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 #22.5

December 1, 2022

Manual Letter #22.5

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of December 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 to the home page:

- Bulletin #22-21-04 DHS Announces a Change to the Income Methodology for Medical Assistance, MinnesotaCare and Minnesota Family Planning Program
- Bulletin #22-21-05 DHS Explains Treatment of Minnesota's Public Program Frontline Worker Payments
- Bulletin #22-21-06 DHS Explains Ukrainian Humanitarian Parolee's Eligibility for Minnesota Health Care Programs
- Bulletin #22-21-07 DHS Announces the Extension of MinnesotaCare Premium Reductions through 2025
- Bulletin #22-21-08 DHS Explains Treatment of Post 9/11 Veteran Service Bonus Payments for Minnesota Health Care Programs
- Bulletin #22-21-09 DHS Announces Changes to Annuities Evaluation for MA-LTC and AC Eligibility

This manual letter is added to the EPM home page.

B. Section 1.2.1 Minnesota Health Care Programs (MHCP) Application Forms

We removed the reference to DHS-6696F, since it is an obsolete form.

C. Section 1.2.2 MHCP Application Submission

We clarified agencies may not require a new application or request a new signature when they assign a new application filer due to a change in circumstances.

D. Section 2.1.1.2.1.3.1 Medical Assistance (MA) Cost Effective Insurance

We added Medicare to the not reviewed for cost-effectiveness list.

E. Section 2.1.1.2.3 MA Cost Sharing

We clarified parental fees only apply to parents with children under 18.

F. Section 2.1.1.2.4 MA Referral Other Benefits

We clarified a person is not required to enroll in Medicare when their premiums were determined to not be cost-effective under the former policy.

G. Section 2.1.2.3 MA County Residency

We added two types of excluded time services.

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

We added information to the rental income section of the policy.

I. Section 2.3.5.4.1 Medical Assistance for Employed Persons with Disabilities (MA-EPD) Medicare

We clarified income must be at or below 200% FPG for a MA-EPD person to receive Medicare part B reimbursement.

J. Section 2.3.6.2.1 TEFRA Level of Care

We clarified level of care requirements for MA under the TEFRA option: hospitals and nursing facilities may include, but are not limited to, Severe Emotional Disturbance.

K. Section 2.4.1.3.2 Medical Assistance for Long-Term Care (MA-LTC) Transfer Penalty

We added clarification to the effect on MA eligibility when assets counted as a transfer penalty are returned.

L. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations

We clarified the way annuities are evaluated for MA-LTC.

M. Section 3.2.3.2 MinnesotaCare Employer Sponsored Coverage

We added the 2023 health care affordability standard for employee-sponsored coverage.

N. Appendix C

We updated this appendix with the Medicare cost sharing amounts for the 2023 benefit year.

O. Appendix F

We revised standards and guidelines in Appendix F that become effective January 1, 2023.

II. Documentation of Changes

This section of the manual letter documents all changes made to an existing section. Deleted text is displayed with strikethrough formatting and newly added text is displayed with underline formatting. Links to the revised and archived versions of the section are also provided.

A. EPM Home Page
B. Section 1.2.1 MHCP Application Forms
C. Section 1.2.2 MHCP Application Submission
D. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance
E. Section 2.1.1.2.3 MA Cost Sharing
F. Section 2.1.1.2.4 MA Referral Other Benefits
G. Section 2.1.2.3 MA County Residency
H. Section 2.3.3.3.2.1 MA-ABD Countable Income
I. Section 2.3.5.4.1 MA-EPD Medicare
J. Section 2.3.6.2.1 TEFRA Level of Care
K. Section 2.4.1.3.2 MA-LTC Transfer Penalty
L. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations
M. Section 3.2.3.2 MinnesotaCare Employer Sponsored Coverage
N. Appendix C
O. Appendix F

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

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

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

Manual Letters

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

MHCP EPM Manual Letter #22.5, December 1, 2022

MHCP EPM Manual Letter #22.4, September 1, 2022

MHCP EPM Manual Letter #22.3, June 1, 2022

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 #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 #22-21-02 DHS Announces the Increase in Medical Assistance Spenddown Standard for Certain People.
- Bulletin #22-21-04 DHS Announces a Change to the Income Methodology for Medical Assistance, MinnesotaCare and Minnesota Family Planning Program
- Bulletin #22-21-05 DHS Explains Treatment of Minnesota's Public Program Frontline Worker Payments
- Bulletin #22-21-06 DHS Explains Ukrainian Humanitarian Parolee's Eligibility for Minnesota Health Care Programs
- Bulletin #22-21-07 DHS Announces the Extension of MinnesotaCare Premium Reductions through 2025
- Bulletin #22-21-08 DHS Explains Treatment of Post 9/11 Veteran Service Bonus Payments for Minnesota Health Care Programs
- Bulletin #22-21-09 DHS Announces Changes to Annuities Evaluation for MA-LTC and AC Eligibility

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 #22.4, September 1, 2022

B. Section 1.2.1 MHCP Application Forms

Minnesota Health Care Programs

1.2.1 Application Forms

Many people may apply for Minnesota's Insurance Affordability Programs (IAP) using the MNsure online or a paper application. However, there are different application forms designed to collect the information needed based on the applicant's situation. Applicants must not be asked to answer questions that are not applicable to determining their eligibility. Using the correct application form helps speed up the eligibility determination. When using a paper application form, it is important to choose the most appropriate form and to follow the instructions about where to send the form.

MNsure Online Application

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

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

Eligibility is evaluated in the following order:

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

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

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

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

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

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

Eligibility is evaluated in the following order:

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

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

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

MHCP Application for Certain Populations (DHS-3876)

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

- Age 65 or older
- Blind or has a disability
- Applying only for Medicare Savings Program
- 21 years old or older, has no children under age 19, and has Medicare coverage
- Receiving Supplemental Security Income (SSI)
- Applying for MA for Employed Persons with Disabilities (MA-EPD)

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

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

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

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

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

- request Developmental Disabilities Waiver (DD) services.

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

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

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

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

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

Application Supplements

A supplemental form may be required to collect additional information needed to determine eligibility. Agencies may only require an applicant to provide information necessary to make an eligibility determination and cannot require applicants to provide information they already provided. Therefore, an applicant or enrollee who already completed an application cannot be required to submit a new application unless their eligibility is denied or coverage closed. Instead, a supplement is used to make a complete eligibility determination.

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

Applicants who submit their application through the MNsure online or paper application (DHS-6696) may need to provide additional information if their eligibility cannot be determined in the new eligibility system or if further evaluation is needed for MA-ABD, long-term care services, or Medicare Savings Program eligibility. This paper supplement gathers information not requested on the MNsure application, needed to determine eligibility for:

- MA for people age 65 and older, people who are blind, or have a disability
- MA for people receiving care and rehabilitation services from the Center for Victims of Torture
- Refugee MA
- MA with a spenddown
- MA payment for long-term care facility services
- MA payment for home and community-based waiver services
- Medicare Savings Programs

DHS-6696A is available in English, Hmong, Russian, Somali, Spanish and Vietnamese. Applicants submit DHS-6696A to their county or tribal servicing agency.

Supplement to the MHCP Application DHS-3417 or DHS-3876 (DHS-6696B)

The Combined Application Form (DHS-5223) dated prior to January 2014 and the Health Care Programs Application (DHS-3417) are no longer used to apply for health care. However, when an applicant submits one of these forms they can complete this short supplement instead of a new MHCP application.

When an applicant submits the MHCP Application for Certain Populations (DHS-3876) and they do not meet the criteria to use DHS-3876, they must complete this short supplement to have an eligibility determination. This paper supplement gathers information needed to determine eligibility for:

- MA-FCA
- MinnesotaCare
- APTC
- QHP without subsidy

DHS-6696B is available in English, Hmong, Russian, Somali, Spanish and Vietnamese. Applicants submit DHS-6696B to their county or tribal servicing agency.

MHCP MA Payment for Inpatient Hospital Care for Inmates (DHS-6696G)

This form is a supplement to DHS-6696 for inmates requesting MA payment of hospital services while incarcerated. The correctional facility assists with the application. Applicants submit DHS-6696G and a completed DHS-6696 to DHS Health Care Eligibility Operations.

MHCP Individual Discharge Information Sheet (DHS-3443)

This form is a supplement for people leaving prison to help determine health care eligibility upon release. Applicants must submit DHS-3443 with a completed application; a DHS-6696, DHS-3876, DHS-5038 or DHS-3531. Applicants submit the two forms to the county or tribal servicing agency in which the applicant resided before entering the correctional system.

Other Forms

MHCP Payment of Long-Term Care Services for MA for Families with Children and Adults (DHS-3543A)

MA enrollees using the Families with Children and Adults bases of eligibility use this form to request payment for services in a long-term care facility. Enrollees submit DHS-3543A to their county or tribal servicing agency.

MHCP Request for Payment of Long-Term Care Services (DHS-3543)

MA enrollees using the People Who are Age 65 or Older, Blind or Disabled bases of eligibility use this form to request payment for services in a long-term care facility or a home and community-based waiver program. Enrollees submit DHS-3543 to their county or tribal servicing agency.

MHCP Request to Reopen MA (DHS-5038)

This form is used to request MA coverage reopen after the person was incarcerated less than a year. Applicant submit DHS-5038 to the county or tribal servicing agency in which:

- the applicant resided before entering the correctional system, or
- the applicant plans to live if the previous county of residence is unknown or the person came from another state.

MNsure Appendix A - Health Coverage from Jobs (DHS-6696D)

This form requests missing information about employer subsidized health insurance availability. People can take this form to their human resources department to be filled out. It is included in DHS-6696 and the MNsure online application. Applicants submit DHS-6696D to their county or tribal servicing agency.

~~MNsure Application Additional Information Requested (DHS-6696F)~~

~~This form requests missing information from an incomplete DHS-6696. It includes steps three through nine of DHS-6696. Applicants submit DHS-6696F to their county or tribal servicing agency.~~

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

This form obtains a signature from a Minnesota Health Care Programs applicant or enrollee when the person fails to sign the application or renewal. Applicants submit DHS-6696C to their county or tribal servicing agency.

Request to Apply for MHCP (DHS-3417B)

This form sets the date of application. An applicant must submit a complete application within 30 days of the written request. Applicants submit DHS-3417B to their county or tribal servicing agency.

Legal Citations

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 45, section 155.405

Code of Federal Regulations, title 45, section 155.310

Minnesota Statutes, section 256B.04

Minnesota Statutes, section 256B.08

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Manual Letter #19.6, November 1, 2019

Manual Letter #18.2, April 1, 2018

Manual Letter #17.2 June 1, 2017

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

C. Section 1.2.2 MHCP Application Submission

Minnesota Health Care Programs

1.2.2 Application Submission

Who Can File an Application

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

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

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

Responsibilities of the Application Filer

Application filers:

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

Application Filer and Change in Circumstances

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

Agencies may not require an MHCP enrollee to submit a new application or provide a written signature when assigning a new application filer due to a change in circumstance, including situations where the original application signer is no longer in the household.

Assistance with the Application

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

Legal Citations

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

Code of Federal Regulations, title 42, section 435.603

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.908

Code of Federal Regulations, title 45, section 155.20

Code of Federal Regulations, title 45, section 155.300

Code of Federal Regulations, title 45, section 155.305

Code of Federal Regulations, title 45, section 155.310

Code of Federal Regulations, title 45, section 155.315

Code of Federal Regulations, title 45, section 155.330

Code of Federal Regulations, title 45, section 155.335

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Manual Letter #21.4, October 1, 2021

D. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance

Medical Assistance

2.1.1.2.1.3.1 Cost-Effective Health Insurance

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

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

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

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

Health Insurance Reviewed for Cost Effectiveness

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

Group Health Plans

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

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

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

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

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

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

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

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

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

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

Individual Health Plans

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

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

TRICARE Plans

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

LTC Insurance

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

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

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

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

Medicare

While Medicare is not reviewed or reimbursed as CEHI, certain enrollees may receive help to pay their Medicare premiums. See EPM section 2.3.5.4.1 MA-EPD Medicare, section 2.5.4.4.1 Program IM Medicare, and section 4.2 Medicare Savings Programs for more information.

FSAs, HSAs, and MSAs

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

Though these accounts receive tax-preferred treatment for payment of qualified medical expenses, account funds are spent at the account holder's choosing – they are never legally required to spend the funds for any particular purpose, health care related or otherwise. MA can only pay an enrollee's costs for other insurance coverage strictly limited to health services.

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

HRAs and VEBAs

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

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

MinnesotaCare

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

Plans Available to People Who are Enrolled in Medicare

An enrollee who is also enrolled in Medicare cannot have their premiums for a group health plan, individual health plan, TRICARE plan, or LTC insurance reviewed or reimbursed for CEHI because it is not cost effective to do so.

Medical Support

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

Medical Support Reviewed for Cost Effectiveness

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

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

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

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

Medical Support Not Reviewed for Cost Effectiveness

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

Methods for Determining Cost Effectiveness

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

Standard Calculation

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

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

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

2:1 Ratio Calculation

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

Dental and Vision Insurance Reviewed for Cost Effectiveness

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

Dental and vision plan options cannot be reviewed for cost effectiveness unless a health plan covering the enrollee is cost effective under the standard calculation. If a health plan is cost effective under the 2:1 ratio calculation, or not cost effective under either calculation, the dental and vision plan options cannot be reviewed for cost effectiveness.

Premium Payments for CEHI

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

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

Submitting Proof of Premium Payment

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

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

Retroactive Eligibility

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

Managed care exclusions

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

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

Redetermination of Cost Effectiveness

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

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

Legal Citations

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

Code of Federal Regulations, title 42, section 435.1015

Minnesota Rules, part 9505.0071

Minnesota Rules, part 9505.0430

Minnesota Statutes, section 256B.056, subdivision 8

Minnesota Statutes, section 256B.0625, subdivision 15

United States Code, title 26, section 220

United States Code, title 26, section 223

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

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

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

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

United States Code, title 26, section 1396e

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Manual Letter #21.4, October 1, 2021

E. Section 2.1.1.2.3 MA Cost Sharing

Medical Assistance

2.1.1.2.3 Cost Sharing

Cost sharing includes those costs a Medical Assistance (MA) enrollee pays towards their health care. MA cost sharing includes deductibles, medical visit and prescription copays. Some enrollees also have premiums, spenddowns, waiver obligations or parental fees.

Deductibles and Copays

Adults age 21 or older have:

- A monthly deductible
- Copays for non-preventative visits
- Copays for nonemergency emergency room (ER) visits
- Copays for prescription drugs

Excluded from Deductibles or Copay

- Pregnant women,
- American Indians ~~and~~
- Alaska Natives,
- people under age 21,
- people in hospice care,
- people enrolled in MA for women with breast or cervical cancer,
- Refugee MA enrollees ~~and~~
- people in long-term care facilities ~~have no deductibles or copays.~~

Monthly copays and deductibles are limited to 5 percent of family income.

See Summary of Coverage, Cost Sharing and Limits (DHS-3860) for more information.

Premiums

Premiums are a bill enrollees pay monthly for their health care. MA for Employed Persons with Disabilities (MA-EPD) enrollees have a monthly premium. See the MA-EPD Premium policy for more information.

Spenddowns

A spenddown is a cost-sharing approach that allows MA eligibility for people whose income exceeds financial eligibility requirements. Federal rules refer to this population as "medically needy." MA enrollees can become income eligible for MA by “spending down” their excess income to the appropriate income limit. The excess income is reduced by deducting certain medical expenses.

There are two types of spenddowns.

Medical Spenddown

Medical Spenddowns are for enrollees that live in the community. Not all MA bases of eligibility offer MA with a medical spenddown. See the MA for Families With Children (MA-FCA) Medical Spenddown policy and the MA for People Who are Age 65 and Older, Blind or Disabled Medical Spenddown policy for more information.

Long-Term Care Spenddown

Some enrollees eligible for the payment of long-term care services may be obligated to contribute toward the cost of services. The amount of income that a person is obligated to contribute to the cost of LTC services is based on basis of eligibility and household composition.

Not all MA bases of eligibility require enrollees contribute toward the cost of long-term care facility services (nursing facility). See the MA for Long Term Care Services chapter for more information.

Parental Fees

Parents may be liable for a fee to reimburse part of their children's costs if their income is not considered in determining MA eligibility for their disabled children. Parental fees apply to children under the age of 18 receiving MA through the TEFRA option, children receiving home and community based waiver services, children placed in a Regional Treatment Center, when MA pays the cost of care, and children in 24-hour out-of-home placement. See the MA TEFRA subchapter and MA for Long-Term Care Services Home and Community-Based Service Waivers subsection for more information.

County, tribal or state servicing agencies may assess parental fees when a child lives apart from both parents or when a child has a non-custodial parent.

Parents are not responsible for a parental fee in any of the following circumstances:

- Parental rights have been terminated.
- The child on MA is an emancipated minor.
- The child receives state or Title IV-E adoption assistance.

The Minnesota Department of Human Services (DHS) collects parental fees. The child’s, county, tribal or state servicing agency must make a referral to the DHS parental fee unit. The county, tribal

or state servicing agency sends the Important Notice and Parental Fee Worksheet (DHS-2977) to parents.

Parental Fee Amount

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

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

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

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

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

Undue Hardship

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

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

Non-Cooperation with Parental Fee Requirements

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

- Refusal to submit the necessary information to DHS in determining a fee can result in a bill for the full reimbursement cost of MA services.

Failure to pay the parental fee can result in the account being turned over to a collection agency, garnishment of wages, or taking the parent's state tax refund

Waiver Obligations

A waiver obligation is the amount a person is obligated to contribute toward the cost of home and community based waiver services. People age 65 and older, receiving Elderly Waiver (EW) services, with income above the Special Income Standard Elderly Waiver (SIS-EW) maintenance needs allowance pay a waiver obligation. The waiver obligation is based on actual income and deductions in a given month. See the Home and Community-Based Waiver for People Age 65 or Older subsection for more information.

Legal Citations

Code of Federal Regulations, title 42, section 412.424

Code of Federal Regulations, title 42, section 435.225

Code of Federal Regulations, title 42, section 447.55

Minnesota Rules, part 9550, subpart 6200-6240

Minnesota Statutes, section 252.27

Minnesota Statutes, section 256B.14

Minnesota Statutes, section 256B.057

Minnesota Statutes, section 256B.063

Minnesota Statutes, section 256B.0631

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F. Section 2.1.1.2.4 MA Referral Other Benefits

Medical Assistance

2.1.1.2.4 Referral for Other Benefits

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

To meet this requirement, an enrollee must:

Submit an application for the program they appear to be eligible for, following the rules of that program

Provide any requested information needed to determine eligibility for the program

Provide documentation of the decision about their eligibility for the program

- If a person is denied because they do not meet the eligibility criteria for the program, they are not required to appeal the decision.
- If a person is denied because they did not provide necessary documentation, or did not cooperate in the eligibility determination, they have not met this requirement.

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

Social Security benefits

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

Retirement Survivors Disability Insurance

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

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

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

- Dependent survivors of a wage earner who has died

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

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

Supplemental Security Income

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

Medicare

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

People age 65 or older who qualify for RSDI or Railroad Retirement Board (RRB) benefits

Citizens and qualifying non-citizens age 65 or older who pay a Medicare Part A premium

People certified disabled by SSA, after a 24-month waiting period. People with Amyotrophic Lateral Sclerosis (ALS) are eligible the same month they start receiving RSDI benefits.

Widows and widowers and divorced widows and widowers with a SSA certified disability, after a two-year waiting period

People with 1619(a) or 1619(b) status

People with End-Stage Renal Disease (ESRD) defined as permanent kidney failure requiring dialysis or a kidney transplant

DHS previously evaluated Medicare premiums for cost-effectiveness, but Medicare premiums are no longer evaluated for cost-effectiveness. People whose premiums were evaluated under the previous policy and determined not cost-effective have good cause for not meeting the requirement to enroll in Medicare if eligible.

Medicare Part A

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

Medicare Part B

Medicare Part B is medical insurance. There is a monthly premium for Part B. MA enrollees must apply and maintain Medicare Part B coverage, even if they are required to pay a premium.

Medicare Savings Programs (MSP), the Medicare Buy-In and MA-EPD can help eligible clients with premiums and other costs. People who are in an Institution for Mental Diseases (IMD) may also receive help paying for premiums and other costs. People have a wide variety of Medicare-approved plans from which to choose.

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

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

Medicare Part D

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

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

Railroad Retirement Benefits

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

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

Retiree benefits

Disability benefits

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

Survivor benefits

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

Financial Needs

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

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

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

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

Exceptions

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

Legal Citations

Code of Federal Regulations, title 42, section 435.608

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G. Section 2.1.2.3 MA County Residency

Medical Assistance

2.1.2.3 County Residency

Medical Assistance (MA) has rules about county residence. County residency policy determines the:

- County of service
- County of financial responsibility

County of Service

The county of service is responsible for administering the case, including, but not limited to:

- Processing paper applications
- Processing change in circumstances
- Processing renewals
- Gathering proofs and documentation
- Issuing manual notices
- Creating case notes

County of Financial Responsibility

The county of financial responsibility is responsible for paying the county share of MA services. The county of financial responsibility is the county where the person lives on the day the county receives a written request for assistance except in the following circumstances:

- When an enrollee moves to a different county, the new county becomes the county of financial responsibility after two full calendar months following the month of the move.
- When an applicant moves to a new county during the application processing period, the county in which the client resided at the time ~~of~~ the application was submitted is financially responsible, whether or not the county that received the application has acted on the application. The new county becomes the county of financial responsibility after two full calendar months following the month of the move.
    - Example: John applied for MA in County A on October 4th. On October 20th, he submits all required information to County A and reports that he moved to County B on October 15. County A finishes processing the application and determines John is eligible for MA. County B becomes the county of financial responsibility beginning January 1. November and December are the two full calendar months after the month John moved.

- When a person lives in an excluded time facility or receives excluded time services, the county of financial responsibility is the county in which the person lived immediately before the excluded time started.
- When a person leaves an excluded time facility or no longer receives excluded time services, and lives in a county other than the one in which the person lived immediately before the excluded time started, the new county becomes the county of financial responsibility after two full calendar months following the month the excluded time ends.

Excluded Time

Excluded time facilities and situations include:

- Hospitals
- Long-Term Care Facilities (LTCF)
- Shelters (other than emergency shelters)
- Halfway houses
- Foster homes for children receiving Title IV-E and Non-Title IV-E Foster Care
- Adult foster care
- Board and lodging facilities
- Maternity homes
- Battered women's shelters
- Correctional facilities
- Regional treatment centers (RTC)
- Placement in a facility based on an emergency hold
- Placements in day training and habilitation programs
- Assisted living services
- Placements with an indeterminate commitment, including independent living

A person may receive excluded time services while living at home or in a group living situation. Excluded time services include:

- Participation in a rehabilitation facility which meets the definition of a long-term sheltered workshop
- ~~Receipt of~~ Receiving services from a Semi-Independent Living Services (SILS) Program
- Receiving integrated community supports or day support services
- Participation in d~~D~~ay training and habilitation programs

Safe at Home

When a person is a Safe at Home (SAH) program participant, they use a PO Box address assigned to them. SAH provides a mail forwarding service. The county of financial responsibility and county of residence are the county in which the person lives. More information about SAH Address Confidentiality Program is available from the Minnesota Secretary of State.

Legal Citations

Minnesota Statutes, section 5B, subdivision 1 to 13

Minnesota Statutes, section 256G.02, subdivision 4

Minnesota Statutes, section 256G.02, subdivision 6

Minnesota Statutes, section 256G.07, subdivision 1

Minnesota Statutes, section 256J.75, subdivision 2

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H. Section 2.3.3.3.2.1 MA-ABD Countable Income

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

2.3.3.3.2.1 Countable Income

This policy provides information on types of income that must be counted when calculating a person's income for Medical Assistance (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 (FSA), a Health Reimbursement Arrangement (HRA), or a Health Savings Account (HSA).
- ~~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 paid.

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. See Rental Income for more information~~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. See Rental Income for more information~~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.~~
- 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.

Rental Income

Rental income is any payment received for the use or occupation of real property. These policies apply to both earned and unearned rental income.

- Net rental income is the gross rental income minus verified rental and repair expenses (allowable expenses).
    - When allowable expenses paid in a month exceed the gross rental income in the same month, the excess expenses can be subtracted from the next month's gross rental income.
- Security or other deposits held for the tenant are not income while subject to return to the tenant. At the time any amount is used or no longer held for the tenant, it is income.

Prorating Rental Income

If expenses are incurred, but only a portion of those expenses apply to the property that is for rent, then the following prorating policies apply:

- In multiple family residences:
    - If the units in the building are of approximately equal size, allowable expenses must be prorated on the number of units designated for rent compared to the total number of units.
    - If the units are not of approximately equal size, allowable expenses must be prorated based on the number of rooms in the rental units compared to the total number of rooms in the building. (The rooms do not have to be occupied).
    - Any expenses strictly related to a particular rental unit are deducted in total from the rent for that unit. Those expenses are not prorated.
- In rooms in a single residence:
    - Allowable expenses must be prorated based on the number of rooms designated for rent compared to the number of rooms in the house.
    - Bathrooms do not count as rooms in the house. Basements and attics only count if they have been converted to living spaces (e.g., recreation rooms).
    - Any expenses strictly related to a particular rental room are deducted in total from the rent for that room. Those expenses are not prorated.
- On Land:
    - Expenses are prorated based on the percentage of total acres for rent.

Legal Citations

Code of Federal Regulations, title 42, section 435.631

Code of Federal Regulations, title 42, section 435.831

Minnesota Statutes, section 256B.056, subdivision 4

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Previous Versions
Manual Letter #22.2, March 1, 2022

I. Section 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 using the MA-EPD income methodology
- 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 #22.2, March 1, 2022

J. Section 2.3.6.2.1 TEFRA Level of Care

Medical Assistance under the TEFRA Option

2.3.6.2.1 Level of Care

Medical Assistance (MA) under the TEFRA option is for children with a disability who are otherwise ineligible for MA because household income is above the MA for Families with Children and Adults (MA-FCA) income limit. The TEFRA option for children with a disability is named after the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 that created the option.

The State Medical Review Team (SMRT) reviews all referrals for MA under the TEFRA option to determine:

- if the child is considered disabled according to the Social Security standards, and
- if the child's needs meet the level of care requirements.

The child must meet one of the following level of care requirements:

- Hospital (including, but not limited to, Severe Emotional Disturbance)
- Intermediate care facility for people with developmental disabilities (ICF-DD)
- Nursing facility (including, but not limited to, Severe Emotional Disturbance)

See the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Certification of Disability policy for more information.

Legal Citations

United States Code, title 42, section 1396A, subdivision e

Code of Federal Regulations, title 42, section 435.225

Minnesota Statutes, section 256B.055, subdivision 12

Minnesota Statutes, section 256B.092

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

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Manual Letter #20.2, June 1, 2020

K. Section 2.4.1.3.2 MA-LTC Transfer Penalty

Medical Assistance for Long-Term Care Services

2.4.1.3.2 Transfer Penalty

The transfer penalty for uncompensated transfers is a period of ineligibility for Medical Assistance for Long-Term Care Services (MA-LTC). The transfer penalty only applies to people who meet all of the other criteria to receive MA-LTC. See MA-LTC Eligibility Requirements for more information regarding MA-LTC eligibility. Therefore, the transfer penalty cannot start until a person would be otherwise eligible for MA-LTC. This section discusses how the transfer penalty is calculated.

Uncompensated Transfer Amount

The calculation for the transferred penalty starts by determining the uncompensated transfer amount.

The amount of the uncompensated transfer varies for certain assets. See Other Asset Transfer Considerations for transfers involving the following assets:

- An annuity
- A life estate
- A trust

The uncompensated amount of all other transfers is the amount of income transferred or the fair market value (FMV) of the asset transferred, less any encumbrances and compensation received, on the transfer date.

Determining the Transfer Penalty

The transfer penalty begin date depends on several factors, including:

- When the transfer took place
- When the transfer was reported or discovered
- When the person first applied for or requested MA-LTC
- When the person was otherwise eligible
- Whether the person was receiving LTC services at the time the transfer was reported or discovered

The transfer penalty is applied differently for applicants and enrollees.

Applicants Requesting MA-LTC

For applicants, the transfer penalty may be imposed for transfers made during the lookback period. The transfer penalty is calculated by adding together all uncompensated transfers and dividing that amount by the MA Statewide Average Payment for a Skilled Nursing Facility (SAPSNF) in effect in the month the applicant was found to be otherwise eligible for MA-LTC. The penalty period is the full number of months plus any partial months resulting from this calculation.

- The partial month is an amount that the MA-LTC payment is reduced in that month.
- If the transfer penalty amount is less than a full month of eligibility for MA-LTC, the MA-LTC payments are reduced by the transfer penalty amount.

If the person is eligible for MA during the transfer penalty period, MA will pay for non-LTC services.

The transfer penalty period begins with the first month for which the person is requesting and is otherwise eligible for MA-LTC. Once the transfer penalty has started it runs uninterrupted until it expires, even if the person is no longer in a long term care facility (LTCF) or receiving MA or MA LTC services.

Enrollees Receiving MA-LTC

For enrollees, a transfer penalty may be imposed for transfers made during the lookback period but not previously reported and transfers made while the person was enrolled in MA-LTC. The transfer penalty is calculated by adding together all uncompensated transfers and dividing by the SAPSNF in effect at the time of the last renewal. The penalty period is the full number of months plus any partial months resulting from this calculation.

- The partial month is an amount that the MA-LTC payment is reduced in that month.
- If the transfer penalty amount is less than a full month of eligibility for MA-LTC, the MA-LTC payments is reduced by the transfer penalty amount.

If the person remains eligible for MA during the transfer penalty period, MA will pay for non-LTC services.

The transfer penalty period begins with the first month following the month in which a 10-day notice is provided. In order to impose the full transfer penalty, the agency must send the 10-day notice no later than three calendar months after the uncompensated transfer is reported or otherwise discovered. If the agency does not send the 10-day notice within those three calendar months, only the remaining months of the transfer penalty following the month the 10-day notice is sent can be imposed. Once the transfer penalty has started it runs uninterrupted until it expires, even if the person is no longer in a LTCF or receiving MA or MA LTC services.

Imposing a Transfer Penalty for People who are Married

The policy below describes how a transfer penalty is applied when one or both spouses of a married couple receive MA-LTC.

The transfer penalty is applied as follows if only one spouse is requesting MA-LTC:

- If both spouses are receiving LTC services but only one spouse is applying for or enrolled in MA-LTC, the entire transfer penalty is applied to the MA-LTC spouse regardless of which spouse transferred the asset.
- If one spouse is receiving MA-LTC, the entire transfer penalty is applied to the spouse who is receiving MA-LTC regardless of which spouse made the uncompensated transfer.

Transfer penalties are divided between spouses when they are both requesting MA-LTC and receiving LTC services.

- If one spouse is subject to an existing transfer penalty period at the time the other spouse requests MA-LTC, any remaining transfer penalty is divided evenly between the spouses.
- If the transfer penalty is not exhausted when one spouse's MA-LTC ends, the remaining balance is applied to the remaining spouse receiving MA-LTC until the penalty expires.

Eliminating a Transfer Penalty

A transfer penalty is imposed on the date the agency calculates a transfer penalty and sends the person a notice regarding the penalty period. Once the penalty is imposed, it runs continuously and without interruption until it expires. The transfer penalty cannot be reduced or shortened. The only way to eliminate a transfer penalty is if the person receives a full return of the transferred assets. A transfer penalty is not eliminated if assets are partially returned.

Clarification of Full Return

A transfer penalty cannot end unless the transferor(s) receives a full return of the transferred assets. When the transferee is returning the same transferred asset, the value of the asset at the time of the return must be equal to or greater than the value of the asset at the time of the transfer in order to be considered a full return.

For non-cash transfers, the transferee has the option to substitute a cash payment in exchange for the return of the transferred asset. The amount of the cash payment must be equal to or greater than the uncompensated amount used to calculate the transfer penalty. If the value of the transferred asset has decreased or the transferee no longer has the transferred asset, the only way the transfer penalty can end is if the transferee provides a cash payment to the transferor. A transferee cannot substitute a non-cash asset in exchange for the transferred asset.

In order to return transferred assets, the transferee must make the returned asset or its cash equivalent available to the transferor. It is available if the transferor has both the legal authority and the actual ability to use the asset or to convert it to cash. A direct payment of the transferor's obligations by the transferee (such as payment of his or her nursing home bill) is not a return of transferred assets because the assets are never actually available to the transferor.

Verification Requirements

The transfer penalty cannot end due to full return of the asset(s) unless a person has verified that:

- The transferee returned all of the transferred assets or their cash equivalent to the transferor.
- The value of the returned asset at the time of the return is equal to or greater than the value of the asset at the time of the transfer.

Upon receipt of the verification, the transfer penalty ends the first of the month following the month of the full return.

Effect of Returned Assets on Eligibility for MA

~~Once returned, the assets are treated as if they had been available to the transferor from the date of the transfer.~~ Asset eligibility is evaluated when the assets are returned to determine a person's ongoing eligibility for MA. If the return of assets results in excess countable assets, the enrollee must ~~should~~ be provided the opportunity to reduce excess countable assets. If the enrollee is unable to reduce ~~the~~ assets to within the asset limit, MA eligibility ~~should~~ must be redetermined and if appropriate, closed with ~~timely~~ advance notice. See MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Excess Assets for more information.

~~If the asset would have put the person over the MA asset limit during that time, an overpayment occurred during the months the person was an MA enrollee.~~

Eligibility for MA-LTC

A person is not automatically eligible for MA-LTC upon the end of a transfer penalty. Ending the transfer penalty only eliminates a barrier for MA-LTC identified in a previous request. When a transfer penalty ends (or is eliminated), a determination must be made to ensure the person currently meets all eligibility requirements for MA-LTC.

- People not enrolled in MA when the transfer penalty ends must reapply for MA if it is outside the application processing period associated with the last completed application
- People enrolled in MA when the transfer penalty ends must submit a Minnesota Health Care Programs (MHCP) Request for Payment of Long-Term Care Services (DHS-3543) if they had a gap of one calendar month or more between the date the transfer penalty was imposed and the date of the request for MA-LTC.

Legal Citations

Minnesota Statutes, section 256B.0595

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

Social Security Act §1917(c)

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L. Section 2.4.1.3.4 MA-LTC Other Asset Transfer Considerations

Medical Assistance for Long-Term Care Services

2.4.1.3.4 Other Asset Transfer Considerations

This section describes if a person has received adequate compensation for transfers involving the following types of assets:

- Annuities
- Coverdell Education Savings Account
- Life Estates
- Trusts

Annuities not Evaluated under the Transfer Policy

Annuities are not evaluated under the uncompensated transfer policy in the following situations:

- The annuity is a deferred annuity in the accumulation phase. An annuity in the accumulation phase is evaluated as an available asset.
- Revocable or assignable annuities are evaluated as an available asset. See Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Annuities for information on verifying these annuities.
- The annuity is an employer sponsored retirement fund. See MA-ABD Retirement Funds and Retirement Plans for more information.
- Annuities that meet a transfer exception are not evaluated for a transfer penalty; however, any annuity that meets an exception is evaluated for availability. See MA-ABD Annuities for more information.

If an annuity is not evaluated under the transfer analysis, it is evaluated to determine whether it is an available asset or if it provides unearned income.

Annuities Evaluated under the Transfer Policy

Certain annuitized annuities purchased by or on behalf of the person requesting MA for Long-Term Care (LTC) or the person's spouse must be evaluated to determine if an uncompensated transfer occurred within the lookback period.

~~There are two sets of policies for evaluating these transfers: Method 1 and Method 2. Method 2 is used to evaluate annuities that do not include all of the elements of annuities evaluated under Method 1.~~

~~The policies described below do not apply to employment-based pension plans held in the form of an annuity. See Retirement Funds.~~

~~Method 1 Transfer Analysis~~

An annuity is evaluated to determine if an uncompensated transfer occurred ~~under Method 1~~ if it includes all of the following elements~~meets all of the following criteria~~:

- The annuity was purchased with the funds of the person requesting MA-LTC.
- The person requesting MA-LTC is a payee under the annuity contract.
- An annuity transaction occurred within the lookback period. See EPM section 2.4.1.4.1 MA-LTC Annuity Disclosures for the definition of an annuity transaction.
- The annuity is in the annuitization phase.

For A~~a~~nnuities that include these elements, ~~meet the Method 1 transfer analysis criteria are evaluated as follows:~~an uncompensated transfer occurred unless all of the following criteria are met:

A. The annuity is a commercial annuity

B. The annuity provides for payments in equal amounts during the term of the annuity with no deferral of payments and no balloon payments

- If either, or both, of these criteria are not met the value of the uncompensated transfer is the total amount of funds annuitized less any payments the person or his or her spouse already received.

C. The annuity is actuarially sound using the life expectancy tables published by the Chief Actuary of the Social Security Administration (SSA). The current actuarial life table is found on SSA's website.

- If this criteria is not met, the value of the uncompensated transfer is the total amount of the funds annuitized that will not be returned to the person requesting MA-LTC, or the person's spouse, within the applicable life expectancy.

~~The value of the uncompensated transfer is the total amount annuitized less any payments the person or their spouse already received.~~

~~The transfer of any ownership interest or payments, through a gift, assignment or sale, from an annuity to anyone other than the person requesting MA-LTC or their spouse may be an uncompensated transfer.~~An uncompensated transfer also occurred if the ownership interest or payments the person or their spouse were entitled to receive is transferred or assigned to a third party without receiving adequate compensation. The amount of the uncompensated transfer is the cash value of the ownership interest or payments the person or their spouse was entitled to receive, as of the transfer date, after subtracting any compensation received.

~~Method 2 Transfer Analysis~~

~~An annuity is evaluated under Method 2 if it meets all of the following criteria:~~

- ~~The annuity was purchased with the funds of the person and their spouse within the lookback period~~
- ~~The person requesting MA-LTC and/or their spouse is:~~
  - ~~An owner~~
  - ~~A payee~~
  - ~~An annuitant~~
  - ~~A combination of the above~~
  - ~~None of the above~~
    - ~~The funds of the person and their spouse were used to purchase an annuity to benefit someone other than the person and their spouse, or someone other than the person and their spouse holds ownership of the annuity.~~
- ~~The person requesting MA-LTC is a payee under the annuity and no annuity transaction has occurred.~~
- ~~The annuity is in the annuitization phase.~~

~~Annuities that meet the Method 2 transfer analysis criteria are evaluated as follows:~~

~~I. The purchase of an annuity is an uncompensated transfer unless all of the following criteria are met:~~

- ~~the annuity is a commercial annuity;~~
- ~~the annuity provides for payment of principal and interest in equal monthly installments during the term of the annuity contract; and~~
- ~~principal and interest payments from the annuity begin at the earliest possible date after annuitization~~
- ~~the annuity is actuarially sound using the applicable actuarial life table.~~

~~The value of the uncompensated transfer is the total amount annuitized less any payments the person or their spouse already received.~~

~~II. The transfer of any ownership interest or payments, through a gift, assignment or sale, from an annuity to anyone other than the person requesting MA-LTC or their spouse may be an uncompensated transfer.~~

~~An uncompensated transfer occurred if ownership interest or payments the person or their spouse were entitled to receive is transferred to a third party without receiving adequate compensation. The amount of the uncompensated transfer is the cash value of the ownership interest or payments the person or their spouse was entitled to receive, as of the transfer date, after subtracting any compensation received.~~

Actuarial Soundness

An annuity is actuarially sound if the cash value, on the date it was annuitized, is less than or equal to the amount of payments the person will receive during the payee's life expectancy. If both the person and their spouse are listed as payees under the annuity contract, the person with the longest life expectancy is used to determine actuarial soundness.

The life expectancy of the person requesting or receiving MA-LTC or their spouse is determined using the actuarial life table found on the SSA website.

Any portion of the annuity that is funded with money contributed by a third party is not included in the cash value used to determine actuarial soundness.

Coverdell Education Savings Accounts Evaluated under the Transfer Policy

Funds in a Coverdell Education Savings Account (ESA) may be transferred or "rolled over" to a member of the beneficiary's family. When a designated beneficiary "rolls over" funds in a Coverdell ESA to a family member, the rollover must be evaluated as an uncompensated transfer.

Life Estates Evaluated under the Transfer Policy

There are several instances when a life estate transfer of assets must be evaluated to determine if an uncompensated transfer occurred. See Uncompensated Transfers for more information on transfer policy. See Purchases as Transfers for more information when a person purchases a life estate interest in another person's home.

A life estate must be evaluated to determine if an uncompensated transfer occurred by the original owner of the property when:

- The life estate is established during the lookback period.
    - The value of the transfer is the value of the remainder interest, at the time the life estate was established, less any compensation received. See MA-ABD Life Estate and Remainder Interests.
- The life estate is sold prior to the dealth of the life estate owner or terminated to expiration under the terms of the life estate.
    - The amount of the uncompensated transfer is the value of the life estate interest on the date of the sale or termination, less any allowable costs related to the sale of the property, and less any compensation received. See MA-ABD Life Estate and Remainder Interests.

Allowable costs of the sale of property held in life estate

Payment of a pro rata or proportional share of allowable costs related to the sale of a property held in life estate is not considered an uncompensated transfer so long as the costs are divided pro rata between the life estate owner and the remainderman. Allowable costs for the life estate owner are limited to the following:

- Seller's closing costs, including real estate broker fees
- Expenses required by the county or state
- Repairs necessary for the sale
- Buyer's closing costs, including real estate broker fees, so long as the life estate owner receives no less than two-thirds the value of the life estate interest

Payment of costs associated with making improvements (rather than repairs) to the property by the life estate owner is considered an uncompensated transfer. See MA-ABD Life Estate and Remainder Interests

Trusts Evaluated under the Transfer Policy

Client Funded Trusts

If a non-excluded asset is placed in a trust, during the lookback period or while the person is receiving MA-LTC, an uncompensated transfer takes place if the grantor is no longer able to access all or a portion of the trust income or trust corpus. The amount of the uncompensated transfer is the portion of the trust income or trust corpus that is considered unavailable.

Any distributions from the trust that are not to or for the benefit of the beneficiary are an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is to or for the benefit of someone other than the beneficiary.

Special Needs Trusts

Special needs trusts are excluded assets when determining eligibility for MA. However, funds entering and leaving the trusts must be evaluated to determine if an uncompensated transfer occurred.

- The establishment, or addition to a special needs trust before the beneficiary reaches age 65 is not considered an uncompensated transfer and a penalty cannot be imposed.
- A distribution from a special needs trust that does not meet the sole benefit requirement is an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is not for the sole benefit of the trust beneficiary.
- A special needs trust cannot be added to after the beneficiary reaches age 65. Additions to the trust after the beneficiary reaches age 65 are not considered excluded assets. The value of any non-excluded assets added to the trust after the beneficiary reaches age 65 are considered available to the beneficiary.

See MA-ABD Special Needs for more information.

Pooled Trusts

Pooled trusts may be considered excluded assets when determining eligibility for MA. However, funds entering and leaving the trusts must be evaluated to determine if an uncompensated transfer occurred.

- The establishment, or addition to a pooled trust before the beneficiary reaches age 65 is not considered an uncompensated transfer and a penalty cannot be imposed.
- The establishment of a pooled trust after the beneficiary reaches age 65 is evaluated as an uncompensated transfer. The amount of the transfer is the amount for which the beneficiary has not received adequate compensation. The beneficiary must provide proof that adequate compensation was received.
- An addition to a pooled trust by a beneficiary or a beneficiary's spouse after the beneficiary reaches age 65 is evaluated as an uncompensated transfer. The amount of the uncompensated transfer is the amount for which the beneficiary has not received adequate compensation. The beneficiary must provide proof that adequate compensation was received.
- A distribution from a pooled trust that does not meet the sole benefit requirement is an uncompensated transfer. The amount of the uncompensated transfer is the amount of the distribution that is not for the sole benefit of the trust beneficiary.

See MA-ABD Pooled Trusts for more information.

Legal Citations

Minnesota Statutes, section 256B.0595

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

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

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M. Section 3.2.3.2 MinnesotaCare Employer Sponsored Coverage

MinnesotaCare

3.2.3.2 Employer-Sponsored Coverage

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

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

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

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

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

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

Minimum Value Standard for Employer-Sponsored Coverage

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

Affordability Standard for Employer-Sponsored Coverage

An employer-sponsored health plan is affordable if the employee's portion of the annual premiums for employee-only coverage does not exceed ~~9.61~~9.12 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 the employee and the spouse expect to file taxes jointly.

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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N. Appendix C

Appendix C

Medicare Cost Sharing Amounts

This appendix provides cost sharing amounts for Medicare.

Medicare Part A Cost Sharing Amounts

Cost Type	~~2021~~	2022	2023
Premium	~~Varies~~	Send SVES	Send SVES
Deductible	~~$1,484~~	$1,556	$1,600
Hospital Coinsurance days 61-90	~~$371~~	$389	$400
Hospital Coinsurance days 91-150	~~$742~~	$778	$800
Skilled Nursing Facility Coinsurance days 1-20	~~$0~~	$0	$0
Skilled Nursing Facility Coinsurance days 21-100	~~$185.50~~	$194.50	$200

Medicare Part B Cost Sharing Amounts

Cost Type	~~2021~~	2022	2023
All Other Premium Amounts	~~Varies~~	Send SVES	Send SVES
Deductible	~~$203~~	$233	$226
MSHO and SNBC plans that will pay the portion listed of the Medicare Part B Premium	~~None~~	None	None

Medicare Part D Cost Sharing Amounts

Standard Benefit Information

Cost Type	~~2021~~	2022	2023
Premium	~~Varies~~	Varies	Varies by plan
Annual Deductible	~~$445~~	$480	$505
Coinsurance Costs	~~25% of drug costs between $445.01 and $4,130 (Cap of $6,550)~~	25% of drug costs between $480.01 and $4,430 (Cap of $7,050)	25% of drug costs between $505.01 and $4,660 (Cap of $7,400)
Coverage Gap Costs	~~100% of costs between the initial coverage limit based on drug costs between $4,130.01 and $6,550.~~ ~~75% discount on brand name drugs~~ • ~~75% discount on generic drugs~~	100% of costs between the initial coverage limit based on drug costs between $4,430.01 and $7,050 • 75% discount on brand name drugs • 75% discount on generic drugs	100% of costs between the initial coverage limit based on drug costs between $4,660.01 and $7,400 • 75% discount on brand-name drugs • 75% discount on generic drugs
Copayments	~~$3.70 generic drugs~~ • ~~$9.20 brand name drugs~~	• $3.95 generic drugs • $9.85 brand name drugs	• $4.15 generic drugs • $10.35 brand-name drugs

Extra Help Full Subsidy Information

Cost Type	~~2021~~	2022	<u>2023</u>
Premium	~~$0~~	$0	<u>$0</u>
Annual Deductible	~~$0~~	$0	<u>$0</u>
Coinsurance Costs	~~None~~	None	<u>None</u>
Coverage Gap Costs	~~None~~	None	<u>None</u>
Copayments	~~<100% FPG~~ • ~~$1.30 generic drugs~~	<100% FPG • $1.35 generic drugs	<u>≤100% FPG</u> • <u>$1.45 generic drugs</u>

	• ~~$4.20 brand name drugs~~	• $4.00 brand name drugs	• $4.30 brand name drugs

Extra Help Partial Subsidy Information

Cost Type	~~2021~~	2022	2023
Premium	~~Sliding scale premiums~~	Sliding scale premiums	Sliding scale premiums
Annual Deductible	~~$92~~	$99	$104
Coinsurance Costs	~~15%~~	15%	15%
Coverage Gap Costs	~~None~~	None	None
Copayments	• ~~$3.70 generic drugs~~ • ~~$9.20 brand name drugs~~	• $3.95 generic drugs • $9.85 name brand drugs	• $4.15 generic drugs • $10.35 brand-name drugs

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O. Appendix F

Appendix F

Standards and Guidelines

This appendix provides figures used to determine eligibility for a person, or in a specific calculation completed to determine eligibility.

Community Spouse Allowances

The Community Spouse Allowances are used when determining the long-term care (LTC) income calculation's community spouse allocation.

Basic Shelter Allowance

The Basic Shelter Allowance is used to determine if the community spouse has any excess shelter expenses.

Effective Dates	Basic Shelter Allowance
July 1, 2022 to June 30, 2023	$687
July 1, 2021 to June 30, 2022	$653

Maximum Monthly Income Allowance

The Maximum Monthly Income Allowance, along with the Minimum Monthly Income Allowance, is used to determine the community spouse's monthly maintenance needs amount.

Effective Dates	Maximum Monthly Income Allowance
January 1, 2023 to December 31, 2023	$3,715.50
January 1, 2022 to December 31, 2022	$3,435
~~January 1, 2021 to December 31, 2021~~	~~$3,259.50~~

Minimum Monthly Income Allowance

The Minimum Monthly Income Allowance, along with the Maximum Monthly Income Allowance, is used to determine the community spouse's monthly maintenance needs amount.

Effective Dates	Minimum Monthly Income Allowance
July 1, 2022 to June 30, 2023	$2,289
July 1, 2021 to June 30, 2022	$2,178

Utility Allowance

The Utility Allowance is allowed as a shelter expense if the community spouse is responsible for heating or cooling costs.

Effective Dates	Utility Allowance
October 1, 2022 to September 30, 2023	$586
October 1, 2021 to September 30, 2022	$488

The Electricity and Telephone Allowances are allowed as shelter expenses if the community spouse is not responsible for heating or cooling expenses, but is responsible for electricity or telephone expenses.

Effective Dates	Electricity Allowance
October 1, 2022 to September 30, 2023	$185
October 1, 2021 to September 30, 2022	$149

Effective Dates	Telephone Allowance
October 1, 2022 to September 30, 2022	$55
October 1, 2021 to September 30, 2022	$56

Federal Poverty Guidelines

The federal poverty guidelines (FPG) are used to determine income eligibility for the Minnesota Health Care Programs (MHCP).

Refer to Insurance and Affordability Programs (IAPs) Income and Asset Guidelines (DHS-3461A) for the current FPG.

Home Equity Limit

The Home Equity Limit is applied only in specific situations and at certain times.

Effective Dates	Home Equity Limit
January 1, 2023 to December 31, 2023	$688,000
January 1, 2022 to December 31, 2022	$636,000
~~January 1, 2021 to December 31, 2021~~	~~$603,000~~

IRS Mileage Rate

The IRS mileage rate is used in many calculations to determine eligibility or reimbursement costs.

Effective Dates	IRS Mileage Rate
July 1, 2022 to December 31. 2022	62.5 cents
January 1, 2022 to December 31, 2022	58.5 cents

Long-Term Needs Allowances

The LTC needs allowances provide figures for needs allowances used in the LTC income calculation and for determining the community spouse or family allocation amounts.

Clothing and Personal Needs Allowance

The Clothing and Personal Needs Allowance is used when the enrollee is not eligible for any of the other LTC needs allowances.

Effective Dates	Clothing and Personal Needs Allowance
January 1, 2023 to December 31, 2023	$121
January 1, 2022 to December 31, 2022	$111
~~January 1, 2021 to December 31, 2021~~	~~$105~~

Home Maintenance Allowance

The Home Maintenance Allowance can be deducted from a person's LTC income calculation if certain conditions are met.

Effective Dates	Home Maintenance Allowance
July 1, 2022 to June 30, 2023	$1,133
July 1, 2021 to June 30, 2022	$1,074

Special Income Standard for Elderly Waiver Maintenance Needs Allowance

The Special Income Standard for Elderly Waiver (SIS-EW) maintenance needs allowance is used in the LTC income calculation for persons who have income at or below the Special Income Standard (SIS).

Effective Dates	Maintenance Needs Allowance
July 1, 2022 to June 30, 2023	$1,152
July 1, 2021 to June 30, 2022	$1,059

Maximum Asset Allowance

The Maximum Asset Allowance is used for the community spouse asset allowance for an asset assessment.

Effective Dates	Minimum	Maximum
January 1, 2023 to December 31, 2023	No minimum	$148,620
January 1, 2022 to December 31, 2022	No minimum	$137,400
~~January 1, 2021 to December 31, 2021~~	~~No minimum~~	~~$130,380~~

MinnesotaCare Premium Amounts

MinnesotaCare premiums are calculated using a sliding fee scale based on household size and annual income.

Refer to MinnesotaCare Premium Estimator Table (DHS-4139) for information about MinnesotaCare premiums. The table provides an estimate of the premium before receiving the actual bill. The premium calculated by the system and listed on the bill is the official calculation and the amount to be paid.

Pickle Disregard

The Pickle Disregard is a disregard of the Retirement, Survivors and Disability Insurance (RSDI) cost of living adjustment (COLA) amounts for Medical Assistance (MA) Method B and the Medicare Savings Programs (MSP).

Effective Date	Pickle Disregard
January 1, 2023 to December 31, 2023	1.087
January 1, 2022 to December 31, 2022	1.059
~~January 1, 2021 to December 31, 2021~~	~~1.013~~

Remedial Care Expense

The Remedial Care Expense deduction amount can be used as a health care expense when meeting a spenddown or as an income deduction in an LTC income calculation.

Effective Dates	Remedial Care Expense
January 1, 2023 to June 30, 2023	$244
July 1, 2022 to December 31, 2022	$234
~~January 1, 2022 to June 30, 2022~~	~~$195~~

Roomer and Boarder Standard Amount

The Roomer and Boarder Standard income is used in calculating the amount of self-employment income a person who rents or boards another person has to add to the MA Method A income calculation.

Roomer and Boarder Standard	Amount
Roomer Amount	$71
Boarder Amount	$155
Roomer plus Boarder Amount	$226

Special Income Standard

The Special Income Standard (SIS) is used to determine certain criteria for the Elderly Waiver (EW) Program.

Effective Dates	SIS
January 1, 2023 to December 31, 2023	$2,742
January 1, 2022 to December 31, 2022	$2,523
~~January 1, 2021 to December 31, 2021~~	~~$2,382~~

Statewide Average Payment for Skilled Nursing Facility Care

The statewide average payment for skilled nursing facility (SAPSNF) care amount is used to determine a transfer penalty for MA. The SAPSNF is updated annually in July.

Effective Dates	SAPSNF
July 1, 2022 to June 30, 2023	$9,312
July 1, 2021 to June 30, 2022	$8,781

Student Earned Income Exclusion

The Student Earned Income Exclusion is a disregard of earned income for people who are under age 22 and regularly attending school. It is only available for MA Method B and MSP.

Effective Date	Monthly	Annual
January 1, 2023 to December 31, 2023	$2,220	$8,950
January 1, 2022 to December 31, 2022	$2,040	$8,230
~~January 1, 2021 to December 31, 2021~~	~~$1,930~~	~~$7,770~~

Supplemental Security Income Maximum Payment Amount

These figures are the maximum benefit amounts for people eligible for Supplemental Security Income (SSI). A person's SSI benefit amount is based on the income of the person and certain responsible household members.

SSI benefit payments may be deducted from the LTC income calculation if the person qualifies for the Special SSI Deduction.

Effective Date	Individual
January 1, 2023 to December 31, 2023	$914
January 1, 2022 to December 31, 2022	$841
~~January 1, 2021 to December 31, 2021~~	~~$794~~

Effective Date	Couple
January 1, 2023 to December 31, 2023	$1,371
January 1, 2022 to December 31, 2022	$1,261
~~January 1, 2021 to December 31, 2021~~	~~$1,191~~

Tax Filing Income Threshold For Children and Tax Dependents

The tax filing income threshold refers to the income level at which a person must file a federal income tax return. The thresholds for tax dependents determines whether a child's or tax dependents income is counted or excluded when calculating household income for MA-FCA and MinnesotaCare eligibility.

The income threshold for tax filing varies based on the tax dependents age and marital status and whether the person is blind. If a child or tax dependent has income at or below these thresholds, his or her income will not count toward the household income for MA-FCA and MinnesotaCare eligibility.

The income threshold applies to the taxable income that a child or tax dependent is expected to receive in the tax year. Nontaxable income, such as Supplemental Security Income (SSI) and veteran's benefits, is not included in determining whether a child's or tax dependent's income is at or below the income threshold. Any nontaxable portion of a child's Social Security dependent or survivor benefits is not included.

The income thresholds for children and tax dependents are:

Tax Filing Income Thresholds for Tax Dependents

Marital Status	**Age over 65?**	**Blind?**	**Income Type**	~~**2020 Tax Year Threshold Amount**~~	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
Single	No	No	Earned Income	~~$12,200~~	$12,400	$12,950
Single	No	No	Unearned Income	~~$1,100~~	$1,100	$1,150
Single	No	No	Gross Income	~~Larger of $1,100 or Earned Income Reported up to $11,850 + $350~~	Larger of $1,100 or Earned Income Reported up to $12,050 + $350	Larger of $1,150 or Earned Income Reported up to $12,550 + $400
Single	Yes	No	Earned Income	~~$13,850~~	$14,050	$14,700
Single	Yes	No	Unearned Income	~~$2,750~~	$2,750	$2,900
Single	Yes	No	Gross Income	~~Larger of $2,750 or Earned Income Reported up to $11,850 + $2,000~~	Larger of $2,750 or Earned Income Reported up to $12,050 + $2,000	Larger of $2,900 or Earned Income Reported up to $12,550 + $2,150
Single	No	Yes	Earned Income	~~$13,850~~	$14,050	$14,700
Single	No	Yes	Unearned Income	~~$2,750~~	$2,750	$2,900
Single	No	Yes	Gross Income	~~Larger of $2,750 or Earned Income Reported up to $11,850 + $2,000~~	Larger of $2,750 or Earned Income Reported up to $12,050 + $2000	Larger of $2,900 or Earned Income Reported up to $12,550 + $2,150

Marital Status	**Age over 65?**	**Blind?**	**Income Type**	~~**2020 Tax Year Threshold Amount**~~	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
Single	Yes	Yes	Earned Income	~~$15,500~~	$15,700	$16,450
Single	Yes	Yes	Unearned Income	~~$4,400~~	$4,400	$4,650
Single	Yes	Yes	Gross Income	~~Larger of $4,400 or Earned Income Reported up to $11,850 + $3,650~~	Larger of $4,400 or Earned Income Reported up to $12,050 + $3,650	Larger of $4,650 or Earned Income Reported up to $12,550 + $3,900
Married	No	No	Earned Income	~~$12,200~~	$12,400	$12,950
Married	No	No	Unearned Income	~~$1,100~~	$1,100	$1,150
Married	No	No	Gross Income	~~Larger of $1,100 or Earned Income Reported up to $11,850 + $350~~	Larger of $1,100 or Earned Income Reported up to $12,050 + $350	Larger of $1,150 or Earned Income Reported up to $12,550 + $400
Married	Yes	No	Earned Income	~~$13,500~~	$13,700	$14,350
Married	Yes	No	Unearned Income	~~$2,400~~	$2,400	$2,550
Married	Yes	No	Gross Income	~~Larger of $2,400 or Earned Income Reported up to $11,850 + $1,650~~	Larger of $2,400 or Earned Income Reported up to $12,050 + $1,650	Larger of $2,550 or Earned Income Reported up to $12,550 + $1,800

Marital Status	**Age over 65?**	**Blind?**	**Income Type**	~~**2020 Tax Year Threshold Amount**~~	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
Married	No	Yes	Earned Income	~~$13,500~~	$13,700	$14,350
Married	No	Yes	Unearned Income	~~$2,400~~	$2,400	$2,550
Married	No	Yes	Gross Income	~~Larger of $2,400 or Earned Income Reported up to $11,850 + $1,650~~	Larger of $2,400 or Earned Income Reported up to $12,050 + $1,650	Larger of $2,550 or Earned Income Reported up to $12,550 + $1,800
Married	Yes	Yes	Earned Income	~~$14,800~~	$15,000	$15,750
Married	Yes	Yes	Unearned Income	~~$3,700~~	$3,700	$3,950
Married	Yes	Yes	Gross Income	~~Larger of $3,700 or Earned Income Reported up to $11,850 + $2,950~~	Larger of $3,700 or Earned Income Reported up to $12,050 + $2,950	Larger of $3,950 or Earned Income Reported up to $12,550 + $3,200

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