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 #21.4

October 1, 2021

Manual Letter #21.4

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of October 1, 2021. The effective date of new or revised policy may not be the same date the information is added to the EPM. Refer to the Summary of Changes to identify when the Minnesota Department of Human Services (DHS) implemented the policy.

I. Summary of Changes

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

A. EPM Home Page

DHS Bulletin #21-21-11, DHS Announces New Federal Medical Assistance funding for 1115 Substance Use Disorder (SUD) system Reform Demonstration, was published on August 19, 2021, is not added to the EPM home page because it is incorporated into the EPM with this manual letter.

We added the following bulletins to the home page:

- Bulletin #21-21-02, DHS Explains Treatment of Coronvirus Response Payments under the American Rescue Plan Act of 2021, for MHCP
- Bulletin #21-21-05, DHS Announces a Change to the MAGI Methodology for Medical Assistance and MinnesotaCare
- Bulletin #21-21-06 DHS Announces MinnnesotaCare Premium Reductions for 2021 and 2022
- Bulletin #21-21-07 DHS Explains Redetermination and Closure of MHCP for Enrollees Not Validly Enrolled due to Abuse
- Bulletin #21-21-08 DHS Explains Treatment of RentHelpMN Assistance and Child Tax Credit Payments for Minnesota Health Care Programs
- Bulletin #21-21-09, DHS Explains Changes to the Evaluation of Transfers to Pooled Trusts for MA-LTC and AC
- Bulletin #21-21-10, DHS Announces a Change to Medical Assistance Eligiblity for Citizens of the Freely Associated States

This manual letter is also added to the manual letters section of the home page.

B. Section 1.2.2 MHCP Application Submission

The change to this section provides examples of who is and is not permitted to be an application filer for a deceased individual.

C. Section 1.3.1.2 MHCP Authorized Representative

We added "and Rights" to the "Responsibilities of Authorized Representative" header. We also, added language added to "AREP Receipt of Forms and Notices" paragraph referencing EPM 1.3.1.5 Notices.

D. Section 2.1.1.2.1.3 Medical Assistance (MA) Third Party Liability

We removed fundraisers for medical expenses, since under federal and state laws they are not a MA third party liability.

E. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance

We added individual health plans in which the network providers primarily practice outside of both Minnesota and Tribal nations that share geography with Minnesota to the list of types of health insurance not reviewed or reimbursed for cost effectiveness.

F. Section 2.1.1.2.1.3.3 MA Other Third Party Liability

We removed fundraisers for medical expenses, since they do not constitute a MA third-party liability under federal and state laws.

G. Section 2.1.1.2.4 MA Referral Other Benefits

We clarify the requirement to apply for other benefits is post-eligibility except in cases of previous non-cooperation.

H. Section 2.2.3.4 MA-FCA Income Methodology

We clarify that pre-tax deductions on paychecks are not included in the MAGI methodology and must be subtracted so that wages counted include only federally taxable income.

I. Section 2.3.3.2.7.10.1 MA-ABD Life Insurance Funded Burial Contracts

We clarify when life insurance, for a life insurance funded burial (LIFB), is purchased for someone else's life, other than the purchaser, it will be treated as a life insurance policy instead of a LIFB.

J. Section 2.3.3.4.2 MA-ABD Health Care Expenses

We added to the conditions that must be met for non-reimbursable expenses to be used to meet a medical spenddown.

K. Section 2.5.4 IMD

We added MA enrollees who reside in an IMD facility and participate in the 1115 Substance Abuse Disorder (SUD) System Reform Demonstration continue to be eligible for federally funded MA.

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 1.2.2 MHCP Application Submission

C. Section 1.3.1.2 MHCP Authorized Representative

D. Section 2.1.1.2.1.3 MA Third Party Liability

E. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance

F. Section 2.1.1.2.1.3.3 MA Other Third Party Liability

G. Section 2.1.1.2.4 MA Referral Other Benefits

H. Section 2.2.3.4 MA-FCA Income Methodology

I. Section 2.3.3.2.7.10.1 MA-ABD Life Insurance Funded Burial Contracts

J. Section 2.3.3.4.2 MA-ABD Health Care Expenses

K. Section 2.5.4 IMD

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 #21.1, January 1, 2021

MHCP EPM Manual Letter #21.2, March 1, 2021

MHCP EPM Manual Letter #21.3, June 1, 2021

MHCP EPM Manual Letter #21.4, October 1, 2021

2020 Manual Letter

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 #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)
- Bulletin #21-21-01, DHS Announces Automatic Medical Assistance Eligibility for Children in Foster Care or Receiving Northstar Kinship Assistance
- Bulletin #21-21-09, DHS Explains Changes to the Evaluation of Transfers to Pooled Trusts for MA-LTC and AC
- Bulletin #21-21-10, DHS Announces a Change to Medical Assistance Eligiblity for Citizens of the Freely Associated States

COVID-19 Emergency Bulletins: These bulletins announce temporary policy modifications, which supercede policies in this manual, during the COVID-19 emergency. Because these bulletins provide temporary guidance, they will not be incorporated into this manual.

- Bulletin #20-21-02, DHS Announces Temporary Policy Changes to Minnesota Health Care Programs During the COVID-19 Peacetime Emergency
- Bulletin #20-21-03, DHS Announces Medical Assistance for COVID-19 Testing of Uninsured Individuals x Bulletin #20-21-04, DHS Explains Treatment of Federal Coronavirus Aid, Relief, and Economic Security Act Payments for Minnesota Health Care Programs
- Bulletin #20-21-05, DHS Explains Treatment of Federal Pandemic Unemployment Compensation Payments for Minnesota Health Care Programs
- Bulletin #20-21-06, DHS Explains Treatment of State, Local and Tribal COVID-19 Relief Payments for Minnesota Health Care Programs
- Bulletin #20-21-10, DHS Announces Updates to Temporary Policies for Minnesota Health Care Programs during the COVID-19 Public Health Emergency
- Bulletin #20-21-13, DHS Announces a Change to Processing PARIS Interstate Matches for MHCP Enrollees During the COVID-19 Public Health Emergency
- Bulletin #20-21-14, DHS Explains Treatment of Coronavirus Response Payments under the Consolidated Appropriations Act, 2021, for Minnesota Health Care Programs
- Bulletin #21-21-02, DHS Explains Treatment of Coronvirus Response Payments under the American Rescue Plan Act of 2021, for MHCP
- Bulletin #21-21-03, DHS Explains Treatment of PUA and PEUC for Minnesota Health Care Programs

- Bulletin #21-21-04, DHS Explains Redetermination and Closure of MHCP for Enrollees Not Validly Enrolled due to Fraud or Agency Error
- Bulletin #21-21-05, DHS Announces a Change to the MAGI Methodology for Medical Assistance and MinnesotaCare
- Bulletin #21-21-06 DHS Announces MinnnesotaCare Premium Reductions for 2021 and 2022
- Bulletin #21-21-07 DHS Explains Redetermination and Closure of MHCP for Enrollees Not Validly Enrolled due to Abuse
- Bulletin #21-21-08 DHS Explains Treatment of RentHelpMN Assistance and Child Tax Credit Payments for Minnesota Health Care Programs

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 #20.2, June 1, 2020
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
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B. Section 1.2.2 MHCP Application Submission

Minnesota Health Care Programs

1.2.2 Application Submission

Who Can File an Application

An application filer may file an application for Minnesota Health Care Programs (MHCP). An application filer includes the following people:

- The applicant
- An adult who is in the applicant's Medical Assistance (MA), MinnesotaCare, or tax household
- An applicant's minor parents who are in the applicant's tax or MA household
- The applicant's spouse
- An authorized representative. See the MHCP Authorized Representative policy for more information.
- A minor who is applying for coverage who does not live with a parent, legal guardian, or an adult acting responsibly for the minor and who will not be claimed as a tax dependent
- People acting responsibly for a child under the age of 18 including:
  - An adult who lives with the child and who assumes primary responsibility for the minor
  - A social services professional who is not an authorized representative or legal custodian
  - Both custodial and non-custodial parents may file an application on behalf of a child. However, to have MA eligibility determined the child must apply with the parent with whom they child live.
- People acting responsibly for an incapacitated individual
- People acting responsibly for a deceased individual, including, but not limited to, the following:
  - A guardian or conservator
  - An executor or administrator of the deceased's estate
  - The surviving spouse
  - A surviving family member.

  Employees of, or entities contracted by health care providers who would receive MHCP payment cannot be application filers for a deceased individual.

Responsibilities of the Application Filer

Application filers:

- May report changes on behalf of an applicant or enrollee.
- May respond to requests for information regarding any person in their MA, MinnesotaCare, or tax household.
- May make all attestations required for a determination on behalf of an applicant.
- May attest to the joint filing status of their spouse.
- May sign and return the annual renewal notice on an enrollee's behalf.

Application Filer and Change in Circumstances

After an application is submitted, the application filer may change due to a change in circumstance. Changes in circumstance that could cause the application filer to change include the application filer's death or the application filer leaves the household. In these cases, a new person must assume the role and responsibilities of the application filer for that household's application.

Assistance with the Application

A person can choose anyone to help them with an application or renewal. However, only a person meeting the definition of an application filer or an authorized representative can submit the application or renewal on behalf of the applicant. The person is only able to sign the application or renewal if they are the application filer or authorized representative.

Legal Citations

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

Code of Federal Regulations, title 42, section 435.603

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.908

Code of Federal Regulations, title 45, section 155.20

Code of Federal Regulations, title 45, section 155.300

Code of Federal Regulations, title 45, section 155.305

Code of Federal Regulations, title 45, section 155.310

Code of Federal Regulations, title 45, section 155.315

Code of Federal Regulations, title 45, section 155.330

Code of Federal Regulations, title 45, section 155.335

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C. Section 1.3.1.2 MHCP Authorized Representative

Minnesota Health Care Programs

1.3.1.2 Authorized Representative

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

Responsibilities and Rights of an Authorized Representative

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

Authorized representatives have the responsibility and right to:

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

Authorized Representative Receipt of Forms and Notices

Unless the applicant or enrollee indicates otherwise, the authorized representative must be sent ~~will receive~~ all forms and copies of eligibility and premium notices. See EPM 1.3.1.5 Notices for a list of required notices.

Who Can Be an Authorized Representative?

Authorized representatives must:

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

Who Cannot Be an Authorized Representative?

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

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

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

Designating an Authorized Representative

Any applicant or enrollee may designate an authorized representative, unless the person has a court or tribal court-appointed guardian. If a person has a court or tribal court-appointed guardian, only the guardian may designate an authorized representative.

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

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

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

- A completed Authorized Representative Designation attached to any MHCP application
- A completed Giving Permission for Someone to Act on My Behalf (DHS-3437) or Minnesota Family Planning Program (MFPP) - Giving Permission for Someone to Act on My Behalf (DHS-3437A)
- A written statement that clearly indicates the applicant or enrollee is giving permission to a specified person to act on their behalf in the health care application or eligibility process, including the name, address, and phone number of the person designated to act on their behalf. The statement must be signed by the applicant or enrollee as well as the person being designated to act on the applicant or enrollee's behalf.
- A court or tribal court order establishing legal guardianship

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

Servicing Agency Designation of an Authorized Representative

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

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

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

How Long Does the Designation Last?

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

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

Disqualification of an Authorized Representative

Servicing agencies may disqualify authorized representatives who:

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

- Refuse to provide required information

Only a court or tribal court can disqualify a guardian or conservator.

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

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

Authorized Representative Receipt of Forms and Notices

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

Authorization to Release Information

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

Legal Citations

Code of Federal Regulations, title 42, section 435.923

Code of Federal Regulations, title 45, section 155.227

Minnesota Rules, part 9505.0085, subpart 2

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D. Section 2.1.1.2.1.3 MA Third Party Liability

Medical Assistance

2.1.1.2.1.3 Third Party Liability

Third parties are people, entities, or programs that are, or may be, liable to pay all or part of the medical costs provided to Medical Assistance (MA) enrollees.

A third party may be liable to pay all or part of the medical costs provided to MA enrollees because MA is the payer of last resort, with limited exception, such as Indian Health Services. This means enrollees with third party liability (TPL) must have medical costs covered by TPL paid by those sources before MA pays claims.

A third party payer includes, but is not limited to:

- Other health care coverage, such as group health plans, COBRA continuation of group health plans, individual health plans, Medicare, and military insurance
- Medical support from absent parents
- Other sources such as automobile insurance, court judgments or settlements, and workers' compensation~~, and fundraisers to pay for medical expenses~~

Other Health Care Coverage

Applicants and enrollees must cooperate with identifying sources of existing health coverage and assign rights to other health care coverage. Those who fail to cooperate with TPL requirements may be denied coverage or have their MA coverage ended. See the MA Cooperation policy for more information.

People must cooperate with TPL requirements by:

- Providing information to assist the Minnesota Department of Human Services (DHS) or an enrollee's managed care plan to pursue any third party liable for payment, and applying for other benefits that may help pay for their medical costs. This includes:
  - Cooperation with completing Medical Service Questionnaires (MSQs) when the person has received a service that potentially indicates a third party may be responsible
  - Giving complete information about third party health, dental, vision and long-term care insurance policies that cover MA enrollees
- Enrolling or maintaining enrollment in:
  - A group health plan that is cost effective
  - A group health plan when there is no cost for the policyholder to cover all family members enrolled in MA

MA eligibility continues for people who do not enroll in, cooperate with or assign rights to a group health plan if they cannot do so on their own behalf. See MA Cost Effective Health Insurance for more information.

- Assigning rights to DHS for medical support and payment for medical care from any third party

Enrollees do not have to cooperate with TPL requirements when they are Safe at Home (SAH) Address Confidentiality program participants and the policyholder is their probable assailant.

Medical Support

Medical support may include cash payments or health insurance coverage that a parent who does not live with their children must provide or is court-ordered to provide to meet the medical needs of their children. Parents and relative caretakers who are referred for medical support must cooperate with the county, tribal or state servicing agency as a condition of their own eligibility, unless they show good cause for non-cooperation. See MA Medical Support for more information.

Other Third Party Liability

In some situations, automobile insurance, homeowner insurance, court judgments or settlements, workers' compensation and other third parties may pay health care costs. See MA Other Third Party Liability for more information.

Legal Citations

Code of Federal Regulations, title 42, sections 433.135 to 433.154

Code of Federal Regulations, title 42, section 435.610

Federal Register, Vol.60, No.131 (July 10, 1995), page 35498

Minnesota Statutes, section 256B.042

Minnesota Statutes, section 256B.056

United States Code, title 42, section 1396a

United States Code, title 42, section 1396e

United States Code, title 42, section 1396g-1

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E. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance

Medical Assistance

2.1.1.2.1.3.1 Cost-Effective Health Insurance

Health insurance other than Medical Assistance (MA) that covers an enrollee is a liable third party. A subset of third party liability (TPL) includes group health plans, individual health plans, TRICARE plans, and certain long-term care (LTC) insurance. When an enrollee is covered by, or could be covered by, health insurance that falls within this subset of TPL, MA will pay the premium, or a portion of the premium, if it is cost effective to have the enrollee covered by the other health insurance.

Cost effective means that paying for the other health insurance, and for any MA services the other health insurance does not cover, will cost less than paying for MA services without the other health insurance.

When a county or tribal agency determines that a group health plan, individual health plan, TRICARE plan, or LTC insurance is cost effective, it is called cost-effective health insurance (CEHI).

Enrollees who have CEHI for their primary coverage are covered for the same MA services as enrollees without CEHI because MA pays for any MA services the CEHI does not cover.

Health Insurance Reviewed for Cost Effectiveness

County and tribal agencies review whether a group health plan, individual health plan, TRICARE plan, or LTC insurance available to an enrollee is cost effective. A person must be an MA applicant or enrollee for an agency to review their other health insurance options for CEHI.

Group Health Plans

A group health plan, including a self-insured plan, is a plan of, or contributed to by, an employer, including a person who is self-employed, or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. A group health plan is often referred to as employer-sponsored insurance. For purposes of CEHI, the term group health plan also includes continuation coverage of an employer or employee-sponsored group health plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A person may have access to a group health plan through their own employer or a family member’s employer.

As a condition of eligibility for MA, an enrollee must:

- Report access to a group health plan at the time of application or any time after when access to a group health plan becomes available

- Cooperate in determining whether the coverage under a group health plan coverage is cost effective. Enrollees have 10 days to provide information about a group health plan to maintain MA eligibility.
- Report when coverage under a group health plan ends or changes

If an enrollee has access to a group health plan through their employer and is notified that one or more group health plans available to the enrollee is cost effective, the enrollee must:

- Enroll in the cost-effective group health plan at the earliest possible date if they are not currently enrolled
  - An enrollee loses MA eligibility if they refuse to apply for enrollment in a cost-effective group health plan. The person remains ineligible until the next open enrollment period for the group health plan.
  - A plan sponsor of a group health plan must allow an employee and their dependents to enroll in the plan during a special enrollment period if all of the following conditions are met:
    - The employee or their dependents are eligible for the group health plan and are eligible for MA to pay the premium for the group health plan as CEHI
    - The employee requests such enrollment within 60 days from the date the employee or their dependents were determined eligible for CEHI reimbursement
- Maintain enrollment in a cost-effective group health plan if they are already enrolled. An enrollee already enrolled in a cost-effective group health plan may choose to enroll in a different group health plan through the same employer if the following is true:
  - The new group health plan is also cost effective; and
  - There is no lapse in group health plan coverage.
  - When there is only one cost-effective group health plan option available to the enrollee and they are enrolled in that option, disenrollment from the plan results in termination of MA eligibility. The person remains ineligible until the next open enrollment period for the group health plan.

An enrollee with access to a cost-effective group health plan through their own employer loses MA eligibility if they do not cooperate with these requirements, with the exception of a pregnant woman eligible for CHIP-funded MA.

An enrollee who has access to a cost-effective group health plan through a family member's employer does not lose MA eligibility if they do not enroll in the group health plan. This is because the enrollee cannot enroll in the plan on their own behalf. See MA Cooperation for more information.

An enrollee does not have to cooperate with CEHI requirements when the enrollee is a Safe at Home (SAH) Address Confidentiality program participant and the policyholder, or the potential policyholder, of the other health insurance is the enrollee's probable assailant.

Individual Health Plans

An individual health plan is a health plan other than job-based coverage that a person can purchase on the private insurance market. An enrollee is not required to enroll or maintain enrollment in an individual health plan if it is cost effective. Enrollment is optional.

Individual health plans available on the MNsure marketplace cannot be reviewed for cost effectiveness.

TRICARE Plans

TRICARE is the health care program for uniformed U.S. service members. An enrollee with access to a TRICARE plan is not required to enroll or maintain enrollment in the plan if it is cost effective. Enrollment is optional.

LTC Insurance

An LTC insurance policy is cost effective for an enrollee who is currently paying a premium for the policy and living in a nursing facility if the policy covers nursing facility costs and their Medicare co-insurance for the current nursing facility stay. An enrollee is not required to enroll or maintain enrollment in this type of LTC insurance. Enrollment is optional.

Not Reviewed for Cost Effectiveness: Certain Health Care Accounts, Arrangements, and Plans

The following types of health insurance are not reviewed or reimbursed for cost effectiveness:

- Health flexible spending accounts (FSAs)
- Health savings accounts (HSAs)
- Archer medical savings accounts (MSAs)
- Health reimbursement arrangements (HRAs)
- Voluntary employees' beneficiary associations (VEBAs)
- MinnesotaCare
- Group health, individual health, TRICARE and LTC insurance plans for people who are eligible for a Medicare Savings Program (MSP)
- Individual health plans in which the network providers primarily practice in another state (outside of both Minnesota and Tribal nations that share geography with Minnesota).

FSAs, HSAs, and MSAs

FSAs, HSAs, or MSAs are not legally responsible by statute, contract, or agreement for payment of a claim for a health care item or service.

Though these accounts receive tax-preferred treatment for payment of qualified medical expenses, account funds are spent at the account holder's choosing – they are never legally

required to spend the funds for any particular purpose, health care related or otherwise. MA can only pay an enrollee's costs for other insurance coverage strictly limited to health services.

A person with an HSA or MSA must also be covered by a high-deductible health plan (HDHP) for the HSA or MSA to be valid. An HDHP that is a group health plan may be reviewed for cost effectiveness, but the HSA or MSA is not.

HRAs and VEBAs

While HRAs generally are classified as group health plans, only employers can make contributions to HRAs. Because beneficiaries of an HRA do not pay premiums or make contributions, there is no cost to reimburse.

A VEBA is a tax-exempt account that may include health benefit plans, life insurance, disability insurance, accident insurance, vacation, or other employee benefits. Because VEBAs can be complex, technical, and variable, the administrative cost of reviewing them for CEHI makes them not cost effective.

MinnesotaCare

County and tribal agencies do not review or reimburse premiums paid for MinnesotaCare under the MA CEHI program. A person cannot be eligible for MA and MinnesotaCare at the same time.

Plans Available to People Who are Eligible for an MSP

An enrollee who is receiving reimbursement for Medicare through an MSP cannot have their premiums for a group health plan, individual health plan, TRICARE plan, or LTC insurance reviewed or reimbursed for CEHI.

Medical Support

County and tribal agencies review certain court-ordered medical support for cost effectiveness. Medical support includes health insurance coverage that a noncustodial parent provides, or is court-ordered to provide, to meet the medical needs of their child. See the MA Medical Support policy for more information.

Medical Support Reviewed for Cost Effectiveness

If a parent has been ordered by a court to carry health insurance for their children, the health insurance is reviewed for cost effectiveness when the parent is enrolled in MA.

If the court-ordered parent is not enrolled in MA, the health insurance can be reviewed for cost effectiveness only when all of the following criteria are met:

- The court-ordered parent left a job and has continued dependent coverage available through COBRA.
- The child support officer determined that the court-ordered parent is no longer financially able to keep the coverage in effect.

When the criteria are met and the health insurance is determined to be cost effective, the county or tribal agency reimburses premiums to the former employer or the custodial parent directly. The agency does not reimburse the non-custodial parent for the cost of premiums.

Medical Support Not Reviewed for Cost Effectiveness

County and tribal agencies do not review health insurance for cost effectiveness when a parent who is not enrolled in MA has been ordered by a court to carry health insurance for their children, except as noted in the previous section.

Methods for Determining Cost Effectiveness

There are only two methods to determine the cost effectiveness of group health plans, individual health plans, and TRICARE plans.

Standard Calculation

Under the standard calculation for cost effectiveness, a health plan is cost effective when the monthly insurance premium (or prorated portion of a family premium) plus 1/12th of the annual average cost factor by age, is less than the current MA managed care monthly rate for people of the same age.

The annual average cost factor is the average paid costs of health insurance, including the deductible, coinsurance, and copayments, plus the cost of MA wraparound benefits and administrative costs in a preceding calendar year, averaged by age group or pregnancy status for individuals with CEHI coverage.

When more than one enrollee is considered for CEHI coverage under a single health plan, the prorated premium and average annual costs by age for each individual are added together and compared to the combined MA managed care rate for the individuals.

2:1 Ratio Calculation

Under the 2:1 ratio calculation for cost effectiveness, a health plan is cost effective when the plan's annual covered medical expenses for enrollees exceed annual premium costs, plus the annual average cost factor, by at least a 2:1 ratio and the enrollees' medical conditions remain the same.

Dental and Vision Insurance Reviewed for Cost Effectiveness

If a group health plan, individual health plan, or TRICARE plan is cost effective under the standard calculation, the county or tribal agency can also review whether dental and vision plan options available to an enrollee are cost effective. The agency determines the cost effectiveness of dental and vision plans by factoring the dental and vision plan premiums into the standard calculation.

Dental and vision plan options cannot be reviewed for cost effectiveness unless a health plan covering the enrollee is cost effective under the standard calculation. If a health plan is cost effective

under the 2:1 ratio calculation, or not cost effective under either calculation, the dental and vision plan options cannot be reviewed for cost effectiveness.

Premium Payments for CEHI

County and tribal agencies reimburse the policyholder, employer, or insurer for CEHI premiums when an enrollee either enrolls or remains enrolled in the CEHI.

Premium payment is limited to one health plan and, if available, one dental plan and vision plan.

Submitting Proof of Premium Payment

For a CEHI policyholder to be reimbursed directly by the county or tribal agency, the policyholder must submit proof to the agency showing they paid the CEHI premiums. The policyholder has up to 12 months from the date the CEHI was reported to submit proof of premiums paid during that time span.

- Reported means information about the insurance was provided to the agency that leads the agency to determine the insurance was cost effective.
- For the policyholder's final premium payment in the 12-month span, the agency provides the policyholder an extra 10 days starting from the beginning of the first month that follows the 12-month span to submit proof of the final premium payment.

Retroactive Eligibility

A person can receive retroactive MA eligibility for up to three months before the month of MA application. If the person was covered by other health insurance during the retroactive eligibility period, and the health insurance is determined cost effective, the agency reimburses CEHI premiums paid during that period if proof of payment is submitted. See MHCP Retroactive Eligibility for more information.

Managed care exclusions

Enrollees with coverage under a cost-effective group or individual health plan are excluded from enrollment in managed care. MA pays fee-for-service for any services that enrollees are entitled to under MA that their CEHI does not cover. However, there can be a one-month overlap of managed care enrollment and reimbursement for CEHI when an enrollee is unable to timely disenroll from MA managed care because of administrative processes.

Refer to the Prepaid Minnesota Health Care Programs Manual for more information.

Redetermination of Cost Effectiveness

County and tribal agencies must redetermine the cost effectiveness of a CEHI plan for which premiums are being paid when any of the following occurs:

- The agency conducts an MA renewal

- There is a change to the health insurance plan that may affect whether it is cost effective, including, but not limited to:
  - A change in the plan's premium
  - An enrollee is added or dropped from the health insurance plan coverage
  - A person covered under the health insurance plan loses MA eligibility

Legal Citations

Code of Federal Regulations, title 42, sections 433.147 and 433.148

Code of Federal Regulations, title 42, section 435.1015

Minnesota Rules, part 9505.0071

Minnesota Rules, part 9505.0430

Minnesota Statutes, section 256B.056, subdivision 8

Minnesota Statutes, section 256B.0625, subdivision 15

United States Code, title 26, section 220

United States Code, title 26, section 223

United States Code, title 26, section 501, paragraph (c), clause (9)

United States Code, title 26, section 5000, paragraph (b)

United States Code, title 26, section 9801, paragraph (f), clause (3)

United States Code, title 26, section 1396d, paragraph (a), clause (29)

United States Code, title 26, section 1396e

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F. Section 2.1.1.2.1.3.3 MA Other Third Party Liability

Medical Assistance

2.1.1.2.1.3.3 Other Third Party Liability

In some situations, Medical Assistance (MA) enrollees may have access to third party liability other than health care coverage for all or part of their medical expenses related to an illness, accident or injury. The DHS Benefit Recovery Section (BRS) assists in the coordination of Third Party Liability (TPL) benefits and MA.

Examples of TPL that are not health care coverage include, but are not limited to the following:

- Workers' Compensation may be liable for the cost of medical care and subsistence related to on-the-job injuries
- Auto insurance policies may cover medical costs related to auto accidents or injuries involving a motor vehicle
- Homeowners or business liability policies may cover medical costs related to accidents on the home or business owner's property
- Tort claims and lawsuits may result in court-ordered awards for recovery of medical expenses caused by another party's negligence or malpractice including but not limited to:
  - Product liability
  - Medical malpractice
  - Pedestrian injuries
- ~~Funds raised by a community group or organization available to pay for medical expenses~~
- Health Reimbursement Account (HRA) is considered a Group Health Plan (GHP) as provided for Under the Internal Revenue Code.

Actual or potential non-health care coverage TPL payments are not a barrier to MA eligibility; however, the enrollee must cooperate in providing information to determine whether those third parties are liable.

Accidents and Injuries

Enrollees must complete a Medical Service Questionnaire (MSQ) (DHS-2237A) when there is an accident or injury with possible TPL coverage. Adults who fail to cooperate with TPL requirements may have their MA coverage ended. See the MHCP Cooperation policy for more information.

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G. Section 2.1.1.2.4 MA Referral Other Benefits

Medical Assistance

2.1.1.2.4 Referral for Other Benefits

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

To meet this requirement, an enrollee must:

- Submit an application for the program they appear to be eligible for, following the rules of that program
- Provide any requested information needed to determine eligibility for the program
- Provide documentation of the decision about their eligibility for the program
    - If a person is denied because they do not meet the eligibility criteria for the program, they are not required to appeal the decision.
    - If a person is denied because they did not provide necessary documentation, or did not cooperate in the eligibility determination, they have not met this requirement.

The requirement to apply for other benefits is post-eligibility, unless the person previously had eligibility closed because of non-cooperation with the requirement to apply for other benefits. If the person previously had eligibility closed due to non-cooperation with the requirement to apply for other benefits, and still appears to be eligible for the other benefits, the person must verify they applied for those benefits before they can be determined eligible for MA.

Social Security benefits

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

Retirement Survivors Disability Insurance

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

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

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

- Dependent survivors of a wage earner who has died

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

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

Supplemental Security Income

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

Medicare

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

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

Medicare Part A

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

Medicare Part B

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

MA enrollees enrolled in Medicare Part A are not required to enroll in Medicare Part B or enroll in an MSP if they have primary coverage under an employer group health insurance plan through:

- Their own current employment or their spouse's current employment.
- A parent's current employment where the enrollee is a disabled child (of any age).

Medicare Part D

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

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

Railroad Retirement Benefits

The federal Railroad Retirement Board (RRB) administers railroad retirement benefits and Medicare for railroad workers and their families. People who work for a railroad have railroad retirement withheld from their earnings instead of Social Security. If a person has earned enough Social Security credits to receive Social Security benefits as well as railroad retirement benefits, the beneficiary receives the larger of the two.

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

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

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

Financial Needs

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

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

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

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

Exceptions

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

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Code of Federal Regulations, title 42, section 435.608

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H. Section 2.2.3.4 MA-FCA Income Methodology

Medical Assistance for Families with Children and Adults

2.2.3.4 Income Methodology

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

- Household income includes:
  - The types of income included in Federal taxable income, including losses, minus Federal income tax adjustments
  - Nontaxable foreign earned income and housing cost of citizens or residents of the United States living abroad
  - Nontaxable interest income
  - Nontaxable Social Security and tier one railroad retirement benefits
- Household income does not include:
  - Scholarships, awards or fellowship grants used for education purposes and not for living expenses
  - Certain American Indian/Alaska Native income
- Lump sum income is counted in the month received if it is from a type of income that is included in MAGI methodology. If the lump sum is from an income type that is not included in a person's modified adjusted gross income, it is not counted.

Refer to the MAGI Fact Sheet for a quick reference guide on MAGI.

Current income is the income a person actually receives in a current or past month, and expects to receive during each month of their 12-month certification period.

Current income is reported and counted based on how frequently a person receives it. A person may receive income weekly, biweekly (every other week), semi-monthly (twice a month), monthly, quarterly, or in other frequencies.

Current monthly income is counted in the month received.

- Income received less frequently than monthly is counted based on the average monthly income.
- Income that varies month to month including, but not limited to, seasonal income, temporary census income, and unemployment compensation and seasonal income are reported and counted based on the annual amount a person expects to receive during the 12-month certification period.

Federal Taxable Income

Federal taxable income are the different types of income that appear in the Income section of the Internal Revenue Service (IRS) form 1040, IRS form 1040-A and or IRS form 1040-EZ. Only the taxable portions of these types of income are included in the adjusted gross income.The types of losses that are reported on federal income tax returns can offset income. See the appropriate IRS form instructions for examples of federal taxable income. The general types of taxable income include the following:

- Wages, salary and tips
    - Payroll or pre-tax deductions for childcare, health insurance, retirement plans, transportation assistance and other employee benefits are not taxable and are not included in a person's adjusted gross income. These types of deductions must be subtracted from a person's gross wages when they appear on a paystub or wage record.
    - Medicaid waiver payments received by a person who provides HCBS waiver services (personal care services, habilitation services, and other services) to an eligible person living with them are not taxable and not included in a person's adjusted gross income. See Internal Revenue Bulletin 2014-4 for more information.

      If the eligible person does not live with the person providing the HCBS waiver services, the Medicaid waiver payments are taxable and are included in the person's adjusted gross income.
- Interest
- Dividends
- Taxable refunds, credits or offsets of state and local income taxes
- Alimony received (spousal maintenance) based on a divorce decree or separation agreement executed before January 1, 2019.
    - Alimony received based on a divorce decree or separation agreement dated on or after January 1, 2019, is not taxable income. It does not need to be reported and is not countable income under the MAGI methodology.
    - If the divorce decree or separation agreement is modified on or after January 1, 2019, and the modification expressly provides for that the alimony tax law changes apply, then the alimony received on or after the date of modification is not considered countable income under the MAGI methodology.
    - Applicants and enrollees must determine whether the alimony payments they receive are based on a divorce decree or sepration agreement executed or modified on or after January 1, 2019, and report accordingly.
- Verification of the date of a divorce decree or separation agreement, or a modification to these, is not required. Business income or loss (includes self-employment)

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

  Generally, money a person receives through a fundraising or donation event is considered a personal gift if the money was given directly or indirectly without the expectation of receiving anything in return. Personal gifts are not included in a person's adjusted gross income.
- Net operating loss, including a carryforward loss

Federal Income Tax Adjustments

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

- Educator expenses
- Certain business expenses of reservists, performing artists and fee-basis government officials
- Health savings account
- Moving expenses
  - Through December 31, 2025, moving expenses are permitted only for households that include active duty members of the military who move because of a military order and a permanent change in station,
- Deductible portion of self-employment tax
- Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE) and qualified plans
- Self-employed health insurance
- Penalty on early withdrawal of savings
- Alimony paid (spousal support) based on a divorce decree or separation agreement executed before January 1, 2019,

    - Alimony paid based on a divorce decree or separation agreement executed on or after January 1, 2019, is not an allowable adjustment to income. It should not be reported as an adjustment to income and is not permitted as an adjustment under the MAGI methodology.
    - If the divorce decree or separation agreement is modified on or after January 1, 2019, and the modification expressly provides for that the alimony tax law changes apply, then the alimony paid on and after the date of modification is not an allowable adjustment under the MAGI methodology.
    - Applicants and enrollees must determine whether the alimony they pay is based on a divorce decree or separation agreement executed or modified before January 1, 2019, and report accordingly.
- Verification of the date of a divorce decree or separation agreement, or a modification to these, is not required. IRA deduction
- Student loan interest

Scholarships, Awards or Fellowship Grants

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

American Indian and Alaska Native Income

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

- Distributions from Alaska Native Corporations and Settlement Trusts
- Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior
- Distributions and payments from rents, leases, rights of way, royalties, usage rights or natural resource extraction and harvest from:
    - rights of ownership or possession in properties held in trust under the supervision of the Secretary of the Interior; or
    - federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources.
- Distributions resulting from real property ownership interests related to natural resources and improvements:
    - located on or near a reservation or within the most recent boundaries of a prior federal reservation, or
    - resulting from the exercise of federally protected rights relating to such real property ownership interests.

- Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom
- Student financial assistance provided under the Bureau of Indian Affairs education programs

Lump Sum Income

Under MA-FCA, lump sum income is one-time income that is not predictable. Periodic reoccurring income is not lump sum income. Lump sum income is only counted under MA-FCA if it is a type of income that is included in the calculation of modified adjusted gross income (MAGI).

Examples of lump sum income that is part of the MAGI calculation include, but are not limited to:

- Winnings (lottery, gambling)
- Alimony settlements
- Wage bonuses

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Code of Federal Regulations, title 42, section 435.603

Code of Federal Regulations, title 45, section 155.305

Minnesota Statutes, section 256B.057

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I. Section 2.3.3.2.7.10.1 MA-ABD Life Insurance Funded Burial Contracts

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

2.3.3.2.7.10.1 Life Insurance Funded Burial Contracts

Life Insurance Funded Funeral Arrangements

A life insurance funded burial (LIFB) contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract. Life insurance funded burial contracts are not burial insurance.

A life insurance policy purchased by an MA applicant or enrollee to fund a burial contract for someone other than the MA applicant or enrollee, such as a spouse, is treated as a life insurance policy, not a life insurance funded burial. See EPM 2.3.3.2.7.10.

If an annuity policy is being used to fund a burial contract, it is called an annuity-funded burial (AFB) and follows LIFB policies. Otherwise, see Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Annuities for how the annuity is evaluated as an asset.

Proceeds

Proceeds of a life insurance policy are the face value of the policy plus any additions payable at maturity or death. This does not include dividends, cash surrender value (CSV) or interest.

Dividend Accumulations

Dividend accumulations of a life insurance policy as part of the value of the policy or the burial contract are not excluded assets. Dividend accumulations are separate assets and must be evaluated separately.

If ownership of the life insurance policy has been irrevocably assigned, then absent evidence to the contrary, the dividend accumulations are also assigned.

Contingent Beneficiary

A person’s estate must be named as contingent beneficiary when irrevocably assigning ownership of a life insurance policy to fund a burial arrangement. If a person’s estate is not named as the contingent beneficiary, the policy is treated as a life insurance policy, not a life insurance funded burial or annuity funded burial.

Effect of Revocable Assignment of Ownership

Burial Spaces

The burial space exclusion does not apply. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the person dies and therefore no spaces are being held for the person.

Burial Funds

The life insurance funded burial arrangement is evaluated under the life insurance policy. The burial funds exclusion may apply.

Example

Emma has a burial contract funded by the revocable assignment of ownership of a life insurance policy. The face value of both the burial contract and the life insurance policy is $3,000 and the CSV of the life insurance policy is currently $1,700. The total asset value of Emma's burial contract is equal to the CSV of $1,700.

The burial space exclusion does not apply to Emma's contract. However, Emma can exclude $1,500 of the CSV under the burial funds exclusion. The remaining $200 of the CSV is considered a countable asset.

Effect of Irrevocable Assignment of Ownership

Burial Spaces

The burial space exclusion may apply, depending on the nature of the contract (See MA-ABD Burial Space Exclusion). Any portion of the contract that represents the purchase of a burial space has no effect on the burial funds exclusion.

Burial Funds

The life insurance policy and the burial contract are not assets because the person no longer owns them. The face value of the burial funds portion of the contract (if any) offsets the $1,500 burial funds exclusion because the contract represents an irrevocable arrangement available to meet the person's burial.

Example

Bill has made provision for his burial by irrevocably assigning ownership of a life insurance policy on his life to a funeral home to fund a burial contract. The face value of the life insurance policy is $3,000.

The burial contract identifies the purchase of $1,300 of burial spaces and $1,700 of burial funds. The $1,700 burial funds portion of the contract is not an asset because he no longer owns them, but, since the assignment of policy ownership is irrevocable, the $1,700 burial funds portion reduces the $1,500 burial funds exclusion. Bill may not designate any additional assets under the burial funds exclusion (the $1,700 reduced the $1,500). The $1,300 space purchase is not an asset either, but does not reduce the burial funds exclusion.

Effect of Revocable Assignment of Proceeds

Burial Spaces

The burial space exclusion does not apply to the CSV of the life insurance policy. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the person dies and, therefore, no spaces are being held for the person.

Burial Funds

The life insurance funded burial arrangement is evaluated under the life insurance policy. The asset value of the burial contract is equal to the CSV of the life insurance policy.

Treatment of CSV

If the face value of all life insurance policies on the person's life is $1,500 or less, the CSV is excluded under the life insurance exclusion.

If the face value of all policies exceeds $1,500, the CSV of the policy is applied according to the burial funds exclusion, if applicable (See MA-ABD Burial Funds Exclusion).

Examples

Lydia has a burial contract funded by the revocable assignment of the proceeds of an insurance policy on her life, with a face value of $1,300. The CSV of the policy is $1,000. If this is the only life insurance policy she owns on her life, then the CSV of the life insurance policy would be excluded under the life insurance exclusion and the burial exclusions would not apply, because the FV is $1,500 or less.

The life insurance policy's face value of $1,300 reduces the maximum $1,500 burial fund exclusion by that same amount. So, Lydia may designate an additional $200 in under the burial funds exclusion.

If Lydia has another life insurance policy on her life and the total face value of the two policies exceeds $1,500 (and, therefore, the life insurance exclusion does not apply), then $1,500 of the CSV may be excludable under the burial funds exclusion. No burial space exclusion applies.

Effect of Irrevocable Assignments of Proceeds

When there is an irrevocable assignment of proceeds or an irrevocable designation of a beneficiary, but the insured has not irrevocably assigned ownership, the CSV is a countable asset if the person has access to the CSV. Each policy may be different and must be reviewed to determine the terms of the contract. If the policy indicates that the person does not have access to the CSV, then the CSV is not a countable asset because it is unavailable.

Burial Spaces

The burial space exclusion may apply, depending on the nature of the contract (See MA-ABD Burial Space Exclusion). Any portion of the contract that represents the purchase of a burial space may be excluded and has no effect on the burial funds exclusion.

Burial Funds

If the CSV of the life insurance policy and the burial contract are unavailable, because the person cannot access them, then the face value of the burial funds portion of the contract (if any) offsets the $1,500 burial funds exclusion. This is because the contract represents an irrevocable arrangement available to meet the person’s burial.

Life Insurance Policy Placed In A Trust

A life insurance company may provide a person with the option of irrevocably transferring ownership of a revocable life insurance policy that funds a burial contract to a trust established by the company. If a policy is placed in such a trust, the asset value of the policy (its CSV) is evaluated as follows: ~~according to the rules governing trust funds (see MA-ABD Trusts).~~

Treatment of Policy's CSV

The CSV is not an asset when a person does not own or have the legal right to direct the use of trust assets to meet his or her support and maintenance.

Treatment of Dividends

If the policy's CSV is not an asset, then, any dividends paid on the policy are also not an asset.

Person Retains Right to Change Funeral Firm

Under an irrevocable trust arrangement, the life insurance policy's CSV is not an asset even if the person retains the right to change the funeral firm that will provide the burial goods and services.

Burial Fund Exclusion Offset

A revocably assigned life insurance policy placed in an irrevocable life insurance trust is treated the same as a life insurance policy for which the ownership has been irrevocably assigned to fund a burial contract. This means that the value of the burial funds portion of the contract (if any) reduces the $1,500 burial funds exclusion.This is because the burial funds portion of the contract represents an irrevocable arrangement that is available to meet the person's burial expenses.

Legal Citations

United States Code, title 42, section 1382b

Code of Federal Regulations, title 20, section 416.1230

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

Minnesota Statutes, section 72A.325

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J. Section 2.3.3.4.2 MA-ABD Health Care Expenses

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

2.3.3.4.2 Health Care Expenses

To be eligible for Medical Assistance (MA) with a spenddown, people may reduce excess net income by deducting allowable health care expenses that are not subject to payment by a third party.

The person, or one of the following family members, can incur the health care expenses:

- Spouse if the spouse's income is used to determine the person's eligibility
- Legal dependents if they are included in the person's family size or would have been included when the bills were incurred
- Siblings, half-siblings, and step-siblings who are included in the person's family size
- Parents or stepparents who live with the person if their income is actually used to determine the person's eligibility or they are included in the person's family size

The family members do not have to be applying or eligible for MA to use their health care expenses to meet the spenddown of the family member applying for MA with a spenddown.

Allowable Health Care Expenses to Meet a Medical Spenddown

Allowable health care expenses include:

- Paid or unpaid bills incurred in the current spenddown period
- Unpaid bills incurred before the current spenddown period

Payments from a health savings account (HSA) funded by the person are not considered third party payments.

Health care expenses incurred before the spenddown satisfaction date are not eligible for MA payment.

Types of Health Care Expenses

Allowable health care expenses are deducted from the spenddown in the following order:

1. Health insurance expenses incurred during the current six-month period. This includes:
    - Health, dental and long-term care (LTC) insurance premiums
    - Indemnity policy premiums that reimburse health care expenses
    - Medicare premiums

- Medical Assistance for Employed Persons with Disabilities (MA-EPD) obligations
- Co-pays
- Deductibles, including MA family deductibles

2. Unpaid health care expenses that the person is still obligated to pay and that were incurred before the six-month period.
   - The health care expense may be:
     - An expense charged directly to the person by a medical provider
     - An expense that a medical provider has transferred for collection to a person or agency actively pursuing the collection
     - A loan payment owed to a person, financial institution, or credit company for which the loan proceeds are paid to a medical provider. Interest and service charges applied to a loan are not a health care expense.
   - The health care expense cannot have been:
     - Used to calculate a spenddown during a prior certification period, whether or not the calculation resulted in the spenddown being met. Except the expense may be used to meet another spenddown if eligibility for the entire certification period was denied.
     - An MA-covered service incurred in a prior certification period of MA
3. Non-reimbursable health care expenses that are not covered by MA, incurred during the current six-month period, including:
   - MA co-payments
   - Non-reimbursed Health Care Access Services
   - Health care expenses for dependents or financially responsible relatives who are not eligible for MA
   - A remedial care expense for people living in a residential living arrangement and there is a Group Residential Housing (GRH) agreement with the county agency
   - Alternative Care (AC) costs
   - Expenses paid by the Insurance Extension Program that pays health insurance premiums for individuals who are HIV positive

<u>To qualify as an allowable spenddown expense for MA, the non-reimbursable health care service must meet all the following conditions:</u>

- <u>Prescribed or recommended in writing by the person's physician or dentist.</u>
- <u>Directly benefits the person or a member of the person's immediate family</u>
- <u>Available through a licensed medical provider but not necessarily obtained through a licensed medical provider.</u>
- <u>Not be reimbursable through the county health care access plan.</u>
- <u>Medically necessary.</u>

A medically necessary service is a health service rendered for any of these situations:

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

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

For other expenses, medical necessity can be established through the completion of the Medical Need form, DHS-6112.

4. MA-covered services received during the current six-month period that will be paid by MA, including:
   - Waiver services received through the a home and community based services waiver
   - Personal care attendant (PCA) services
   - Targeted case management services

Reporting Health Care Expenses

People must report and verify all health care expenses used to meet a medical spenddown, except for the remedial care expense.

Legal Citations

Code of Federal Regulations, title 42, section 435.831

Minnesota Statutes, section 256B.056, subdivision 5

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K. Section 2.5.4 IMD

2.5.4 Institutions for Mental Diseases

Minnesota provides health care for people who meet Medical Assistance (MA) eligibility criteria while living in an Institution for Mental Diseases (IMD). This health care may be federally or state-funded. State-funded MA for people living in an IMD is also known as Program IM.

An IMD is a hospital, nursing facility, or other institution of 17 beds or more that primarily provides diagnosis and treatment for people with mental illness or chemical dependency. See Appendix E Institutions for Mental Diseases for more information.

People must have an MA basis of eligibility and meet all of the MA eligibility requirements associated with their basis. People are in one of the following eligibility groups:

- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD)
- MA for Employed Persons with Disabilities (MA-EPD)
- MA for Families With Children and Adults (MA-FCA)

When an MA enrollee moves into an IMD, they do not need to file a new application for health care.

The following people continue to be eligible for federally funded MA while living in an IMD:

- People age 65 or older
- Children younger than age 21 in an accredited, licensed inpatient psychiatric hospital
- People residing in an IMD that is an accredited, licensed inpatient psychiatric hospital who received MA covered services prior to their 21st birthday. Enrollees who continue to receive these services in the same facility after age 21 are covered by MA until they turn age 22.
- People residing in an IMD facility approved to participate in the 1115 Substance Use Disorder (SUD) System Reform Demonstration
- People enrolled in Refugee Medical Assistance (RMA)
- People ages 21 up to 65 enrolled in a managed care plan with a length of stay of no more than 15 days during the calendar month

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

General Requirements

MA-ABD General Requirements

MA-EPD General Requirements

- MA-FCA General Requirements

Non-Financial Eligibility

- MA-ABD Bases of Eligibility
- MA-ABD Certification of Disability
- MA-FCA Bases of Eligibility
- MA Citizenship and Immigration Status
- MA County Residency
- MA Social Security Number
- MHCP State Residency

Financial Eligibility

- MA-ABD Financial Eligibility
- MA-EPD Financial Eligibility
- MA-FCA Financial Eligibility

Post-Eligibility

- MA Begin and End Dates
- MA Benefit Recovery
- MHCP Change in Circumstances
- MA Cooperation
- Program IM Medicare
- MA Cost Sharing
- MHCP Fraud
- IMD Health Care Delivery
- MHCP Inconsistent Information
- IMD Leave Days
- MA-EPD Premiums and Cost Sharing
- MA Qualifying Health Coverage
- MA Referral for Other Benefits
- MA-ABD Renewals
- MA-FCA Renewals

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