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 #20.4

December 1, 2020

Manual Letter #20.4

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of December 1, 2020. 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

We added the following DHS bulletin:

- #20-21-11, DHS Clarifies Medical Assistance Policies for Accepting Self-Attestation of Certain Eligibility Factors
- #20-21-12, DHS Clarifies Treatment of Non-Homestead Life Estate in Medical Assistance for Long-Term Care (LTC)

The following DHS bulletins as are incorporated into the EPM with this manual letter.

- #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA)
- #20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle
- #20-21-09, DHS Clarifies Use of Electronic Signatures for Minnesota Health Care Programs Eligibility Forms

Bulletin #20-21-10, DHS Announces Updates to Temporary Policies for Minnesota Health Care Programs MHCP eligibility applications, renewals and other eligibility forms, is not added to the EPM home page because its contents will not be incorporated into the EPM

We also added a link to the manual letter

B. Section 1.2.4 MHCP Processing Period

The change to this section clarifies the processing periods must be extended when the applicant is cooperating with providing information needed to process the application.

C. Section 1.2.6 MHCP Signature

The changes to this section incorporate DHS Bulletin #20-21-09, DHS Clarifies Use of Electronic Signatures for Minnesota Health Care Programs Eligibility Forms, and includes the addition of a link to a list of forms that require a signature for Medical Assistance eligibility.

D. Section 1.3.1.4 MHCP Data Privacy

We removed the reference to the Data Practices Manual, since the manual is obsolete.

E. Section 1.3.2.1 MHCP Change in Circumstances

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), with the addition of when to use the AVS when a person reports a change in circumstances that results in eligibility for MA-ABD, with an asset test.

F. Section 1.3.2.4 MHCP Inconsistent Information

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), with information when an unreported account is received through the AVS.

G. Section 1.5 MHCP Mandatory Verifications

The update to this section clarifies providing required documentation is primarily the responsibility of the applicant or enrolleeperson, however, agencies must assist.

H. Section 2.1.1.2.1.3.2 MA Medical Support

This update incorporates additional material related to medical support referrals, which includes details about cooperation, good cause, and when referrals are required.

I. Section 2.3.1 MA-ABD General Requirements

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to include reference links to the new Account Validation Service (AVS) and Authorization to Obtain Financial Information page.

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to clarify the AVS does not replace the requirement for proof of assets.

K. Section 2.3.1.2 MA-ABD Account Validation Service (AVS)

The addition of this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to incorporate the AVS policy.

L. Section 2.3.1.3 MA-ABD Authorization to Obtain Information

The addition of this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to incorporate the AVS authorization to obtain financial information policy.

M. Section 2.3.3.2.3 MA-ABD Excluded Assets

The update to this section incorporates updates for Nazi Persecution payments, which are an excluded asset, even when a person inherits it from the original recipient.

N. Section 2.3.3.2.7.5 MA-ABD Contract for Deed and Other Property Agreements

The update to this section clarifies the policy for reasonable effort to sell a contract for deed and other property agreements.

O. Section 2.3.3.3.2.3 MA-ABD Excluded Income

The update to this section incorporates updates for Nazi Persecution payments, which are excluded income, even when a person inherits it from the original recipient.

P. Section 2.3.5.1 MA-EPD General Requirements

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to include reference links to the new Account Validation Service (AVS) and Authorization to Obtain Financial Information page.

Q. Section 2.3.5.1.1 MA-EPD Mandatory Verifications

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to include the requirement of the AVS summary Report.

R. Section 2.3.5.1.3 MA-EPD Work Requirements

The update to this section is to clarify earned income for MA-EPD applicants and enrollees is determined for a six-month period.

S. Section 2.4.2.1.1 MA-LTC Asset Assessment for Planning Purposes

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to clarify the AVS must not be used for planning purposes.

T. Section 2.4.2.1.2 MA-LTC Community Spouse Asset Allowance

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to clarify the signature of the community spouse on the AVS authorization is not required to complete the CSAA.

U. Section 2.5.1 MA for Women with Breast and Cervical Cancer

The changes to this section incorporate DHS Bulletin ##20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle, to include the Screen Our Ciricle program as a recognized program.

V. Section 2.5.1.1.1 MA-BC Applications

The changes to this section incorporate DHS Bulletin ##20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle, to include the Screen Our Ciricle program as a recognized program.

W. Section 2.5.1.1.2 MA-BC Mandatory Verifications

The changes to this section incorporate DHS Bulletin ##20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle, to include the Screen Our Ciricle program as a recognized program.

X. Section 2.5.1.2.1 MA-BC Basis of Eligibility

The changes to this section incorporate DHS Bulletin ##20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle, to include the Screen Our Ciricle program as a recognized program.

Y. Section 4.2.1 MSP General Requirements

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to include reference links to the new Account Validation Service (AVS) and Authorization to Obtain Financial Information page.

Z. Section 4.2.1.3 MSP Mandatory Verifications

The changes to this section incorporate DHS Bulletin #19-21-02, DHS Announces Implementation of the Account Validation Service (AVS) for Medical Assistance (MA), to include the requirement of the AVS summary Report.

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 1.2.4 MHCP Processing Period

C. Section 1.2.6 MHCP Signature

D. Section 1.3.1.4 MHCP Data Privacy

E. Section 1.3.2.1 MHCP Change in Circumstances

F. Section 1.3.2.4 MHCP Inconsistent Information

G. Section 1.5 MHCP Mandatory Verifications

H. Section 2.1.1.2.1.3.2 MA Medical Support

I. Section 2.3.1 MA-ABD General Requirements

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

K. Section 2.3.1.2 MA-ABD Account Validation Service (AVS)

L. Section 2.3.1.3 MA-ABD Authorization to Obtain Information

M. Section 2.3.3.2.3 MA-ABD Excluded Assets

N. Section 2.3.3.2.7.5 MA-ABD Contract for Deed and Other Property Agreements

O. Section 2.3.3.3.2.3 MA-ABD Excluded Income

P. Section 2.3.5.1 MA-EPD General Requirements

Q. Section 2.3.5.1.1 MA-EPD Mandatory Verifications

R. Section 2.3.5.1.3 MA-EPD Work Requirements

S. Section 2.4.2.1.1 MA-LTC Asset Assessment for Planning Purposes

T. Section 2.4.2.1.2 MA-LTC Community Spouse Asset Allowance

U. Section 2.5.1 MA for Women with Breast and Cervical Cancer

V. Section 2.5.1.1.1 MA-BC Applications

W. Section 2.5.1.1.2 MA-BC Mandatory Verifications

X. Section 2.5.1.2.1 MA-BC Basis of Eligibility

Y. Section 4.2.1 MSP General Requirements

Z. Section 4.2.1.3 MSP Mandatory Verifications

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 #20.1, March 1, 2020

MHCP EPM Manual Letter #20.2, June 1, 2020

MHCP EPM Manual Letter #20.3, September 1, 2020

MHCP EPM Manual Letter #20.4, December 1, 2020

2019 Manual Letter

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

MHCP EPM Manual Letter #19.7. December 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 #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
- ~~Bulletin #20-21-07, DHS Announces Medical Assistance for Women with Breast for Cervical Cancer Eligibility Through Screen Our Circle~~

- Bulletin #20-21-11, DHS Clarifies Medical Assistance Policies for Accepting Self-Attestation of Certain Eligibility Factors
- Bulletin #20-21-12, DHS Clarifies Treatment of Non-Homestead Life Estate in Medical Assistance for Long-Term Care (LTC)

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.

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Manual Letter#20.3, September 1, 2020

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Manual Letter #20.1 March 1, 2020

Manual Letter #19.7, December 1, 2019

Manual Letter #19.6, November 1, 2019

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
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B. Section 1.2.4 MHCP Processing Period

Minnesota Health Care Programs

1.2.4 Processing Period

Minnesota Health Care Programs (MHCP) applications must be processed as soon as possible and within the following number of days from the date of application:

- 15 working days for a pregnant woman
- 60 days for people requesting an MA eligibility determination under a disability basis of eligibility
- 45 days for all other applicants

Processing periods ~~may~~ must be extended when the applicant is cooperating with providing information needed to process the application.

The processing period begins the date the online application is submitted or the county, tribal or state servicing agency receives a paper application. See the MHCP Date of Application policy for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.911

Code of Federal Regulations, title 42, section 435.912

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 45, section 155.310

Minnesota Rule, part 9505.0090

Minnesota Statutes, section 256L.05

Minnesota Statutes, section 256B.08

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C. 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. See EPM 1.2.2 Application Submission, for a description of an application filer and EPM 1.3.1.2 Authorized Representative, for a description of an authorized representative. ~~. 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.~~ A Signature may be handwritten or it may be electronic if it meets certain criteria.

- A person under 18 who 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.

Renewal Signature

The enrollee, a person who qualifies as an application filer, or their authorized representative must sign a renewal form when a renewal signature is required.

- A signature is required on paper renewal forms including the pre-populated renewal form.
- No signature is required when eligibility is automatically renewed using information in an enrollee's case file and data provided by trusted electronic sources.

Other Minnesota Health Care Programs (MHCP) Eligibility Forms

Refer to the Eligibility Forms that Require a Signature document for a quick reference guide to MHCP eligibility forms that require a signature.

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.~~

A valid electronic signature may be used to sign MHCP applications, renewals, and other eligibility forms that require a signature.

To be considered a valid electronic signature, the signature must be:

- gathered via software that complies with the Electronic Signatures in Global and National Commerce Act (ESIGN) and submitted with a certificate of completion, audit record, or similar audit trail; or
- gathered or transmitted electronically and meet all of the following criteria:
  - The signature must show the signor's intent to sign and be logically associated with or attached to a specific form.

    A signature on a form meets this criterion.

    A signature that is not on a form must be dated and include a short statement indicating intent and association. Acceptable statements include but are not limited to:

    - "I understand that I am signing the DHS-[form number] and I agree to all the terms and conditions of the form."
    - "I understand that I am signing [title of specific MHCP application or form] and I agree to all the terms and conditions of the form."
  - The signature must identify the person who is signing.

    A legible handwritten signature or a typed or legibly printed name accompanied by a handwritten signature (legible or not) meets this criterion.
  - The signature must be received in a form that is tamper-proof and cannot be modified.

Examples of valid electronic signatures:

- A signature on the Minnesota Eligibility Technology System (METS) online application available on the MNsure website.
- An image of a legible handwritten signature transmitted electronically such as by fax, email, or text message that is dated and includes an acceptable statement of intent.
- A signature captured by a software product that complies with ESIGN, submitted with a completion certificate.

Examples of signatures that are not valid electronic signatures:

- A signature gathered electronically that is submitted along with a form but does not include an acceptable statement of intent.
- An image of a handwritten signature that is placed on a form by digitally copying and pasting it into the document.
- A typed name created by selecting a script or calligraphy font that has not been gathered via software that complies with ESIGN.
- A signature gathered via software that complies with ESIGN that is not accompanied by a certificate of completion, audit record or audit trail.

Special Circumstances

A person who is mentally competent but unable to sign the application due to physical 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.

If a person has a court or tribal 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 using information in their case file and data provided 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

Minnesota Statues, chapter 325L

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D. Section 1.3.1.4 MHCP Data Privacy

Minnesota Health Care Programs

1.3.1.4 Data Privacy

Applications and other forms collect sensitive information on an individual that is needed to determine eligibility. Individuals can be harmed by the reckless disclosure of information about them, and, accordingly, there are significant penalties under both state and federal law for government agencies that violate laws designed to protect individuals and groups from such disclosure of information.

All Minnesota Health Care Programs (MHCP) application forms include a Notice of Privacy Practices. There is also a brochure on Information access and privacy (DHS-2667) that describes applicant and enrollee privacy rights.

Sharing of Information

State, county and tribal servicing agencies will only share information about applicants and enrollees as needed and as allowed or required by law.

Information sharing with providers

A provider can obtain the following information about MHCP enrollees without a release form from the enrollee:

- Major program
- Prepaid health plan
- Spenddowns
- Special transportation
- Copay
- Hospice
- Waiver eligibility
- Minnesota Restricted Recipient Program (MRRP)
- Other health insurance coverage
- Medicare coverage
- Fee-for-service benefit limits

Long-term care providers can also obtain the following without a release form from an applicant or enrollee:

- Confirmation that the person has applied for MA

- Effective date of MHCP approval, denial or termination

Information sharing with Applicants

Information about an adult applicant cannot be shared without the individual's consent, even with the application filer. This includes spouses, attorneys. In certain situations, another individual may have the legal authority to access the applicant's data or act on their behalf, such as an authorized representative, guardian, navigator, or persons with a power of attorney. State, tribal and county servicing agencies should request a copy of the legal document to verify that the legal relationship exists. If there is no legal relationship, consent must be obtained from the applicant either verbally or through the DHS-3549 General Consent/Authorization for Release of Information.

Information about an adult applicant can be shared with a legal guardian. Legal guardians of an adult have the same rights to access data as the individual.

Information sharing about Children

Parents generally have the right to access their child's private information, State, tribal and county servicing agencies can disclose information about minors to their parents, except in the following four circumstances:

- If the minor is emancipated
- If the state law provides minor with the right to obtain treatment without parental consent
- If the agency has a reasonable belief that a minor has been, or may be subject to, abuse or neglect, or that the disclosure of private information could endanger the minor
- If the child asks the agency to deny parental access to their information. In this scenario, the agency can decide whether to honor the request for privacy.

~~The Notice of Privacy Practices and the Minors section of the Minnesota Department of Human Services (DHS) Data Practices Manual describes in detail what information may or may not be shared about children younger than age 18.~~

Safe at Home Address Confidentiality Program

The Safe at Home (SAH) Address Confidentiality Program helps survivors of violence by providing a substitute address for individuals and their children who move to a new location unknown to assailants or probable assailants. SAH participants can apply for MHCPs using their SAH address. The Minnesota Secretary of State, who administers this program, assures that participants receive their mail.

A person is not required to provide proof of participation in the SAH program. A court order is required to release a SAH participant's information, including confirming or denying program participation.

Safe at Home program participants are granted good cause for not cooperating with medical support if they verify participation in the program with the ID card. SAH participants may also request and be

granted good cause for late premium payments and for late submission or completion of renewals. See the MA Medical Support policy for more information.

MHCP enrollees participating in the Safe at Home program must notify their county, tribal or state servicing agency of their county of residence, but do not have to provide their address. Managed care enrollment and county of financial responsibility are determined by county of residence.

Immigration Information

Immigration information applicants and enrollees provide to state, county and tribal servicing agencies is private. Immigration information is only used to determine MHCP eligibility. Immigration information is only shared when the law allows it or requires it, such as to verify identity. In most cases, applying for health coverage will not affect an applicant's immigration status unless they are applying for payment of long-term care services. See the U.S. Immigration and Customs Enforcement (ICE), Clarification of Existing Practices Related to Certain Health Care Information website for more information.

People do not have to provide immigration information when they are:

- Applying for Emergency MA (EMA) or MA for people receiving services at the Centers for Victims of Torture (MA-CVT)
- Helping someone else apply
- A pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS)
- Not an applicant

Data Practices Violations

Willful violation of data privacy laws by a public employee is just cause for dismissal or suspension without pay. It is also a crime.

An individual affected by an agency's violation of data privacy laws can seek several remedies under state and federal law. Applicants and enrollees may also file a lawsuit under the Minnesota Government Data Practices Act. They may also send a written complaint to the county, tribal or state servicing agency, the provider, or the federal civil rights office at:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (Voice)
800-368-1019 (Toll Free)
800-537-7697 (TTY)

312-886-1807 (Fax)

If an applicant or enrollee thinks that DHS or MNsure has violated their privacy rights, they may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

Minnesota Department of Human Services – MNsure
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

HIPAA

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides for the protection of individually identifiable health information that is transmitted or maintained in any form or medium. The privacy rules affect the day-to-day business operations of all organizations that provide medical care and maintain personal health information.

Applicants and enrollees are informed of their rights under HIPAA at application, renewal or any other time information is requested.

HIPAA also creates uniform methods to bill and share health information electronically between health care providers, payers and other organizations involved with health care delivery and payment.

State, county and tribal servicing agencies must follow HIPAA provisions as follows:

- If a provision of the HIPAA privacy regulations conflicts with a state law, whichever offers more privacy protection governs.
- If HIPAA and state law do not conflict, both state and federal privacy laws are followed.

Record Retention Policy

State, county and tribal servicing agencies maintain data in accordance with state and federal law. Information provided in an application for coverage is subject to the False Claims Act and may be retained for up to ten years. After the appropriate period, data is destroyed in a manner that prevents their contents from being determined, including the shredding of paper files and permanently removing electronic data to prevent the possibility of recovery. County servicing agencies must follow the County Human Services General Records Retention Schedule.

Data Review

MHCP applicants and enrollees may review private data that contain information about them. Both private and public data is shown to the subject of the data upon request.

Release of Information

An applicant or enrollee can complete the General Consent/Authorization for Release of Information (DHS-3549) to authorize the release of their information. In addition, they can authorize the release of their information to a Long Term Care Facility on the Long-Term Care/County Communication Form (DHS-3050).

Legal Citations

Code of Federal Regulations, title 45, section 155.310

Code of Federal Regulations, title 45, section 155.1210

Code of Federal Regulations, title 45, section 164.502

Code of Federal Regulations, title 45, section 164.508

Health Information Portability and Accountability Act, Public Law 104-191, 110 Stat. 1936 (1996)

Minnesota Rules, part 1205.0500

Minnesota Rules, part 1205.1500

Minnesota Statutes, chapter 5B

Minnesota Statutes, chapter 13

Minnesota Statutes, section 138.17

Minnesota Statutes, sections 144.341 to 144.347

Minnesota Statutes, section 256B.056

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E. 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.

The Account Validation Service (AVS) must be used when a person enrolled in MA for Families with Children and Adults (MA-FCA), MinnesotaCare, or another Insurance Affordability Program reports a change in circumstances that results in eligibility for MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) or Medicare Savings Programs (MSP). However, the eligibility determination for MA-ABD must not be delayed by the 10-day AVS processing period.

MinnesotaCare

When a MinnesotaCare enrollee reports a change in circumstance that maintains MinnesotaCare eligibility but results in a different premium or cost sharing amount such as a change in income, the effective date of the premium change depends on whether it is a premium decrease or

premium increase. A premium decrease is effective the month after the change was reported. A premium increase is effective for the month billed with the next regular billing cycle.

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

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

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

Medicare Savings Programs

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

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

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

Exceptions

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

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

Legal Citations

Code of Federal Regulations, title 42, section 435.916
Code of Federal Regulations, title 45, section 155.330
Minnesota Rules, part 9505.0115, subpart 1
Minnesota Statutes 256B.057

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F. 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 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 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 unreported account is received through the Account Validation Service (AVS) for the person, their spouse, or their sponsor.

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

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G. Section 1.5 MHCP Mandatory Verifications

Minnesota Health Care Programs

1.5 Mandatory Verifications

Each Minnesota Health Care Program (MHCP) has specific verification requirements. Refer to the specific program sections for detailed information about mandatory verifications.

Electronic verification sources are used first to verify information provided by the applicant or enrollee. If electronic verification is unsuccessful or unavailable, paper proofs may be required to determine eligibility. In some circumstances, self-attestation is acceptable without further verification. Refer to specific eligibility requirements for information on what types of proofs may verify information and when self-attestation is acceptable.

In addition to mandatory verifications, proofs may be required when the information provided by the applicant or enrollee is inconsistent with information the county, tribal or state servicing agency has from other sources. See the MHCP Inconsistent Information policy for more information about situations when proofs may be required.

Applicants and enrollees are primarily responsible for providing required paper proofs. However, agencies must assist applicants and enrollees in obtaining proof if the person is unable to provide it. Do not deny or close eligibility for people who are making a good faith effort to obtain the required proofs.

Legal Citations

Code of Federal Regulations, title 42, sections 435.940 to 435.956

Code of Federal Regulations, title 45, sections section 155.305 to 155.320

Minnesota Statutes, section 256B.056

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H. Section 2.1.1.2.1.3.2 MA Medical Support

Medical Assistance

2.1.1.2.1.3.2 Medical Support

The Medical Assistance (MA) program requires parents or relative caretakers to help provide health care for their children. When both parents live with the child, this requirement is generally met by deeming the parents' income to the child. When one parent does not live with the child, a referral for medical support may be required.

Medical support is health insurance coverage or cash payments that a parent, who is not living with the child, provides or is court-ordered to provide to meet the medical needs of their child. For MA eligibility, the parent or relative caretaker who lives with the child is required to cooperate with medical support referral requirements for children younger than age 19 on MA.

Assignment of Rights and Cooperation

A parent or relative caretaker assigns the child's right to medical support by signing a paper or online health care application or renewal form.

County, tribal or state servicing agencies are required to mail a medical support referral packet to the parent or relative caretaker. The MA enrolled parent or relative caretaker must return the form within 30 days of the date on the referral packet. Regardless of whether the forms are returned or not, the county, tribal or state servicing agency must initiate a referral to the county or tribal child support agency, also called the IV-D agency.

For medical support, cooperation may include:

- Establishing paternity
- Establishing an order for medical support, or enforcing an existing order
- Providing information about non-custodial parents
- Forwarding any medical support payments received directly from the non-custodial parent to the Department of Human Services (DHS)

A pregnant woman, or a parent or relative caretaker who is pregnant, is not required to cooperate with medical support for the child she is expecting or for any other child during pregnancy or during the postpartum period.

Non-Cooperation

The county or tribal child support office determines non-cooperation with medical support requirements and notifies the county, tribal or state servicing agency. The parent or relative caretaker's MA coverage is closed with 10-day notice.

If MA is closed for non-cooperation, MA coverage cannot be reopened until the parent or relative caretaker cooperates with medical support requirements. If the parent or relative caretaker cooperates, MA may reopen the first day of the month in which cooperation occurs.

The ~~child's~~ MA coverage of a child, or of anyone without the legal ability to assign rights, is not impacted by ~~their parent or relative caretaker's~~ non-cooperation with medical support requirements, such as the non-cooperation of a parent or relative caretaker.

Good Cause

A parent or relative caretaker may request "good cause" when there are circumstances beyond their control which keeps them from cooperating with medical support requirements. Information about good cause is included in the medical support referral packet sent to parents who are referred to medical support. A good cause committee reviews the good cause request. A person may withdraw a claim of good cause at any time in the process.

A parent or relative caretaker who meets all other program requirements are eligible for health care coverage while the good cause claim is being decided. If the good cause committee notifies the worker that the caretaker is not cooperating or does not meet the criteria for a good cause claim, the parent or relative caretaker's MA may be closed with ten-day notice.

Good cause claims must be reviewed annually. If a household with an approved good cause claim moves to another county, the review date for the good cause exemption remains one year from the date it was approved by the good cause committee at the original county.

If a household with an approved good cause claim moves to another county, the new county good cause committee is not required to make the same good cause finding. If the custodial parent or relative caretaker requests it, the county committees must share the evidence between counties.

When Medical Support Referrals are Made

A medical support referral is made when a child younger than age 19 resides with one parent or a relative caretaker, both the child and the parent or relative caretaker are eligible for MA, and none of the Referral Not Required criteria below applies.

Referral Not Required

A medical support referral is not made in any of the following circumstances:

- One parent in a two-parent household has a temporary absence. Refer to Section 1.4.4 Minnesota Health Care Programs Temporary Absence for more information.
- Only a child, and not a parent or relative caretaker, is enrolled in MA.
- The parent is deceased.
- The parent or relative caretaker is pregnant.

- The parent is a minor child under age 18 or is an emancipated minor.
- The child receives Northstar Adoption Assistance.
- The child receives Northstar Foster Care or Kinship Assistance.
- A parent is involuntarily out of the household because he or she is being detained by U.S. Immigration and Customs Enforcement (ICE) or is waiting for immigration authorization from U.S. Citizenship and Immigration Services (USCIS) from outside of the United States.

Voluntary Referral

A parent or relative caretaker may request voluntary medical support or child support referral services from the county or tribal IV-D agency when a referral for MA eligibility purposes is not required. The county or tribal IV-D agencies can assist people in getting the medical or child support referral services.

Legal Citations

Code of Federal Regulations, title 42, section 435.610

Code of Federal Regulations, title 42, section 433.145

Code of Federal Regulations, title 42, section 433.146

Code of Federal Regulations, title 42, section 433.147

Code of Federal Regulations, title 42, section 433.148

Minnesota Statutes, section 256.741

Minnesota Statutes, section 256B.056, subdivisions 6 and 8

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I. Section 2.3.1 MA-ABD General Requirements

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

2.3.1 General Requirements

This subchapter provides general policy information that applies to Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD).

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

MHCP Applications

MA-ABD Mandatory Verifications

MA-ABD Account Validation Service (AVS)

MA-ABD Authorization to Obtain Financial Information

MA Responsibilities

- MA Benefit Recovery
  - MA Estate Recovery
  - MA Liens
  - MA Third Party Liability
    - MA Cost Effective Insurance
    - MA Medical Support
    - MA Other Third Party Liability
- MA Cooperation
- MA Cost Sharing
- MHCP Fraud
- MHCP Inconsistent Information
- MA Referral for Other Benefits

MHCP Retroactive Coverage

MHCP Rights

- MHCP Appeals
- MHCP Authorized Representative

MHCP Civil Rights

MHCP Data Privacy

MHCP Notices

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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. 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 verified as excluded it does not need to be verified again at renewal.
    - An applicant or enrollee must verify assets even if the Account Validation Service (AVS) was requested.

    Assets that are counted for a person with an asset limit must be verified even if the asset belongs to a person who is not applying for Medical Assistance (MA) or does not have an asset limit.
  - 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

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K. Section 2.3.1.2 MA-ABD Account Validation Service (AVS)

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

2.3.1.2 Account Validation Service (AVS)

County, tribal and state servicing agencies must use the Account Validation Service (AVS) to electronically check for unreported financial accounts that might be counted for applicants and enrollees whose MA basis of eligibility is MA-ABD and who have an asset test.

The servicing agency must use the AVS at application and when an enrollee's basis of eligibility changes to MA-ABD with an asset test. This includes people who:

• Live in the community
• Live in a long-term care facility and request Medical Assistance for payment of long term care (MA-LTC) with an ABD basis of MA.
• Request services through a home and community-based services (HCBS) program (Brain Injury [BI], Community Alternative Care [CAC], Community Access for Disability Inclusion [CADI], Developmental Disabilities [DD] or Elderly Waiver [EW])
• Request coverage under Medical Assistance for Employed Persons with Disabilities (MA-EPD)
• Request coverage under Medicare Savings Programs (MSP)

The servicing agency must use the AVS for the applicant or enrollee's spouse, sponsor, or sponsor's spouse when their assets are a part of the person's MA determination.

AVS Requirements

The county, tribal or state servicing agencies must:

- Obtain all required information on the Authorization to Obtain Financial Information form (DHS-7823) for the Account Validation Service (AVS) prior to accessing the AVS. See 2.3.1.3 Authorization to Obtain Information.
- Check the AVS results a minimum of 10-days after the date the request was submitted and directly prior to approving eligibility at application.
- Act on all unreported accounts, as follows:
    - For applicants, unreported accounts must be verified before MA eligibility is approved.
    - For enrollees, unreported accounts discovered after MA eligibility is approved are treated as inconsistent information. See 1.3.2.4 MHCP Inconsistent Information.
- Maintain the AVS Summary Report in the person's file at the time of making each eligibility determination.

Exceptions to the 10-day Waiting Period

County, tribal and state servicing agencies must submit a request through the AVS before approving eligibility, but must not delay the eligibility determination solely due to the 10-day AVS waiting period in the following situations:

- An enrollee's eligibility changes from MinnesotaCare or MA for families with children and adults (MA-FCA) to MA-ABD and results in the enrollee having an asset test.
- When an enrollee is being determined eligible for MA-ABD in the month after MA-EPD closes for premium non-payment.
- A person has an immediate medical need at application, such as but not limited to, the person:
  - is in a doctor's office, pharmacy, or hospital in need of services or coverage or has been refused medical services,
  - is in immediate need of prescription medications, or
  - has a high-risk pregnancy.

Legal Citations

United States Code, title 42, section 1396w

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L. Section 2.3.1.3 MA-ABD Authorization to Obtain Information

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

2.3.1.3 Authorization to Obtain Information

To be eligible people who have an asset test must complete a valid Authorization to Obtain Financial Information (DHS-7823) as a condition of eligibility for MA-ABD. The form must be signed and in the case file for the applicant or enrollee and any person whose assets deem to them before the county, tribal or state servicing agency requests their financial information through the Account Validation Service (AVS).

Before submitting a request through the AVS, the county, tribal or state servicing agency must verify a valid authorization is on file.

Each person may sign the same form or a separate form; however, no other authorization or release form may be used in place of the Authorization to Obtain Financial Information (DHS-7823) form.

The Authorization to Obtain Financial Information form(s) must be maintained in the enrollee's case file, even when it is no longer valid. ensure

Authorization Requirements

The Authorization to Obtain Financial Information form must be signed by:

- The personor their authorized representative
  - If the person has a legal guardian, the guardian must sign for the person.
  - If the person has passed away, the personal representative of the estate must sign for the person.
- The person's spouse, sponsor, sponsor's spouse , or their legal representative, if their assets are used to determine the person's eligibility. A sponsor is someone who signed an Affidavit of Support (USCIS I-864) as a condition of the person's, or his or her spouse's, entry to the country.

A separate authorization is needed for each spouse when both spouses are applying or eligible for MA-ABD and have an asset test.

Social Security Number (SSN)

A person's SSN is required to submit a request through the AVS. The SSN must be provided on the current MHCP application or AVS authorization. An SSN known to the agency for any other reason cannot be used to submit the request to the AVS.

Applicants and enrollees who do not have an SSN or meet an exception for providing an SSN for purposes of MA eligibility are not required to provide their SSN for the purpose of submitting a request to the AVS.

Spouses and sponsors are not required to provide an SSN on the authorization form (DHS-7823). MA-ABD eligibility cannot be denied or terminated due to a spouse or sponsor not providing their SSN on the authorization.

Applicants and enrollees, their spouses and sponsors must verifyproof of their assets, regardless of whether the AVS is used to access information about their financial accounts.

Duration of the Authorization

A signed authorization form remains in effect until one of the following occurs:

- The MA application is withdrawn or denied.
- The enrollee's MA is closed. However, an enrollee's authorization remains in effect if eligibility is reinstated due to agency error or delay in processing.
- The enrollee's MA basis of eligibility is no longer MA-ABD with an asset test.
- The person or their authorized representative withdraws the authorization in writing.
- The authorized representative who signed the AVS authorization on behalf of another person is no longer the authorized representative.
- The person dies, even when it is signed by another person on their behalf.

New Authorization Required

A new authorization form is required before a request can be submitted through the AVS when:

- A previously completed authorization is no longer in effect for any of the reasons listed under the Duration of the Authorization section above.
- The agency cannot physically locate the required signed authorization.
- An enrollee gets married or has a change in eligibility that causes the spouse's assets to be considered in the eligibility determination when they previously were not considered.
    - Only the spouse's signature is required if the enrollee's authorization form otherwise remains in effect.
    - The spouse does not need to sign a new form if they already signed the authorization form which remains in effect.
- The authorization is received and there is not an active MHCP program to make it valid or it was not received with or after an application for a MHCP.

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United States Code, title 42, section 1396w

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M. 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, including payments inherited from the original recipient, and any interest accrued from these funds.
- Plan to Achieve Self Support (PASS), assets associated with a person's PASS are excluded if they are not already excluded under another provision
- 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.
    - Coverdell Educational Savings Accounts (ESA)
        - Funds in a Coverdell ESA are excluded for the designated beneficiary of the account.
        - Distributions from a Coverdell ESA are excluded 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

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N. Section 2.3.3.2.7.5 MA-ABD Contract for Deed and Other Property Agreements

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

2.3.3.2.7.5 Contract for Deed and Other Property Agreements

This section provides policy provisions for contracts for deed and other property agreements. The analysis for contracts for deed is used to evaluate all property agreements.

Contract for Deed

A contract for deed is a conditional sales contract for the purchase of real property. It is similar to a mortgage; however:

- Generally, a private party or business, rather than a lending institution, owns the contract for deed.
- The seller of real property via a contact for deed or other property arrangement can often sell the contract to another person(s) or entity.

Property Agreement

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called real estate or land contracts, contracts for deed, deeds of trust, etc.

Contract Creditor (Seller)

Contracts for deed and other property agreements, such as deeds-of-trust, land contracts and mortgages held by the seller, are considered a liquid asset to the seller (creditor). The property itself is not an asset for the seller because the contract seller cannot legally convert it to cash while it is encumbered by the contract for deed. If payments received by the seller consist of both principal and interest, only the interest portion is income. The principal portion of the payments received is treated as a conversion of an asset, so is not income.

Determining Availability of a Contract for Deed or Other Property Agreement – Seller

A contract for deed or other property agreement is unavailable if:

- There is a legal bar prohibiting the sale of the contract for deed or other property agreement.
- The person is making reasonable efforts to sell the contract for deed.

Asset Value of the Agreement – Seller

For a seller, the value of a contract for deed or property agreement is its outstanding principal balance less any encumbrances, unless the person furnishes evidence that it has a lower cash value.

- An amortization schedule can be used to determine the outstanding principal balance and the interest income if the terms of the agreement are known.

Contract Debtor (Buyer)

A person who is the buyer of property by a contract for deed or other property agreement has an equitable interest in the real property and usually has the right to occupy the property. The buyer generally will not receive title to the property until payments are complete under the contract.

Asset Value of the Agreement – Buyer

For a buyer, the contract for deed or other property agreement is an encumbrance against the real property, not an asset.

- A person's equity interest in a home subject to a contract for deed is excluded as a homestead.
- A person's equity interest in real property subject to a contract for deed that is not a home is considered an available asset unless the property is determined to be an unavailable asset or the person is making reasonable efforts to sell the property.
- Reverse mortgages allow owners to convert some of the equity in their homes to cash. Because the payments received from a reverse mortgage are actually a loan against the equity of the borrower's home, such payments are treated as an encumbrance, not as a counted available asset.

Purchase of Interest in a Contract for Deed

A person who purchases the seller's interest in a contract for deed or other property agreement acquires the seller's right to receive payments pursuant to the contract for deed. This is considered a conversion of assets for the seller and the interest of the payments is income for the buyer.

Reasonable Effort to Sell Contract for Deed or Other Property Agreement

A contract for deed or other property agreement is considered unavailable due to reasonable effort to sell if a person can verify all of the following criteria:

1. Attempting to sell the property agreement, which means:
   - ~~o~~ The person must offer the agreement for sale, a minimum of two times, to two separate businesses or individuals that routinely engage in the purchase of interest in property agreement, and ~~Listing the property agreement with a real estate broker, or~~

- ~~Advertising~~ Advertise the ~~property~~ agreement for sale using one or more public forms of advertisement available to residents of the geographic area where the property is located.

2. List~~ing an~~ the property agreement for the appropriate price.The value of the agreement is the principal balance, less any encumbrances, unless proof of lesser value is provided. ~~for the property agreement. The asking price should be the EMV on the tax statement, except when the accuracy of the EMV is disputed.~~
3. The owner must not reject any reasonable offer to buy the property agreement.

Reasonable efforts to sell the property agreement must continue until the property agreement is sold in order to continue the exclusion.

What is a reasonable offer?

A contract creditor (seller) must attempt to get offers for the principal balance of the contract, less encumbrances, or the verified lesser value of the contract if the seller disputes the value. ~~An owner must attempt to get offers for the EMV or the verified FMV if the owner disputes the EMV.~~

- No minimum length of time is required for an owner to try to get offe~~rs close to the EMV (or FMV)~~. The reasonable length of time is based on the local market, or the time period designated in a real estate contract.
- The property agreement must be offered for sale on the open market before the owner may accept an offer lower than the ~~EMV (or FMV)~~ principal balance of the agreement, less any encumbrances.
- An offer for less than two-thirds of the ~~EMV (or FMV)~~ principal balance of the agreement, less encumbrances, is not considered reasonable.

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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, including payments inherited from the original recipient, and any interest accrued from these funds.
- 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
    - 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

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P. Section 2.3.5.1 MA-EPD General Requirements

Medical Assistance for Employed Persons with Disabilities

2.3.5.1 General Requirements

This subchapter provides general policy information that applies to Medical Assistance for Employed Persons with Disabilities (MA-EPD). In general, MA-EPD follows the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) general requirements policies. Specific differences are indicated in the MA-EPD policies listed below.

This subchapter includes policies that apply to MA-EPD and links to policies that apply to MA-ABD.

Topics covered in this subchapter are:

MA-ABD General Requirements

MA-ABD Account Validation Service (AVS)

MA-ABD Authorization to Obtain Financial Information

MA-EPD Mandatory Verifications

MA-EPD Premiums and Cost Sharing

MA-EPD Work Requirements

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Q. Section 2.3.5.1.1 MA-EPD Mandatory Verifications

Medical Assistance for Employed Persons with Disabilities

2.3.5.1.1 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 Employed Persons with Disabilities (MA-EPD) has the following mandatory verifications.

- Assets
  - Verification of assets is required at application and when a new asset is reported. If an asset is determined to be excluded it does not need to be verified again at renewal.
    - An applicant or enrollee must verify assets even if the Account Validation Service (AVS) was requested.
  - Verification of the following assets are not required at application or renewal:
    - Homestead, if it qualifies for the real property homestead exclusion. The only exception applies to people who are applying for or renewing Medical Assistance for Long Term Care eligibility. Refer to Section 2.4.1.2 MA-LTC Home Equity Limit for more information about the exception.
    - 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)
- Income from employment
  - For wage income, only the following forms of verification are acceptable:
    - Pay stubs that include:
      - The employee's name or Social Security Number.
      - Hours worked.
      - Gross pay.
      - Social Security and Medicare taxes withheld.
      - Net pay.
      - Period covered by earnings.
      - Employer's name.
    - A completed Authorization for Release of Employment Information (DHS-2146). This form is only required when the employee does not provide pay stubs containing the

required information, or any other statement from the employer that provides the necessary information.

- For self-employment income one of the following must be provided as verification of earnings:
  - Federal tax forms if the client has been in business long enough to file taxes and was required to file federal income tax for the previous year. Tax forms must include any of the following:
    - Quarterly Schedule ES (Form 1040) Estimated Tax for Individuals, if they were required to pay quarterly self-employment taxes.
    - Form 1040 U.S. Individual Income Tax Return with the "Self-Employment Tax" line completed.
    - Schedule SE (Form 1040) Self-Employment Tax.
  - Business records if the client has not been in business long enough to file a federal income tax return or quarterly estimated taxes, or if tax forms do not accurately reflect self-employment income.
- An enrollee must submit a copy of the federal tax return when it becomes available at the next renewal.
    - Business records may include:
    - Business financial statement.
    - Detailed records of gross receipts and expenses.
    - Business quarterly report.
    - Computer printout showing gross receipts and expenses.
    - Signed statement from the business's accountant verifying projected business income or expenses.

- Immigration status
- Royalties, Honoraria, and Stipends
  - Documentation of royalty, honoraria, or stipend income must show:
    - The nature and amount of payments.
    - Dates of payments.
    - Frequency of payments.
    - Social Security and Medicare tax withholding.
  - This income can be verified with:
    - Tax forms for the previous year identifying royalties, honoraria, or stipends with Medicare and Social Security taxes paid via entries on:
    - Federal Tax Form 1040.

        - Schedule C.
        - Schedule SE.
        - Form 1099-Misc.
    - Pay stubs or written statement from the source of payment showing:
        - Social Security and Medicare taxes withheld.
        - Client's name or Social Security Number.
        - Amount of payment.
        - Dates of payment.
        - Name of the issuer.
    - Quarterly Schedule ES (Form 1040) Estimated Tax for Individuals.
    - Schedule SE (Form 1040) Self-Employment Tax.
- Social Security Number
- Social Security and Medicare taxes paid
- U.S. Citizenship

American Indian and Alaska Native enrollees need to provide proof of status to be exempt from paying MA-EPD premiums.

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R. Section 2.3.5.1.3 MA-EPD Work Requirements

Medical Assistance for Employed Persons with Disabilities

2.3.5.1.3 Work Requirements

A person must be employed to be eligible for Medical Assistance for Employed Persons with Disabilities (MA-EPD). This policy describes specific employment requirements for MA-EPD.

Employment Income

A person must have earned income greater than $65 per month on average for a six-month period at application and renewal from wages or self-employment earnings to be eligible. For wages, earned income is monthly average gross income. For self-employment income, earned income is ~~the~~ net earnings from self-employment, which is the gross income minus all expenses the Internal Revenue Service (IRS) allows as a self-employment expense.

Seasonal self-employment is counted only in the months in which the person is engaged in work activity.

Social Security and Medicare taxes must be withheld from wages. State and federal income taxes need only be paid or withheld if the person earns enough to be required to pay those taxes. A person with self-employment earnings must pay Social Security and Medicare taxes at least annually. Quarterly estimated state and federal income taxes must be paid if the person earns enough to be required to pay those taxes.

A person cannot retain MA-EPD eligibility or become eligible for MA-EPD simply by filing self-employment taxes. Self-employed people generally must:

- work for themselves rather than for an employer
- be responsible for their own work schedule
- not be covered under an employer's liability insurance or Workers' Compensation
- pay Social Security and Medicare taxes

The following are not considered employment income for MA-EPD:

- Gratuitous money allowances
- Honoraria or stipends that only reimburse expenses or do not have Medicare and Social Security taxes withheld or paid annually
- Payments for participation in a clinical trial
- Payments for the sale of blood or blood plasma

Individuals with two sources of employment income, one source that has taxes withheld and one source that does not, are eligible for MA-EPD. The gross monthly earnings from which taxes are withheld must exceed $65.

Verification of Employment Income

Employment income must be verified at application and renewal. See Mandatory Verifications for more information.

Medical Leave or Job Loss Extension

MA-EPD enrollees must receive employment income or must engage in self-employment activities each month unless they meet specific medical leave or job loss criteria. However, medical leave and job loss provisions do not pertain to the month of application or in any retroactive month. An MA-EPD applicant must be employed at application and during any retroactive months.

MA-EPD enrollees are still considered employed if they change jobs and receive no paychecks for one month because of different pay periods in each job.

Four-Month Medical Leave

An MA-EPD enrollee may maintain eligibility, without earnings, for up to four calendar months due to a verified medical condition.

- A physician's statement is necessary to verify the need for medical leave before continuing coverage under MA-EPD.
- The four-month medical leave begins the month after the enrollee is unable to work.
- The four-month medical leave ends the last day of the fourth month in which the enrollee is unable to work, even if the physician's statement states the enrollee is expected to be unable to work for more than four calendar months.

Four-Month Job Loss

An MA-EPD enrollee may maintain eligibility, without earnings, for up to four months due to job loss that was not caused by or attributed to the enrollee. Situations that would allow a four-month extension include, but are not limited to, layoffs due to lack of work or business closing.

- Verification of the reason the enrollee became unemployed is required before continuing coverage under MA-EPD.
- The four-month job loss leave begins after the enrollee stops working or receives the last paycheck, whichever is later.

MA-EPD enrollees who become unemployed for reasons attributable to them, such as poor work performance, discharge for misconduct, or resignation for reasons other than medical leave, are not eligible for the four-month extension.

Employees who become unemployed while on medical leave from their jobs may remain enrolled for four additional months following the month in which they are terminated or laid off.

There is no annual limit on the number of times the MA-EPD medical leave or job loss extensions can be used. The enrollee must return to work between leaves and meet all requirements. Enrollees who remain eligible for MA-EPD due to the four-month job loss extension may not extend eligibility with a medical leave without returning to work between leaves.

Enrollees must continue to pay MA-EPD premiums during the four-month medical leave or job loss extension.

Legal Citations

Minnesota Statutes, section 256B.057, subdivision 9

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S. Section 2.4.2.1.1 MA-LTC Asset Assessment for Planning Purposes

Medical Assistance for Long-Term Care Services

2.4.2.1.1 Asset Assessment for Planning Purposes

An asset assessment is an evaluation of assets owned individually or jointly by a married couple as of a specific date. The Account Validation Service (AVS) cannot be used for planning purposes. The couple must document and provide proof of these assets.

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

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

Legal Citations

Minnesota Statutes, section 256.059

United States Code, title 42, section 1396r-5

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Medical Assistance for Long-Term Care Services

2.4.2.1.2 Community Spouse Asset Allowance

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

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

Determining the Community Spouse Asset Allowance

The CSAA includes the couple's total countable assets as determined by the asset evaluation. The couple must provide proof of the value of all of their assets, regardless of whether the asset is excluded or unavailable.

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

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

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

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

Whereabouts of the Community Spouse are Unknown

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

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

spouse on the Account Validation Service (AVS) authorization (DHS-7823) is not required to complete the CSAA.

Notification Requirements

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

Increased Community Spouse Asset Allowance

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

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

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

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

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

- The community spouse's income, combined with any income allocation from the LTC spouse, is less than the calculated monthly maintenance needs.
- The LTC spouse must make available, and the community spouse must accept, the community spouse income allocation. The couple cannot refuse to make or accept a community spouse income allocation as a way to reduce the community spouse's income in order to qualify for additional income-producing assets.
- The purchase of an income-producing asset for the benefit of the community spouse, under this provision, must occur before MA-LTC may be approved.
- The amount of assets above the CSAA is limited to an amount necessary to produce the additional income needed to meet the community spouse's monthly maintenance needs.
- Assets already producing an income cannot be used to purchase another income-producing asset, unless the asset purchased produces more income.

Transfers from the LTC Spouse to the Community Spouse

Assets considered available to the community spouse through the CSAA must be put in the community spouse's name no later than the LTC spouse's next annual renewal. At the LTC spouse's

next annual renewal, all assets still in the name of the LTC spouse are evaluated in order to determine asset eligibility.

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

Transfers from the Community Spouse to the LTC Spouse

Ownership of assets that are in the community spouse's name but are not included in the CSAA and do not have to be reduced must be transferred to the LTC spouse. Transfer of ownership must be verified before MA-LTC eligibility may be approved.

Community Spouse Does Not Make Assets Available to the LTC Spouse

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

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

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

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

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

Legal Citations

Minnesota Statutes, section 256B.059

Minnesota Statutes, section 256B.0913, subdivision 12

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2.5.1 Medical Assistance for Women with Breast or Cervical Cancer

Medical Assistance for women with Breast or Cervical Cancer (MA-BC) is a basis of eligibility for women who need treatment for breast or cervical cancer, including precancerous conditions and early stage cancer.

~~They~~ To be eligible for MA-BC, a person must be screened and diagnosed through a Centers for Disease Control and Prevention (CDC) funded National Breast and Cervical Cancer Early Detection Program (NBCCEEDP).~~the Sage Screening Program~~.

Minnesota has two screening programs:

- Minnesota Department of Health's Sage Screening Program

  Sage is a statewide comprehensive breast and cervical cancer screening program administered by the Minnesota Department of Health. For eligible women, Sage provides free office visits for breast and cervical exams, as well as a screening mammogram and Pap smears.

- American Indian Cancer Foundation's Screen Our Circle

  Screen Our Circle is the American Indian Cancer Foundation's National Breast and Cervical Cancer Early Detection Program. Screen Our Circle works with urban American Indian and Alaskan Native clinics to increase cancer screening and early cancer detection rates.

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

General Requirements

MA-BC Applications

MA-BC Mandatory Verifications

MHCP Rights

MA Responsibilities

MA Retroactive Coverage

Non-Financial Eligibility

MA-BC Basis of Eligibility

MA Citizenship and Immigration

MA County Residency

MA Living Arrangement

MA Social Security Number

MHCP State Residency

Financial Eligibility

Post-Eligibility

MA Begin and End Dates

MA Benefit Recovery

MHCP Change in Circumstances

MA Cooperation

MA Cost Sharing

MHCP Fraud

MA-BC Health Care Delivery

MHCP Inconsistent Information

MA Qualifying Health Coverage

MA Referral for Other Benefits

MA-BC Renewals

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V. Section 2.5.1.1.1 MA-BC Applications

Medical Assistance for Women with Breast or Cervical Cancer

2.5.1.1.1 Applications

Women, who are screened through the Minnesota Department of Health (MDH) Sage Screening Program or the American Indian Cancer Foundation (AICAF) Screen Our Circle Program and are found to need treatment or diagnostic services for breast or cervical cancer, are potentially eligible for Medical Assistance for women with Breast or Cervical Cancer (MA-BC).

Application Paths

A woman must apply for MA-BC. There are two paths to requesting an MA-BC eligibility determination.

1. A temporary eligibility determination, referred to as presumptive eligibility (PE), may be granted by a Minnesota Health Care Programs (MHCP) provider participating in the Sage Screening Program or Screen Our Circle Program.
2. Some women do not have presumptive eligibility determined and directly apply for MA-BC using the Minnesota MA Application/Renewal Breast and Cervical Cancer (DHS-3525) form.

Forms

Temporary Medical Assistance Authorization (DHS-3525B)

The Temporary Medical Assistance Authorization (DHS-3525B) is completed by the provider and authorizes presumptive eligibility.

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

The Minnesota MA Application/Renewal Breast and Cervical Cancer (DHS-3525) form is for women who were screened by the Sage Screening Program or Screen Our Circle Program, need treatment or diagnostic services for breast or cervical cancer and are seeking MA-BC coverage. Enrollees also use this form to renew eligibility for coverage.

Application Filer

The applicant or an authorized representative is the application filer. Only a person meeting the definition of an application filer or an authorized representative can sign the application or renewal. See the MHCP Authorized Representative policy for more information.

Date of Application

The date of application is the date the county, tribal or state servicing agency receives DHS-3525.

Presumptive Eligibility

PE provides immediate MA-BC coverage for women who need to begin treatment. PE is granted to women who meet the MA-BC presumptive eligibility criteria as determined by a Sage or Screen Our Circle PE provider.

Once a Sage or Screen Our Circle PE provider has granted PE, no additional eligibility criteria may be applied. A woman granted PE cannot be required to attest to or provide more information about her state residency, citizenship or immigration status, household composition, income or other factors. All eligibility factors relevant to PE have been considered by the Sage or Screen Our Circle PE provider when PE is granted.

Temporary MA-BC eligibility is effective on the first day of the month PE is granted by a Sage or Screen Our Circle PE provider and continues through the end of the month following the month it was approved.

The Sage PE provider must complete and submit to the county, tribal or state servicing agency:

- MDH Sage Enrollment form or AICAF Screen Our Circle Enrollment form
- Copy of Temporary Medical Assistance Authorization (DHS-3525B)

The county, tribal or state servicing agency must process DHS-3525B the day the form is submitted. MA-BC must be opened for a woman granted PE, in accordance with the date of the Temporary Medical Assistance Authorization, regardless of other applications that are pending.

If a person granted PE does not submit an application for on-going MA-BC coverage or is not eligible for MA-BC, PE ends the last day of the month following the month PE was granted.

A woman granted PE who is denied ongoing MA-BC eligibility is entitled to receive coverage for the full PE period.

Ongoing Eligibility for MA-BC

To have an ongoing eligibility determination for MA-BC, a woman approved for PE must complete the Minnesota MA Application/Renewal Breast and Cervical Cancer (DHS-3525) form. The DHS-3525 must be submitted to the county, tribal or state servicing agency within 30 days of the date the presumptive eligibility is approved by a Sage or Screen Our Circle PE provider. The county, tribal or state servicing agency must process the application for ongoing MA-BC within 45 days. An applicant may complete and submit the DHS-3525 on the same date PE is approved.

Retroactive Coverage

A woman may request retroactive coverage. The earliest date of eligibility is three months before the date of application or the first day of the month in which the woman was screened by Sage or Screen Our Circle, whichever is later. The woman must have paid or unpaid medical expenses during the retroactive period that would be covered by MA. Women who are granted presumptive eligibility for MA-BC must be found eligible for ongoing MA-BC before retroactive eligibility is granted.

Legal Citations

Code of Federal Regulations, title 42, section 1383

Code of Federal Regulations, title 42, section 1396a(aa)

Code of Federal Regulations, title 42, section 1396r–1b

Code of Federal Regulations, title 42, section 1920B(b)(1)

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W. Section 2.5.1.1.2 MA-BC Mandatory Verifications

Medical Assistance for Women with Breast or Cervical Cancer

2.5.1.1.2 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.

Presumptive Eligibility Period

For presumptive eligibility for MA-BC, the following must be verified:

- Screened by the Minnesota Department of Health Sage Screening Program or the American Indian Cancer Foundation Screen Our Circle Program
- Need for treatment or further diagnostic services for breast or cervical cancer

A ~~Minnesota Department of Health~~ Sage Enrollment form or Screen Our Circle Enrollment form~~, Sage Return Visit form, or Colposcopy Program form~~ are acceptable proof of both Sage screening and the need for treatment.

A Social Security number (SSN) or verification of an SSN~~N~~ is not required for PE. Verification of US citizenship and immigration status is not required for PE.

On-going MA-BC Eligibility

For on-going MA-BC coverage, the following must be verified:

- Screened by the Minnesota Department of Health Sage Screening Program or the American Indian Cancer Foundation Screen Our Circle Program
- Need for treatment or further diagnostic services for breast or cervical cancer

A Minnesota Department of Health Sage Enrollment form or American Indian Cancer Foundation Screen Our Circle Enrollment form~~, Sage Return Visit form, or Colposcopy Program form~~ are acceptable proof of both Sage screening and the need for treatment.

- U.S. Citizenship
- Immigration Status
- Social Security Number

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

Legal Citations

Minnesota Statutes, section 265B.056, subdivision 10

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X. Section 2.5.1.2.1 MA-BC Basis of Eligibility

Medical Assistance for Women with Breast or Cervical Cancer

2.5.1.2.1 Basis of Eligibility

The basis of eligibility for Medical Assistance for women with Breast or Cervical Cancer (MA-BC) requires the person must be:

- Screened by the Minnesota Department of Health Sage Screening Program or by the American Indian Cancer Foundation Screen Our Circle Program
- In need of treatment or further diagnostic services for breast or cervical cancer
- Age 64 or younger
- Not otherwise eligible for MA under the following bases:
  - Parents and relative caretakers, without a spenddown
  - Children younger than age 19, without a spenddown
  - Pregnant women, without a spenddown
  - People who are blind of have a disability including:
    - Supplemental Security Income (SSI) recipients
    - 1619 (a) 1619 (b)
    - Minnesota Supplemental Aid (MSA) recipients
    - People eligible for a Disabled Adult Child, Widow or Widowers' or Pickle disregard
- Not otherwise covered under the following healthcare coverage:
  - Group health care coverage, unless the plan does not cover the needed treatment
  - Individual health care coverage, unless the plan does not cover the needed treatment
  - Medicare
  - Armed forces insurance (TRICARE, CHAMPVA)
  - Peace Corp volunteers health plan
  - Federal employees group health plan

Legal Citations

Breast and Cervical Cancer Prevention and Treatment Act of 2000

Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354)

Minnesota Statutes, section 256B.057 subdivision 10

United States Code, title 42, section 300gg-3(c)

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Y. Section 4.2.1 MSP General Requirements

Medicare Savings Programs

4.2.1 General Requirements

This subchapter provides general policy information that applies to Medicare Savings Programs (MSP). It includes policies that apply to MSPs and links to relevant Minnesota Health Care Programs (MHCP) policies.

MSP Applications

MSP Cooperation

MHCP Fraud

MHCP Inconsistent Information

MSP Mandatory Verifications

MA-ABD Account Validation Service (AVS)

MA-ABD Authorization to Obtain Financial Information

MSP Medicare Overview

MHCP Overpayments

MSP Referral for Other Benefits

MSP Retroactive Coverage

MHCP Rights

- MHCP Appeals
- MHCP Authorized Representative
- MHCP Civil Rights
- MHCP Data Privacy
- MHCP Notices

MSP Types of Medicare Savings Programs

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Z. Section 4.2.1.3 MSP Mandatory Verifications

Medicare Savings Programs

4.2.1.3 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. Medicare Savings Programs (MSP) have the following mandatory verifications:

- Assets
  - Verification of assets is required at application and when a new asset is reported. If an asset is determined to be excluded it does not need to be verified again at renewal.
    - An applicant or enrollee must verify assets even if the Account Validation Service (AVS) was requested.
  - Verification of the following assets are not required at application or renewal:
    - Homestead, if it qualifies for the real property homestead 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
- Enrollment or eligibility to enroll in Medicare Part A
- Income
  - If a person is receiving Supplemental Security Income (SSI), only the SSI income is verified. Eligibility for SSI is accepted as verification of other income SSA considers in determining eligibility.
  - Veteran's Administration (VA) Aid and Attendance benefits and VA unusual medical expense payments must be verified even if the person is receiving SSI.
- Immigration status
- Social Security Number

Legal Citations

Code of Federal Regulations, title 42, section 435.407

Code of Federal Regulations, title 42, section 435.920

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.948

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

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