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 #22.2

March 1, 2022

Manual Letter #22.2

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of March 1, 2022. 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 bulletins:

- Bulletin #21-21-13 DHS Explains Changes to the Evaulation of Client-Funded Irrevocable Trusts for MA-LTC and AC
- Bulletin #22-21-02 DHS Announces the Increase in Medical Assistance Spenddown Standard for Certain People

We added this manual letter.

B. 1.2.4 Minnesota Health Care Programs (MHCP) Processing Period

We incorporated Bulletin #19-21-01 Pre-eligibility Verification for Medical Assistance for Families with Children and Adults.

C. 1.3.1.2 MHCP Authorized Representative

We added clarification how an authorized representative may be designated and who may be a designated authorized representative when an enrollee has a court appointed guardian or conservator.

D. 1.5 MHCP Mandatory Verifications

We incorporated Bulletin #19-21-01 Pre-eligibility Verification for Medical Assistance for Families with Children and Adults.

E. 2.1.2.2.2 Medical Assistance (MA) Immigration Status

We clarified when a lawful permanent residents entered the United States prior to August 22, 1996, and resided in the Untied States continuously, they do not have a 5-year waiting period.

F. 2.2.1.2 Medical Assistance for Families with Children and Adults (MA-FCA) Mandatory Verifications

We incorporated Bulletin #19-21-01 Pre-eligibility Verification for Medical Assistance for Families with Children and Adults.

G. 2.2.3.5 MA-FCA Income Verification

We incorporated Bulletin #19-21-01 Pre-eligibility Verification for Medical Assistance for Families with Children and Adults.

H. 2.3.3.3.2.1 Medical Assistance for People Who Are Age 65 or Older or People Who are Blind or Have a Disability (MA-ABD) Countable Income

We included rebates, refunds or other return of money into the list of What is not Income.

I. 2.3.3.4 MA-ABD Medical Spenddowns

We updated the MA spenddown standard from 81 percent of the Federal Poverty Guidelines (FPG) to 100 percent FPG effective July 1, 2022.

J. 2.3.3.4.2 MA-ABD Health Care Expenses

We included programming charges at a treatment center or institution as expenses that cannot be used to meet a spenddown.

K. 2.3.5 MA for Employed People with Disabilities (MA-EPD)

We added clarification there is no age limit for a person to be enrolled in MA-EPD.

L. 2.3.5.1.2 MA-EPD Premiums Cost Sharing

We clarified when premiums can be charged and how to calculate MA-EPD premiums. We also added a payment schedule.

M. 2.3.5.4.1 MA-EPD Medicare

We included language to indicate Medicare Part B reimbursements must be processed immediately and DHS will reimburses the MHCP servicing agency for premiums paid.

N. 2.4.2.5 MA-LTC Income Calculations

We added clarification when a person is in a long term care facility their Social Security Income (SSI) and Minnesota Supplemental Aid (MSA) is counted into the total income.

O. 2.4.2.5.1 MA-LTC Income Calculation Deductions

We added clarification of the four criteria that must be met to claim a medical expense an income deduction. We also clarified when to apply the Social Security (SSI) and Minnesota Supplemental Aid (MSA) deduction.

P. 3.2.3.2 MinnesotaCare Employer Sponsored Coverage

We updated the affordability standard for people who have access to employer sponsored coverage, to 9.61 percent of the person's annual household income for 2022.

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. 1.2.4 MHCP Processing Period

C. 1.3.1.2 MHCP Authorized Representative

D. 1.5 MHCP Mandatory Verifications

E. 2.1.2.2.2 MA Immigration Status

F. 2.2.1.2 MA-FCA Mandatory Verifications

G. 2.2.3.5 MA-FCA Income Verification

H. 2.3.3.3.2.1 MA-ABD Countable Income

I. 2.3.3.4 MA-ABD Medical Spenddowns

J. 2.3.3.4.2 MA-ABD Health Care Expenses

K. 2.3.5 MA for Employed People with Disabilities (MA-EPD)

L. 2.3.5.1.2 MA-EPD Premiums Cost Sharing

M. 2.3.5.4.1 MA-EPD Medicare

N. 2.4.2.5 MA-LTC Income Calculations

O. 2.4.2.5.1 MA-LTC Income Calculation Deductions

P. 3.2.3.2 MInnesotaCare Employer Sponsored Coverage

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

This manual has been updated to a new format on October 4, 2021. The EPM User Guide provides information about some of the new features.

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 #22.2, March 1, 2022

MHCP EPM Manual Letter #22.1, January 1, 2022

2021 Manual Letter

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

MHCP EPM Manual Letter #21.5, November 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 #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 Eligibility for Citizens of the Freely Associated States
- Bulletin #21-21-13 DHS Explains Changes to the Evaluation of Client-Funded Irrevocable Trusts for MA-LTC and AC
- Bulletin #22-21-02 DHS Announces the Increase in Medical Assistance Spenddown Standard for Certain People

COVID-19 Emergency Bulletins: These bulletins announce temporary policy modifications, which supersede 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 Coronavirus 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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Previous Versions

Manual Letter #22.1, January 1, 2022

Manual Letter #21.5, November 1, 2021

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Manual Letter #20.4, December 1, 2020

Manual Letter #20.3, September 1, 2020

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

Manual Letter #18.4, September 1, 2018

Manual Letter #18.3, June 1, 2018

Manual Letter #18.2, April 1, 2018

Manual Letter #18.1, January 1, 2018

Manual Letter #17.5, December 1, 2017

Manual Letter #17.4, September 1, 2017

Manual Letter #17.3, August 1, 2017

Manual Letter #17.2, June 1, 2017

Manual Letter #17.1, April 1, 2017

Manual Letter #16.4, December 22, 2016

Manual Letter #16.3, September 1, 2016

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

B. 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

The agency generally must process an application, obtain all pre-eligibility verifications, make a determination, and send an approval or denial notice within the processing period. The processing period cannot be used as a waiting period for people requesting health care or extended to provide agencies with additional time for processing. The processing period does not impact the time permitted for an applicant to provide requested information or paper documentation. Processing periods must be extended when the applicant is cooperating with providing information or documentation 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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Manual Letter #20.4, December 1, 2020
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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 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 who is not incapacitated may designate an authorized representative. People who are incapacitated cannot designate an authorized representative. An incapacitated person is someone who a court has determined lacks understanding or capacity to make reasonable personal decisions and is not able to meet their own needs for medical care, nutrition, clothing, shelter, or safety. A court makes a finding of incapacitation when appointing a guardian. A person may also have executed a durable power of attorney that establishes an agent for handling personal affairs in the event of incapacity.~~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 due to physical limitations. See MHCP Signature for more information. ~~, 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 forms or a written statement containing signatures of both applicant or enrollee and the person specified to act on their behalf ~~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.~~

In lieu of a form or written statement designating an authorized representative, documentation of legal authority to act on behalf of the applicant or enrollee serves as the designation. The following documents show legal authority to act on behalf of the applicant or enrollee:

- A court or tribal court order establishing legal guardianship
- A court or tribal court order establishing a conservatorship with the power to apply for assistance on behalf of the person subject to conservatorship
- A valid Power of Attorney
  - A Power of Attorney is a legally binding document that authorizes a person or corporation to act on behalf of the named person, known as the principal, in financial matters.
  - A Power of Attorney may or may not operate when the named person becomes incapacited. If the agent can act in the event of incapacity of the principal, the Power of Attorney is considred a durable 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~~

  The agency should contact its County Attorney or if there is a question about the interpretation or validity of legal documentation.

Designations Involving Guardians and Conservators

If an applicant or enrollee has a court or tribal court-appointed guardian, the applicant or enrollee may not designate an authorized representative on their own behalf. The guardian is the authorized representative unless a court has also appointed a conservator. The guardian must provide a copy of the court order establishing the guardianship as evidence of authority to act on behalf of the protected person.

If an applicant or enrollee has both a guardian and a conservator with the power to apply for assistance on behalf of the person subject to conservatorship, the conservator is the authorized representative. The conservator must provide a copy of the order establishing the conservatorship as evidence of authority to act on behalf of the person subject to the conservatorship.

If an applicant or enrollee does not have a guardian but has a conservator, the applicant or enrollee may designate an authorized representative on their own behalf.

Organization Designated as Authorized Representative

An organization may be designated as an authorized representative. If an organization is named as authorized representative, an employee with authority to act on behalf of the organization must sign the authorized representative designation. The organization has the authority to exercise the rights of, and must carry out the responsibilities of the authorized representative.

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. See EPM 1.3.1.5 Notices for a list of required 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 Statutes, section 524.5-310

Minnesota Statutes, section 524.5-313

Minnesota Statutes, section 524.5-417

Minnesota Rules, part 9505.0085, subpart 2

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D. 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.

- Medical Assistance Mandatory Verifications
- MinnesotaCare Mandatory Verifications
- Medicare Savings Programs Mandatory Verifications
- Minnesota Family Planning Program Mandatory Verifications

The agency must first attempt to use electronic ~~verification~~ data 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.

For certain eligibility factors, verification must occur pre-eligibility, before eligibility is approved. For other eligibility factors, verification can be completed post-eligibility, after eligibility is approved.

In addition to mandatory verifications, proofs may be required for other eligibility factors 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~~ EPM 1.3.2.4 MHCP Inconsistent Information policy for more information about situations when proofs may be required.

Applicants and enrollees are primarily responsible for required paper proofs. However, agencies must assist people 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.

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

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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E. 2.1.2.2.2 MA Immigration Status

Medical Assistance

2.1.2.2.2 Immigration Status

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

MA Eligibility for Noncitizen Children under Age 21 and Pregnant Women

The following people are eligible for MA, regardless of their specific immigration status:

- All lawfully present noncitizen children younger than age 21
- All lawfully present noncitizen pregnant women

People granted Deferred Action for Childhood Arrivals (DACA) are not lawfully present noncitizens for the purpose of MA eligibility and therefore they are not eligible for MA.

See the Appendix H Lawfully Present Noncitizens appendix for more information about lawfully present noncitizens.

Refer to the Immigration Status and Minnesota Health Care Programs Eligibility chart for a quick reference guide to Medical Assistance eligibility for applicants and enrollees who are noncitizens.

MA Eligibility for Noncitizens Age 21 or Older and Not Pregnant

To be eligible for MA, lawfully present noncitizens who are age 21 or older and not pregnant must have a qualified immigration status. People with certain qualified immigration statuses must wait five years after receiving the qualified immigration status before they are eligible for MA.

The date a person enters the United States (also called date of entry) is not always the same as the date they acquire a qualified immigration status. The date of entry is used to determine eligibility for Refugee Medical Assistance for refugees who are ineligible for MA. The date a person obtains a qualified immigration status is used to determine the start of the five-year waiting period, when applicable.

Qualified Immigration Statuses Without a Five-Year Waiting Period

Lawfully present noncitizens with the following qualified immigration statuses are eligible for MA **without** a five-year waiting period:

- Afghan or Iraqi Special Immigrants
- Amerasians
- American Indian noncitizens

- Asylees, including asylees who later adjust to lawful permanent resident status
- Citizens of the Freely Associated States - the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau
- Conditional Entrants
- Cuban/Haitian Entrants
- Lawful permanent residents (LPRs) who entered the United States before August 22, 1996 and have continuously resided in the United States, regardless of when they adjusted to LPR status.
- LPRs who adjusted from asylee or refugee status. LPRs who were formerly asylees or refugees are eligible for MA without a five-year wait.
- Qualified noncitizens who are U.S. veterans or on active military duty and their spouses and children
- Refugees, including refugees who later adjust to lawful permanent resident status
- T-Visa
- Trafficking victims
- Withholding of Removal

Qualified Immigration Statuses With a Five-Year Waiting Period

Lawfully present noncitizens with the following qualified immigration statuses who entered the United States after August 22, 1996, are eligible for MA **after** a five-year waiting period:

- Battered noncitizens
- Immigrants paroled or one year or more
- Lawful permanent residents (LPRs) except:
  - LPRs who adjusted from asylee or refugee status or who entered the United States before August 22, 1996 and have continuously resided in the United States, regardless of when they adjusted to LPR status. ~~LPRs who were formally asylees or refugees are eligible for MA without a five-year wait.~~

MA for Noncitizens Not Otherwise Eligible for Medical Assistance

Four programs are available to certain noncitizens who are not eligible for MA because of their immigration status.

- Children's Health Insurance Program (CHIP) funded MA may be available for pregnant women who are undocumented or noncitizens not otherwise eligible for MA. Eligibility may continue through the 60–day postpartum period. CHIP-funded MA is not available to people enrolled in other health care coverage.
- People who are receiving services from the Center for Victims of Torture (CVT) may be eligible for state funded MA-CVT

- People with a medical emergency may be eligible for Emergency Medical Assistance (EMA)
- People who meet specific criteria may be eligible for federally funded Refugee Medical Assistance (RMA)

Verification

Immigration status must be verified electronically. The county, tribal, or state agency must attempt and exhaust all trusted electronic sources prior to requiring paper documentation from the enrollee. Applicants and enrollees whose immigration status cannot be verified electronically must provide proofs, which then must be validated using electronic sources, such as SAVE. See Immigration documentation types at HealthCare.gov for information about immigration documentation.

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

The 95-day reasonable opportunity period can be extended for MA enrollees who demonstrate a good faith effort to get and provide proof of their immigration status. Enrollees who need more time to obtain the needed documents must receive a notice that tells them the new due date. There is no limit to the number of times the reasonable opportunity period can be extended for a MA enrollee to obtain proof of immigration status. Eligibility and coverage must end with a 10-day advance notice if the person fails to provide proof or assist in the verification process by the end of the reasonable opportunity period or any extension.

During the reasonable opportunity period, the county, tribal or state servicing agency must continue efforts to complete verification of an applicant's immigration status. This includes correcting errant demographic data, re-running electronic sources and checking case records and files for prior instances of successful electronic verification or immigration status documentation received previously. The agency must document efforts to verify an applicant's immigration status during the reasonable opportunity period in the case record. The agency must also help applicants and enrollees obtain required paper proofs.

A person who reapplies for health care coverage, whose immigration status was not previously verified, must be given a new reasonable opportunity period to provide proof of immigration status.

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

Legal Citations

Centers for Medicare and Medicaid Services State Health Officials letter re: Individuals with Deferred Action for Childhood Arrivals (August 28, 2012), at www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf

Centers for Medicare & Medicaid Services (CMS) State Health Officials letter re: Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women (July 1, 2010), at www.cms.gov/smdl/downloads/SHO10006.pdf

Children’s Health Insurance Program Reauthorization Action of 2009 (CHIPRA), Public Law 111-3, Section 214

Consolidated Appropriations Act, 2021, Public Law 116-260

Code of Federal Regulations, title 42, section 435.406

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

Minnesota Statutes, section 256B.06, subdivision 4

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193

United States Code, title 8, section 1641

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Manual Letter #17.2, June 1, 2017

Manual Letter #16.4, December 22, 2016

Manual Letter #16.2, August 1, 2016

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

F. 2.2.1.2 MA-FCA Mandatory Verifications

Medical Assistance for Families with Children and Adults

2.2.1.2 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. See individual eligibility requirements for acceptable proof and timelines.

Pre Eligibility Verification

The following ~~information~~ eligibility factors must be verified prior to the eligibility determination ~~for Medical Assistance for Families With Children and Adults (MA-FCA)~~:

- Exceptions to having a Social Security Number. See MA Social Security Number.
- All sources of current income, adjustments and income exceptions, based on the modified adjusted gross income (MAGI) methodology. See 2.2.3.5 MA-FCA Income Verification.
- Projected Annual Income (PAI), if the person is eligible for Medical Assistance through the safety net provision. See 2.2.3.3 MA-FCA Income Limit.

Post Eligibility Verification

The following factors can be verified after eligibility has been approved. If proof is not provided, eligibility may end.

- ~~Current income: All MAGI-based income, excluded income, and income adjustments. MAGI is the acronym for Modified Adjusted Gross Income, which is what current income for MA-FCA is based on. Refer to MA-FCA Income Verification for information about how income is verified for MA-FCA.~~
- Citizenship or Immigration status: See 2.1.2.2.1 Citizenship or 2.1.2.2.2 MA Immigration Status
- Social Security number (SSN): See 2.1.2.5 MA Social Security Number
- ~~U.S. citizenship~~

Spenddown

For MA for parents, relative caretakers, pregnant women and children with a spenddown, the following pre-eligibility verifications ~~must~~ also ~~verify~~ apply:

- Medical expenses to meet a spenddown
- Assets, when an asset limit applies
  - Verification of assets is required at application, renewal, and when a new asset is reported~~.~~
    - At renewal, an excluded asset that was verified does not need to be verified again unless the asset has changed, to determine whether the change affects the exclusion.
  - Verification of the following assets ~~are~~ is not required at application or renewal:
    - Homestead, if it qualifies for the real property homestead exclusion. ~~Refer to Section~~ See 2.4.1.2 MA LTC Home Equity Limit for more information.
    - Vehicles, up to the number of persons in the household of age 16 or older. ~~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

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

Legal Citations

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.952

Minnesota Rules, part 9505.0095

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G. 2.2.3.5 MA-FCA Income Verification

Medical Assistance for Families with Children and Adults

2.2.3.5 Income Verification

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

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

2. ~~The applicant or enrollee's~~ The county, tribal or DHS servicing agency must attempt to verify attested income, adjustments and exceptions ~~are verified~~ using available electronic data sources.

3. Income is considered verified if:

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

~~4.~~ When the attested information indicates MA-FCA eligibility, but electronic data sources are unavailable, or are reporting information that is not reasonably compatible with attestation, the agency must request paper proof from the person. ~~If the information cannot be verified by available electronic sources, the person must provide acceptable proof within 10 days of the request by the county, tribal or state servicing agency. Acceptable proof is paper proof.~~

5. The agency must send a notice to the applicant requesting the paper proof and the date the proof is due to complete the MA-FCA eligibility determination.

   The agency must resolve the discrepancy before granting MA-FCA eligibility. While MA-FCA eligibility is pending, the applicant or enrollee must have an opportunity to resolve errors that prevented successful electronic verification or submit paper proof. The agency must give the applicant at least 10 days to respond to the request, or for a new application until the end of the 45-day application processing period, whichever is later.

6. The person must provide acceptable proof within 10 days of the request by the agency. MA-FCA eligibility for enrollees cooperating and attempting to obtain verification is not denied or closed, except for when proofs are required to complete a renewal.

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

8. An applicant who fails to respond to a request for paper proof is not eligible for MA-FCA. The effective date of the denial is the day after the proof was due.

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

An individual who reports having no income is not required to provide verification or an explanation, unless electronic sources or other information the agency has indicate there is inconsistent information. At application, information from electronic data sources that indicate a person has a source of income, such as wages from a job, is inconsistent information when the person has reported no income from that source. Inconsistent information about income at application must be resolved before MA is approved. See EPM 1.3.2.4 MHCP Inconsistent Information for the full policy.

Paper Proof that Clarifies Income, Adjustments and Exceptions

Applicants may correct or revise their attested information during the application process. A request for information or paper proof submitted by the applicant may provide additional sources of income the applicant forgot to report, or revisions to the amount of income reported from a source. Information received from the applicant while MA-FCA is pending, including income amounts from paper proof that clarify the applicant's current income, must be used in the initial eligibility determination. This information is considered a correction to the applicant's attested income.

An applicant may report a change in circumstances, such as income, while MA-FCA eligibility is pending. When an applicant reports a change that occurred after the date of application, the new information does not impact the initial eligibility determination. The agency must determine eligibility using the original verified information for the month of application and any retroactive months requested. Then, the agency must redetermine eligibility based on the new information received from the applicant, according to standard policies about changes in circumstances.

Proof Received After Denial

When an applicant provides paper proof after the effective date of denial, the submission is considered a new request for coverage. Standard application and begin date policies and procedures apply based on the date the agency received the proof. See EPM 2.1.4.1 MA Begin and End Dates for the full policy.

A new application may not be needed if the person is currently eligible for another insurance affordability program (including unassisted qualified health plan) or is a household member on an open case with other eligible people. The agency must verify current income before MA-FCA eligibility can be determined. A new application may be required if there is no one on the case eligible for an insurance affordability program. Reapplications or redeterminations may result in new paper proofs needed.

Paper Proof ~~Income~~

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

- Pay stub or earnings statement
- Employer statement
- Tax records
- Copy of check
- Business financial records
- ~~Bank s~~Statement from the bank or other financial institution
- Interest or dividend statement
- Award letter
- Proof of alimony
- Receipt or statement of rent you receive
- Proof of asset sale (Capital Gain or Loss)
- Proof or record of other taxable income
- Proof of lump sum income
- Other proof

Federal Income Tax Adjustments

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

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

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

Educator expenses

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

Anticipated adjustment for the current tax year

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

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

- Copy of last filed IRS tax forms ~~1040~~ with this adjustment listed ~~on line 24~~

Anticipated adjustment for the current tax year

- Copy of IRS Form 2106 or 2106 EZ

Health savings account

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment listed ~~on line 25~~

Anticipated adjustment for the current tax year

- Copy of IRS Form 8889

Moving expenses for members of the armed Forces

- Copy of last filed IRS tax ~~F~~form with this adjustments listed ~~on line 26~~

Anticipated adjustment for the current tax year

- Copy of IRS Form 3903

Adjustment portion of self-employment tax

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment listed ~~on line 27~~

Anticipated adjustment for the current tax year

- Copy of IRS Schedule SE

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

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment listed ~~on line 28~~

Anticipated adjustment for the current tax year

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

Self-employed Health Insurance

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment listed ~~on line 29~~

Anticipated adjustment for the current tax year

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

Penalty on Early Withdrawal of Savings

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment listed ~~on line 30~~

Anticipated adjustment for the current tax year

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

Alimony Paid (spousal support)

- Copy of last filed IRS tax ~~F~~form ~~1040~~ with this adjustment and the date of the original divorce or separation agreement listed ~~on line 31~~

Anticipated adjustment for the current tax year

- Copy of court order, divorce or separation instrument indicating the date of the agreement and amount of spousal support

IRA Deduction

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

Anticipated adjustment for the current tax year

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

Student Loan Interest

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

Anticipated adjustment for the current tax year

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

~~**Tuition and Fees**~~

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

~~Anticipated adjustment for the current tax year~~

- ~~Copy of IRS Form 8917~~

~~**Domestic Production Activities**~~

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

~~Anticipated adjustment for the current tax year~~

- ~~Copy of IRS Form 8903~~

Other Income Proofs

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

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

- Tax records
- Income statement

Nontaxable interest income

- Tax records
- Bank statement

Nontaxable Social Security and tier one railroad retirement benefits

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

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

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

Certain American Indian/Alaska Native income

- Proof of American Indian or Alaska Native income

Lump Sum income

- Proof of lump sum income

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

Income Discrepancies

When an applicant appears to qualify for MA-FCA based on the applicant's attested information, and the applicant has not reported any recent changes to income on the application, but an electronic data source indicates the applicant, or a member of the applicant's household, receives a type of income that was not reported, the agency cannot approve MA-FCA eligibility, because there is discrepant income information. The agency must resolve the discrepancy before granting MA-FCA eligibility. The applicant must provide an explanation for the discrepancy or confirm the unreported source of income. In some cases, the agency may already have information received from the applicant that is sufficient to resolve the discrepancy.

Legal Citations

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.952

Minnesota Rules, part 9505.0095

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H. 2.3.3.3.2.1 MA-ABD Countable Income

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

2.3.3.3.2.1 Countable Income

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

Income is counted in the month it is received.

What is not Income

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

- Amounts withheld from unearned income, if both of the following conditions are met:
  - The income is being reduced to repay a prior overpayment from the same source; and
  - The overpaid amount was previously counted as unearned income for MA eligibility.
- Bona fide loans, including student loans, because of the obligation to repay
- Conversion of assets. This includes, but is not limited to, cash received from the sale of assets, money withdrawn from savings accounts or other liquid assets, reverse mortgages, etc.
- Distributions from a Health Flexible Spending Arrangement
- Distributions from a Health Savings Account
- Free rent in exchange for caretaking duties. If the caretaker receives a paycheck with an amount for rent deducted, the gross earnings are earned income, not in-kind income.
- Interest on countable assets
- In-kind benefits or payments
- Rebates, refunds, or other return of money that has already been counted.

Earned Income

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

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

Unearned Income

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

- Annuity payments
- Child support and arrearage payments made for a deceased child are counted for the person who receives the payment.
- Child support and arrearage payments are unearned income for the child, excluding:
  - Court ordered medical support

- Payments to reimburse the custodial parent for medical expenses
- Child support and arrearage payments received and retained by the county child support enforcement agency on behalf of a child enrolled in the Minnesota Family Investment Program (MFIP) or foster care
- Child support payments received by or on behalf of children who:
  - Receive services through the Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI) or Developmental Disabilities (DD) waiver
  - Are enrolled in MA under the TEFRA option

- Disability payments that are part of the employer's benefit package
- Extended income support payments through the Trade Adjustment Reform Act (TAA)
- Interest and dividends earned on excluded assets, unless otherwise excluded. See MA-ABD Countable Assets and MA-ABD Excluded Assets for more information on how these items are treated.
- Irregular or infrequent unearned lump sum income from an individual, organization, or investment. See MA-ABD Disregards and Deductions, unearned lump sum income, for more information.
- Net rental income, which is the gross rental income minus verified rental and repair expenses, when the person spends an average of less than 10 hours per week maintaining or managing the property. Rental deposits used to pay rental expenses or repairs become income to the landlord at the point of use. Verified expenses for providing a room or food or both to a roomer or boarder are subtracted from rental income.
- Regular and frequent gift income
- Retirement, Survivor's, and Disability Insurance (RSDI). See MA-ABD Disregards and Deductions, dependent RSDI benefits, for more information.
- RSDI or Veterans Benefits for the Elderly reissued because an individual representative payee of 15 or more beneficiaries or an organization representative payee misused benefits is counted as income in the month received only if the original payment was not used to determine eligibility
- Retroactive RSDI lump sum payments are counted in the month received
- Pension or retirement benefits from public or private sources
- Severance pay that is not based on accrued leave time
- Spousal maintenance
- Student financial aid, in the following situations:
  - Earnings through the Federal Work Study program are counted for MA for Employed Persons with Disabilities (MA-EPD) if:
    - Average gross monthly earnings exceed $65

        - Social Security and Medicare taxes are withheld
    - Non-Title IV of the Higher Education Act (HEA) and Non-Bureau of Indian Affairs (BIA) grants, scholarships, fellowships and other non-loan financial aid not used for or set aside for educational expenses.
    - Distributions from a Coverdell Educational Savings Accounts (ESA) not used for or set aside for educational expenses.
- Tribal per capita payments from casinos
- Unemployment Insurance
- Veteran's Administration (VA) benefits
- Workers' Compensation

Availability of Income

For MA-ABD and MSP, income is available when the person has a legal interest and the ability to use that income for support and maintenance. Available income is counted unless it is excluded under another policy; income that is not available is not counted toward a person's income limit. See MA-ABD Excluded Income and MA-ABD Disregards and Deductions for more information. Income is usually available in the following situations:

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

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

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

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

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Code of Federal Regulations, title 42, section 435.831

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

2.3.3.4 Medical Spenddowns

A medical spenddown is a cost-sharing approach that allows Medical Assistance (MA) eligibility for people whose income is greater than the applicable income limit. Federal rules refer to this population as “medically needy.”

People with an aged, blind or disabled basis of eligibility, who are not eligible for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) because they are over the income limit and who have medical expenses may be eligible for MA-ABD with a spenddown.

See the MA for Families and Children Medical Spenddown policy for more information about medical spenddowns for parents, pregnant women and children.

Topics included in this section are:

MA-ABD Medical Spenddown Types

MA-ABD Health Care Expenses

Retroactive Eligibility for MA-ABD with a Medical Spenddown

A person may qualify for MA-ABD with a Medical Spenddown up to three months before the month of application.

MA-ABD with a Medical Spenddown and Other Insurance Affordability Programs

A person may be eligible for MA-ABD with a Medical Spenddown in the same month they are or were eligible for or enrolled in MinnesotaCare, Advanced Premium Tax Credits or qualified health plan (QHP) without subsidy. Eligibility for or enrollment in MinnesotaCare, APTC or QHP without subsidy is not a barrier to eligibility for MA-ABD with a Medical Spenddown.

MA-ABD Spenddown Standard

The spenddown standard for MA-ABD with a spenddown is:

- Before June 1, 2019: 80% FPG
- On or after June 1, 2019 through June 30, 2022: 81% FPG
- On or after July 1, 2022: 100% FPG

Legal Citations

Code of Federal Regulations, title 42, section 435.811

Code of Federal Regulations, title 42, section 435.831

Code of Federal Regulations, title 42, section 435.840

Minnesota Statutes, section 256B.056, subdivision 5

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J. 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.

Unused portions of allowable health care expenses incurred during the current six-month period can be carried over and applied to future months.

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

- Prescribed or recommended in writing by the person’s physician or dentist.
- Directly benefits the person.

- Available through a licensed medical provider but not necessarily obtained through a licensed medical provider.
- Not reimbursable through the county health care access plan.
- Medically necessary.

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.

MA can be approved with a monthly spenddown for people who apply, and have not yet received services sufficient to meet their spenddown, but who document that they will be receiving services sufficient to meet their spenddown.

Health Care Expenses not allowed to meet a Spenddown

The following are not allowed to meet a spenddown:

- Room and, when applicable, board charges in a residential living arrangement, including fuel, food, utilities, household supplies and other costs necessary to provide room and board.
- The additional charge for a private room in a skilled nursing facility (SNF), when not medically necessary, is not covered by MA and is also not an allowable spenddown expense. When the private room is medically necessary, the charge is covered by MA.
- Cost of care programming charges at a treatment center or institution.

Legal Citations

Code of Federal Regulations, title 42, section 435.831

Code of Federal Regulations, title 42, section 483.10

Minnesota Statutes, section 256B.056, subdivision 5

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K. 2.3.5 MA for Employed People with Disabilities (MA-EPD)

2.3.5 Medical Assistance for Employed Persons with Disabilities

Medical Assistance for Employed Persons with Disabilities (MA-EPD) is a work incentive health care program that provides MA coverage to employed people with certified disabilities. A person must earn more than $65 a calendar month to be eligible for MA-EPD. A person must use the blind or disabled basis of eligibility under MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD). An MA-EPD consumer brochure (DHS-2087L) is available.

People may continue to be eligible for MA-EPD after reaching the age of 65, as long as they continue to meet the other eligibility requirements. To be eligible for MA-EPD, applicants age 65 or older must have been certified disabled prior to age 65.

The following people are not eligible for MA-EPD:

- SSI recipients
- People with 1619a or 1619b status

People who are eligible for MA-EPD may also be eligible for other Minnesota Health Care Programs (MHCP). MHCPs include MA under different bases of eligibility, MinnesotaCare and Advance Premium Tax Credits. Each person's unique situation determines which MHCP is most affordable and provides the services the person needs. MA-EPD has unique financial eligibility policies that may be beneficial for people nearing age 63.

Home and Community-Based Services Waivers are available to people enrolled in MA-EPD. People must meet the general long-term care eligibility requirements. MA-EPD eligibility and premium policies apply to the person.

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

General Requirements

MA-ABD General Requirements

MA-EPD Mandatory Verifications

MA-EPD Premiums and Cost Sharing

MA-EPD Work Requirements

Non-Financial Eligibility

MA-ABD Non-Financial Eligibility

MA-EPD Living Arrangement

Financial Eligibility

MA-EPD Assets

Post-Eligibility

MA-EPD Medicare

MA-ABD Post-Eligibility

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Manual Letter #16.4, December 22, 2016

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

L. 2.3.5.1.2 MA-EPD Premiums Cost Sharing

Medical Assistance for Employed Persons with Disabilities

2.3.5.1.2 Premiums and Cost Sharing

People enrolled in Medical Assistance for Employed Persons with Disabilities (MA-EPD) must pay monthly premiums to establish and maintain coverage. A premium is based upon:

1. A person's gross countable income. The minimum amount will be $35 per month, with a sliding scale for people with gross income at or below 300% of the Federal Poverty Guidelines (FPG). If income is greater than 300% FPG, the rate is 7.5% of gross income.
2. An additional fee that is equal to 0.5% of unearned income. The fee is paid no matter how low gross income is.

The total MA-EPD premium is the combined amount.

An American Indian or Alaska Native who has provided verification of American Indian or Alaska Native status is exempt from paying a premium for MA-EPD. The premium exemption begins the first month after the month the verification was received, unless the verification was received when the application was processed.

An American Indian is defined as a person who is:

- A member of a federally recognized Indian tribe;
- Considered by the Secretary of the interior to be an Indian for any purpose: or
- Determined to be an Indian under regulations promulgated by the U.S. Secretary of Health and Human Services.

Any formal documentation form a tribe, Indian Health Services (HIS), or the Bureau of Indian Affairs (BIA) that verifies a person is an American Indian is acceptable as verification.

~~Premium free MA-EPD coverage for people who are American Indian or Alaska Native begins the first month of MA-EPD eligibility.~~

An online MA-EPD premium estimator is available. A person's county or tribal servicing agency is responsible for collecting the initial MA-EPD premium. The Minnesota Department of Human Services (DHS) bills for ongoing MA-EPD premiums monthly.

~~MA-EPD coverage does not begin until the initial premium is paid. Applicants who request retroactive coverage must pay the premium for any retroactive months before coverage is approved for the retroactive period.~~

~~Applicants who request retroactive coverage must pay the premium for any retroactive months before coverage is approved for the retroactive period. Applicants can choose which retroactive months they want covered and the months do not need to be consecutive.~~

MA-EPD applicants must pay the initial premium in full within 30 days, before coverage can begin. People can choose which retroactive months they want coverage for, and the months do not have to be consecutive. If the initial premium is not paid within 30 days, MA-EPD coverage will be denied and eligibility is redetermined under all bases. An MA-EPD applicant not eligible for Minnesota Health Care Programs (MHCP) under any basis must reapply for MHCP.

~~The average anticipated gross monthly countable income is used to calculate the MA-EPD premium amount for a six-month period. The actual gross monthly income is used to calculate the MA-EPD premium amount during any retroactive months.~~

~~MA-EPD premiums are calculated for a six-month period. The premium amount is the same for all six months, because the premium is based on average anticipated income.~~

~~Premiums can be changed during the six-month period only in the following situations:~~

- ~~A reported change results in a decreased premium. The decreased premium is effective the first day of the month after the change is reported.~~
- ~~Income guidelines change because of a change in law,~~
- ~~The annual increase in FPG standards~~
- ~~To include increased RSDI benefit amounts when the RSDI COLA disregard ends, effective July 1 of each year~~

~~Premiums are recalculated at each six-month renewal.~~

Gross Countable Income

Gross countable income includes countable earned and unearned income of the person and anyone whose income deems to the person, without any disregards or deductions applied. See the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Countable Income policy for more information.

Excluded Income

The MA-ABD excluded income policy applies to MA-EPD. See the MA-ABD Excluded Income policy for more information.

Deeming

Only the MA-EPD enrollee’s income is counted for adults age 18 and older. No spousal income is deemed to the MA-EPD spouse. Parental income is deemed for MA-EPD applicants and enrollees younger than age 18.

Disregards and Deductions

MA-EPD enrollees do not use standard MA-ABD deductions and disregards, because premiums are calculated using the gross countable income.

Family Size

Family size is used to determine premium rates. Family size is determined for each person separately. Family size may be different for each person on an application or in a household.

For MA-EPD enrollees age 21 or older, family size includes the following, if they are living with the person:

- Enrollee
- Spouse (unless they are enrolled in MA-EPD)
- Biological or adopted children, including those who are temporarily absent
- Spouse's biological or adopted children, including those who are temporarily absent
- Unborn children of the person or their spouse

For MA-EPD enrollees under age 21, family size includes the following if they are living with the person:

- Enrollee
- Spouse (unless they are enrolled in MA-EPD)
- Biological or adoptive parents
- Stepparent, if the biological or adoptive parent also lives with the person
- Siblings (biological, adopted, or step siblings)
- Unborn children of the person, their spouse or their biological, adoptive or step parents listed above

Monthly Premium Invoices

DHS will send a monthly MA-EPD invoice to enrollees the first month after the initial premium payment is received. These MA-EPD enrollees receive an invoice every month showing the amount of the monthly MA-EPD premium and the due date. Any past-due amount or credit will not be shown on the invoice.

The average anticipated gross monthly countable income is used to calculate the MA-EPD premium amount for a six-month period. The actual gross monthly income is used to calculate the MA-EPD premium amount during any retroactive months.

MA-EPD premiums are calculated for a six-month period. The premium amount is the same for all six months, because the premium is based on average anticipated income.

Premiums can be changed during the six-month period only in the following situations:

- A reported change results in a decreased premium. The decreased premium is effective the first day of the month after the change is reported.

- Income guidelines change because of a change in law.
- The annual increase in FPG standards.
- To include increased RSDI benefit amounts when the RSDI COLA disregard ends, effective July 1 of each year.
- Premiums are recalculated at each six-month renewal.

Premium Payment Schedule		
Date invoice mailed	**Date premium is due**	**For coverage in this month**
December 4	January 4	February
January 4	February 4	March
February 4	March 4	April
March 4	April 4	May
April 4	May 4	June
May 4	June 4	July
June 4	July 4	August
July 4	August 4	September
August 4	September 4	October
September 4	October 4	November
October 4	November 4	December
November 4	December 4	January

Ongoing MA-EPD premiums are due by the fourth day of the month, but can be paid through noon on the last working day of the month. If an MA-EPD enrollee's coverage is closed due to non-payment of a premium, then in the month after the month in which coverage was closed they must pay a premium for two months to have coverage reinstated. Premiums should be paid on time to avoid a gap in coverage.

Premium Payments

The first premium must be paid to the county or tribal agency. Ongoing payments can be made by mail, in person, or online.

For more information about MA-EPD premium payments, see: How do I pay my MA-EPD premium?

Good Cause for Non Payment of MA-EPD Premiums

People who cannot pay their premium may request good cause. A “good cause” request is an enrollee’s request for premium relief because of circumstances outside their control. DHS is responsible for good cause determinations. When a request is approved, premiums are waived for the period necessary for the enrollee to resolve the situation preventing the enrollee from paying premiums.

Good cause is defined as circumstances beyond a person's control or that they could not reasonably foresee resulting in the enrollee being unable or failing to pay the premium.

Good cause does not include choosing to pay other household expenses instead of the premium. A person cannot request good cause for non-payment of an initial premium. Good cause can only be requested for the non-payment of subsequent premiums.

Requesting Good Cause

People must request good cause using the MA-EPD Good Case Request form (DHS-6939). The form can be submitted electronically, or printed and mailed to DHS. Enrollees needing assistance in completing the form can call Disability Hub MN at 866-333-2466.

DHS provides the person with written notice of their decision within 30 days. People may appeal a finding that good cause does not exist. See the MHCP Appeals policy for more information.

Legal Citations

Minnesota Rules, part 9506.0040, subpart 7, items B to D

Minnesota Statutes, section 256B.057, subdivision 9

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M. 2.3.5.4.1 MA-EPD Medicare

Medical Assistance for Employed Persons with Disabilities

2.3.5.4.1 Medicare

Medicare Eligibility

People enrolled in Medical Assistance for Employed Persons with Disabilities (MA-EPD) must enroll in Medicare if eligible.

If not enrolled in Medicare at the time they apply for MA-EPD, Medicare eligible people must apply for Medicare during the next available Medicare general enrollment period (January-March of each year), to continue MA-EPD eligibility.

Medicare Part B Reimbursement

MA-EPD enrollees may have their Medicare Part B premiums reimbursed. Reimbursement is effective the date of MA-EPD eligibility for enrollees who meet both of the following:

- Have income at or below 200% FPG
- Are not eligible for the Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) programs. See the Medicare Savings Programs chapter for more information.
- Medicare Part B premium reimbursements for eligible MA-EPD enrollees must be processed and reimbursed by county, tribal, or state servicing agencies at application, renewal, or when an enrollee reports a change that makes them eligible for reimbursement. DHS reimburses Medicare Part B premium reimbursement payments made to an eligible MA-EPD enrollee by the servicing agency.

Legal Citations

Minnesota Statutes, section 256B.057

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

Medical Assistance for Long-Term Care Services

2.4.2.5 Income Calculations for Long-Term Care Services

Income Calculations

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

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

Community Income Calculation

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

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

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

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

LTC Income Calculation

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

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

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

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

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

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

Total Income

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

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

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

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

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

Beginning and Ending the LTC Income Calculation

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

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

The LTC income calculation ends:

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

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

LTC Spenddown

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

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

Interaction with Medicare Part A Payments

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

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

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

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

Waiver Obligation

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

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

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

Medical Spenddown

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

Legal Citations

Code of Federal Regulations, title 42, section 435.726

Code of Federal Regulations, title 42, section 435.733

Code of Federal Regulations, title 42, section 435.735

Code of Federal Regulations, title 42, section 435.832

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

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Medical Assistance for Long-Term Care Services

2.4.2.5.1 LTC Income Calculation Deductions

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

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

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

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

Special Supplemental Security Income (SSI) Deduction

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

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

~~Note: A person receiving both SSI and RSDI is eligible for the SSI deduction equal to the amount that they receive in SSI benefits.~~

Minnesota Supplemental Aid (MSA) Deduction

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

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

Special Personal Allowance from Earned Income

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

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

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

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

Medicare Premiums

Medicare premiums incurred by an enrollee are deducted when not paid by another program. Medicare premiums paid by other programs include:

- The county, state or tribal agency reimburse to the enrollee
- Paid through the Medicare Buy-In

- Paid through Medicare Part D Extra Help

LTC Needs Allowance

One of the following allowances is deducted:

Clothing and Personal Needs Allowance (PNA)

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

Veteran's Improved Pension

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

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

Home Maintenance Allowance (HMA)

The Home Maintenance Allowance (HMA) is equal to 100% of the federal poverty guidelines (FPG) for a household size of one, minus the PNA. The HMA is adjusted each year on July 1. A person who is eligible for the HMA is also eligible for PNA. The amount listed in Appendix F is a combined total of the HMA and the PNA.

The HMA is used when all of the following apply:

- the person lives in an LTCF;
- the person is expected to be discharged from the LTCF within three full calendar months from the month in which MA-LTC is requested to begin;
- the person has expenses to maintain a home (owned or rented) in the community, including room and board charges in group residential housing (GRH) or assisted living; and
- the person meets one of the following conditions:
  - The person did not live with a spouse, a child under age 21, or a person who could be claimed as a dependent of the person for federal income tax purposes at the time he or she was admitted to an LTCF.
  - The person lived with a spouse at the time he or she was admitted to an LTCF, and the person's spouse was admitted to an LTCF on the same day.

Only one spouse can receive the HMA when both spouses live in an LTCF. The HMA is used for the spouse for which it is most advantageous.

Eligibility for the HMA is based on the anticipated discharge date at the time eligibility for MA-LTC is determined. Eligibility for the HMA is not delayed to see if the person will actually be

discharged on the anticipated discharge date and is not retroactively adjusted if the person lives in the LTCF for more than three full calendar months.

A person must be discharged from an LTCF for a full calendar month before the HMA may be used again.

Special Income Standard Elderly Waiver (SIS-EW) Maintenance Needs Allowance (MNA)

The Special Income Standard Elderly Waiver (SIS-EW) maintenance needs allowance (MNA) is used for people requesting Elderly Waiver (EW) services and who have income at or below the Special Income Standard (SIS). The SIS-EW MNA is updated annually in July. The SIS-EW MNA is not used for a person with income above the SIS.

When an SIS-EW enrollee moves to or from an LTCF:

- The PNA or veteran's improved pension allowance is used beginning the month following the month the SIS-EW enrollee moves into the LTCF.
- The SIS-EW MNA is used beginning the month following the month the person is discharged from the LTCF and begins receiving EW services.

Fees Paid to a Guardian, Conservator, or Representative Payee

Five percent of the enrollee's gross monthly income, up to a maximum of $100, for fees paid to a guardian, conservator or representative payee is deducted. This deduction cannot be increased over $100 even if a higher amount is allowed to be paid by SSA or a court.

Community Spouse Income Allocation

An LTC spouse may allocate a portion of their income to the community spouse when the community spouse's income is insufficient to meet their monthly maintenance needs. The community spouse income allocation is calculated by comparing the community spouse's gross monthly income to the minimum monthly allowance plus any excess shelter costs. The income allocation cannot exceed the maximum monthly allowance.

The community spouse's gross monthly income includes all earned and unearned income, including income received from income-producing assets. No exclusions, disregards or deductions apply. If the community spouse's gross monthly income is greater than or equal to the community spouse's monthly maintenance needs, the community spouse does not qualify for an income allocation. If the community spouse's gross monthly income is less than the community spouse's monthly maintenance needs, the community spouse qualifies for an income allocation.

Calculation of the Community Spouse's Shelter Costs

The community spouse's shelter costs, in excess of the basic shelter allowance, are added to the minimum monthly allowance to calculate the community spouse income allocation. Shelter costs include:

- Rent
- Mortgage payments, including principal and interest
- Real estate taxes
- Homeowner's or renter's insurance
- Required maintenance charges for a cooperative or condominium
- Utility allowance

The amount of a shelter expense is based on the full amount that the community spouse must pay. Shelter expenses do not include charges for services received by a person who resides in a residential living arrangement. An itemized statement of monthly charges to identify the amount the community spouse must pay for rent or any other shelter expense is required.

Verification Requirements

A community spouse income allocation cannot be deducted unless the person, or their authorized representative, provides verification of the community spouse's income and shelter expenses at the time of the request for MA-LTC and at each renewal. The community spouse, or the community spouse's authorized representative, must report and verify changes in the income or shelter expenses of the community spouse.

When to Deduct the Community Spouse Income Allocation

The calculated community spouse income allocation is deducted when there is a community spouse at any time in a given month unless:

- There is a court order for spousal support for an amount that is greater than the calculated community spouse income allocation. When this occurs, the court ordered amount replaces the community spouse income allocation as a deduction. This only applies when a court order establishes support while the couple remains married. It does not apply to a court order in a divorce action.
- The LTC spouse does not have enough income remaining, after other allowable deductions, to allocate to the community spouse.
- Exceptional or unusual circumstances have occurred that result in a temporary financial hardship to the community spouse. In these cases, the community spouse income allocation may be temporarily increased while the community spouse takes the necessary steps to resolve the situation. The increased deduction cannot be applied if the situation is not temporary or the community spouse does not take the needed actions to resolve the situation.
- The LTC spouse can choose not to make an income allocation to the community spouse. A deduction can only be made if the income is actually made available to the community spouse.
- The community spouse chooses to accept a reduced income allocation or chooses not to accept any income allocation. The community spouse income allocation is counted as unearned income for the community spouse when determining eligibility for any Minnesota

Health Care Program (MHCP). A community spouse may choose to not accept the income allocation if it will result in ineligibility for MA.

Family Allocation

A person may allocate a portion of their income to the following family members who have a calculated need:

- A minor child, who does not live with a community spouse
- The following relatives who live with a community spouse:
  - A child under age 21
  - A child age 21 or older who is claimed as a tax dependent
  - Parents who are claimed as tax dependents
  - Siblings who are claimed as tax dependents

Children Not Living with a Community Spouse

A family allocation may be made to the minor children of the person who does not live with a community spouse. The allocation is calculated by adding together the gross monthly earned and unearned income of all minor children not living with a community spouse and comparing it to 100% of the FPG for a family size equal to the number of minor children not living with the community spouse. No exclusions, disregards or deductions apply. The amount of the allocation is the difference between the gross income of the children and the applicable FPG amount. No allocation is allowed if the gross income of the children exceeds the applicable FPG standard.

Family Members Who Live with a Community Spouse

A separate family allocation may be made for each family member who lives with a community spouse. The allocation is calculated by adding together the gross monthly earned and unearned income of the family member who lives with the community spouse and subtracting it from the minimum monthly income allowance for a community spouse. No exclusions, disregards or deductions apply. No allocation is allowed if the gross income of the family member exceeds the minimum monthly income allowance for a community spouse.

Verification Requirements

The family allocation cannot be deducted unless the person, or their authorized representative, provides verification of the family member's income at the time of the request for MA-LTC and at each renewal. Changes in income for the family member must be reported and verified.

When to Deduct the Family Allocation

A family allocation is deducted in the LTC income calculation in each month that there is a family member eligible to receive an allocation. The family allocation is deducted regardless of whether it is made available to the family member if the income of the family member is verified.

A family allocation is counted as unearned income to the family member when determining eligibility for any MHCP.

Court-Ordered Child Support

Court-ordered child support that is garnished from the person's income up to a maximum of $250 per month is deducted. The garnishment can be for current child support or arrearages. The garnishment must be verified.

This deduction does not apply when a family allocation is deducted for the child for whom the court-ordered child support obligation is due unless the calculated family allocation is less than $250. The difference between the calculated family allocation and $250 may be deducted.

Court-Ordered Spousal Maintenance

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

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

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

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

Health Insurance Premiums, Co-payments and Deductibles

The cost of health insurance premiums, co-payments and deductibles incurred by the person that are not subject to payment by MA or a third party, including Extra Help through SSA for Medicare Advantage Plan or Part D coverage or premium reimbursement through MA, are allowable deductions. Health insurance includes Medicare Advantage plans, dental and LTC insurance policies. Only the portion of the premium that reflects coverage for the person is an allowable deduction.

Remedial Care Expense

A remedial care expense deduction is an amount allowed for people who reside in a residential living arrangement or a housing with services establishment where a county agency has a GRH agreement. The amount can change twice a year, on January 1 and July 1.

Medical Expenses

Verified medical expenses incurred by the person that meet the criteria below are deductions in the LTC income calculation:

The ~~M~~medical expense~~s that are~~ must be medically necessary and recognized under state law

Medically necessary expenses include medical services, supplies, devices, or equipment that are provided in any of these situations:

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

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

The ~~M~~medical expense~~s that MA will not pay~~ must not be covered by MA

Medical expenses for MA covered services that the person incurred in a month that MA will pay because the person is, or will be, approved for MA are not deductions. A medical expense incurred in a month in which the person is or will be an MA enrollee is assumed an MA covered service unless the person provides proof that it is not.

Medical expenses that are included in the daily rate that MA pays to a Skilled Nursing Facility (SNF) or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) are medical expenses that MA will pay.

The ~~M~~medical expense~~s~~ must not be covered by a third party

A medical expense is not a deduction if it is subject to payment by a third party. Third parties include people, entities or benefits that are, or may be, liable to pay the expense. This includes:

- Other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system
- Automobile insurance
- Court judgments or settlements
- Workers' compensation benefits

The person must provide proof of the exact amount of the third party payment, such as an Explanation of Medical Benefits (EOMB) statement. The person can also sign a release form so the county, tribal, or state agency can contact the third party directly.

If not yet known, the amount of the medical expense that will be covered by a third party is estimated at the time of the eligibility determination so that application processing is not delayed. The LTC income calculation is adjusted for the applicable month once the actual amount of the expense is verified. If not verified before, the person must provide proof of the actual amount of estimated medical expenses that were used in the LTC income calculation at the time of their next renewal. The deduction is removed from the applicable month if proof is not provided.

The medical expense was incurred during a month in which the person is receiving MA-LTC or during any of the three months prior to the month in which the person requested MA-LTC

Deductions are allowed for verified medical expenses the person incurred during the month the person requested MA-LTC or while the person is receiving MA-LTC, regardless of whether retroactive MA coverage was requested or approved. Medical expenses incurred during a retroactive month must be unpaid as of the date of the request for MA-LTC. Medical expenses incurred during the month the person requested MA may be paid or unpaid.

Medical Expenses not Allowed as a Deduction

Medical expenses are not allowed as a deduction when:

- The medical expense is for LTC services incurred in a month that is included in a transfer penalty period or period of ineligibility for failure to name Minnesota Department of Human Services (DHS) a remainder beneficiary of certain annuities.
- The person paid the medical expense to reduce excess assets.
- The medical expenses were incurred more than three months before the month of application associated with the current period of eligibility.
- The nursing facility expenses were incurred without a required preadmission screening.
- The medical expense was previously used:
  - As a deduction in an LTC income calculation. However, the amount of a medical expense that exceeds the amount of the person's income remaining after all other deductions in one month can be carried forward to future months
  - To meet a medical spenddown

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

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

- A charge for a provider to travel to a person's residence is also not an allowable medical expense deduction if the LTCF pays the cost for the provider to travel to the LTCF through an agreement between the LTCF and the provider.
- The additional charge for a private room in a skilled nursing facility (SNF) when not medically necessary.

Notification

People who report medical expenses must be notified of the:

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

Legal Citations

Code of Federal Regulations, title 42, section 483.10(f)

Code of Federal Regulations, title 42, section 483.10(h)

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

Minnesota Statues, section 256B.35

Minnesota Statutes, section 256I.03

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MinnesotaCare

3.2.3.2 Employer-Sponsored Coverage

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

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

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

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

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

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

Minimum Value Standard for Employer-Sponsored Coverage

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

Affordability Standard for Employer-Sponsored Coverage

An employer-sponsored health plan is affordable if the employee's portion of the annual premiums for employee-only coverage does not exceed 9.~~83~~61 percent of their annual household income for the tax year. The lowest-cost plan for employee-only coverage is used when determining affordability.

Employer-Sponsored Coverage for a Spouse and Dependents

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

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

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

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

Change in Affordability for Employer-Sponsored Coverage

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

If a person is determined eligible for MinnesotaCare because they provide incorrect information regarding the affordability of their employer-sponsored plan at application, they can be disenrolled following 10-day advance notice requirements.

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

Voluntary Disenrollment from Employer-Sponsored Coverage

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

Post-Employment Employer-Sponsored Coverage

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

Legal Citations

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

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

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

Code of Federal Regulations, title 42, section 600.305

Code of Federal Regulations, title 42, section 600.345

Code of Federal Regulations, title 45, section 155.320

Minnesota Statutes, section 256L.07

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