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 #19.6

November 1, 2019

Manual Letter #19.6

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of November 1, 2019. 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

Bulletin #17-21-08, DHS Explains Changes to the MHCP Application for Medical Assistance for Long-Term Care Services (MA-LTC) is removed from the EPM home page because it does not contain MHCP eligibility policy and we do not intend to incorporate any of its content into the EPM.

We are also removing bulletin #18-21-03, Periodic Data Matching for Medical Assistance (MA) and MinnesotaCare, from the EPM home page because we are incorporating the bulletin into the EPM with this manual letter.

This manual letter is also added to the EPM home page.

B. Section 1.2.1 MHCP Application Forms

The change to this section adds a statement that it is important to ensure applicants are not asked questions that are not applicable to determining their eligibility.

C. Section 1.2.3 MHCP Date of Application

We clarify in this section that the date of application for a paper application is when the request for coverage or application is received during normal working hours. The date of application for a paper application or request for coverage submitted after normal working hours via a drop box or other method is the next business day.

D. Section 1.2.6 MHCP Signature

In this section, we clarify when an authorized representative, guardian, or court-appointed conservator must sign the application.

E. Section 1.3.1.2 MHCP Authorized Representative

The changes to this section clarify policies for authorized representative, guardianship, and conservator duties and responsibilities.

We also add that a servicing agency must determine whether a vulnerable adult referral to social services is needed when the servicing agency disqualifies an authorized representative.

F. Section 1.3.2.1 MHCP Change in Circumstances

In this section we add information that a person who becomes newly eligible for MA due to a change in circumstances may request retroactive MA up to 12 months from the month they became eligible for MA.

G. Section 1.3.2.4 MHCP Inconsistent Information

We incorporate DHS bulletin #18-21-03, Periodic Data Matching for Medical Assistance (MA) and MinnesotaCare, into this section by clarifying that the county, tribal, or state servicing agency must evaluate and pursue resolution of inconsistent information.

H. Section 2.1.1.2.4 MA Referral for Other Benefits

The changes to this section provide additional information about railroad retirement benefits and who may qualify for them.

I. Section 2.1.1.2.5 MA Periodic Data Matching

This new section incorporates DHS bulletin #18-21-03, Periodic Data Matching for Medical Assistance (MA) and MinnesotaCare, by providing the policy for periodic data matching for MA.

J. Section 2.3.1.1 Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Mandatory Verifications

We add renewals as a circumstance during which assets must be verified.

K. Section 2.3.3.2.3 MA-ABD Excluded Assets

The change to this section adds food and nutrition program payments as an excluded asset for MA-ABD eligibility.

L. Section 2.3.3.2.7.9.4 MA-ABD Special Needs Trusts

We updated this section to clarify existing eligibility policy for special needs trusts.

M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trusts

We updated this section to clarify existing eligibility policy for pooled trusts.

N. Section 2.3.3.3.2.1 MA-ABD Countable Income

The change to this section clarifies that income is counted in the month it is received.

O. Section 2.3.3.3.2.3 MA-ABD Excluded Income

The change to this section adds food and nutrition program payments as excluded income for MA-ABD eligibility.

P. Section 2.3.6 MA under the TEFRA Option

We clarify in this section that under the TEFRA option children who are otherwise ineligible for MA due to household income may become eligible because only the income of the child is counted when determining eligibility.

Q. Section 2.3.6.1.2 TEFRA Parental Fees

We clarify in this section that parents of TEFRA enrollees are not required to re-verify their income at the time of the child's TEFRA renewal.

R. Section 2.5.3 Emergency Medical Assistance (EMA)

The change to this section clarifies that children with disabilities who are ineligible for MA due to immigration status may be eligible for EMA under the TEFRA option.

S. Section 3.1.2.3 MinnesotaCare Periodic Data Matching

This new section incorporates DHS bulletin #18-21-03, Periodic Data Matching for Medical Assistance (MA) and MinnesotaCare, by providing the policy for periodic data matching for MinnesotaCare.

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 1.3.1.2 MHCP Authorized Representative

F. Section 1.3.2.1 MHCP Change in Circumstances

G. Section 1.3.2.4 MHCP Inconsistent Information

H. Section 2.1.1.2.4 MA Referral for Other Benefits

I. Section 2.1.1.2.5 MA Periodic Data Matching

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

K. Section 2.3.3.2.3 MA-ABD Excluded Assets

L. Section 2.3.3.2.7.9.4 MA-ABD Special Needs Trusts

M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trusts

N. Section 2.3.3.3.2.1 MA-ABD Countable Income

O. Section 2.3.3.3.2.3 MA-ABD Excluded Income

P. Section 2.3.6 MA under the TEFRA Option

Q. Section 2.3.6.1.2 TEFRA Parental Fees

R. Section 2.5.3 EMA

S. Section 3.1.2.3 MinnesotaCare Periodic Data Matching

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

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

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

Manual Letters

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

MHCP EPM Manual Letter #19.1, January 1, 2019

MHCP EPM Manual Letter #19.2, April 1, 2019

MHCP EPM Manual Letter #19.3 June 1, 2019

MHCP EPM Manual Letter #19.4, August 7, 2019

MHCP EPM Manual Letter #19.5, September 1, 2019

MHCP EPM Manual Letter#19.6, November 1, 2019

2018 Manual Letters

MHCP EPM Manual Letter #18.1, January 1, 2018

MHCP EPM Manual Letter #18.2, April 1, 2018

MHCP EPM Manual Letter #18.3, June 1, 2018

MHCP EPM Manual Letter #18.4, September 1, 2018

MHCP EPM Manual Letter #18.5, December 1, 2018

2017 Manual Letters

MHCP EPM Manual Letter #17.1, April 1, 2017

MHCP EPM Manual Letter #17.2, June 1, 2017

MHCP EPM Manual Letter #17.3, August 1, 2017

MHCP EPM Manual Letter #17.4, September 1, 2017

MHCP EPM Manual Letter #17.5, December 1, 2017

2016 Manual Letters

MHCP EPM Manual Letter #16.1, June 1, 2016

MHCP EPM Manual Letter #16.2, August 1, 2016

MHCP EPM Manual Letter #16.3, September 1, 2016

MHCP EPM Manual Letter #16.4, December 1, 2016

Bulletins

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

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

- Bulletin #17-21-05, DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- ~~Bulletin #17-21-08, DHS Explains Changes to the Minnesota Health Care Programs (MHCP) Application for Medical Assistance for Long-Term Care Services (MA-LTC)~~
- ~~Bulletin #18-21-03, Periodic Data Matching for Medical Assistance and MinnesotaCare~~
- Bulletin #19-21-01, Pre-eligibility Verification for Medical Assistance for Families with Children and Adults
- Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA)
- Bulletin #19-21-04, DHS Announces Changes to the MAGI Methodology for Medical Assistance and MinnesotaCare

T. Prior versions of EPM sections are available upon request. 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.

Published: ~~September~~ November 1, 2019

Previous Versions

Manual Letter #19.5, September 1, 2019

Manual Letter #19.4, August 7, 2019

Manual Letter #19.3, June 1, 2019

Manual Letter # 19.2, April 1, 2019

Manual Letter #19.1, January 1, 2019

Manual Letter #18.5, December 1, 2018

Manual Letter #18.4, September 1, 2018

Manual Letter #18.3, June 1, 2018

Manual Letter #18.2, April 1, 2018

Manual Letter #18.1, January 1, 2018

Manual Letter #17.5, December 1, 2017

Manual Letter #17.4, September 1, 2017

Manual Letter #17.3, August 1, 2017

Manual Letter #17.2, June 1, 2017

Manual Letter #17.1, April 1, 2017

Manual Letter #16.4, December 22, 2016

Manual Letter #16.3, September 1, 2016

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

Archive Information

- Publication date: September 1, 2019
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

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. Applicants must not be asked to answer questions that are not applicable to determining their eligibility. Using the correct application form helps speed up the eligibility determination. When using a paper application form, it is important to choose the most appropriate form and to follow the instructions about where to send the form.

MNsure Online Application

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

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

Eligibility is evaluated in the following order:

A. Medical Assistance (MA) for Families with Children and Adults (MA-FCA)
B. MinnesotaCare
C. Advanced premium tax credit (APTC)
D. Qualified health plan (QHP) without subsidy

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

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

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

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

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

Eligibility is evaluated in the following order:

A. MA-FCA
B. MinnesotaCare
C. APTC
D. QHP without subsidy

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

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

MHCP Application for Certain Populations (DHS-3876)

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

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

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

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

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

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

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

- request Traumatic Brain Injury (TBI) services.
- request Developmental Disabilities Waiver (DD) services.

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

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

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

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

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

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

Published: ~~April~~ November 1, 2019~~8~~

Previous Version:

Manual Letter #18.2, April 1, 2018

Manual Letter #17.2 June 1, 2017

Archive Information

- Publication date: April 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

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 during normal working hours. The date of application for a paper application or request for coverage submitted after normal working hours via a drop box or other method is the next business day.

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. Applicants who apply through MNsure.org 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

A. Minnesota Statutes, section 256L.05

Published: ~~April~~ November 1, 2019~~8~~

Previous Version:

Manual Letter #18.2, April 1, 2018

Manual Letter #17.2, June 1, 2017

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

Archive Information

- Publication date: April 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

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. An authorized representative is a person or organization designated by an applicant or enrollee to apply for Minnesota Health Care Programs (MHCP) and to perform the duties required to establish and maintain eligibility. See MHCP Authorized Representative for more information.

- ~~People~~ A person under 18 who ~~do~~ does 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 online application allows 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~~ Special Circumstances

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

- Sign electronically, or
- 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.~~

If a person has a court-appointed guardian, one of following people must sign the application:

- The guardian, or
- An authorized representative designated by the guardian

If a person does not have a court-appointed guardian but does have a court-appointed conservator, any of the following people may sign the application:

- The person
- An authorized representative designated by the person or conservator
- The conservator, if the court has not limited the conservator's powers in such a way that the conservator does not have the power to apply for health care assistance, services, or benefits available to the person

Renewal Signature

The application filer or authorized representative 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~~ using information in their case file and data provided ~~through the new eligibility system~~ by trusted electronic sources.

Legal Citations

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 155.230

Code of Federal Regulations, title 45, section 155.335

Minnesota Statutes, section 256L.05

Minnesota Statutes, section 524.5-313

Minnesota Statutes, section 524.5-417

Published: ~~April~~ November 1, 2019~~8~~

Previous Versions:

Manual Letter #18.2, April 1, 2018

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

Archive Information

- Publication date: April 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

E. Section 1.3.1.2 MHCP Authorized Representative

Minnesota Health Care Programs

1.3.1.2 Authorized Representative

Minnesota Health Care Programs (MHCP) applicants and enrollees may designate an authorized representative at the time of application or at any other time. An authorized representative is a person or organization authorized by an applicant or enrollee to apply for a MHCP and to perform the duties required to establish and maintain eligibility.

Responsibilities of an Authorized Representative

In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees.

Authorized representatives have the responsibility and right to:

- Contact the county, tribal or state servicing agency, including talking with the worker without additional consent
- Contact the help desks, without additional consent
- Have access to eligibility information in the applicant's or enrollee's case file
- Complete and sign forms, such as applications and renewals, for the applicant or enrollee
- Provide documentation
- Appeal agency decisions
- Receive forms and notices
- Pay premiums
- Act on behalf of the applicant or enrollee in all other matters with the county, tribal or state servicing agency
- Maintain the confidentiality of any information regarding the applicant or enrollee provided by the county, tribal or state servicing agency

Who Can Be an Authorized Representative?

Authorized representatives must:

- ~~be~~ Be at least 18 years old,
- ~~have~~ Have access to required information and ability to verify eligibility requirements, and
- ~~agree~~ Agree in writing to accept the responsibilities of an authorized representative.

Who Cannot Be an Authorized Representative?

The following people cannot be an authorized representative for a client on their caseload:

- County, tribal or state servicing agency employees who determine eligibility
- Regional Treatment Center (RTC) reimbursement officers for MA enrollees
- Certified assisters (navigators)

An incarcerated individual can have an authorized representative, but the authorized representative cannot enroll the inmate without his or her consent.

Designating an Authorized Representative

~~Applicants~~ Any applicant~~s~~ or enrollee~~s~~ ~~can~~ may designate an authorized representative, unless the person has a court-appointed guardian. If a person has a court-appointed guardian, only the guardian may designate an authorized representative. ~~Only an applicant or enrollee can choose who they want as their authorized representative. An applicant or enrollee with a court appointed guardian or conservator cannot appoint an authorized representative, however the guardian or conservator can appoint an authorized representative.~~

If an applicant or enrollee has a court-appointed conservator and the court has not limited the conservator's power in such a way that the conservator does not have the power to apply for health care assistance, services, or benefits available to the person, then either the applicant or enrollee, or the conservator, may designate an authorized representative.

Designations by an applicant or enrollee must be in writing and must include the applicant or enrollee's signature unless the applicant or enrollee is unable to sign, in which case legal documentation of authority to act may serve in place of the applicant or enrollee's designation.

~~Applicants and enrollees can~~ A designation may be made by submitting one of the following documents to the county, tribal, or state servicing agency:

- ~~Fill in the authorized representative's name, address, and phone number in the appropriate place on a paper application~~
    - ~~The authorized representative and the applicant must both sign the application unless the applicant is unable to sign. Legal documentation of authority to act on behalf of an applicant/enrollee can serve in place of the applicant/enrollee's signature.~~
- A completed Authorized Representative Designation attached to any MHCP application
- ~~Submit~~ A completed Giving Permission for Someone to Act on My Behalf (DHS-3437) or Minnesota Family Planning Program (MFPP) - Giving Permission for Someone to Act on My Behalf (DHS-3437A)
- ~~Submit an externally created~~ A written statement that clearly indicates the ~~person~~ applicant or enrollee is giving permission ~~for someone~~ to a specified person to act on their behalf in the health care application or eligibility process, including the name, address, and phone number

of the ~~authorized representative~~ person designated to act on their behalf. The statement must be signed by the applicant or enrollee as well as the person being designated to act on the applicant or enrollee's behalf.

- ~~Submit a~~ A court order establishing legal guardianship
- A court order establishing a conservatorship
- ~~Submit a~~ A valid Power of Attorney ~~with language that explicitly lists the right to represent the applicant or enrollee in the health care application or eligibility process.~~
    - A Power of Attorney is a legally binding document that authorizes a person or corporation to act on another person's behalf in financial matters. The powers granted can be limited to certain activities and to a specific period, or they can be general and wide in scope.
    - The Power of Attorney must be dated, signed by the applicant or enrollee, and include the name of the person or corporation who is being appointed to act on the applicant's or enrollee's behalf.
    - ~~Submit a Durable Power of Attorney that explicitly includes the right to represent the applicant or enrollee in health care application or eligibility process.~~ A Power of Attorney is durable if it contains language such as, "This power of attorney shall not be affected by the incapacity of incompetence of the principal," or similar words showing the intent to allow the authority to continue even if the person becomes incapacitated~~.~~

Servicing Agency Designation of an Authorized Representative

The county, tribal or state servicing agency must appoint an authorized representative if the client is not able to do so and is not able to provide information necessary to determine eligibility. This could be a relative or friend who is able to provide the necessary information.

The agency must appoint a social service professional as the applicant or enrollee's authorized representative if no qualified person is available to act as an authorized representative.

Potential authorized representatives for children in foster care or pre-adoptive placement include, but are not limited to, social workers or other representatives of the agency that has legal custody and control of the child.

How Long Does the Designation Last?

The applicant or enrollee may change the authorized representative designation at any time. The ~~authorized representative~~ designation remains in place until:

- Revoked by the applicant or enrollee
- Revoked by the authorized representative
- The legal authority to act on the applicant or enrollee's behalf changes
- The authorized representative is disqualified
- The applicant or enrollee dies

Disqualification of an Authorized Representative

Servicing agencies may disqualify authorized representatives who:

- Knowingly provide false information
- Are unable to provide required information
- Refuse to provide required information

Only a court can disqualify a guardian or conservator.

When a county, tribal or state servicing agency disqualifies an authorized representative, the applicant or enrollee can designate a new one.

If a servicing agency disqualifies an authorized representative, it must determine whether a vulnerable adult referral to social services is needed.

Authorized Representative Receipt of Forms and Notices

Unless the client indicates otherwise, the authorized representative will receive all forms and copies of eligibility and premium notices.

Authorization to Release Information

The General Consent/Authorization for Release of Information (DHS-3549) allows the county, tribal or state servicing agency to share information about the applicant or enrollee with the person or organization specified on the form. These forms do not appoint the person to be an authorized representative.

Legal Citations

Code of Federal Regulations, title 42, section 435.923

Code of Federal Regulations, title 45, section 155.227

Minnesota Rules, part 9505.0085, subpart 2

Published: ~~June~~ November 1, 201~~6~~9

Previous Versions

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

Archive Information

- Publication date: June 1, 2016
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

F. Section 1.3.2.1 MHCP Change in Circumstances

Minnesota Health Care Programs

1.3.2.1 Change in Circumstances

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

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

Reporting Changes

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

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

Inconsistent Information

Changes are discovered in other ways, such as:

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

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

Reporting Deadline

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

Eligibility Redetermination

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

Medical Assistance

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

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

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

When a person enrolled in MinnesotaCare or another Insurance Affordability Program reports a change in circumstance that results in MA eligibility, MA begins the first day of the month the change was reported, if the person does not need or is not eligible for retroactive coverage. The earliest possible begin date for MA is the first day of the month three months prior to the month the change was reported. A person may add a request for retroactive MA coverage up to 12 months from the month the person became eligible for MA. The person may be eligible for each retroactive month they meet the MA eligibility requirements and have paid or unpaid medical expenses that would be covered by MA in each month.

MinnesotaCare

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

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

When a MinnesotaCare enrollee reports a change in circumstances that results in Advance Premium Tax Credit eligibility, MinnesotaCare eligibility and coverage ends the last day of the

month for which advance notice can be given. Generally, 10-day advance notice is required to end MinnesotaCare coverage. See the MHCP Notices policy for more information.

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

Medicare Savings Programs

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

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

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

Exceptions

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

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

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 45, section 155.330

Minnesota Rules, part 9505.0115, subpart 1

Minnesota Statutes 256B.057

Published: ~~September~~ November 1, 2019~~8~~
Previous Versions
Manual Letter #18.4, September 1, 2018
Manual Letter # 16.3, September 1, 2016
Manual Letter #16.1, June 1, 2016 (Original Version)

Archive Information

- Publication date: September 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

G. Section 1.3.2.4 MHCP Inconsistent Information

Minnesota Health Care Programs

1.3.2.4 Inconsistent Information

The county, tribal or state servicing agency must ~~verify~~ evaluate and pursue resolution of inconsistent information when the information provided by the applicant or enrollee is inconsistent with:

- Other information the agency has
- The applicant or enrollee's own statements
- Information collected for purposes of a case review, audit, fraud investigation or overpayment analysis
- Information obtained from electronic sources

The county, tribal or state servicing agency must ~~verify~~ evaluate and pursue resolution of information that is inconsistent with documentation or information on file, if all of the following conditions exist:

- The information is necessary to determine at least one of the following:
  - Eligibility
  - Premium amount
  - Spenddown
- The information is inconsistent with at least one of the following:
  - Other information the agency has
  - A client's own statements
- The client cannot satisfactorily explain an inconsistency

Enrollees must provide information and proofs within 10 days when inconsistent information is received or discovered between renewals. An enrollee's health coverage may end if they fail to respond to an inquiry regarding inconsistent information.

See the MHCP Fraud policy if there is reason to suspect an applicant or enrollee is withholding, concealing or misrepresenting information.

Legal Citations

Code of Federal Regulations, title 42, section 435.952

Minnesota Statutes, section 256B.061

Published: ~~June~~ November 1, 201~~96~~
Previous Versions
Manual Letter #16.1, June 1, 2016 (Original Version)

Archive Information

- Publication date: June 1, 2016
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

H. Section 2.1.1.2.4 MA Referral for Other Benefits

Medical Assistance

2.1.1.2.4 Referral for Other Benefits

Medical Assistance (MA) enrollees who appear to have eligibility for other programs are required to apply for those programs to continue MA eligibility. Enrollees must apply for benefits from other programs if it could increase their income or help pay medical expenses. Enrollees must apply within 30 days of when the county, tribal or state servicing agency notifies them of their potential eligibility, unless they can show good cause for not doing so.

Social Security benefits

Enrollees, potentially eligible for the following benefits, must apply to maintain MA eligibility.

Retirement Survivors Disability Insurance

The federal Social Security Administration (SSA) administers Retirement, Survivors and Disability Insurance (RSDI) benefits. RSDI provides a monthly income based on payroll contributions made via Social Security taxes.

The following people, if qualified under a Social Security number having at least 40 work quarters, may be eligible for RSDI:

- Retired people who meet SSA age requirements
- People certified disabled by SSA
- Dependents of a wage earner who is disabled or retired
- Dependent survivors of a wage earner who has died

RSDI eligible MA enrollees at full retirement age must apply for benefits. MA enrollees who are family members of RSDI eligible people must also apply for potential benefits.

People who are eligible for RSDI may also be eligible for SSI if their RSDI payment is less than the Supplemental Security Income (SSI) income standard.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal supplemental income program operated by SSA and funded by general tax revenues. It provides monthly cash payments to people aged 65 or older and people certified disabled by SSA, who have little or no income, to help them meet basic needs for food, clothing and shelter. MA enrollees, potentially eligible for SSI, must apply for benefits.

Medicare

Enrollees who are potentially eligible for Medicare must apply to maintain MA eligibility. MA will not pay for Medicare-covered services for people who are eligible for, but do not enroll in Medicare Part A without a premium. MA enrollees who meet one of the following may qualify for Medicare:

- People age 65 or older who qualify for RSDI or Railroad Retirement Board (RRB) benefits
- Citizens and qualifying non-citizens age 65 or older who pay a Medicare Part A premium
- People certified disabled by SSA, after a 24-month waiting period. People with Amyotrophic Lateral Sclerosis (ALS) are eligible the same month they start receiving RSDI benefits.
- Widows and widowers and divorced widows and widowers with a SSA certified disability, after a two-year waiting period
- People with 1619(a) or 1619(b) status
- People with End-Stage Renal Disease (ESRD) defined as permanent kidney failure requiring dialysis or a kidney transplant

Medicare Part A

Medicare Part A is federal hospitalization insurance. People who are eligible for premium-free Medicare Part A may not refuse to apply or turn down this coverage to gain or continue MinnesotaCare or Advance Premium Tax Credit (APTC) eligibility.

Medicare Part B

Medicare Part B is medical insurance. There is a monthly premium for Part B. MA enrollees must apply and maintain Medicare Part B coverage, even if they are required to pay a premium. Medicare Savings Programs (MSP), the Medicare Buy-In and MA-EPD can help eligible clients with premiums and other costs. People who are in an Institution for Mental Diseases (IMD) may also receive help paying for premiums and other costs. People have a wide variety of Medicare-approved plans from which to choose.

Medicare Part D

Medicare Part D is prescription drug coverage. Enrollment in Medicare Part D is not required as a condition of MA eligibility. However, there are specific rules established for clients eligible for Medicare Part D who fail or refuse to enroll in, or opt out of, that program. MA cannot pay any prescription drug costs for eligible Part D beneficiaries regardless of whether or not they are enrolled in Medicare Part D. However, prescription drug bills that are not covered by Medicare can be used to meet a medical spenddown.

Medicare eligible MA and MSP enrollees qualify for a full Extra Help subsidy automatically and must select a Medicare Part D benchmark plan. Medicare beneficiaries of all ages can get free assistance with selecting a Part D plan by calling the Senior LinkAge Line® at (800) 333-2433.

Railroad Retirement Benefits

The federal Railroad Retirement Board (RRB) administers railroad retirement benefits and Medicare for railroad workers and their families. People who work for a railroad have railroad retirement

withheld from their earnings instead of Social Security. If a person has earned enough Social Security credits to receive Social Security benefits as well as railroad retirement benefits, the beneficiary receives the larger of the two.

Retiree benefit amounts are based on the number of years of service. Railroad workers who meet certain service requirements are eligible for:

- Retiree benefits
- Disability benefits
- Dependent benefits for spouses, ex-spouses, and children who meet certain criteria, and
- Survivor benefits

RRB eligible MA enrollees at full retirement age must apply for benefits. The railroad worker's family members must also apply for potential benefits if the railroad worker is currently receiving RRB benefits or was receiving or eligible to receive benefits but is now deceased. People turning age 65 who are receiving railroad retirement benefits must apply for Medicare through the RRB.

Financial Needs

Enrollees, potentially eligible for the following benefits, must apply to maintain MA eligibility.

Minnesota Unemployment Insurance (UI) benefits provide a temporary partial wage replacement to workers who become unemployed through no fault of their own.

Workers' Compensation provides benefits for people injured or ill from their job.

MA enrollees who are veterans or a spouse of a veteran, using the People Aged 65 or Older, Blind or Disabled basis, living in a long-term care facility, must apply for the federal Veterans' Aid and Attendance program through the U.S. Department of Veterans Affairs (USDVA).

Exceptions

Enrollees are not required to reapply for benefits that were previously denied unless there has been a change in circumstances or eligibility requirements of the benefit program.

Legal Citations

Code of Federal Regulations, title 42, section 435.608

Published: ~~April~~ November 1, 2019
Previous Versions
Manual Letter #19.2, April 1, 2019
Manual Letter 18.3, June 1, 2018

Archive Information

- Publication date: April 1, 2019
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

I. Section 2.1.1.2.5 MA Periodic Data Matching

Medical Assistance

2.1.1.2.5 Periodic Data Matching

Periodic Data Matching (PDM) is a process that uses electronic data sources to identify Medical Assistance for Families with Children and Adults (MA-FCA) enrollees who may no longer meet eligibility criteria for the program.

Enrollees in MA-FCA are subject to data matching using electronic data sources at least once during an enrollee's 12-month period of eligibility.

The electronic data sources used for periodic data matching provide information about an enrollee's or household member's income, Medicare Part A enrollment, or death.

Notification of Discrepant Information

Discrepant information is electronic data that is not consistent with the case information attested to by the enrollee. An enrollee will receive a discrepancy notice only when the information from an electronic data source indicates the enrollee may no longer qualify for the program in which he or she is currently enrolled.

An enrollee must respond to the discrepancy notice within 30 days from the date on the notice, by mail, in person, or by calling the agency. An enrollee may respond to the discrepancy notice by submitting a response form with confirmed or corrected information. An enrollee who confirms the information on the form is correct must not be required to provide paper verification to resolve the discrepancy.

Extension to Resolve a Discrepancy

An extension of time beyond the 30-day period is available when an enrollee is cooperating with the agency but unable to provide the information needed to resolve a discrepancy before the date of closure. An extension may be granted only upon enrollee request. There is no limit to the number of extensions an enrollee may be granted, if the enrollee is cooperating with the PDM process.

Resolving a PDM discrepancy

- Income discrepancy

  An income-related PDM discrepancy is considered resolved when the agency receives an attestation of current household income from the MA enrollee. No verification is required if the enrollee's attested income is the same as the income listed on the discrepancy notice.

- Medicare Part A discrepancy

A Medicare Part A discrepancy is considered resolved when an enrollee confirms having Medicare Part A or attests that he or she does not have Medicare Part A. If an enrollee disputes having Medicare, the agency must check any other available data sources about Medicare enrollment, and if necessary, refer the enrollee to the Social Security Administration (SSA) to update his or her records. The agency cannot require an enrollee to contact SSA before resolving the discrepancy.

- Death discrepancy

  A death discrepancy is considered resolved when the death is either confirmed or denied by the household. If an enrollee denies the death discrepancy, the agency must resolve the discrepancy and refer the enrollee to SSA to correct his or her records. The agency cannot require an enrollee to contact SSA before resolving the discrepancy.

An enrollee may report changes during the process of resolving their PDM discrepancies. See MHCP Changes in Circumstances for more information.

Failure to Resolve a PDM Discrepancy

An MA enrollee must cooperate with the PDM process as a condition of eligibility. Enrollees who fail to resolve a PDM discrepancy or request an extension within 30 days of the notice are no longer eligible for MA. The enrollee is not eligible for MA, MinnesotaCare, advanced premium tax credits (APTC) or cost-sharing reductions (CSR) until the enrollee resolves all outstanding discrepancies. An enrollee with an outstanding discrepancy may be eligible to purchase a qualified health plan without a subsidy if he or she meets the eligibility criteria.

An MA enrollee whose eligibility ended due to failure to resolve a PDM discrepancy must resolve the outstanding discrepancy to qualify for MA again. Once the person resolves the outstanding discrepancy, the earliest the person can be eligible for MA is the first day of the month in which the person cooperated with the agency to resolve the PDM discrepancy or reapplied.

Legal Citations

Minnesota Statutes, section 256B.0561

Published: November 1, 2019

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

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

2.3.1.1 Mandatory Verifications

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

- Assets
  - Verification of assets is required at application, renewal, and when a new asset is reported. If an asset is determined to be excluded it does not need to be verified again at renewal.
  - Verification of the following assets are not required at application or renewal:
    - Homestead, if it qualifies for the exclusion. Refer to Section 2.3.3.2.7.4.1 MA-ABD Homestead Real Property for more information.
    - Vehicle, if only one is reported. Refer to Section 2.3.3.2.7.7 MA-ABD Automobiles and Other Vehicles Used for Transportation for more information.
    - Household goods and personal effects
- Certification of Disability through Social Security Administration (SSA) or State Medical Review Team (SMRT) for people claiming a blind or disabled basis of eligibility
- Income
  - If a person is receiving Supplemental Security Income (SSI), only the SSI income is verified. Eligibility for SSI is accepted as verification of other income SSA considers in determining eligibility.
    - Note: Veteran's Administration (VA) Aid and Attendance benefits and VA unusual medical expense payments must be verified even if the person is receiving SSI.
- Immigration status
- Medical expenses to meet a spenddown
- Social Security Number
- U.S. Citizenship

County, tribal and state servicing agencies must retain verification documentation in accordance with the County Human Services Records Retention Schedule (DHS-6928).

Legal Citations

Code of Federal Regulations, title 42, section 435.407

Code of Federal Regulations, title 42, section 435.541

Code of Federal Regulations, title 42, section 435.920

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.948

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

Published: ~~April~~ November 1, 2019

Previous Version

Manual Letter #19.2, April 1, 2019

Manual Letter #17.3, August 1, 2017

Manual Letter #17.2 June 1, 2017

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

Archive Information

- Publication date: April 1, 2019
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

K. Section 2.3.3.2.3 MA-ABD Excluded Assets

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

2.3.3.2.3 Excluded Assets

An excluded asset is not counted when calculating a person's total countable assets. An asset can be excluded in whole or in part. Some excluded assets are excluded indefinitely while others are excluded for only a specific period of time. Some excluded assets are excluded only if identifiable from other assets. Income retained after the month of receipt become assets.

Identifiable Assets

Some assets must be identifiable to be excluded under the bases of eligibility for Medical Assistance for People Who Are Age 65 or Older, or People Who Are Blind or Have a Disability (MA-ABD). Identifiable means that the assets can be distinguished from other assets.

An asset is identifiable in the following situations:

- The funds are kept physically apart from other funds, such as a separate bank account.
- The funds are not kept physically apart from other funds, but can be identified using a complete history of account transactions dating back to the initial date of deposit. The person's own records should be used, if possible. The person's allegation regarding the date and amount of a deposit of excluded funds is accepted if it agrees with the evidence on file for receipt of the funds.
    - When a withdrawal is made from a commingled account, the non-excluded funds are assumed to be withdrawn first, leaving as much of the excluded funds in the account as possible.
    - The excluded funds remaining in the account can only be added to by deposits of subsequently received excluded funds and excluded interest.
    - If interest on the excluded funds is excluded, the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded at the time the interest is posted. The excluded interest is then added to the excluded funds in the account.

Excluded Assets if Identifiable

The following assets are excluded if they are identifiable. Exclude the assets indefinitely unless another time period is indicated. Descriptions of each type of assets are located in Appendix A Types of Assets.

- Achieving a Better Life Experience (ABLE) account

- Agent Orange Settlement Fund payments
- Blood Product Settlement payments
- Corporation for National and Community Service (CNCS) payments. Payments to volunteers, including the following payments authorized under the Domestic Volunteer Services Act, are excluded:
    - AmeriCorps
    - Urban Crime Prevention Program
    - Special Volunteer Programs under Title I
    - Demonstration Programs under Title II
    - Senior Corp:
        - Retired Senior Volunteer Program (RSVP)
        - Foster Grandparent Program
        - Senior Companions
- Food and nutrition program payments. This includes assistance provided by:
    - Programs established under the Child Nutrition Act, including the Women, Infants, and Children (WIC) Nutrition Program and federally funded school breakfast and milk programs.
    - National School Lunch program
    - Supplemental Nutrition Assistance Program (SNAP)
    - Minnesota Food Assistance Program
    - Minnesota Grown Supplemental Food Program
- Individual Development Accounts (IDA)
- Japanese and Aleutian Restitution payments
- Jensen Settlement Agreement payments. Payments received by class members are excluded. Funds received under this agreement from countable assets at the time of application and at each renewal are deducted.
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Nazi Persecution payments
- Radiation Exposure Compensation Trust Fund (RECTF) payments
- Real estate taxes, homeowner's insurance and funds set aside for upkeep expenses of the property a person owns. Up to one year's expenses are excluded. Funds must be kept in a separate account.
- Relocation Assistance payments, federal
- Retroactive Retirement, Survivors and Disability Insurance (RSDI) and Supplemental Security Income (SSI) benefits are excluded for the nine calendar months following the month in which

the person receives the benefits. Any accrued interest on that account is counted as income in the month received and as an asset in the following months.

  - People under age 18 who have representative payees and are eligible for past-due SSI payments must have the funds segregated in a dedicated account in order for the exclusion to apply. If a bank requires a deposit of funds in order to open such an account, these funds may remain commingled in the account until the end of the month following the month in which the retroactive benefits are paid.
  - Supplemental Needs Trusts policy is followed if the lump sum payment is issued under the Sullivan vs Zebley decision, and is used to fund a supplemental needs trust. See MA-ABD Supplemental Needs Trusts for more information.

- Ricky Ray Hemophilia Relief Fund payments
- Student financial aid
  - Exclude the following types of student financial aid income:
    - Student financial aid received under Title IV of the Higher Education Act
    - Student financial aid received from the Bureau of Indian Affairs (BIA)
  - Non-Title IV and non-BIA grants, scholarships, fellowships and other non-loan financial aid, if used or set aside to pay educational expenses until the month following the last month the student is enrolled in classes.
  - Distributions from a Coverdell Educational Savings Accounts (ESA) if the funds are used for educational expenses.
    - Excluded for the designated beneficiary of the account for nine months following the month of receipt of a distribution.
    - Excluded for anyone who is not a beneficiary who contributes money to the account beginning the month after the month the funds are transferred into the account.
    - Excluded, due to being a conversion of an asset, for a contributor who is the designated beneficiary beginning with the month after the month the cash is transferred into the account.
  - Veteran's Affairs (VA) benefits designated as educational assistance both under graduate and graduate students until the month following the last month the student is enrolled in classes.
  - Plan to Achieve Self Support (PASS) student financial aid
  - Training expenses paid by the Trade Adjustment Reform Act of 2002
  - Qualified Tuition Programs (QTP), also known as a 529 Plan, for the designated beneficiary (the student or future student) who is not the owner of the account and does not have any rights to the funds in the account. The account is counted as an asset for the owner.
- Supplemental Security Income (SSI) Dedicated Child Account

- Tribal payments and interests. The following tribal assets are excluded. See MA-ABD Tribal Payments and Interests for other assets owned by American Indians that may not be excluded.
  - Tribal trust or restricted lands, individual interest
  - Tribal per capita payments from a tribal trust
  - Tribal land settlements and judgments
- Uniform Gift to Minors Act/Uniform Transfers to Minors Act (UGMA/UTMA)
  - The full value of assets established under the UGMA/UTMA is excluded.
    - An adult designated to receive, maintain and manage custodial property on behalf of a minor beneficiary is not the owner of UGMA/UTMA assets because he or she cannot legally use any of the funds for his or her support and maintenance.
  - When the UGMA/UTMA property is transferred to the beneficiary at the end of the custodianship (usually at the age of 18 or 21 depending on state law) the property becomes available to the beneficiary. It is counted as income in the month of transfer and as an asset in the following month.
- Veterans' Children with Certain Birth Defects payments
- Vietnamese Commando Compensation Act payments

Excluded Assets Regardless of Identifiability

The following assets may be excluded whether or not they are identifiable. These assets are excluded indefinitely unless another time period is indicated.

- Adoption Assistance payments are excluded in the month of receipt and thereafter.
- Accrued Interest on assets is excluded if any excess is properly reduced at eligibility redetermination.
- Alaska Native Claims Settlement Act (ANCSA) payments
- Appeal Payments are excluded as assets in the month received and for three months after the month of receipt.
- Clinical trial participation payments excluded by SSI. The first $2,000 a person receives during a calendar year is excluded.
- Cobell Settlement for American Indians for a period of 12 months beginning with the month of receipt. This exclusion applies to all household members.
- Crime victim payments
- Disaster assistance, federal payments
- Disaster assistance, state payments
- Filipino Veterans Equity Compensation (FVEC) payments

- Foster Care payments
- Gifts to Children with Life Threatening Conditions from 501(c)(3) tax-exempt corporation. These are not considered assets of a parent and apply only to children who are under age 18.
    - Cash gifts up to $2,000 in any calendar year are excluded. The amount of total cash payments that exceed $2,000 each year are counted as an asset.
        - Multiple cash gifts in the same calendar year are added together and up to $2,000 of the total is excluded, even if none of the cash gifts exceeds $2,000 individually.
- Homestead real property
- Household goods and personal effects
- I-35W Bridge Collapse payments. The following payments made to survivors of the I-35W bridge collapse are excluded:
    - Payments from the I-35W Emergency Hardship Relief Fund
    - Payments from the Catastrophic Survivor Compensation Fund
- James Zadroga 9/11 Health and Compensation Act of 2010
- Kinship payments
- Proceeds from the Sale of a Homestead are excluded if a person:
    - Plans to use the proceeds to buy another homestead, and
    - Does so within three full calendar months of receiving the funds
- Reimbursements for replacement of lost, damaged or stolen excluded assets are excluded for the month of receipt and nine months thereafter. The funds are excluded for up to nine more months if the person tries to replace the assets during that time, but cannot do so for good reason.
- Representative Payee Misuse payments. If a person's SSI, RSDI, or Veterans Benefits for the Elderly is reissued because an individual representative payee misuses benefits, the reissuance is excluded as an asset for nine months if retained after the month of receipt.
- State Annuities for Certain Veterans
- Relocation payments, state and local
- Tax credits, rebates, and refunds are excluded for 12 months after the month of receipt
- Term life insurance

Potentially Excluded Assets

Some assets may be excluded under the following policies. See the corresponding pages for more information:

MA-ABD Tribal Payments and Interests

MA-ABD Burial Space Exclusion

MA-ABD Burial Fund Exclusion

MA-ABD Retirement Funds & Plans

MA-ABD Trusts

MA-ABD Automobile and other vehicles used for transportation

Self-Support Excluded Assets

Self-Support is the use of certain property to earn wages, to produce goods and services for personal use, or to derive income from property. Self-Employment is one type of self-support.

Self-Employment Excluded Assets

All assets of a trade or business, regardless of value, that are in current use and needed for the person to earn income are excluded. Current use includes seasonal use of an asset. The excluded assets can be real or personal property, including liquid assets. There is no limit to the amount of assets that can be excluded under this provision.

When a person alleges owning trade or business property not already being excluded, it must be determined whether a valid trade or business exists, and if the property is in current use. A person must provide a written statement with the following information:

- A description of the trade or business
- A description of the assets of the trade or business
- The number of years the business has been operating
- The identity of any co-owners
- The estimated gross and net earnings of the trade or business for the current tax year

Self-employment assets not currently in use because of reasons beyond the person's control can be excluded if they expect to resume use of the asset within one year. The person must sign a written statement with the following information:

- The reason the asset is not in use
- The date the asset was last used
- When the asset is expected to be used again

The exclusion is extended for an additional year if the reason for not using the asset is a disabling condition. The person must sign a written statement with the following information:

- The nature of the disabling condition
- When the activity ceased

- When the property is expected to be used again

Income Producing Self-Support Assets

Up to $6,000 of the equity value of non-business, non-liquid, income-producing property that produces an annual return of at least six percent of the equity value is excluded:

- The $6,000 exclusion is limited to the combined equity value of all property meeting the six percent rule.
- If the person owns more than one piece of income-producing property, each piece must meet the six percent return on the equity value.
- If the earnings drop below six percent for reasons beyond the person's control, the property is excluded up to 24 months to allow the property to resume producing a six percent return.

Non-Income Producing Self-Support Assets

Nonbusiness property essential to self-support can be real or personal property. It produces goods or services essential to daily activities if, for example, it is used to:

- Grow produce or livestock solely for personal consumption in the person's household; or
- Perform activities essential to the production of food solely for home consumption.

Up to $6,000 of the equity value for each asset is excluded. Any portion of the property's equity value in excess of $6,000 is not excluded.

While this category of property may encompass a vehicle used solely in a nonbusiness self-support activity (e.g., a garden tractor, or a boat used for subsistence fishing), it does not include any vehicle that qualifies as an automobile. See MA-ABD Automobiles and Other Vehicles for Transportation for more information.

When a person alleges owning property that he or she uses to produce goods or services necessary for daily activities, obtain his or her statement giving:

- A description of the property;
- How it is used; and
- An estimate of its current market value and any encumbrances on it

Personal Property Used by an Employee

Non-liquid personal property used by a person in employment, whether it is required by the employer or not, is excluded. The person must provide a written statement with the following information:

- The name, address and telephone number of the employer

- A general description of the personal assets used for work
- A general description of the person's job duties
- Whether the personal assets are currently being used

Personal property not currently in use because of reasons beyond the person's control can be excluded if they expect to resume use of the asset within one year. The person must sign a written statement with the following information:

- The reason the asset is not in use
- The date the asset was last used
- When the asset is expected to be used again

The exclusion is extended for an additional year if the reason for not using the asset is a disabling condition. The person must sign a written statement with the following information:

- The nature of the disabling condition
- When the activity ceased
- When the property is expected to be used again

If the statement indicates that the person no longer intends to resume using the assets for employment, they become countable assets unless unavailable or excluded under another provision.

Legal Citations

Code of Federal Regulations, title 20, section 416.1248

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

Minnesota Statutes, section 256B.056, subdivision 3

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

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

Published: ~~April~~ November 1, 2019

Previous Versions

Manual Letter #19.2, April 1, 2019

Manual Letter #18.3, June 1, 2018

Manual Letter #18.1, January 1, 2018

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

Archive Information

- Publication date: April 1, 2019
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

L. Section 2.3.3.2.7.9.4 MA-ABD Special Needs Trusts

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

2.3.3.2.7.9.4 Special Needs Trusts

A ~~S~~special ~~N~~needs ~~T~~trust is a trust established for the sole benefit of a person under age 65 who is certified disabled. The ~~property held within~~ principal or corpus of a trust that meets all the requirements of a ~~S~~special ~~N~~needs ~~T~~trust is ~~an~~ excluded ~~asset~~.

Trust Requirements

A trust must satisfy all of the following ~~statutory~~ legal requirements in order to be excluded as a ~~S~~special ~~N~~needs ~~T~~trust. ~~If a trust does not meet all of the requirements, the trust is not an excluded asset.~~

Date Established

It is established on or after August 11, 1993.

Beneficiary Age Limit for Establishing a Special Needs Trust

~~The trust~~ It is established before the beneficiary ~~turns~~ reaches age 65. A special needs trust established before the beneficiary reaches age 65 remains ~~an~~ excluded ~~asset~~ after the beneficiary reaches age 65.

Established By

A ~~S~~special needs trust~~s~~ established before December 13, 2016, must be established ~~by~~ through the actions of the beneficiary's parents, grandparents, legal guardian, or a court. ~~Special needs trust established before December 13, 2016, cannot be established by the beneficiary.~~

A ~~S~~special needs trust established on or after December 13, 2016, ~~include trusts~~ may also be established by the actions of the beneficiary on their own behalf. A special needs trust established before December 13, 2016, cannot be established by the beneficiary.

Funded By

It is funded with the income or assets of the beneficiary. A special needs trust may also contain assets of other people.

Disability Standard

The beneficiary must meet the disability criteria of the Supplemental Security Income (SSI) program at the time the trust is established. A person with a disability established by the Social Security Administration (SSA) or State Medical Review Team (SMRT) meets this qualification.

The trust does not meet the criteria for the exclusion if the beneficiary's disability began after the trust was established.

If SSA or SMRT did not determine the beneficiary's disability at the time the trust was established, SMRT must determine whether the beneficiary was disabled according to SSI disability criteria at the time the trust was established.

Sole Benefit Requirement

The trust must be established for and used for the sole benefit of the disabled beneficiary and must provide that all disbursements are for the sole benefit of the beneficiary, with the following exceptions:

- The trust may allow reasonable compensation for a trustee or trustees to manage the trust.
- The trust may also allow reasonable costs associated with investment, legal, or other services rendered on behalf of the beneficiary with regard to the trust.

~~The trust provisions must state that disbursements from the trust must be for the sole benefit of the beneficiary at the time the trust is established and any time in the future.~~

A trust is not excluded as a special needs trust if it includes a provision that allows for either of the following:

- Benefits to other people or entities during the beneficiary's lifetime, or
- Termination of the trust prior to the beneficiary's death with payment of the corpus to another person or entity, other than repaying the State

Trusts that allow for payments to a spouse or dependents during the lifetime of the beneficiary do not meet this requirement even if the beneficiary does not currently have a spouse or dependent.

DHS Remainder Beneficiary

The trust must ~~contain a provision stating~~ provide that, upon the death of the beneficiary or earlier termination of the trust, the Minnesota Department of Human Services (DHS), or "the State" receives all amounts remaining in the trust, up to an amount equal to the total amount of Medical Assistance (MA) paid on behalf of the beneficiary.

- ~~Trust provisions allowing payment of administrative expenses and fees are acceptable if the trust also contains a provision that the expenses and fees must be reasonable.~~
- ~~Trust provisions are also acceptable if the trust clearly states reasonable and necessary administrative expenses may be paid only if DHS is provided with advance notice and approves such expenses.~~

~~Trusts that include provisions that allow for payment of the following expenses prior to repayment to the State do not qualify as a Special Needs Trust:~~

- ~~Payment for last illness and funeral, outstanding debts or other payments~~

- ~~Payment of administrative expenses or attorney and trustee fees if the trust does not require such payment(s) to be reasonable~~

Allowable Administrative Expenses

The trust may pay the following types of administrative expenses from the trust before the repayment of DHS as the remainder beneficiary:

- Taxes due from the trust to the State, other states, or federal government because of the death of the beneficiary
- Reasonable expenses for the administration of the trust estate, such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust.

  For these administrative expenses, the trust must provide that:

  - The DHS Special Recovery Unit (SRU) must receive advance notice and must approve any payment of administrative expenses before such expenses are paid, and
  - The administrative expenses must be reasonable

Prohibited Expenses and Payments

A trust that provides for payment of any of the following expenses prior to repayment of DHS is not excluded as a special needs trust:

- Taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate;
- Inheritance taxes due for residual beneficiaries;
- Payment of debts owed to third parties;
- Funeral expenses; or
- Payments to residual beneficiaries.

Evaluation of Trust ~~Assets~~ Principal and Additions to the Trust

Trust ~~Corpus~~ Principal

The ~~Trust assets~~ trust principal, including any income generated by the trust ~~assets~~ that is retained by the trust, ~~are~~ is considered excluded ~~assets~~ as long as the trust is established~~, or~~ and any additions occur~~,~~ before the beneficiary reaches age 65.

Additions to the Trust Before Age 65

Additions to the trust principal made directly to the trust before the beneficiary reaches age 65 are excluded.

Income not irrevocably assigned to the trust is not considered to be made directly to the trust and therefore is counted as income to the beneficiary. A court order irrevocably assigning income to

the trust is required to show an irrevocable assignment. If an assignment is revocable, the payment is income to the beneficiary because the beneficiary is legally entitled and eligible to receive it, unless another income exclusion applies. Note that certain payments to a beneficiary are not assignable by law. Send a HealthQuest if you have questions about assignability of income to a trust.

Additions to the Trust At or After Age 65

Additions to the trust after the beneficiary reaches age 65 are not ~~considered~~ excluded ~~assets~~. The value of any non-excluded assets added to the trust after the beneficiary reaches age 65 ~~are~~ is considered available to the beneficiary.

However, if the beneficiary's right to receive payments from an annuity, support payments, or Survivor Benefit Plan (SBP) payments was irrevocably assigned to the trust before the beneficiary reached age 65, the payments are excluded and do not disqualify the trust as a special needs trust.

Interest, dividends, or other earnings of the trust after the beneficiary reaches age 65 remain excluded.

~~Distributions~~ Evaluation of Trust Disbursements

Disbursements of cash from the trust made directly to the beneficiary or to a person acting on the beneficiary's behalf~~,~~ are counted as unearned income in the month received.

~~Payments made by the trustee~~ Disbursements to a third party that result in the beneficiary receiving non-cash items, are not counted. Disbursements that do not count as income may include, but are not limited to those made for educational expenses, therapy, transportation, professional fees, medical services not covered by Medicaid, phone bills, recreation, and entertainment.

Disbursements must be for the sole benefit of the beneficiary.

Consider disbursements to be for the sole benefit of the beneficiary if the trustee makes payments of any sort from the principal or income of the trust to another person or entity such that the beneficiary derives the primary benefit from the payment.

Purchased goods that require registration or titling, such as a vehicle or real property, must generally be registered or titled in the name of the beneficiary, the trustee, or the trust.

Special Needs Trust Verifications

Verification of a Special Needs Trust is required. A copy of the trust instrument and most recent trust accounting along with a completed Special Needs/Pooled Trust Referral Form (DHS-4759) must be sent to the DHS Special Recovery Unit (SRU).

Annual Reporting by Trustees

The trustee of a Special Needs Trust with a beneficiary who is an MA applicant or ~~recipient for MA~~ enrollee is required by state law to submit an annual trust accounting directly to the SRU. The person is not required to provide this information as part of the renewal process.

If the person or the person's authorized representative or trustee provides this information to the county, the information must be forwarded to the SRU.

Legal Citations

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

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

Minnesota Statutes, section 501C.1205, subdivisions 3 and 4

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

Published: ~~June~~ November 1, 2019

Previous Versions

Manual Letter #19.3, June 1, 2019

Manual Letter # 17.4 December 1, 2017

Manual Letter #17.1, April 1, 2017

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

Archive Information

- Publication date: June 1, 2019
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trusts

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

2.3.3.2.7.9.5 Pooled Trusts

A ~~P~~pooled ~~T~~trust is a trust established for the sole benefit of a beneficiary who is certified disabled. The ~~property held within~~ principal or corpus of a trust that meets all the requirements of a ~~P~~pooled ~~T~~trust is ~~an~~ excluded ~~asset~~.

Trust Requirements

A trust must satisfy all of the following ~~statutory~~ legal requirements in order to be excluded as a ~~P~~pooled ~~T~~trust. ~~If a trust does not meet all of the requirements, the trust is not an excluded asset.~~

Date Established

~~The trust must be~~ It is established on or after August 11, 1993.

Beneficiary Age Limit

There is no age limit for a person to establish a ~~P~~pooled ~~T~~trust; however, a transfer of funds into a pooled trust for a person who has reached age 65 must be evaluated under the transfer policy. See Medical Assistance for Long-Term Care Services (MA-LTC) Other Asset Transfer Considerations.

Trust Management

A non-profit association establishes and manages a ~~P~~pooled ~~T~~trust~~s~~. A separate account, known as a sub-account, is maintained for each beneficiary of the trust, but for purposes of investment and management of the trust~~;~~, the funds are pooled.

~~Account Establishment~~ Established By

~~The~~ A pooled trust must be established through the actions of the beneficiary, beneficiary's parents or grandparents, legal guardian or a court ~~establishes pooled trust accounts~~.

Funded By

~~It must be~~ A pooled trust is funded with the income or assets of the beneficiary. A ~~P~~pooled ~~T~~trust may also contain assets of other people.

Disability Standard

The beneficiary must meet the disability criteria of the Supplemental Security Income (SSI) program at the time the trust is established. A person with a disability established by the Social Security Administration (SSA) or State Medical Review Team (SMRT) meets this qualification.

The trust does not meet the criteria for the exclusion if the beneficiary's disability began after the trust was established.

If SSA or SMRT did not determine the beneficiary's disability at the time the trust was established, SMRT must determine whether the beneficiary was disabled according to SSI disability criteria at the time the trust was established.

Sole Benefit Requirement

The trust sub-account must be established for and used for the sole benefit of the disabled beneficiary and ~~. The trust provisions~~ must ~~state~~ provide that all disbursements ~~from the trust must be~~ are for the sole benefit of the beneficiary~~ at the time the trust is established and any time in the future~~, with the following exceptions:~~.~~

- The trust may allow reasonable compensation for a trustee or trustees to manage the trust.
- The trust may also allow reasonable costs associated with investment, legal, or other services rendered on behalf of the beneficiary with regard to the trust.

A trust is not excluded as a pooled trust if it includes a provision that allows for either of the following:

- Benefits to other people or entities during the beneficiary's lifetime, or
- Termination of the trust prior to the beneficiary's death and payment of the trust corpus to another person or entity, other than repaying the State.

~~Trusts that allow for payments to a spouse or dependents during the lifetime of the beneficiary do not meet this requirement even if the beneficiary does not currently have a spouse or dependent.~~

DHS Remainder Beneficiary

The trust must ~~contain a provision stating~~ provide that, upon the death of the beneficiary or earlier termination of the trust, to the extent that amounts remaining in the beneficiary's sub-account are not retained by the trust, the Minnesota Department of Human Services (DHS) or "the State" receives ~~all~~ such remaining amounts ~~remaining in the trust~~, up to an amount equal to the total amount of Medical Assistance (MA) paid on behalf of the beneficiary. A remainder amount of up to ten percent of the value of the beneficiary's sub-account at the time of death may be retained by the trust.

- ~~Trust provisions allowing payment of administrative expenses and fees are acceptable if the trust also contains a provision stating that the expenses and fees must be reasonable.~~
- ~~The trust is also is also acceptable if the trust clearly states reasonable and necessary administrative expenses may be paid only if DHS is provided with advance notice and approves such expenses.~~
- ~~An additional remainder amount of up to ten percent of the value of the beneficiary's sub-account at the time death may be retained the trustee.~~

~~Trusts that include provisions that allow for payment of the following expenses prior to repayment to the state do not qualify as a Pooled Trust:~~

- ~~Payment for last illness and funeral, outstanding debts or other payments~~
- ~~Payment of administrative expenses or attorney and trustee fees if the trust does not require such payment(s) to be reasonable~~

Allowable Administrative Expenses

The trust may pay the following types of administrative expenses from the trust before repayment of DHS as the remainder beneficiary:

- Taxes due from the trust to the State, other states, or federal government because of the death of the beneficiary
- Reasonable expenses for the administration of the trust estate, such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust.

  For these administrative expenses, the trust must provide that:

  - The DHS Special Recovery Unit (SRU) must receive advance notice and must approve any payment of administrative expenses before such expenses are paid, and
  - The administrative expenses must be reasonable.

Prohibited Expenses and Payments

A trust that provides for payment of any of the following expenses before repayment of DHS is not excluded as a pooled trust:

- Taxes due from the estate of the beneficiary other than those arising from inclusion of the trust in the estate;
- Inheritance taxes due for residual beneficiaries;
- Payment of debts owed to third parties;
- Funeral expenses; or
- Payments to residual beneficiaries, other than the trustee.

Evaluation of Trust ~~Assets~~ Principal and Additions to the Trust

Trust ~~Corpus~~ Principal

~~Trust assets~~ The trust principal, including any income generated by the trust ~~assets~~ that is retained by the trust, ~~are~~ is considered excluded ~~assets~~.

Additions to the Trust

Additions to the trust principal made directly to the trust are excluded; however, an addition or transfer of funds to a pooled trust for a person who has reached age 65 must be evaluated under the transfer policy. See MA-LTC Other Asset Transfer Considerations.

Income not irrevocably assigned to the trust is not considered to be made directly to the trust and is therefore counted as income to the beneficiary. A court order irrevocably assigning income to the trust is required to show an irrevocable assignment. If an assignment is revocable, the payment is income to the beneficiary because the beneficiary is legally entitled and eligible to receive it, unless another income exclusion applies. Note that certain payments to a beneficiary are not assignable by law. Send a HealthQuest if you have questions about assignability of income to a trust.

~~Distributions~~ Evaluation of Trust Disbursements

Disbursements of cash from the trust made directly to the beneficiary or~~,~~ to a person acting on the beneficiary's behalf~~,~~ are counted as unearned income in the month received.

~~Payments~~ Disbursements made by the trustee to a third party that result in the beneficiary receiving non-cash items, are not counted. Disbursements that do not count as income may include, but are not limited to those made for educational expenses, therapy, transportation, professional fees, medical services not covered by MA, phone bills, recreation, and entertainment.

Disbursements must be for the sole benefit of the beneficiary.

Consider disbursements to be for the sole benefit of the beneficiary if the trustee makes payments of any sort from the principal or income of the trust to another person or entity such that the beneficiary derives the primary benefit from the payment.

Purchased goods that require registration or titling, such as a vehicle or real property, must generally be registered or titled in the name of the beneficiary, the trustee, or the trust.

- ~~Note that for MA for Long-Term Care (MA-LTC) services applicants and enrollees, funds entering and leaving the trusts must be evaluated to determine if an uncompensated transfer occurred. See Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations for more information.~~

Pooled Trust Verifications

Verification ~~of the existence~~ of a ~~P~~pooled ~~T~~trust is required to determine eligibility. In addition, the trustee should provide a copy of the most recent accounting along with a copy of the trust instrument. Both documents must be sent along with a completed Special Needs/Pooled Trust Referral Form (DHS-4759) to the DHS Special Recovery Unit (SRU).

Annual Reporting by Trustees

The trustee of a ~~P~~pooled ~~T~~trust with a beneficiary who is an MA applicant or ~~recipient for MA~~ enrollee is required by state law to submit an annual trust accounting directly to SRU. The beneficiary is not required to provide this information as part of the renewal process.

If the person or person's authorized representative or trustee provides this information to the county, that information must be forwarded to SRU.

Legal Citations

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

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

Minnesota Statutes, section 501C.1205, subdivisions 3 and 4

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

Published: ~~December~~ November 1, 201~~9~~7

Previous Versions

Manual Letter #17.5, December 1, 2017

Manual Letter #17.1, April 1, 2017

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

Archive Information

- Publication date: December 1, 2017
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

N. Section 2.3.3.3.2.1 MA-ABD Countable Income

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

2.3.3.3.2.1 Countable Income

This policy provides information on types of income that must be counted when calculating a person's income for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) and Medicare Savings Programs (MSP). Some of these types of income are subject to disregards and deductions; see the MA-ABD Disregards and Deductions policy for more information. See the MSP chapter for more information.

Income is counted in the month it is received.

What is not Income

Some items received by a person are not counted as income in the month received. See MA-ABD Countable Assets and MA-ABD Excluded Assets for more information on how these items are treated if retained after the month of receipt. Items that are not income include, but are not limited to:

- Amounts withheld from unearned income, if both of the following conditions are met:
  - The income is being reduced to repay a prior overpayment from the same source; and
  - The overpaid amount was previously counted as unearned income for MA eligibility.
- Bona fide loans, including student loans, because of the obligation to repay
- Conversion of assets. This includes, but is not limited to, cash received from the sale of assets, money withdrawn from savings accounts or other liquid assets, reverse mortgages, etc.
- Distributions from a Health Flexible Spending Arrangement
- Distributions from a Health Savings Account
- Interest on countable assets
- In-kind benefits or payments

Earned Income

Earned income is cash people receive in exchange for work or service, including employment and self-employment. See Appendix B Income Types for descriptions of the different types of income. The following types of earned income is counted:

- Employee income, including, but not limited to:
  - Cash payments to clergy for housing

  - Commissions
  - Severance pay, based on accrued leave time
  - Tips
  - Vacation donation compensation
  - Wages
- Irregular or infrequent earned lump sum, non-gift, or income from an employer, trade or business. See MA-ABD Disregards and Deductions, earned lump sum income, for more information.
- Net earnings from self-employment, which is the gross income minus all expenses the Internal Revenue Service (IRS) allows as a self-employment expense
- Net rental income, which is the gross rental income minus verified rental and repair expenses, when the person spends an average of at least 10 hours per week maintaining or managing the property. Rental deposits are not income while subject to return to the tenant. Rental deposits used to pay rental expenses become income at the point of use. Verified expenses for providing a room or food or both to a roomer or boarder are subtracted from rental income.
- Other income received in exchange for work or service, including, but not limited to:
  - Jury duty pay
  - Picket duty pay
  - Blood and blood plasma sales
  - Royalties and honoraria

Unearned Income

Unearned income is cash that people receive without being required to perform work or service. The following types of unearned income is counted in a person's income calculation:

- Annuity payments
- Child support and arrearage payments made for a deceased child are counted for the person who receives the payment.
- Child support and arrearage payments are unearned income for the child, excluding:
  - Court ordered medical support
  - Payments to reimburse the custodial parent for medical expenses
  - Child support and arrearage payments received and retained by the county child support enforcement agency on behalf of a child enrolled in the Minnesota Family Investment Program (MFIP) or foster care
  - Child support payments received by or on behalf of children who:

    - Receive services through the Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI) or Developmental Disabilities (DD) waiver
    - Are enrolled in MA under the TEFRA option
- Disability payments that are part of the employer's benefit package
- Extended income support payments through the Trade Adjustment Reform Act (TAA)
- Interest and dividends earned on excluded assets, unless otherwise excluded. See MA-ABD Countable Assets and MA-ABD Excluded Assets for more information on how these items are treated.
- Irregular or infrequent unearned lump sum income from an individual, organization, or investment. See MA-ABD Disregards and Deductions, unearned lump sum income, for more information.
- Net rental income when the person spends an average of less than 10 hours per week maintaining or managing the property. Rental deposits used to pay rental expenses or repairs become income to the landlord at the point of use. Verified expenses for providing a room or food or both to a roomer or boarder are subtracted from rental income.
- Regular and frequent gift income
- Retirement, Survivor's, and Disability Insurance (RSDI). See MA-ABD Disregards and Deductions, dependent RSDI benefits, for more information.
- RSDI or Veterans Benefits for the Elderly reissued because an individual representative payee of 15 or more beneficiaries or an organization representative payee misused benefits is counted as income in the month received only if the original payment was not used to determine eligibility
- Retroactive RSDI lump sum payments are counted in the month received
- Pension or retirement benefits from public or private sources
- Severance pay that is not based on accrued leave time
- Spousal maintenance
- Student financial aid, in the following situations:
    - Earnings through the Federal Work Study program are counted for MA for Employed Persons with Disabilities (MA-EPD) if:
        - Average gross monthly earnings exceed $65
        - Social Security and Medicare taxes are withheld
    - Non-Title IV of the Higher Education Act (HEA) and Non-Bureau of Indian Affairs (BIA) grants, scholarships, fellowships and other non-loan financial aid not used for or set aside for educational expenses.
    - Distributions from a Coverdell Educational Savings Accounts (ESA) not used for or set aside for educational expenses.

- Tribal per capita payments from casinos
- Unemployment Insurance
- Veteran's Administration (VA) benefits
- Workers' Compensation

Availability of Income

For MA-ABD and MSP, income is available when the person has a legal interest and the ability to use that income for support and maintenance. Income is usually available in the following situations:

- The person receives the income
- Someone else receives the income on the person's behalf
- The employer or other payer owes the person money, but withholds the income at the person or the court's request
- Income is withheld from payments due to a garnishment or to pay a legal debt or obligation

For MA-ABD and MSP, income is unavailable when the person:

- Cannot gain access to the income
- Receives money to cover someone else's expenses and then uses that money to pay those expenses
- Receives benefits under credit life and disability insurance coverage. Payments under these policies cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are sent directly to the loan or mortgage company and are not available to the person.

A person must try to gain access to potentially available income.

Legal Citations

Code of Federal Regulations, title 42, section 435.631

Code of Federal Regulations, title 42, section 435.831

Minnesota Statutes, section 256B.056, subdivision 4

Published: ~~June~~ November 1, 201~~98~~

Previous Versions

Manual Letter #18.3, June 1, 2018

Manual Letter #18.1, January 1, 2018

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

Archive Information

- Publication date: June 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

O. Section 2.3.3.3.2.3 MA-ABD Excluded Income

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

2.3.3.3.2.3 Excluded Income

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

Excluded income includes:

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

- Disaster assistance, state payments
- Employment and training reimbursements and allowances
- Family Support Grant (FSG) payments
- Filipino Veterans Equity Compensation Fund payment
- Food and nutrition program payments. This includes assistance provided by:
    - Programs established under the Child Nutrition Act, including the Women, Infants, and Children (WIC) Nutrition Program and federally funded school breakfast and milk programs
    - National School Lunch program
    - Supplemental Nutrition Assistance Program (SNAP)
    - Minnesota Food Assistance Program
    - Minnesota Grown Supplemental Food Program
- Gifts to Children with Life Threatening Conditions from 501(c)(3) tax-exempt corporation. This are not considered income of a parent and apply only to children who are under age 18.
    - Any in-kind gift not converted to cash is excluded.
    - Cash gifts up to $2,000 in any calendar year are excluded. The amount of total cash payments that exceed $2,000 each year are counted as an asset.
        - Multiple cash gifts in the same calendar year are added together and up to $2,000 of the total is excluded, even if none of the cash gifts exceeds $2,000 individually.
- Hostile fire pay
- Housing and Urban Development (HUD) subsidies
- Individual Development Accounts (IDA)
- In-kind income
- Interest on funds that commingle countable and excluded assets
- James Zadroga 9/11 Health and Compensation Act of 2010
- Japanese American and Aleutian Restitution payments
- Jensen Settlement Agreement payments
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Lump sum income
    - Some lump sum income that is used to pay for certain expenses is not counted, including:
        - Costs associated with getting the lump sum, such as attorney's fees
        - Any portion of the lump sum earmarked for and used to pay medical expenses not covered by insurance or any Minnesota Health Care Program (MHCP), such as a prosthetic device

        - Any portion of the lump sum recovered by the DHS Benefit Recovery Section (BRS)
        - Any portion of the lump sum earmarked for and used to pay funeral and burial costs paid upon the death of a spouse or child
    - SSI lump sum payments
        - Retroactive SSI lump sum payments are excluded as income in the month received.
        - If a person's SSI is reissued because a representative payee misuses benefits, the reissuance is excluded as income.
    - Social Security Disability Insurance (SSDI) and Veterans Affairs (VA) payment due to representative payee misuse. If a person's SSDI or Veterans Benefits for the Elderly is reissued because an individual representative payee misuses benefits, the reissuance is excluded if the original payment of the income was used to determine the eligibility.
    - Medicare Part B Premium Reimbursements. This lump sum is excluded as income in the month received if the Medicare Part B premiums being reimbursed to the client were not used as an MA spenddown expense.
- Nazi Persecution payments
- Participation incentive payments
- Public assistance payments from the following programs:
    - Minnesota Family Investment Program (MFIP)
    - Diversionary Work Program (DWP)
    - General Assistance (GA)
    - General Residential Housing (GRH)
    - Minnesota Supplemental Aid (MSA)
    - Refugee Cash Assistance (RCA)
    - Title IV-E and non-Title IV-E Kinship Assistance
    - Title IV-E and non-Title IV-E Adoption Assistance
    - Foster Care Assistance
    - Mille Lacs Band of Ojibwe Elder Supplement Assistance Program
    - ~~Supplemental Nutrition Assistance Program (SNAP)~~
    - SSI
        - Note: VA Aid and Attendance benefits and VA unusual medical expense payments are not excluded, even if the person is receiving SSI.
- Radiation Exposure Compensation Trust Fund (RECTF) payments
- Refunds of rental security and utility deposits
- Reimbursements for out-of-pocket expenses incurred while performing volunteer services, jury duty or employment

- Reimbursements for medical expenses
- Reimbursements for replacement of property
- Relocation assistance payments, federal
- Ricky Ray Hemophilia Relief Fund payments
- Student financial aid. The following types of student financial aid income are excluded:
    - Student financial aid received under Title IV of the Higher Education Act, with the exception of Federal Work Study earnings which may count for Medical Assistance for Employed Persons with Disabilities (MA-EPD)
    - Student financial aid received from the Bureau of Indian Affairs (BIA), with the exception of Federal Work Study earnings which may count for MA-EPD
    - Non-Title IV and non-BIA grants, scholarships, fellowships and other non-loan financial aid, if used or set aside to pay educational expenses. Refer to MA-ABD Countable Income for funds that are not used for or set aside for educational expenses.
    - Distributions from a Coverdell Educational Savings Accounts (ESA) if the funds are used for educational expenses. Refer to MA-ABD Countable Income for funds that are not used for educational expenses.
    - VA benefits designated as educational assistance
    - Plan to Achieve Self Support (PASS) student financial aid
    - Training expenses paid by the Trade Adjustment Reform Act of 2002
- Tax credits, rebates and refunds
- Third party vendor payments, which include, but are not limited to:
    - MSA or GRH payments made directly to a facility
    - Emergency payments to a utility company made by an emergency assistance program such as Emergency General Assistance (EGA)
- Tribal payments. The following types of tribal payments are excluded:
    - Tribal trust or restricted lands, individual interest: Exclude the first $2,000 received from this income source.
    - Tribal per capita payments from a tribal trust: Exclude all funds from this income source.
    - Tribal land settlements and judgments: Excluded all funds from this income source.
- Veterans' Children with Certain Birth Defects payments
- Vietnamese Commando Compensation Act payments
- Vocational Rehabilitation Payments

Legal Citations

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

Published: ~~January~~ November 1, 201~~9~~8
Previous Versions:
Manual Letter #18.1, January 1, 2018
Manual Letter #17.2, June 1, 2017
Manual Letter #16.1 June 1, 2016 (Original Version)

Archive Information

- Publication date: November 1, 2017
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

P. Section 2.3.6 MA under the TEFRA Option

2.3.6 Medical Assistance under the TEFRA Option

Medical Assistance (MA) under the TEFRA option is for children with a disability who are otherwise ineligible for MA because household income is above the MA for Families with Children and Adults (MA-FCA) income limit. 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.

Under the TEFRA option, children who are otherwise ineligible for MA due to household income may become eligible. ~~o~~Only the income of the child is counted when determining eligibility for MA. Parents' income is not counted~~,~~. ~~instead they~~ Parents may be required to pay a parental fee.

MA under the TEFRA option is available for children who meet all of the following:

- Are under age 19
- Live with at least one biological or adoptive parent
- Require a level of care:
  - comparable to that provided in a hospital, nursing home or an intermediate care facility for people with developmental disabilities (ICF/DD), and
  - for which the cost for home care would not be more than MA would pay for the child's care in a medical institution.
- Are certified disabled

Children who are eligible for MA when counting parental income do not need to use the TEFRA option. Children approved under a home and community-based services waiver do not need to use the TEFRA option.

In general, MA eligibility under the TEFRA option follows the policies for MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) ~~policies~~. Specific differences are indicated in the policies for MA under the TEFRA option ~~policies~~ listed below.

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

General Requirements

TEFRA Applications

MA Cooperation

MHCP Fraud

MHCP Inconsistent Information

TEFRA Parental Fee

MA Referral for Other Benefits

MHCP Rights

MA Third Party Liability

MA Cost Effective Insurance

MA Medical Support

MA Other Third Party Liability

TEFRA Non-Financial Eligibility

MA-ABD Non-Financial Eligibility

MA-ABD Bases of Eligibility

MA-ABD Certification of Disability

MA Citizenship and Immigration Status

MA County Residency

MHCP State Residency

MA Social Security Number

TEFRA Level of Care

TEFRA Financial Eligibility

TEFRA Post-Eligibility

MA Begin and End Dates

MHCP Overpayments

MA Third Party Liability

MA Cost-Effective Insurance

MA Medical Support

MA Other Third Party Liability

MHCP Change in Circumstances

MA Cooperation

MA Cost Sharing

MHCP Fraud

MA-ABD Health Care Delivery

MA Inconsistent Information

MA Qualifying Health Coverage

MA Referral for Other Benefits

MA-ABD Renewals

Published: ~~June~~ November 1, 201~~96~~

Previous Versions

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

Archive Information

- Publication date: June 1, 2016
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

Q. Section 2.3.6.1.2 TEFRA Parental Fees

Medical Assistance under the TEFRA Option

2.3.6.1.2 Parental Fees

Medical Assistance (MA) under the TEFRA option is for children with a disability who are otherwise ineligible for MA because household income is above the MA for Families with Children and Adults (MA-FCA) income limit. 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.

Because MA under the TEFRA option only considers the child's income in deciding eligibility, parents must share the cost of care by paying a parental fee.

The Minnesota Department of Human Services (DHS) collects parental fees. The child's, county, tribal or state servicing agency must make a referral to the DHS parental fee unit. The county, tribal or state servicing agency sends the Important Notice and Parental Fee Worksheet (DHS-2977) to parents.

Parental Fee Amount

DHS uses the birth and adoptive parent's adjusted gross income (AGI) as reported on the previous year's federal tax return to compute parental fees.

Parents can estimate the amount of the parental fee using the worksheet and information on DHS-2977.

Parents receive a determination order that indicates what the parental fee is for the fiscal year and the amount of monthly payments.

Parental fee amounts can change each fiscal year due to annual changes in the FPG or changes in AGI or family size. Parents have the obligation to tell DHS when there is a change in household size, the child leaves the home, other health insurance coverage starts or stops, or there is change in monthly income in excess of 10%. The parents can send a letter to:

Department of Human Services
Financial Operations Division
PO Box 64171
St. Paul, MN 55164-0171

Parents of TEFRA enrollees are not required to re-verify their income at the time of the child's TEFRA renewal.

Undue Hardship

Parents may request a change to the parental fee when they incur any of the following expenses, not reimbursed by any public or private sector by sending a letter to DHS:

- Payments for medical expenses not covered by MA or health insurance, but that would be allowable as a federal tax deduction under the Internal Revenue Code.
- Expenditures for adaptations to the parents' vehicle that are necessary to accommodate the child's medical needs and are a type that would be allowable as a federal tax deduction under the Internal Revenue Code.
- Expenditures for physical adaptations to the child's home that are necessary to accommodate the child's physical, behavioral, or sensory needs and are a type that would be allowable as a federal tax deduction under the Internal Revenue Code.
- Unexpected, sudden or unusual expenditures by the parents since the last renewal or within the past 12 months that are not reimbursed by any type of insurance or civil action and which are a type allowable as a casualty loss deduction under the Internal Revenue Code.
- When a peculiar tax status creates a gross disparity between the amount of income allocated to them and the amount of the cash distributions made to them.

Non-Cooperation with Parental Fee Requirements

A child's MA coverage is not closed when a parent does not cooperate with parental fee requirements. Action may be taken against the parent in either of the following circumstances:

- Refusal to submit the necessary information to DHS in determining a fee can result in a bill for the full reimbursement cost of MA services.
- Failure to pay the parental fee can result in the account being turned over to a collection agency, garnishment of wages, or taking the parent's state tax refund.

Legal Citations

Code of Federal Regulations, title 42, section 1396A, subdivision e

Code of Federal Regulations, title 42, section 435.225

Code of Federal Regulations, title 42, section 412.424

Minnesota Rules, part 9550, subpart 6200-6240

Minnesota Statutes, section 252.27

Minnesota Statutes, section 256B.14

The Tax Equity and Fiscal Responsibility Act (TEFRA), Public Law 97-248, section 134

Published: ~~June~~ November 1, 2019~~6~~

Previous Versions

Archive Information

- Publication date: June 1, 2016
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

R. Section 2.5.3 Emergency Medical Assistance

2.5.3 Emergency Medical Assistance

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

The following people may qualify for EMA:

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

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

Children with disabilities who are ineligible for MA due to immigration status may be eligible for EMA under the TEFRA option.

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

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

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

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

General Requirements

MHCP Applications

EMA Mandatory Verifications

MA Responsibilities

MHCP Retroactive Eligibility

MHCP Rights

Non-Financial Eligibility

MA-ABD Bases of Eligibility

MA-ABD Non-Financial Eligibility

MA-ABD Certification of Disability

MA-FCA Bases of Eligibility

MA-FCA – Non-Financial Eligibility

MA County Residency

MA Living Arrangement

MHCP State Residency

MA-FCA Renewals

MA-ABD Renewals

Financial Eligibility

MA-ABD Financial Eligibility

MA-FCA Financial Eligibility

MA under the TEFRA Option

Post-Eligibility

MA Begin and End Dates

MA Benefit Recovery

MHCP Change in Circumstances

MA Cooperation

MA Cost Sharing

MHCP Fraud

EMA Health Care Delivery

MHCP Inconsistent Information

MA Referral for Other Benefits

MA-ABD Renewals

MA-FCA Renewals

Legal Citation

Code of Federal Regulations, title 42, section 435.139

Code of Federal Regulations, title 42, section 435.350

Code of Federal Regulations, title 42, section 440.255

Minnesota Statutes, section 256B.06, subdivision 4

Published: ~~June~~ November 1, 2019~~8~~

Previous Versions

Manual Letter #18.3, June 1, 2018

Manual Letter #16.4, December 22, 2016

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

Archive Information

- Publication date: June 1, 2018
- Archived date: November 1, 2019
- Links:
  - Archived page
  - Revised page

S. Section 3.1.2.3 MinnesotaCare Periodic Data Matching

MinnesotaCare

3.1.2.3 Periodic Data Matching

Periodic Data Matching (PDM) is a process that uses electronic data sources to identify MinnesotaCare enrollees who may no longer meet eligibility criteria for MinnesotaCare.

Enrollees in MinnesotaCare are subject to data matching using electronic data sources at least once during an enrollee's 12-month period of eligibility.

The electronic data sources used for periodic data matching provide information about an enrollee's or household member's income, Medicare Part A enrollment, or death.

Notification of Discrepant Information

Discrepant information is electronic data that is not consistent with the case information attested to by the enrollee. An enrollee will receive a discrepancy notice only when the information received from an electronic data source indicates the enrollee may no longer qualify for the program in which he or she is currently enrolled.

An enrollee must respond to the discrepancy notice within 30 days from the date on the notice, by mail, in person, or by calling the agency. An enrollee may respond to the discrepancy notice by submitting a response form with confirmed or corrected information. An enrollee who confirms the information on the form is correct must not be required to provide paper verification to resolve the discrepancy.

Extension to Resolve a Discrepancy

An extension of time beyond the 30-day period is available when an enrollee is cooperating with the agency but unable to provide the information needed to resolve a discrepancy before the date of closure. An extension may be granted only upon enrollee request. There is no limit to the number of extensions an enrollee may be granted, if the enrollee is cooperating with the PDM process.

Resolving a PDM discrepancy

- Income discrepancy

  An income-related PDM discrepancy is considered resolved when the agency receives an attestation of projected annual income for the household from the MinnesotaCare enrollee. No verification is required if the enrollee's attested projected annual income is the same as the projected annual income listed on the discrepancy notice.

- Medicare Part A discrepancy

A Medicare Part A discrepancy is considered resolved when an enrollee confirms having Medicare Part A or attests that he or she does not have Medicare Part A. If an enrollee disputes having Medicare, the agency must check any other available data sources about Medicare enrollment, and if necessary, refer the enrollee to the Social Security Administration (SSA) to update his or her records. The agency cannot require an enrollee to contact SSA before resolving the discrepancy.

- Death discrepancy

  A death discrepancy is considered resolved when the death is either confirmed or denied by the household. If an enrollee denies the death discrepancy, the agency must resolve the discrepancy and refer the enrollee to SSA to correct his or her records. The agency cannot require an enrollee to contact SSA before resolving the discrepancy.

An enrollee may report changes during the process of resolving their PDM discrepancies. See MHCP Changes in Circumstances for more information.

Failure to Resolve a PDM Discrepancy

A MinnesotaCare enrollee must cooperate with the PDM process as a condition of eligibility. Enrollees who fail to resolve a PDM discrepancy or request an extension within 30 days of the notice are no longer eligible for their current program. The enrollee is not eligible for MinnesotaCare, MA, advanced premium tax credits (APTC) or cost-sharing reductions (CSR) until the enrollee resolves all outstanding discrepancies. An enrollee with an outstanding discrepancy may be eligible to purchase a qualified health plan without a subsidy if he or she meets the eligibility criteria.

A MinnesotaCare enrollee whose eligibility ended due to failure to resolve a PDM discrepancy must resolve the outstanding discrepancy to qualify for MinnesotaCare again. Once the person resolves the outstanding discrepancy, the earliest the person can be eligible for MinnesotaCare is the first day of the month in which the person cooperated with the agency to resolve the PDM discrepancy or reapplied. MinnesotaCare coverage begins the first day of the month after the month in which eligibility is approved and a first premium payment is received, if the person is required to pay a premium. See MinnesotaCare Begin and End Dates for more information.

Legal Citations

Minnesota Statutes, section 256B.0561

Published: November 1, 2019