another person or persons
- Placing an asset into joint ownership with another person thereby reducing or eliminating ownership, interest, control or right to sell or dispose of an asset
- Any action that results in a person giving up the right to income or assets to which the person is entitled, unless:
    - The person cannot afford to take action to obtain the asset or income.
    - The cost of taking the action is more than the asset or income is worth. Examples of this type of transfer include:
        - Refusing to accept an inheritance or testamentary gift, unless the costs associated with accepting it exceed the value of the gift.
        - A spouse's refusal to take an action to receive his or her elective share of a spouse's estate when the value of the elective share is greater than the provisions for the surviving spouse in a will.
- Waiving pension income or diverting it to a trust or similar device for the benefit of another
- Refusing to take affordable legal action to obtain court-ordered payments that are not being paid, such as child support ~~and alimony~~ or spousal support
- Not accepting or taking action to obtain a right to personal injury settlements
- Diverting personal injury settlements by the defendant into a trust or similar legal device to be held for the benefit of the plaintiff
- Certain purchases

Uncompensated transfers do not include:

- A distribution of assets as directed by a court order
- Any actions taken during a person's lifetime that does not result in a transfer of ownership until after the person's death including:

- Creating or modifying a transfer on death deed (TODD)
- Creating or modifying a will
- Changing a designation on a life insurance policy

~~Actions taken during a person's lifetime that do not result in a transfer of ownership until after the person's death are not an actual transfer. This includes when a person creates a transfer on death deed (TODD), creates a will, or changes a beneficiary designation on a life insurance policy.~~

Certain Purchases as Transfers

A transfer takes place when a person purchases personal care or other types of services, personal or real property, a life estate interest, or an interest in a financial arrangement such as a promissory note, loan, or mortgage. The purchase may be made with cash or with another asset that has a value equivalent to the agreed upon purchase price. When a person pays more than the fair market value (FMV) of the item they are purchasing, an uncompensated transfer may have occurred. This section discusses how to evaluate purchases under transfer rules.

Purchase of Personal Care Services

The purchase of personal care services is paying another person to provide services that aid the purchaser in performing their activities of daily living. Payment for these services is not an uncompensated transfer when:

- The care or services directly benefit the person; and
- The purchaser provides compensation in an amount consistent with customary fees charged for providing similar services in the community in which the purchaser resides; and
- When a relative of the purchaser provides the care or services, a written and notarized agreement is in place on or before the date the care or services begin. The agreement must:
  - Be signed by the person receiving the care or services and the relative(s) who will be providing the care or services
  - Include an itemized list of the care or services that will be provided
  - Specify the amount of time that is anticipated to be spent providing the care and services; and
  - State the period of time the agreement covers.

The requirement to have a written agreement prior to services being provided is waived when compensation for the services provided by the relative(s) was made within 60 days after the services were provided.

Purchase of Other Services

The purchase of other services occurs when a person pays someone to perform services such as lawn care, snow shoveling, tax preparation, etc. These services are not an uncompensated transfer if:

- The service directly benefits the person; and
- The person paid an amount consistent with customary fees charged for similar services in the community in which the person resides.

Purchase of Interest in Promissory Notes, Loans and Mortgages

The purchase of an interest in a promissory note, loan, or mortgage occurs when a person buys the right to receive the payments under a contract from another person or entity. These purchases are not an uncompensated transfer if the contract meets all of the following requirements:

- The terms of the contract provide for payments to be made in equal amounts
- There is no provision for deferral of payments
- There is no provision for balloon payments
- Cancellation of the balance due upon the death of the purchaser is prohibited and
- The repayment terms are actuarially sound

Repayment terms are actuarially sound if the person will receive all of the payments within their anticipated life expectancy. To determine the total amount a person expects to receive during their life expectancy, the figure that corresponds to the purchaser's age at the time of purchase is found on the Social Security Administration (SSA) Actuarial Table, and is then multiplied by the total annual payment the purchaser will receive under the contract. If the purchase price of the interest is:

- Less than or equal to the total amount the purchaser expects to receive in their anticipated lifetime, the purchase is actuarially sound and no further evaluation under transfer rules is required.
- More than the amount that the purchaser expects to receive in their anticipated lifetime, the purchase is not actuarially sound. The difference between the purchase price and the total amount the purchaser can expect to receive during their anticipated lifetime (including principal and interest), is counted as the uncompensated value.

Purchase of Personal and Real Property

In general, a purchase price for personal or real property in an amount that exceeds the FMV of the personal or real property is an uncompensated transfer. The amount of the uncompensated transfer is the difference between the FMV of the personal or real property and the purchase price.

Purchase of a Life Estate Interest in Another Person's Home

The purchase of a life estate interest in another person's home gives the purchaser the right to occupy the property and may allow the purchaser to retain income earned by the property depending on the terms of the life estate agreement. The purchase of a life estate interest in another person's home is evaluated to determine if an uncompensated transfer has occurred.

The purchase of a life estate in another person's home is not an uncompensated transfer if:

- The FMV was more than or equal to the purchase price; and
- The person resided in the home for more than 12 consecutive months.

The purchase of a life estate in another person's home is an uncompensated transfer if either of the following occur:

- The person did not reside in the home for 12 consecutive months following the date of purchase, even if the FMV was more than or equal to the purchase price or
- The FMV was less than the purchase price of the life estate interest. The uncompensated amount is the difference between the value of the life estate interest and the purchase price.

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R. Section 2.4.2.3.1 MA-LTC Home and Community Based Services 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 my 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.

Children who are enrolled in MA Northstar Adoption Assistance or Northstar IV-E Foster Care or Title IV-E Kinship Assistance continue to use the Northstar Adoption Assistance Basis of Eligibility when they request HCBS waivers.

If a person enrolled in MA Northstar Title IV-E Foster Care or Title IV-E Kinship Assistance requests HCBS waivers, use the MA Northstar Title IV-E Foster Care and Title IV-E Kinship Assistance Basis of Eligibility.

Income Limits and Methodology

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

Legal Citations

Minnesota Statutes, section 256B.056

Minnesota Statutes, section 256B.0913

Minnesota Statutes, section 256B.092

Minnesota Statutes, section 256B.093

Minnesota Statutes, section 256B.49

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Medical Assistance for Long-Term Care Services

2.4.2.5 Income Calculations for Long-Term Care Services

Income Calculations

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

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

Community Income Calculation

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

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

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

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

LTC Income Calculation

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

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

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

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

A LTC income calculation starts with the amount of a person's total income and applies certain deductions. This calculation may result in an LTC spenddown, waiver obligation or medical spenddown. The LTC income calculation determines the LTC spenddown, waiver obligation or medical spenddown, if any, based on anticipated total income and deductions for each month of a six-month period.

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

Total Income

The anticipated amount of a person's total income is used in the LTC income calculation in the month it is expected to be received. Total income includes the gross amount of income a person receives from any source, except:

- Excluded income
  - Note: If a person is residing in an LTCF, Supplemental Security Income (SSI) and Minnesota Supplemental Aid (MSA) are counted in the month of receipt See MA LTC Income Calculation Deductions for more information.
- The person's spouse's income
- Sponsor income if the sponsor is the person's community spouse
- LTC insurance payments (LTC insurance payments are considered third-party liability)

Total income is not averaged or annualized. The Retirement, Survivors, Disability Insurance (RSDI) cost of living adjustment disregard is not applied in the LTC income calculation.

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

Retroactive adjustments are made for each month in the six-month period where the actual income or deductions differ from the anticipated income or deductions, including months in which SSI benefits are retroactively reduced by SSA because the person was in an LTCF, resulting in an SSI overpayment.

Beginning and Ending the LTC Income Calculation

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

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

The LTC income calculation ends:

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

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

LTC Spenddown

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

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

Interaction with Medicare Part A Payments

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

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

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

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

Waiver Obligation

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

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

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

Medical Spenddown

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

Legal Citations

Code of Federal Regulations, title 42, section 435.726

Code of Federal Regulations, title 42, section 435.733

Code of Federal Regulations, title 42, section 435.735

Code of Federal Regulations, title 42, section 435.832

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

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T. Section 2.4.2.5.1 MA-LTC Income Calculation Deductions

Medical Assistance for Long-Term Care Services

2.4.2.5.1 LTC Income Calculation Deductions

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

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

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

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

Special Supplemental Security Income (SSI) Deduction

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

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

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

Minnesota Supplemental Aid (MSA) Deduction

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

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

Special Personal Allowance from Earned Income

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

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

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

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

Medicare Premiums

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

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

LTC Needs Allowance

One of the following allowances is deducted:

Clothing and Personal Needs Allowance (PNA)

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

Veteran's Improved Pension

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

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

Home Maintenance Allowance (HMA)

The Home Maintenance Allowance (HMA) is equal to 100% of the federal poverty guidelines (FPG) for a household size of one. 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 judgement and decree for dissolution or marriage; and
- garnished from a source of the person's income

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

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

Health Insurance Premiums, Co-payments and Deductibles

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

Medically necessary ~~medical~~ expenses include ~~is a~~ medical services, supplies, devices, or equipment that are ~~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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U. Section 3.2.3.2 MinnesotaCare Employer-Sponsored Coverage

MinnesotaCare

3.2.3.2 Employer-Sponsored Coverage

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

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

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

When an employer offers open enrollment less often than annually for a plan that meets the minimum value and affordability standards, an employee is considered eligible for the employer-sponsored coverage during the first coverage year that follows each open enrollment period. The employee is not eligible for MinnesotaCare for the first coverage year after each open enrollment opportunity.

When an employer offers open enrollment less often than annually for a plan that meets the minimum value and affordability standards and there was no open enrollment opportunity for the current coverage year an employee is not considered to be eligible for the employer-sponsored coverage until after the next open enrollment period. The employee may be eligible for MinnesotaCare, if the employee meets all other MinnesotaCare eligibility factors, until the employer-sponsored plan is offered again.

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

Minimum Value Standard for Employer-Sponsored Coverage

An employer-sponsored health plan meets the minimum value standard if it covers at least 60 percent of the total allowed costs under the plan, and the plan's benefits include substantial coverage of inpatient hospital and physician services.

Affordability Standard for Employer-Sponsored Coverage

An employer-sponsored health plan is affordable if the employee's portion of the annual premiums for employee-only coverage does not exceed 9.56 percent of their annual household income for the tax year. The lowest-cost plan for employee-only coverage is used when determining affordability.

Employer-Sponsored Coverage for a Spouse and Dependents

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

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

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

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

Change in Affordability for Employer-Sponsored Coverage

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

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

Voluntary Disenrollment from Employer-Sponsored Coverage

People who are ineligible for MinnesotaCare because they are enrolled in employer-sponsored coverage may qualify for MinnesotaCare if the employer-sponsored coverage does not meet either the affordability or minimum value standard and they disenroll from the coverage. Eligibility begins the month after the employer-sponsored coverage ends.

Post-Employment Employer-Sponsored Coverage

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

Legal Citations

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

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

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

Code of Federal Regulations, title 42, section 600.305

Code of Federal Regulations, title 42, section 600.345

Code of Federal Regulations, title 45, section 155.320

Minnesota Statutes, section 256L.07

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V. Section 3.2.4 MinnesotaCare Social Security Number

MinnesotaCare

3.2.4 Social Security Number

The Department of Human Services (DHS) uses Social Security numbers (SSNs) to identify applicants and enrollees and to administer MinnesotaCare. DHS matches SSNs against records in electronic data sources to identify and verify household income and household size based on the most recent tax return filed by the household tax filer.

All people seeking MinnesotaCare must provide an SSN if they have one.

A person who is not applying for coverage cannot be required to provide an SSN.

Verification

Each applicant's SSN must be verified electronically with the Social Security Administration (SSA). If an applicant cannot recall his or her SSN, the county, tribal or state servicing agency must assist the applicant in:

- Contacting the SSA to confirm the applicant's SSN if one has already been issued, or
- Resolving discrepancies in the case file that are preventing successful electronic verification.

Eligibility cannot be delayed for an otherwise eligible applicant pending the verification of a SSN. A notice must be sent to the person to inform them that they have 95 days from the date of the notice to resolve an inconsistency. The 95-day period can be extended if the applicant is making a good faith effort to resolve the verification.

A newly issued or corrected SSN must be electronically verified with the SSA. The agency must assist the applicant in resolving discrepancies in the case file that are preventing successful verification. Electronic verification is ultimately required to verify a person's SSN.

MinnesotaCare is ended with 10-day advance notice, if after the 95-day period the enrollee fails to ~~cooperate~~ follow through with the SSN verification process.

Legal Citations

Code of Federal Regulations, title 45, section 155.305

Code of Federal Regulations, title 45, section 155.310

Code of Federal Regulations, title 45, section 155.315

Minnesota Statutes, section 256L.04

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W. Section 3.3.4 MinnesotaCare Income Verification

MinnesotaCare

3.3.4 Income Verification

MinnesotaCare requires verification of a person's attested Projected Annual Income (PAI). PAI must be verified through an available electronic data source or by paper proof, if electronic data sources are unsuccessful or unavailable.

The PAI is determined using the MinnesotaCare Income Methodology policy.

Household PAI includes the PAI of everyone in the household composition whose income counts. See the MinnesotaCare Household Composition policy for more information.

Eligibility is approved for applicants who meet all other eligibility criteria who attest to PAI within MinnesotaCare limit. If verification of PAI is required, the person or people whose MinnesotaCare eligibility depends on the verification are given a reasonable opportunity period of 90 days to provide appropriate proof of PAI. The 90 days begins on the date the notice is mailed informing the household of the requirement to verify. The 90-day reasonable opportunity period can be extended if the household is making a good faith effort to attain the needed information. Eligibility must end with 10-day notice when PAI is not verified using electronic or paper verification as stated below.

If someone appears to be newly eligible for MinnesotaCare after reporting a change in circumstances, verification of PAI must be provided prior to the approval of MinnesotaCare eligibility. See EPM 1.3.2.1 MHCP Change in Circumstance for full policy.

An individual who reports having no income is not required to provide verification or an explanation, unless electronic sources or other information the agency has indicate there is inconsistent information. See EPM 1.3.2.4 MHCP Inconsistent Information for full policy.

Electronic Verification

Electronic sources verify PAI when:

The attested household PAI is at or below the MinnesotaCare income limit and electronic sources indicate the household PAI is at or below the limit.

The attested household PAI is at or below the MinnesotaCare income limit and electronic sources indicates the household PAI is above the limit but is reasonably compatible.

Paper Verification

When self-attestation of PAI is below the MinnesotaCare income limit and electronic sources indicate the person's household PAI is above the limit, and the amounts are not reasonably compatible, the

person must provide paper proof to verify PAI. Paper proof is also required when electronic sources are unavailable.

The person must provide a complete copy of their most recently filed federal tax return if they have filed a federal tax return in the last three years. This includes people who currently do not expect to file a tax return for the next tax year. A complete federal tax return includes all forms and schedules. If a person expects their PAI will be different from what their most recently filed tax return shows, the person must explain why and include proof. Examples of types of proofs for income and income tax adjustments are located in the Medical Assistance for Families With Children and Adults Income Verification policy.

The county, tribal or state servicing agency must review the federal tax return and proofs to confirm that the person has reported all sources of income listed on the tax return or has explained why an income source has ended.

Federal Tax Return Only

When the person submits a federal tax return as the only proof of PAI and:

- The modified adjusted gross income derived from the tax return is less than or equal to the PAI attested on the application or renewal, the attested PAI is verified.
- The modified adjusted gross income derived from the tax return is more than the PAI attested on the application or renewal, the new amount is the PAI used to determine health care eligibility.

Federal Tax Return and Other Paper Proof

When the person submits a federal tax return and other paper proof, the modified adjusted gross income derived from the tax return information and paper proof of any changes, the new amount is the PAI used to determine health care eligibility.

Other Paper Proof

When the person has not filed a federal tax return within the last three years, and modified adjusted gross income is derived from other paper proof, the new amount is the PAI used to determine health care eligibility.

Partial or No Other Paper Proof

A signed Yearly Income Statement (DHS-7117) can verify PAI for a person who is unable to provide other proof. The Yearly Income Statement can be used on its own, or it may be used in conjunction with other paper proof if the person is able to provide only partial proof of PAI. The person must provide a copy of their most recently filed federal tax return if they have filed a federal tax return in the last three years. The Yearly Income Statement must indicate the total amount of PAI, even if paper proof exists for some of the PAI amount. The Yearly Income Statement verifies PAI only if a person has no other proof.

A person can also submit a signed affidavit to the county, tribal or state servicing agency including any partial proof and a copy of their most recently filed federal tax return if they have filed a federal tax return in the last three years.

Legal Citations

Code of Federal Regulations, title 42, section 600.345

Code of Federal Regulations, title 45, section 155.315

Code of Federal Regulations, title 45, section 155.320

Minnesota Statutes, section 256L.05, subdivision 2

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