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 #23.3

June 1, 2023

Manual Letter #23.3

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of June 1, 2023. 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.

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 recently published bulletins. We also added this manual letter.

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

We added information on when to use the DHS-6696A and DHS-6696B when an enrollee needs to be determined for a new basis of eligibility at or between renewals.

C. Section 1.2.4 MHCP Processing Period

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

D. Section 1.3.2.1 MHCP Change in Circumstances

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

E. Section 1.7.2 MHCP Direct Reimbursement of Medicare Premiums

We added this section to clarify when MA enrollees are eligible for direct reimbursement of their Medicare Part A and/or Part B premiums.

F. Section 2.1.4.1 Medical Assistance (MA) Begin and End Dates

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

G. Section 2.1.4.3 MA Renewals

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

H. Section 2.2.2.1 Medical Assistance for Families, Children and Adults (MA-FCA) Bases of Eligibility

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

I. Section 2.2.4.2 MA-FCA Renewals

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

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

We added clarification to the policy when verification is received after a denial.

K. Section 2.3.2.1 MA-ABD Bases of Eligibility

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

L. Section 2.3.2.2 MA-ABD Certification of Disability

We added clarification for the Developmentally Disabled (DD) waiver.

M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trust

WE incorporated information from Bulletin #21-21-09 DHS Explains Changes to the Evaluation of Transfers to Pooled Trusts for MA-LTC and AC.

N. Section 2.3.3.4.2 MA-ABD Health Care Expenses

We clarified expenses for LTC considered non-reimbursable health care expenses when a person in ineligible due to a transfer penalty.

O. Section 2.3.4.2 MA-ABD Renewals

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

P. Section 2.3.5.2 MA-ABD Non-Financial Eligibility

We added a link to the new MA-EPD Bases of Eligibility section.

Q. Section 2.3.5.2.1 MA-EPD Bases of Eligibility

We consolidated MA-EPD bases of eligibility policy into this section.

R. Section 2.3.5.2.2 MA-EPD Living Arrangement

We changed the section number from 2.3.5.2.1 to 2.3.5.2.2.

S. Section 2.3.5.3.1 MA-EPD Assets

We moved the MA-EPD bases of eligibility policy from this section into the new MA-EPD Bases of Eligibility section 2.3.5.2.1.

T. Section 2.3.5.4.1 MA-EPD Medicare

We added clarification of what criteria the enrollee needs to meet to have their Medicare Part B premiums reimbursed for MA-EPD.

U. Section 2.4.1 Medical Assistance for Long-Term Care Services (MA-LTC) Eligibility Requirements

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

V. Section 2.4.1.3.2 MA-LTC Transfer Penalty

We added clarification for when a person is MA eligible during a transfer penalty and how to calculate income during the period of ineligibility.

W. Section 2.4.1.4.2 MA-LTC Naming DHS a Preferred Remainder Beneficiary

We added clarification for when a person is MA eligible during a transfer penalty and how to calculate income during the period of ineligibility.

X. Section 2.4.2.5 MA-LTC Income Calculations for Long-Term Care Services

We clarify which policy does not apply during full months of MA-LTC ineligibility.

Y. Section 2.5.1.4.2 Medical Assistance with Breast or Cervical Cancer (MA-BC) Renewals

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

Z. Section 2.5.2.4.2 Medical Assistance for People Receiving Services at the Center for Victims of Torture (MA-CVT) Renewals

We incorporated information from Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure.

AA. Section 3.2.3.2 MinnesotaCare Employer-Sponsored Coverage

We incorporated information from Bulletin #23-21-02 DHS Announces Changes to the MinnesotaCare Employer Sponsored Coverage Affordability Test

BB. Appendix F

The following standards and guidelines are updated in Appendix F and become effective July 1, 2023:

- Basic Shelter Allowance
- Minimum Monthly Income Allowance
- Home Maintenance Allowance
- Special Income Standard for Elderly Waiver Maintenance Needs Allowance
- Remedial Care Expense
- Statewide Average Payment for Skilled Nursing Facility Care

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 1.2.4 MHCP Processing Period

D. Section 1.3.2.1 MHCP Change in Circumstances

E. Section 1.7.2 MHCP Direct Reimbursement of Medicare Premiums

F. Section 2.1.4.1 MA Begin and End Dates

G. Section 2.1.4.3 MA Renewals

H. Section 2.2.2.1 MA-FCA Bases of Eligibility

I. Section 2.2.4.2 MA-FCA Renewals

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

K. Section 2.3.2.1 MA-ABD Bases of Eligibility

L. Section 2.3.2.2 MA-ABD Certification of Disability

M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trust

N. Section 2.3.3.4.2 MA-ABD Health Care Expenses

O. Section 2.3.4.2 MA-ABD Renewals

P. Section 2.3.5.2 MA-ABD Non-Financial Eligibility

Q. Section 2.3.5.2.1 MA-EPD Bases of Eligibility

R. Section 2.3.5.2.2 MA-EPD Living Arrangement

S. Section 2.3.5.3.1 MA-EPD Assets

T. Section 2.3.5.4.1 MA-EPD Medicare

U. Section 2.4.1 MA-LTC Eligibility Requirements

V. Section 2.4.1.3.2 MA-LTC Transfer Penalty

W. Section 2.4.1.4.2 MA-LTC Naming DHS a Preferred Remainder Beneficiary

X. Section 2.4.2.5 MA-LTC Income Calculations for Long-Term Care Services

Y. Section 2.5.1.4.2 MA-BC Renewals

Z. Section 2.5.2.4.2 MA-CVT Renewals

AA. Section 3.2.3.2 MinnesotaCare Employer Sponsored Coverage

BB. Appendix F

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

After June 1, 2023, policy clarifications and additions will be announced through an email subscription. Anyone can subscribe to receive the updates by adding their email to the subscription list. DHS is discontinuing the use of manual letters to announce policy clarifications and additions.

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. It does not provide procedural instructions or system information. Minnesota Health Care Programs policies are based on the state and federal laws and regulations that govern the programs. See the 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 #23.3, June 1, 2023

MHCP EPM Manual Letter #23.2, March 1, 2023

MHCP EPM Manual Letter #23.1, January 1, 2023

2022

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

- ~~Bulletin #23-21-02 DHS Announces Changes to the MinnesotaCare Employer Sponsored Coverage Affordability Test~~
- Bulletin #23-21-03 DHS Changes Evaluation Process for Long-Term Care Partnership Policies for Medical Assistance for Long-Term Care Services
- Bulletin #23-21-04 DHS Clarifies Afghan Humanitarian Parolees' Eligibility for Public Programs and Services
- Bulletin #23-21-06 DHS Ends the Medical Assistance for COVID-19 Testing of Uninsured Individuals Coverage Group
- Bulletin #23-21-07 DHS Clarifies MA Eligibility Policy and Coverage Suspension for People who are Incarcerated
- Bulletin #23-21-08 DHS Announces Key MHCP Eligibility Policies during the Unwinding Period
- Bulletin #23-21-09 DHS Announces the Resumption of Minnesota Health Care Programs Annual Eligibility Renewals
- Bulletin #23-21-10 DHS Announces New Minnesota Health Care Programs Renewal Form for Families, Children and Adults
- Bulletin #23-21-11 Updates to Cost-Effective Health Insurance for Medical Assistance
- Bulletin #23-21-12 DHS Cancels Unpaid MinnesotaCare Premiums and Temporarily Waives Premiums for all Enrollees
- Bulletin #23-21-13 DHS Clarifies Medical Assistance Eligibility Policy for when a Disability Certification Ends
- Bulletin #23-21-14 DHS Explains Transition from COVID-19 Temporary MA-EPD Policies to Standard MA-EPD Policies
- Bulletin #23-21-15 DHS Revises the MHCP Application, Renewal and Supplement Forms for Certain Populations
- Bulletin #23-21-16 DHS Clarifies Requirement to Redetermine Medical Assistance Eligibility Under All Bases Before Closure
- Bulletin #23-21-18 DHS Announces a Simplified Renewal Process for Certain MA-ABD Enrollees

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

- Bulletin #20-21-02, DHS Announces Temporary Policy Changes to Minnesota Health Care Programs During the COVID-19 Peacetime Emergency

- Bulletin #20-21-03, DHS Announces Medical Assistance for COVID-19 Testing of Uninsured Individuals x Bulletin #20-21-04, DHS Explains Treatment of Federal Coronavirus Aid, Relief, and Economic Security Act Payments for Minnesota Health Care Programs

- Bulletin #20-21-05, DHS Explains Treatment of Federal Pandemic Unemployment Compensation Payments for Minnesota Health Care Programs

- Bulletin #20-21-06, DHS Explains Treatment of State, Local and Tribal COVID-19 Relief Payments for Minnesota Health Care Programs

- Bulletin #20-21-10, DHS Announces Updates to Temporary Policies for Minnesota Health Care Programs during the COVID-19 Public Health Emergency

- Bulletin #20-21-13, DHS Announces a Change to Processing PARIS Interstate Matches for MHCP Enrollees During the COVID-19 Public Health Emergency

- Bulletin #20-21-14, DHS Explains Treatment of Coronavirus Response Payments under the Consolidated Appropriations Act, 2021, for Minnesota Health Care Programs

- Bulletin #21-21-02, DHS Explains Treatment of 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

- Bulletin #22-21-11 DHS Announces Temporary Policy to Accept Minnesota Address updates on USPS Returned Mail for Minnesota Health Care Programs

- Bulletin #23-21-05 DHS Announces Temporary Policy to Accept Contact Information Updates from MCOs for MHCP
- Bulletin #23-21-08 DHS Announces Key MHCP Eligibility Policies during the Unwinding Period
- Bulletin #23-21-09 DHS Announces the Resumption of Minnesota Health Care Programs Annual Eligibility Renewals

- Bulletin #23-21-17 DHS Explains Handling Renewal-Related Returned Mail During the Unwinding Period

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, and
- ~~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.

EPM Subscription

To sign up for updates or to access your subscriber preferences, please enter your contact information below.

Email address

Submit

After you add your email to the distribution list, you will have the opportunity to select which sections of the EPM you want to be notified when an update occurs.

Published: ~~March~~ June 1, 2023

B. Section 1.2.1Minnesota Health Care Programs (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~~ METS or if further evaluation is needed to determine their eligibility for MA-ABD, long-term care services, or Medicare Savings Programs~~ eligibility~~. The MHCP Request for Information (DHS-3271) must accompany the DHS-6696A when an applicant needs a subsequent determination.

This supplement is form is also used to gather the information needed to redetermine eligibility for current MA-FCA enrollees who have a change in circumstances and no longer qualify for their current MA basis of eligibility at or between renewals, or who request a determination under an MA-ABD basis of eligibility. The MHCP Request for Information to Determine Eligibility for Certain Populations (DHS-8431) must accompany the DHS-6696A when an enrollee needs a new determination.

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~~for Certain Populations (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. The MHCP Request for Information (DHS-3271) must accompany the DHS-6696B when an applicant needs a subsequent determination.

This form is also used to gather the information needed to redetermine eligibility for enrollees who lose their basis of eligibility at or between renewals, or who request a determination for a different MA basis of eligibility or program. The MHCP Request for Information to Determine Eligibility for Families with Children and Adults (DHS-8432) must accompany the DHS-6696B when an enrollee needs a new 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 for Health Coverage and Help Paying Costs Signature Page (DHS-6696C)

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

Request to Apply for MHCP (DHS-3417B)

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

Legal Citations

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 45, section 155.405

Code of Federal Regulations, title 45, section 155.310

Minnesota Statutes, section 256B.04

Minnesota Statutes, section 256B.08

Published: ~~December~~ June 1, 2023 ~~2022~~
Previous Version:
Manual Letter #22.5, December 1, 2022

C. Section 1.2.4 MHCP Processing Period

Minnesota Health Care Programs

1.2.4 Processing Period

Minnesota Health Care Programs (MHCP) Applications

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

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

The agency generally must process an application, obtain all pre-eligibility verifications, make a determination, and send an approval or denial notice within the processing period. The processing period cannot be used as a waiting period for people requesting health care or extended to provide agencies with additional time for processing. The processing period does not impact the time permitted for an applicant to provide requested information or paper documentation. Processing periods must be extended when the applicant is cooperating with providing information or documentation needed to process the application.

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

MHCP Supplements for Enrollees

An MHCP supplemental form is required to gather additional information to determine eligibility under a different MA basis or other Minnesota health care program.

The MHCP supplemental form must be processed by the county or tribal agency as soon as possible and within the following number of days from the date received:

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

See EPM section 1.2.1 MHCP Application Forms policy for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.911

Code of Federal Regulations, title 42, section 435.912

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 45, section 155.310

Minnesota Rule, part 9505.0090

Minnesota Statutes, section 256L.05

Minnesota Statutes, section 256B.08

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Previous Versions
Manual Letter #22.2, March 1, 2022

D. Section 1.3.2.1 MHCP Change in Circumstances

Minnesota Health Care Programs

1.3.2.1 Change in Circumstances

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

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

Reporting Changes

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

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

Inconsistent Information

Changes are discovered in other ways, such as:

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

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

Reporting Deadline

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

Eligibility Redetermination

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

Medical Assistance

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

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

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

When an MA enrollee reports a change in circumstance that results in the loss of their current MA basis of eligibility, they must be redetermined under all MA bases they are potentially eligible for, without interruption in their coverage. If an enrollee is no longer eligible for MA under any basis, eligibility must be redetermined for

- MinnesotaCare
- Advance Premium Tax Credits
- Qualified Health Plan

The agency must send the relevant MHCP supplemental form (DHS-6696A or DHS-6696B) to the enrollee when additional information is required to determine eligibility under another MA basis or a different health care program. See the MHCP Application Forms policy for more information.

When additional information is required to determine eligibility under another basis:

- The enrollee must remain eligible under their current MA basis without interruption in their coverage until the eligibility redetermination is complete.
- The enrollee has 35 days to provide the relevant supplemental form and an additional 35 days to provide requested proofs.

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

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

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

MinnesotaCare

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

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

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

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

Medicare Savings Programs

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

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

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

Exceptions

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

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

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 42, section 435.1200

Code of Federal Regulations, title 42, section 457.350

Code of Federal Regulations, title 45, section 155.330

Minnesota Rules, part 9505.0115, subpart 1

Minnesota Statutes 256B.057

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Manual Letter #20.4, December 1, 2020

E. Section 1.7.2 MHCP Direct Reimbursement of Medicare Premiums

Minnesota Health Care Programs

1.7.2 Direct Reimbursement of Medicare Premiums

Certain Medical Assistance (MA) enrollees are eligible for direct reimbursement of their Medicare Part A and/or Part B premiums. The county or tribal agency reimburses the enrollee for their Medicare premium to ensure that Medicare benefits are not interrupted. See 1.7.1 Medicare Buy-In for more information about the Medicare Buy-In.

Medical Assistance for Employed Persons with Disabilities (MA-EPD)

Medical Assistance for Employed Persons with Disabilities (MA-EPD) enrollees may be eligible for direct reimbursement of their Part B premiums. Reimbursement is effective the date of MA-EPD eligibility for enrollees who meet both of the following: have income at or below 200% FPG and are not eligible for the Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) programs. See EPM 2.3.5.4.1 MA-EPD Medicare for more information.

People Residing in an Institution for Mental Diseases (IMD)

Certain individuals are eligible for direct reimbursement of their Medicare Part A and/or Part B premiums from the agency:

- MA enrollees who are enrolled in an MSP and lose that coverage due to residing in an Institution for Mental Disease (IMD), or
- MA applicants who would be eligible for an MSP if they did not reside in an IMD.

See EPM 2.5.4.4.1 Program IM Medicare for more information.

If an enrollee meets the requirements above, the enrollee must be reimbursed the full Medicare Part A and/or Part B premium amount for any month(s) they are eligible for the reimbursement. There is no time limit for the processing of an agency reimbursement for such premiums.

The Late Request for Medicare Reimbursement (DHS-3918) form is used to request reimbursement of the Medicare Part A and/or Part B premium paid to the enrollee from the Department of Human Services if it is submitted 12 months or more after the Medicare Part A and/or Part B premium was paid.

Legal Citations

Minnesota Statutes, section 256B.057

Minnesota Rules, part 9505.0430

Published: June 1, 2023

F. Section 2.1.4.1 Medical Assistance (MA) Begin and End Dates

Medical Assistance

2.1.4.1 Begin and End Dates

Overview

Medical Assistance (MA) eligibility and coverage are separate concepts:

- Eligibility refers to when a person meets the MA eligibility rules.
- Coverage refers to when a person can receive MA benefits.

MA begin and end date policy also applies to Medicare Savings Programs (MSP) and the Minnesota Family Planning Program (MFPP).

Generally, MA eligibility and coverage begin and end dates are the same. However, there are situations where eligibility and coverage do not begin or end on the same day. Differences are explained on the policy pages for the types of MA listed below. The eligibility and coverage begin and end dates may not be the same in the following situations:

- Medical Assistance for Employed Persons with Disabilities (MA-EPD)
- MA with a medical spenddown for families and children
- MA with a spenddown for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD)
- Hospital Presumptive Eligibility (HPE) for MA for Families with Children and Adults (MA-FCA)
- Emergency Medical Assistance (EMA)
- MA for women with Breast or Cervical Cancer presumptive eligibility
- Minnesota Family Planning Program (MFPP) presumptive eligibility
- The coverage and eligibility end date exceptions described below

When an MA enrollee received coverage for a month they were not eligible for MA, an overpayment may exist. See the MHCP Overpayment policy for more information.

Eligibility Begin Date

MA eligibility begins the first day of the month that a person meets the program eligibility rules. It can begin no earlier than the first day of the month of application, if a person does not request retroactive coverage or is not eligible for retroactive coverage. Retroactive coverage can begin no earlier than the first day of the month, three months before the month of application. People must meet all eligibility requirements in each retroactive month to have coverage in that month, and people may be eligible for some but not all months prior to the month of application.

If a request for an eligibility determination does not require a new application, the month the request for coverage is received is the application month.

When an enrollee is eligible under a new basis, eligibility begins the first day of the month the required supplemental form is submitted. See EPM section 1.3.2.1 Change in Circumstance for more information.

Generally, people who meet all eligibility requirements at any time during a month are eligible for the entire month. The exceptions are:

- When a person is born, eligibility can begin no earlier than the date the person was born.
- When a person moves to Minnesota, eligibility can begin no earlier than the date the person became a Minnesota resident.
- When a person is approved for a spenddown, eligibility begins the date the person meets their spenddown.

Coverage Begin Date

MA coverage begins the same date MA eligibility begins.

Eligibility End Date

When an MA enrollee reports a change in circumstances that results in the loss of MA eligibility, the MA eligibility generally ends on the last day of the month in which the change occurred. The exceptions are:

- When an MA enrollee dies, eligibility ends the date the person died.
- When the change occurred too late in the month to send a 10-day advance notice, MA eligibility ends the last day of the month following the month in which the change occurred.
- When an MA enrollee reports a change in circumstance that maintains MA eligibility but results in a beneficial or adverse action, the existing MA eligibility ends the day before the new eligibility begins.
- Eligibility ends, with a 10 day advance notice, if the enrollee fails to provide the requested supplemental form and any additional information required to complete a redetermination for all possible programs within the required time frame. See EPM section 1.3.2.1 Change in Circumstances for more information.

Coverage End Date

MA coverage ends if an MA enrollee no longer meets the eligibility requirements or becomes incarcerated.

Coverage End Date due to Ineligibility

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

Coverage End Date due to Change in Basis

When a MA enrollee is eligible under a new basis, coverage under the current basis ends the last day of the month, prior to the start of eligibility under the new basis.

When a MA enrollee fails to provide the requested supplemental form and any additional information required to complete a redetermination, coverage ends the last day of the month for which advance notice can be given. See EPM section 1.3.2.1 Change in Circumstances for more information.

Coverage End Date due to Incarceration

When a MA enrollee is incarcerated in a state prison, county detention facility, or city jail the enrollee must report the incarceration. MA coverage ends the date of incarceration.

Legal Citations

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 435.907

Code of Federal Regulations, title 42, section 435.915

Code of Federal Regulations, title 42, section 435.916

Minnesota Rules, part 9505.0110

Minnesota Rules, part 9505.0015, subpart 5

Minnesota Rules, part 9505.0085

Minnesota Statutes, section 256B.04

Minnesota Statutes, section 256B.08

Minnesota Statute 256B.056, subd.7

Minnesota Statute 256B.061

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Previous Versions

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

G. Section 2.1.4.3 MA Renewals

Medical Assistance

2.1.4.3 Renewals

Medical Assistance (MA) enrollees must have eligibility renewed every six or 12 months. Renewing eligibility means redetermining eligibility. Most MA enrollees have an annual renewal. Some MA enrollees have a six-month renewal. Some MA enrollees are exempt from the renewal requirement.

The types of MA that have specific renewal policies are:

- MA for Families with Children and Adults (MA-FCA) Renewals
- MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) Renewals, including MA for Employed Persons with Disabilities MA-EPD), MA under the TEFRA Option for children with disabilities, 1619 (a), 1619 (b), and Medicare Savings Programs (MSP)
- Children receiving Title IV-E or non-Title IV-E Foster Care, Kinship Assistance, or Adoption Assistance
- MA for women with Breast or Cervical Cancer (MA-BC) Renewals
- MA for people receiving services at the Center for Victims of Torture (MA-CVT) Renewals

Exempt from Renewal

The types of MA that are exempt from health care renewals, unless specified, are:

- Auto newborns have eligibility renewed the month following the month of their first birthday
- ~~Children receiving Title IV-E or non-Title IV-E Adoption Assistance~~
- ~~Children receiving Title IV-E Foster Care or Title IV-E Kinship Assistance~~
- People enrolled in Refugee Medical Assistance (RMA)
- People enrolled in Transitional MA (TMA) or Transition Year MA (TYMA), unless a scheduled renewal is due when TMA or TYMA is ending
- ~~People receiving Minnesota Supplemental Aid (MSA) must renew their MSA benefit, but not their automatic MA~~
- Pregnant people have eligibility renewed the month following the month the 12 month postpartum ends

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.056, subdivision 7a

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Previous Versions

Manual Letter #22.4, September 1, 2022

H. Section 2.2.2.1 MA-FCA Bases of Eligibility

Medical Assistance for Families with Children and Adults

2.2.2.1 Bases of Eligibility

Minnesota provides Medical Assistance (MA) to certain groups of people as allowed under law. These groups are referred to as a basis of eligibility. A person's basis of eligibility determines the non-financial criteria and financial methodology used to determine MA eligibility.

The following are the bases of eligibility for MA for Families with Children and Adults (MA-FCA):

- Parent:
  - Biological, natural, adoptive or step parent
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
- Caretaker Relative, including foster parents, legal guardians or others, who are:
  - A relative of a child younger than age 19, by blood, adoption, or marriage. Including:
- First cousins, nephews, nieces, aunts or uncles and people of preceding generations as denoted by grand, great or great-great
- Stepfather, stepmother, stepbrother or stepsister
- Spouses and former spouses of the people named above
  - Living with a child younger than age 19
  - Has primary responsibility for the child's care
- Pregnant Woman:
  - A woman who is pregnant
  - A woman within the 12 Month post-partum period
- Auto Newborn: child born to a mother enrolled in MA
- Infant: child age 0 through 1
  - Children's Health Insurance Program (CHIP) funded MA may be available for infants with income between 275% and 283% FPG who are not enrolled in other health insurance.
  - A CHIP funded infant who has or gains other health insurance becomes eligible for MA as a non-CHIP funded infant
- Child age 2 through 18
- Child age 19 and 20
- Adult age 21 through 64 who:

- Is not eligible for or enrolled in Medicare Part A or Medicare Part B
- Is not a Supplemental Security Income (SSI) recipient
- Is not eligible for MA under 1619 a/b
- Is not a former SSI recipient who stopped receiving SSI when they began receiving Retirement, Survivor, Disability (RSDI) benefits from the Social Security Administration (SSA) under a deceased spouse or deceased or retired parent's earning record
- Is not eligible for MA under the parent, caretaker relative, pregnant woman or former foster care basis of eligibility

Adults not eligible for this basis may meet the eligibility requirements for MA for People Who Are Age 65 or Older or People Who Are Blind or Have a Disability.

- Former Foster Child:
  - Was in Title IV-E or Non-IV-E foster care on 18th birthday
  - Currently younger than age 26
  - Was enrolled in MA or MinnesotaCare when foster care ended
  - Is not eligible for MA under the parent, relative caretaker, pregnant woman or child age 19 and 20 basis of eligibility

Beginning and Ending Bases of Eligibility

A person must have one of the following bases of eligibility for MA-FCA. A person whose basis of eligibility ends must be evaluated for other MA bases of eligibility before MA is closed.

Applicants who meet eligibility requirements at any time within a month are eligible for the entire month with the following exceptions:

- A person's eligibility ends on the date of death
- A person's eligibility begins the date they become a Minnesota resident
- A person's eligibility begins the date they meet their spenddown requirement

The begin and end dates for the following bases of eligibility are:

- Pregnant woman:
  - Begins the first day of the month of conception
  - Ends the last day of the month following the 12 month postpartum period
  - Begin and end dates for the pregnant woman basis of eligibility are determined using information the application or enrollee attests. Verification of pregnancy is not required to establish this basis.
- Auto newborn:
  - Begins the first day of the month of birth

- Ends the last day of the month of their first birthday
- Infant:
- Begins the first day of the month of birth
- Ends the last day of the month of their second birthday
- Child age 2 through 18:
- Begins the first day of the month following their second birthday
- Ends the last day of the month of their 19th birthday
- Child age 19 and 20:
- Begins the first day of the month following their 19th birthday
- Ends the last day of the month of their 21st birthday
- Parent or caretaker relative:
- Begins the first day of the month of the birth or adoption of a child under the age of 19 or the first day of the first full month when a child younger than age of 19 moves into their home.
- Ends the last day of the month when:
- The only child or youngest child for whom the person is a parent or relative caretaker turns 19
- The only child, or all children who live in the home under the age 19, leave the home and the absence is not temporary
- The parent or caretaker relative no longer lives with a child younger than age 19
- Adults without children:
- Begins the first day of the month following their 21st birthday
- Ends the last day of the month prior to their 65th birthday
- Former foster child:
- Begins no earlier than the first day of the month after the month that Medicaid for Title IV-E foster care or Non-Title IV-E ends
- Ends the last day of the month following their 26th birthday

Multiple Bases of Eligibility

People may have more than one basis of eligibility. A person's countable income, asset limit, cost sharing, service delivery options and benefits may differ depending on the eligibility basis used. The county, tribal or state servicing agency must allow a person with multiple bases of eligibility to have eligibility determined under the basis that best meets their needs.

Change in Basis of Eligibility for Enrollees

A change in circumstances may affect an MA enrollee's basis of eligibility. People who lose eligibility under one basis must be redetermined under another basis without interruption in their coverage. Additional information may be required to determine continued eligibility under another basis. Some changes that may affect an enrollee's basis of eligibility include, but are not limited to:

- Age
    - An auto newborn basis of eligibility ends the last day of the month in which the child turns one
    - A child basis of eligibility ends the last day of the month of the child's 21st birthday
    - An adult without children basis of eligibility ends the month before the enrollee's 65th birthday
- Disability status
- Household Composition
- Medicare A or B. An adult without children basis of eligibility ends the month before the enrollee is eligible for or enrolled in Medicare A or B.
- Pregnancy. A pregnant basis of eligibility ends on the last day of the month in which the 12 month postpartum period ends.

If an enrollee is no longer eligible for MA under ~~any~~ their current basis of eligibility, they~~,~~ must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. ~~under another Minnesota Insurance Affordability Program.~~ See EPM section 1.3.2.1 Change in Circumstances for more information.

Legal Citations

Code of Federal Regulations, title 42, section 431.213

Code of Federal Regulations, title 42, section 435

Code of Federal Regulations, title 42, section 435.916

Code of Federal Regulations, title 42, section 457.1

Minnesota Statutes, section 256B.055, subdivision 6

Minnesota Statutes, section 256B.06, subdivision 4, 5 & 10

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Manual Letter #22.4, September 1, 2022

I. Section 2.2.4.2 MA-FCA Renewals

Medical Assistance for Families with Children and Adults

2.2.4.2 Renewals

Enrollees in Medical Assistance for Families with Children and Adults (MA-FCA) must have eligibility renewed every 12 months. ~~Renewing eligibility means redetermining eligibility.~~ The first annual renewal is 12 months from the month of application and renewals occur annually thereafter as long as the enrollee remains eligible for MA. Eligibility for retroactive coverage months do not affect when an enrollee's annual renewal occurs.

The agency must make a redetermination of MA-FCA eligibility without requiring information from the enrollee, if able to do so based on reliable information contained in the enrollee's case file and other information accessed through electronic data sources.

Enrollees in MA for Families and Children with a Medical Spenddown must complete an annual renewal and a six-month income renewal. See MA for Families with Children and Adults Medical Spenddown for more information.

Annual Renewal Month

The annual renewal month is the month in which eligibility is redetermined for the next 12 months. The first annual renewal month after application is 12 months from the month of application and occurs annually thereafter as long as the enrollee remains eligible for MA.

Consent to Use Federal Tax Information

Applicants have the option when completing the application to allow the use of income data from the Internal Revenue Service to renew eligibility. Applicants choose one of six options for authorizing automatic eligibility redeterminations:

- Five years
- Four years
- Three years
- Two years
- One year
- Do not use information from my tax returns to renew my coverage

When authorized by the applicant, eligibility is redetermined using information in the case file that can be verified through electronic data sources.

Automatically Renewed MA-FCA Enrollees

Enrollees who have their eligibility automatically renewed receive a notice that includes a summary of the information used to renew their eligibility. If all of the information is correct, the enrollee does not need to do anything. If any of the information is inaccurate, the enrollee must report any corrections or changes.

Renewal Form for MA-FCA Enrollees

Enrollees whose eligibility is not automatically renewed will receive a renewal form. Enrollees must review, make any changes or updates, sign and return the renewal form to their servicing agency within 30 days from the issuance date on the renewal notice.

Late Renewals

A late renewal is a renewal for which either of the following is true:

- the renewal form is received before the last day of the fourth month following closure
- any additional information or verifications that were required are received before the last day of the fourth month following closure

Eligibility for enrollees who do not return the renewal form, or who return the form but do not provide all the information and verifications needed to renew eligibility, is closed. However, eligibility for enrollees who are closed for failing to renew may be redetermined without requiring a new application if the form is returned within four months of the date of closure. A late renewal is a new application. All application policies apply.

When Eligibility Ends at Renewal

Changes reported during an enrollee's renewal may affect an MA enrollee's basis of eligibility. Enrollees who lose eligibility under one basis must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. See EPM 1.3.2.1 Change in Circumstance for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.056, subdivision 7a

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Manual Letter #19.3, June 1, 2019

J. Section 2.3.1.1 MA-ABD Mandatory Verifications

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

2.3.1.1 Mandatory Verifications

Mandatory verifications must be verified through an available electronic data source or by paper proof, if electronic data sources are unsuccessful or unavailable. Self-attestation of certain eligibility factors may be accepted if electronic data sources are unsuccessful or unavailable and paper proof does not exist or is not available.

Medical Assistance for People Who Are Age 65 or Older and People Who are Blind or Have a Disability (MA-ABD) has the following mandatory verifications.

Pre Eligibility Verification

The following eligibility factors must be verified prior to the eligibility determination:

- Assets
  - Verification of assets is required at application, renewal, and when a new asset is reported.
- At renewal, an excluded asset that was verified does not need to be verified again unless the asset has changed, to determine whether the change affects the exclusion
- An applicant or enrollee must verify assets even if the Account Validation Service (AVS) was requested.

    Assets that are counted for a person with an asset limit must be verified even if the asset belongs to a person who is not applying for Medical Assistance (MA) or does not have an asset limit.
  - Verification of the following assets ~~are~~ is not required at application or renewal:
- Homestead, if it qualifies for the exclusion. Refer to Section 2.3.3.2.7.4.1 MA-ABD Homestead Real Property for more information.
- Vehicle, if only one is reported. Refer to Section 2.3.3.2.7.7 MA-ABD Automobiles and Other Vehicles Used for Transportation for more information.
- Household goods and personal effects
- Certification of Disability through Social Security Administration (SSA) or State Medical Review Team (SMRT) for people claiming a blind or disabled basis of eligibility
- Income

- If a person is receiving Supplemental Security Income (SSI), only the SSI income is verified. Eligibility for SSI is accepted as verification of other income SSA considers in determining eligibility.

- Note: Veteran's Administration (VA) Aid and Attendance benefits and VA unusual medical expense payments must be verified even if the person is receiving SSI.

- Medical expenses to meet a spenddown

Post Eligibility Verification

If the following factors cannot be verified at application, they can be verified after eligibility has been approved so long as the applicant meets all other eligibility requirements. If proof is not provided by the conclusion of the reasonable opportunity period (ROP), eligibility may end.

- Social Security Number: See 2.1.2.5 MA Social Security Number
- Citizenship: See 2.1.2.2.1 MA Citizenship
- Immigration status: See 2.1.2.2.2 MA Immigration Status

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

Verification Received After Denial

When an applicant's MA eligibility is denied and the applicant provides a required verification after the 10-day deadline indicated on the denial notice, the submission is considered a new request to apply that sets a new date of application. See 1.2.3 MHCP Date of Application for more information.

When a former enrollee provides a requested verification after the effective date of closure, the submission is considered a new request to apply that sets a new date of application. A new application must be completed to reapply, unless the proof is received within the four-months following closure for failure to complete a renewal. See 2.3.4.2 MA-ABD Renewals for more information.

Standard application and begin date policies and procedures apply based on the date the agency received the proof. See 2.1.4.1 MA Begin and End Dates for the more information.

Self-Attestation

Self-attestation, either verbal or in writing, of the following eligibility factors may be accepted if electronic data sources are unsuccessful or unavailable and paper proof does not exist or is not available:

- Income
- Assets
- Medical expenses to meet a spenddown

- Certification of Disability through Social Security Administration (SSA)
- Exceptions to having a Social Security Number.

Paper proof is considered not available if neither the applicant or enrollee, nor the agency can obtain it. The county, tribal and state servicing agency must make efforts to assist the applicant or enrollee in obtaining the requested paper proof, if it exists. This includes obtaining authorization from the applicant or enrollee to contact a third party on their behalf, if appropriate. Decisions to accept an applicant's or enrollee's self-attestation must be based on the individual case circumstances.

Self-attestation cannot be accepted in place ~~lieu~~ of electronic verification or paper documentation of an applicant or enrollee's citizenship, immigration status, or social security number.

Legal Citations

Code of Federal Regulations, title 42, section 435.407

Code of Federal Regulations, title 42, section 435.541

Code of Federal Regulations, title 42, section 435.920

Code of Federal Regulations, title 42, section 435.945

Code of Federal Regulations, title 42, section 435.948

Code of Federal Regulations, title 42, section 435.949

Code of Federal Regulations, title 42, section 435.952

Code of Federal Regulations, title 42, section 435.956

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K. Section 2.3.2.1 MA-ABD Bases of Eligibility

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

2.3.2.1 Bases of Eligibility

Minnesota provides Medical Assistance (MA) to certain groups of people as allowed under law. These groups are referred to as a basis of eligibility. A person's basis of eligibility determines the non-financial criteria and financial methodology used to determine MA eligibility.

The bases of eligibility for Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) are:

- People age 65 or older
- People certified blind
- People certified disabled

Multiple Bases of Eligibility

People may have more than one basis of eligibility. A person's countable income, asset limits, cost sharing, service delivery options and benefits may differ depending on the eligibility basis used. The county, tribal or state servicing agency must allow a person with multiple bases of eligibility to have eligibility determined under the basis that best meets their needs.

Beginning and Ending Bases of Eligibility

When an enrollee's basis of eligibility ends, they must be evaluated for other MA bases of eligibility and other health care programs before their coverage is closed.

The begin and end dates for the following bases of eligibility are:

- Adults age 65 and older:
  - Begins the first day of the month of their 65th birthday
- People certified blind or disabled:
  - Begins the first day of the month of the disability onset date as determined by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)
  - Ends the last day of the last month a person is certified disabled as determined by SSA or SMRT

The blind or disabled basis of eligibility continues while a person appeals their disability status, until an adverse ruling by an administrative law judge. The blind or disabled basis of eligibility ends the last day of the month in which the appeal results in a finding the person no longer meets the SSA or SMRT disability criteria. See MA-ABD Certification of Disability for more information.

If SSA benefits are denied solely on earnings above Substantial Gainful Activity (SGA), the blind or disabled basis of eligibility can only be continued with a new disability determination from SMRT. The blind or disabled basis of eligibility may continue while the SMRT determination is completed. See the MA-ABD Certification of Disability policy for more information.

Change in Basis of Eligibility for Enrollees

A change in circumstances may affect an MA enrollee's basis of eligibility. People who lose eligibility under one basis must be redetermined under another basis without interruption in their coverage. Additional information may be requested to determine continued eligibility under another basis. Some changes that may affect an enrollee's basis of eligibility include, but are not limited to:

- A disability certification ending
- Becoming pregnant. A pregnant basis of eligibility ends on the last day of the month in which the 12 month postpartum period ends.
- Becoming a parent or relative caretaker of a minor child
- Turning age 21 or 65

If an enrollee is no longer eligible for MA under ~~any~~ their current basis of ~~,~~ eligibility, they must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. ~~under another Minnesota Health Care Program.~~ See EPM section 1.3.2.1 Change in Circumstances for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.121

Code of Federal Regulations, title 42, section 435.201

Code of Federal Regulations, title 42, section 435.230

Code of Federal Regulations, title 42, section 435.330

Code of Federal Regulations, title 42, section 435.520

Code of Federal Regulations, title 42, section 435.522

Code of Federal Regulations, title 42, section 435.530

Code of Federal Regulations, title 42, section 435.540

Code of Federal Regulations, title 42, section 435.541

Code of Federal Regulations, title 42, section 435.911

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.055

Minnesota Statutes, section 256B.057

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L. Section 2.3.2.2 MA-ABD Certification of Disability

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

2.3.2.2 Certification of Disability

Disability or blindness must be certified by the Social Security Administration (SSA) or the State Medical Review Team (SMRT). The certification process is also called a disability determination.

People receiving the following benefits may or may not be certified disabled by SSA or SMRT.

- Short-term disability
- Long-term disability
- Long-term care insurance
- Veterans' Administration (VA)
- Railroad Retirement Board (RRB)
- Worker’s Compensation

Medicare

People may or may not need a new disability determination if they are eligible for Medicare, and lose their RSDI benefits because they earn more than the Substantial Gainful Activity (SGA) level. Some people are eligible for a Medicare extension as long as SSA considers these people to remain disabled. A person continues to be certified disabled to meet a disabled basis for as long as SSA considers these people to remain certified disabled. Other people may be former beneficiaries of Social Security benefits who are currently receiving Medicare and are not considered certified disabled by SSA.

An active certification of disability from SSA cannot be determined solely from the benefit status or the receipt of disability benefits. The status of the certification of disability determines whether a person meets a disabled basis for MA. Former beneficiaries of Social Security benefits (SSI or RSDI) who are enrolled in Medicare but no longer considered disabled by SSA must be referred to SMRT for a disability determination.

Only a SSA or SMRT certification of disability is valid for the purposes listed below.

Disability Certification for MA Eligibility

People must be certified disabled and use the disabled or blind basis of eligibility to:

- Enroll in MA for Employed Persons with Disabilities (MA-EPD)

- MA-EPD enrollees who lose their certification of disability with SSA must be referred to SMRT for a certification of disability. An MA-EPD enrollee who is referred to SMRT remains eligible for MA-EPD during the time SMRT is making its determination.

- Access MA under 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. Children with a disability and household income above the MA income limit need a disability certification and level of care determination to use the TEFRA option.
  - SMRT makes the level of care determination.
- Receive home and community-based services through the:
  - Brain Injury (BI) waiver
  - Community Alternative Care (CAC) waiver
  - Community Access for Disability Inclusion (CADI) waiver
  - Developmental Disabilities (DD) Waiver

~~A disability certification is not needed for services under the Developmentally Disabled (DD) waiver. The county case manager determines if the person meets the criteria for a developmental disability.~~

Children turning 18 need a new disability certification under the adult standards to continue using a blind or disabled basis of eligibility.

Disability Certification for Other Reasons

Some MA enrollees get a disability certification for managed care reasons including:

- To be excluded from managed care enrollment
- A person does not have to use a disabled basis of eligibility for Medical Assistance in order to be excluded from managed care enrollment.
  - To enroll in Special Needs Basic Care (SNBC), a specialized managed care plan for people age 18-64 with a certified disability

Additional reasons for needing a disability certification include:

- Community Support Grant (CSG) eligibility
- Family Support Grant (FSG) eligibility
- Aged 65 and older and establishing a pooled trust
- Establish an asset transfer penalty exception
- Creating certain trusts

State Medical Review Team Certification of Disability

SMRT completes disability determinations for people not certified disabled by SSA. SMRT certifies disability using the same disability criteria as the SSA.

Referral Process

Since the SSA disability determination process can be long, the county, tribal or state servicing agency completes a SMRT Referral for a Disability Determination. Referrals are sent in only through the Integrated Service Delivery System (ISDS).

Expedited Case Criteria

SMRT expedites the disability determination process in the following situations where the person is likely to meet disability criteria:

- The person has a condition that appears on the SSA Compassionate Allowance Listing (CAL)
- The person is awaiting discharge from a facility and can be discharged immediately if MA is approved
- The person has a potentially life-threatening situation and requires immediate treatment or medication
- There is a county error that may jeopardize a client's benefits. This circumstance is reviewed and accepted on a case by case basis.

Continuing Disability Review

People certified disabled by SMRT need a continuing disability review every one to seven years. Disability standards are different for children and adults, so at age 18, a child must be evaluated under the adult standards. Newborns certified disabled due to a low-birth weight must be reviewed prior to age one.

Additional SMRT Referrals:

The following people need a SMRT referral:

- People whose Supplemental Security Income (SSI) or Retirement, Survivors, and Disability Insurance (RSDI) application is pending or being appealed.
- People who are not eligible for SSI or RSDI, because they earn more than the substantial gainful activity (SGA) level.
- People whose SSI, RSDI, or 1619(a) for 1619(b) benefits are terminated.
- People who are enrolled in Medicare but not considered certified disabled by SSA.
- People who are receiving a Medicare extension during which they are still considered certified disabled by SSA should receive a SMRT referral two months before the Medicare extension ends.

Legal Citations

Code of Federal Regulations, title 42, sections 404.1501 to 404.1599

Code of Federal Regulations, title 42, sections 416.901 to 416.999d

Code of Federal Regulations, title 42, section 435.541

Minnesota Statutes, section 256.01

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M. Section 2.3.3.2.7.9.5 MA-ABD Pooled Trust

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

2.3.3.2.7.9.5 Pooled Trusts

A pooled trust is a type of irrevocable trust established and managed by a non-profit association that "pools" the assets of multiple individuals from separate sub-accounts for investment and management purposes. A pooled trust agreement consists of an overarching "master trust" established by a non-profit association and a "joinder agreement" that contains provisions specific to the sub-account beneficiary. A pooled trust is ~~a trust~~ established for the sole benefit of a beneficiary who is certified disabled. The principal or corpus of a trust that meets all the requirements of a pooled trust is excluded.

Trust Requirements

A trust must satisfy all of the following legal requirements in order to be excluded as a pooled trust.

Date Established

It is established on or after August 11, 1993.

Beneficiary Age Limit

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

Trust Management

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

Established by

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

Funded By

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

Disability Standard

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

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

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

Sole Benefit Requirement

The trust sub-account must be established and used for the sole benefit of the disabled beneficiary. Disbursements must also be used for the beneficiary's sole benefit and may not be used on items that are otherwise covered by public assistance benefits, with the following exceptions: ~~The trust sub-account must be established for and used for the sole benefit of the disabled beneficiary and must provide that all disbursements are for the sole benefit of the beneficiary, with the following exceptions:~~

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

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

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

DHS Remainder Beneficiary

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

Allowable Administrative Expenses

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

- Taxes due from the trust to the State, other states, or federal government because of the death of the beneficiary

- Reasonable expenses for the administration of the trust estate, such as an accounting of the trust to a court, completion and filing of documents, or other required actions associated with termination and wrapping up of the trust.

  For these administrative expenses, the trust must provide that:

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

Prohibited Expenses and Payments

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

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

Evaluation of Trust Principal and Additions to the Trust

Trust Principal

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

Additions to the Trust

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

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

Evaluation of Trust Disbursements

Funds from a beneficiary's sub-account must be disbursed for the sole benefit of the beneficiary, and may not be used on items that are otherwise covered by public assistance benefits.

Disbursements of cash from the trust made directly to the beneficiary or to a person acting on the beneficiary's behalf are counted as unearned income in the month received. Disbursements made by the trustee to a third party that result in the beneficiary receiving non-cash items, are not counted. Disbursements that do not count as income may include, but are not limited to those made for educational expenses, therapy, transportation, professional fees, medical services not covered by MA, phone bills, recreation, and entertainment.

~~Disbursements must be for the sole benefit of the beneficiary.~~

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

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

Pooled Trust Verifications

For a person of any age who transfers funds to a pooled trust sub-account, a copy of the master trust, joinder agreement and any accompanying documentation are required verifications. ~~Verification of a pooled trust is required to determine eligibility. In addition, the trustee should provide a copy of the most recent accounting along with a copy of the trust instrument. Both~~ These documents ~~must~~ should be sent along with a completed Special Needs/Pooled Trust Referral Form (DHS-4759) to the DHS Special Recovery Unit (SRU) at dhs.srutrusts@state.mn.us.

Annual Reporting by Trustees

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

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

Legal Citations

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

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

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

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

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Manual Letter #19.4, November 1, 2019

N. Section 2.3.3.4.2 MA-ABD Health Care Expenses

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

2.3.3.4.2 Health Care Expenses

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

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

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

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

Allowable Health Care Expenses to Meet a Medical Spenddown

Allowable health care expenses include:

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

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

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

Types of Health Care Expenses

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

1. Health insurance expenses not paid for or reimbursed by MA and incurred during the current six-month period. This includes:
    - Health, dental, vision and long-term care (LTC) insurance premiums
    - Indemnity policy premiums that reimburse health care expenses

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

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

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

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

- Prescribed or recommended in writing by the person's physician or dentist.
- Directly benefits the person.
- Available through a licensed medical provider but not necessarily obtained through a licensed medical provider.
- Not reimbursable through the county health care access plan.
- Medically necessary.

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

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

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

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

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

Reporting Health Care Expenses

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

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

Health Care Expenses Not allowed to meet a Spenddown

The following are not allowed to meet a spenddown:

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

Legal Citations

Code of Federal Regulations, title 42, section 435.831

Code of Federal Regulations, title 42, section 483.10

Minnesota Statutes, section 256B.056, subdivision 5

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Manual Letter #22.2, March 1, 2022

O. Section 2.3.4.2 MA-ABD Renewals

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

2.3.4.2 Renewals

Annual Renewal

All Medical Assistance for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) enrollees must complete an annual renewal. The first annual renewal is 12 months from the month of application and renewals occur annually thereafter as long as the enrollee remains eligible for MA. Eligibility for retroactive coverage months do not affect when an enrollee's annual renewal occurs.

Six-Month Renewal

MA-ABD enrollees with a medical spenddown must complete a six-month income renewal, with the exception of the following people:

- People whose only source of income is from an unvarying unearned income source that is expected to continue indefinitely. This type of income includes:
  - Retirement, Survivors, and Disability Insurance (RSDI) benefits
  - Private pensions
  - Veterans' benefits
  - Public assistance benefits, such as Minnesota Family Investment Program (MFIP), General Assistance (GA) and Minnesota Supplemental Aid (MSA)
- People whose only source of income is from an excluded income source, such as Supplemental Security Income (SSI)

Monthly Renewals

MA-ABD enrollees do not have to complete monthly renewals.

Late Renewals

A late renewal is a renewal for which either of the following is true:

- the renewal form is received before the last day of the fourth month following closure; or
- any additional information or verifications that were required are received before the last day of the fourth month following closure.

Eligibility for enrollees who do not return the renewal form, or who return the form but do not provide all the information and verifications needed to renew eligibility, is closed. However, eligibility for enrollees who are closed for failing to renew may be redetermined without requiring a new application if the form is returned within four months of the date of closure. A late renewal is a new application. All application policies apply.

When Eligibility Ends at Renewal

Changes reported during an enrollee's renewal may affect an MA enrollee's basis of eligibility. Enrollees who lose eligibility under one basis must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. See EPM 1.3.2.1 Change in Circumstances for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256.01

Minnesota Statutes, section 256B.056

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Previous Versions

Manual Letter #18.2. April 1, 2018

P. Section 2.3.5.2 MA-ABD Non-Financial Eligibility

Medical Assistance for Employed Persons with Disabilities

2.3.5.2 Non-Financial Eligibility

This subchapter includes non-financial eligibility policies. This covers eligibility factors not related to a person's income or assets. In general, MA-EPD follows the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) non-financial eligibility policies. Specific differences are indicated in the MA-EPD policies indicated below.

This subchapter includes policies that apply to Medical Assistance for Employed Persons with Disabilities (MA-EPD) and links to policies that apply to MA-ABD.

Topics covered in this subchapter are:

MA-ABD Non-Financial Eligibility

MA-EPD Bases of Eligibility

MA-EPD Living Arrangement

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Previous Versions

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

Q. Section 2.3.5.2.1 MA-EPD Bases of Eligibility

Medical Assistance for Employed Persons with Disabilities

2.3.5.2.1 Bases of Eligibility

In general, MA for Employed Persons with Disabilities (MA-EPD) follows the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) non-financial eligibility policies. People must be certified disabled and use the disabled or blind basis of eligibility to enroll in MA-EPD. Disability or blindness must be certified by the Social Security Administration (SSA) or the State Medical Review Team (SMRT).

Changing Basis of Eligibility after Job Loss

When an MA-EPD enrollee stops working, their eligibility must be redetermined under another MA basis of eligibility. The MA-EPD asset limit and policies continue to apply to the person for up to 12 months, when eligibility is redetermined under MA-ABD. After 12 months, MA-EPD asset limit and policies no longer apply. If the person loses MA for one calendar month or more, the MA-EPD asset limit and policies no longer apply. Eligibility must be redetermined under all MA bases when the MA-EPD asset limit and policies no longer apply.

Changing Basis of Eligibility after Age 65

Some MA-EPD income and asset rules continue to apply when redetermining basic MA eligibility for an enrollee, age 65 or older, who loses eligibility for MA-EPD for any reason and who was enrolled in MA-EPD during each of the 24 consecutive months before their 65th birthday.

When redetermining basic MA eligibility under these circumstances:

- The income of a spouse is not deemed to the person
- The assets of a spouse are not deemed to the person
- MA-EPD asset limits continue to apply
- MA-EPD asset disregards and exclusions continue to apply

Legal Citations

Minnesota Statutes, section 256B.057

Published: June 1, 2023

R. Section 2.3.5.2.2 MA-EPD Living Arrangement

Medical Assistance for Employed Persons with Disabilities

2.3.5.2.2~~1~~ Living Arrangement

Medical Assistance for Employed Persons with Disabilities (MA-EPD) enrollees may live in a variety of living arrangements. This policy discusses living arrangements and MA-EPD.

Community Living Arrangement

Community living arrangements have no impact on MA eligibility. See Appendix D Community Living Arrangements for more information.

Institutions for Mental Diseases

An Institution for Mental Diseases (IMD) is a hospital, nursing facility, or other institution or residential program that has 17 or more beds and is primarily engaged in providing diagnosis, treatment or care of people with mental diseases. A list of IMDs that provide treatment for people with mental illness (MI) is also available online. MA-EPD enrollees may continue MA-EPD while living in an IMD, as long as they meet the MA-EPD work requirements.

Long-Term Care Facility

A long-term care facility (LTCF) is a place such as a skilled nursing facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or medical hospital in which the individual receives skilled nursing services (swing bed). People who live in a LTCF while working even during the four-month medical leave period may continue MA-EPD, as long as they continue to pay the premium.

Legal Citations

Minnesota Statutes, section 256B.055, subdivisions 11 to 14

Published: ~~December~~ June 1, 2023 ~~2017~~
Previous Version:
Manual Letter #17.5, December 1, 2017

S. Section 2.3.5.3.1 MA-EPD Assets

Medical Assistance for Employed Persons with Disabilities

2.3.5.3.1 Assets

Assets are items of value that people own like bank accounts, stocks and bonds, cars, and real estate.

Medical Assistance for Employed Persons with Disabilities (MA-EPD) limits the amount of assets people can own to be eligible for coverage. There are also rules about what people must do with their assets in order to establish and maintain eligibility.

Asset Limit

The asset limit is $20,000 for people age 21 and older. Children younger than 21 have no asset limit.

Asset Exclusions

In general, the MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD) asset policies apply to MA-EPD. See the MA-ABD Asset chapter for more information. In addition to the MA-ABD asset exclusions, MA-EPD also excludes:

- Retirement accounts including:
  - Individual retirement accounts (IRA), including IRAs held in the form of an annuity
  - 401(k) plans
  - 403(b) plans
  - Keogh plans
  - Pension plans
- Medical expense accounts set up through an employer, including Health Savings Accounts (HSA)
- Spousal assets, including the spouse's share of jointly held assets

~~Changing Basis of Eligibility after Job Loss~~

~~When an MA-EPD enrollee stops working, their eligibility is redetermined under another MA basis of eligibility. The MA-EPD asset limit and policies continue to apply to the person for up to 12 months, when eligibility is redetermined under MA-ABD. If the person loses MA for one calendar month or more, the MA-EPD asset limit and policies no longer apply.~~

Changing Basis of Eligibility after Age 65

~~The MA-EPD income and asset rules continue to apply when redetermining basic MA eligibility for an enrollee, age 65 or older, who loses eligibility for MA-EPD for any reason and who was enrolled in MA-EPD during each of the 24 consecutive months before their 65th birthday. This includes the MA-EPD asset disregards and exclusions, including the disregard of a spouse's assets.~~

Legal Citations

Minnesota Statutes, section 256B.057

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Manual Letter #19.2, April 1, 2019

T. Section 2.3.5.4.1 MA-EPD Medicare

Medical Assistance for Employed Persons with Disabilities

2.3.5.4.1 Medicare Part B for MA-EPD Enrollees

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~~ one of the following:

- Based on the individual's own income and assets, meets the requirements for Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) programs. See EPM section 4.2 Medicare Savings Programs for more information.
- If not eligible for QMB or SLMB, has income at or below 200% FPG.
- ~~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~~.

For the eligible MA-EPD enrollees not eligible for QMB or SLMB with income at or below 200% FPG, Medicare Part B premium reimbursements must be processed and reimbursed by the county of financial responsibility 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 county of financial responsibility.

Legal Citations

Minnesota Statutes, section 256B.057

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Manual Letter #22.5, December 1, 2022

U. Section 2.4.1 MA-LTC Eligibility Requirements

Medical Assistance for Long-Term Care Services

2.4.1 Eligibility Requirements

This subchapter provides general policy information that applies to Medical Assistance for Long-Term Care Services (MA-LTC).

If an enrollee is no longer eligible for MA under their current basis, they must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. See EPM 1.3.2.1 Change in Circumstances for more information.

LTC Eligibility Factors

People requesting MA-LTC must meet all of the following eligibility factors to be eligible:

- Must be eligible for MA
- Requires a nursing facility level-of-care as determined through a Long-Term Care Consultation (LTCC)
- Must have home equity at or below the home equity limit
- Must not be subject to a period of ineligibility under the uncompensated transfer rules
- Must name the state the remainder beneficiary of certain annuities

Eligibility for MA

People who request MA-LTC are required to meet all of the eligibility requirements for MA before determining if the person meets the ~~eligibility requirements~~ LTC Eligibility Factors ~~for MA-LTC.~~ MA eligibility for people requesting MA-LTC is determined under MA for People Who Are Age 65 or Older and People Who Are Blind or Have a Disability (MA-ABD), MA for Employed Persons with Disabilities (MA-EPD), or MA with Families with Children and Adults (MA-FCA) ~~basis of eligibility~~.

Bases of Eligibility

People ~~eligible for~~ enrolled in MA ~~with an~~ ABD ~~basis of eligibility~~ are eligible to receive MA-LTC if they meet the ~~other~~ LTC Eeligibility ~~requirements~~ Factors.

People ~~eligible for~~ enrolled in MA ~~with an~~ FCA ~~basis of eligibility~~ who meet the LTC Eligibility Factors are ~~only~~ eligible to receive MA-LTC in a long-term care facility (LTCF) only ~~if they meet the other LTC eligibility requirements~~. People eligible for MA-FCA ~~They~~ are not eligible to receive services through a home and community-based services (HCBS) waiver. If a person with an FCA basis of eligibility needs services through an HCBS waiver, the person ~~would need to~~ must be determined eligible under ~~one of the~~ MA-ABD ~~bases of eligibility.~~

People enrolled in MA for Employed Persons with Disabilities (MA-EPD) who meet the LTC Eligibility Factors are eligible to receive MA-LTC. People who are enrolled in MA-EPD and meet the LTC Eligibility Factors use the MA-ABD income methodology and are subject to MA-EPD asset limits. See EPM 2.3.5.3.1 MA-EPD Assets.

Minnesota Health Care Programs Applications

MA applicants who are requesting LTC services should use the following form:

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

MA enrollees who are requesting LTC services should use one of the following forms:

- Minnesota Health Care Programs Request for Payment of Long-Term Care Services (DHS-3543)
- Minnesota Health Care Programs Payment of Long-Term Care Services for MA for Families with Children and Adults (DHS-3543A)

MA enrollees who are requesting MA-LTC coverage of waiver services should submit one of the following forms:

- MA-ABD enrollees: Minnesota Health Care Programs Request for Payment of Long-Term Care Services (DHS-3543)
- MA-FCA enrollees (to be determined for MA-ABD): Supplement to MNsure Application for Health Coverage and Help Paying for Costs (DHS-6696A)

Claims for MA-LTC services cannot be paid until the enrollee is determined eligible for MA-LTC.

- If the enrollee is requesting services because of a move to an LTCF, eligibility can begin the date the enrollee moved into the LTCF or the date that all eligibility requirements for MA-LTC are met, whichever is later.
- If the enrollee is requesting services through an HCBS waiver, eligibility can begin no earlier than the date of the LTCC or the date the enrollee meets all eligibility requirements for MA-LTC, whichever is later.

Notification

People who request MA-LTC are notified of the results of the eligibility determination through either a system generated or a manual notice. ”Notice of Action for Medical Assistance (MA) Payment of Long-Term Care Services” (DHS-4915).

The lead agency assessor or case manager, or the LTCF, is notified when the person becomes eligible so that LTC services can begin.

Legal Citations

Minnesota Statutes, section 256B.056, subdivision 2a

Minnesota Statutes, section 256B.056, subdivision 11

Minnesota Statutes, section 256B.057

Minnesota Statutes, section 256B.0595

Minnesota Statutes, section 256B.0911

Code of Federal Regulations, title 42, section 435.916

United States Code, title 42, section 1396p

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V. 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.

MA Eligibility During the Transfer Penalty

A person may still be eligible for MA with an ABD basis of eligibility or MA with an FCA basis of eligibility during the transfer penalty period. A person's eligibility must be evaluated for other MA bases of eligibility and other health care programs before closing or denying coverage. A person may be subject to a medical spenddown when applicable.

MA will only pay for non-LTC services during the transfer period if the person is eligible for MA.

Income Calculations During a Period of Ineligibility

MA-LTC income methodologies do not apply during full months of MA-LTC ineligibility, however, a person may still be eligible for MA with an ABD basis of eligibility or MA with an FCA basis of eligibility during the transfer penalty period. A person must be determined eligible based on the income methodology associated with their basis:

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

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

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 be provided the opportunity to reduce excess countable assets. If the enrollee is unable to reduce assets to within the asset limit, MA eligibility must be redetermined and if appropriate, closed with 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.

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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W. Section 2.4.1.4.2 MA-LTC Naming DHS a Preferred Remainder Beneficiary

Medical Assistance for Long-Term Care Services

2.4.1.4.2 Naming DHS a Preferred Remainder Beneficiary

After a person is determined eligible for MA for Long-Term Care Services (MA-LTC), the person and his or her spouse must name Minnesota Department of Human Services (DHS) as a preferred remainder beneficiary of their annuity, if the annuity meets certain requirements, prior to approval of MA-LTC.

The policies described in this section do not apply to employment-based pension plans held in the form of an annuity. See MA for People Who Are Age 65 or Older and People Who are Blind or Have a Disability (MA-ABD) Retirement Accounts and Retirement Plans.

Preferred Remainder Beneficiary

The preferred remainder beneficiary is the person or entity required to be named as a beneficiary of a death benefit under an annuity. A preferred remainder beneficiary has preferential rights to the death benefit. As the preferred remainder beneficiary, DHS may receive up to the total amount of MA paid on behalf of the person and their spouse when a death benefit becomes payable under the terms of the annuity contract.

DHS is a secondary beneficiary if the person's spouse, child under 18, or a child of any age who is certified disabled (based upon the criteria of the Supplemental Security Income (SSI) program) is named a beneficiary under the annuity and is alive at the time the death benefit is payable.

A Person Must Name DHS a Preferred Remainder Beneficiary

People who request or renew eligibility for MA-LTC and their spouses are required to designate DHS as a preferred remainder beneficiary for each annuity that meets all of the following criteria:

- they have an ownership interest in the annuity;
- at least one annuity transaction occurred within the lookback period; and
- the annuity provides for a death benefit and allows someone other than a surviving spouse to be named a beneficiary.

Verification from the annuity issuer is required if a person or their spouse claims it is not possible for DHS to be named a preferred remainder beneficiary.

Failure to Name DHS the Preferred Remainder Beneficiary

If a person or their spouse fails to name DHS the preferred remainder beneficiary, and they are otherwise eligible for MA-LTC, the appropriate value of the annuity must be determined to calculate a period of ineligibility based upon the phase of the annuity as follows:

- The value of the annuity is the current cash value (cash surrender value) of the annuity if the annuity is in the accumulation phase.
- The value of the annuity is the total amount of money annuitized if the annuity is in the annuitization phase.

- The period of ineligibility is calculated by dividing the value of the annuity 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 period of ineligibility 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 period of ineligibility is less than a full month of eligibility for MA-LTC, the MA-LTC payments is reduced by the remaining amount.
- The period of ineligibility begins with the first month for which the person is requesting and meets all of the other criteria to receive MA-LTC. The Notice of Action for Payment of Long-Term Care Services (DHS-4915) is a required notice when a person fails to name DHS a preferred remainder beneficiary. This is the official notification of denial or ending of MA-LTC.
- If the person is eligible for MA during the period of ineligibility, MA will pay for non-LTC services.

MA Eligibility During the Period of Ineligibility

A person may still be eligible for MA with an ABD basis of eligibility or MA with an FCA basis of eligibility during the transfer penalty period. A person's eligibility must be evaluated for other MA bases of eligibility and other health care programs before closing or denying coverage. A person may be subject to a medical spenddown when applicable.

MA will only pay for non-LTC services during the transfer period if the person is eligible for MA.

Income Calculations During a Period of Ineligibility

MA-LTC income methodologies do not apply during full months of MA-LTC ineligibility, however, a person may still be eligible for MA with an ABD basis of eligibility or MA with an FCA basis of eligibility during the transfer penalty. A person must be determined eligible based on the income methodology associated with their basis:

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

Cooperation after a Period of Ineligibility is Imposed

When a person cooperates after a period of ineligibility for MA-LTC due to failure to name DHS a preferred remainder beneficiary, eligibility for MA-LTC begins no earlier than the first day of the month in which the person:

- cooperates and names DHS a preferred remainder beneficiary, and
- meets all other eligibility requirements.

- A person is not automatically eligible for MA-LTC upon the end of a period of ineligibility.

Ending the period of ineligibility only eliminates a barrier for MA-LTC identified in a previous request. When a period of ineligibility ends, a determination must be made to ensure the person currently meets all eligibility requirements for MA-LTC.

- People not enrolled in MA when the period of ineligibility 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 period of ineligibility ends must submit a 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 period of ineligibility was imposed and the date of the request for MA-LTC.

Requirements for Annuity Issuers

Annuity issuers are required to communicate certain information to county, tribal, and state agencies about annuities that designate DHS as a preferred remainder beneficiary. Annuity issuers who receive a signed and dated "Issuer of Annuity Notice of Obligation" (DHS-5037) are required to:

- Confirm that DHS has been named a preferred remainder beneficiary.
- Notify the county agency of changes made to the amount of income or principal being withdrawn from the annuity and to the beneficiary designation by the annuity owner.
- Inform DHS when the death benefit becomes payable and request the amount of MA subject to recovery by DHS.
- If applicable, describe a valid reason why it is not possible to name DHS a preferred remainder beneficiary.

- Non-cooperation by the issuer to name DHS a preferred remainder beneficiary of the annuity is not a valid reason for DHS not to be named a preferred remainder beneficiary.

Forms Required to Name DHS a Preferred Remainder Beneficiary

Upon request of the county, tribal, or state agency a person must complete the Annuity Designation for MA LTC Applicants (DHS-5036). This form is used when the person requesting MA LTC, or their spouse, owns the annuity.

- The county, tribal, or state agency will send an Issuer of Annuity Notice of Obligation (DHS-5037) to the annuity issuer along with the signed DHS-5036. The DHS-5037 provides the annuity issuer instructions regarding:
- Naming DHS as a preferred remainder beneficiary

- Completing the Confirmation/Status of Request portion of the form and returning it to the county agency within 30 days
- The annuity issuer's ongoing obligation to communicate with the county and state agency under federal and state laws when DHS is named a preferred remainder beneficiary.

Change in Annuity Income or Preferred Remainder Beneficiary

Any information that indicates a change since the last request for MA-LTC in either the amount of income or principal the person or their spouse is withdrawing from the annuity, or that DHS is no longer named as a preferred remainder beneficiary, must be evaluated to determine if:

- An uncompensated transfer has occurred
- A penalty period applies
- A change in the amount of available income from the annuity has occurred

Legal Citations

Minnesota Statutes, section 256B.056, subdivision 11

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

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X. Section 2.4.2.5 MA-LTC Income Calculations for Long-Term Care Services

Medical Assistance for Long-Term Care Services

2.4.2.5 Income Calculations for Long-Term Care Services

Income Calculations

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

The following policies do not apply during full months of MA-LTC ineligibility due to a transfer penalty or when the person fails to name DHS the preferred remainder beneficiary on an annuity. Refer to sections 2.4.1.3.2 Transfer Penalty and 2.4.1.4.2 Naming DHS a Preferred Remainder Beneficiary for more information.

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

Community Income Calculation

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

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

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

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

LTC Income Calculation

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

- Are expected to reside in a LTCF for at least 30 consecutive days
  - An MA enrollee who is absent from an LTCF on a leave day is still considered to be residing in a LTCF.
  - A Group Residential Housing (GRH), assisted living, or a non-Medicaid certified facility, is not an LTCF.
- Request EW and have income at or below the SIS
- Request EW and have income above the SIS and have a community spouse

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

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

Total Income

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

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

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

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

Retroactive adjustments are made for each month in the six month period where the actual income or deductions differ from the anticipated income or deductions, including months in which SSI

benefits are retroactively reduced by SSA because the person was in an LTCF, resulting in an SSI overpayment.

Beginning and Ending the LTC Income Calculation

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

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

The LTC income calculation ends:

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

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

LTC Spenddown

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

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

Interaction with Medicare Part A Payments

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

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

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

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

Waiver Obligation

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

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

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

Medical Spenddown

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

Legal Citations

Code of Federal Regulations, title 42, section 435.726

Code of Federal Regulations, title 42, section 435.733

Code of Federal Regulations, title 42, section 435.735

Code of Federal Regulations, title 42, section 435.832

Minnesota Statutes, section 256B.0575

Minnesota Statutes, section 256B.058

Minnesota Statutes, section 256B.0915

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Y. Section 2.5.1.4.2 MA-BC Renewals

Medical Assistance for Women with Breast or Cervical Cancer

2.5.1.4.2 Renewals

Enrollees in Medical Assistance for women with Breast or Cervical Cancer (MA-BC) must have eligibility renewed every 12 months. Renewing eligibility means redetermining eligibility.

Annual Renewal Month

The annual renewal month is the month in which eligibility is redetermined for the next 12 months. The first annual renewal month after application is 12 months from the month of application for ongoing MA-BC and occurs annually thereafter as long as the enrollee remains eligible for MA-BC.

The enrollee must complete the Minnesota MA Application/Renewal Breast and Cervical Cancer (DHS-3525) and Certification of Further Treatment Required (DHS-3525A) and submit the forms to their county, tribal or state servicing agency. The form and any required proofs are due before the renewal date. Enrollees can submit the original renewal form or a photocopy, fax or scanned form to their county, tribal or state servicing agency.

When Eligibility Ends at Renewal

Changes reported during an enrollee's renewal may affect an MA enrollee's basis of eligibility. Enrollees who lose eligibility under one basis must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. See EPM 1.3.2.1 Change in Circumstance for more information.

Legal Citations

Code of Federal Regulations, title 42, 435.916

Minnesota Statutes, section 256B.057, Subd. 10(c)

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Z. Section 2.5.2.4.2 MA-CVT Renewals

Medical Assistance Center for Victims of Torture

2.5.2.4.2 Renewals

Enrollees in Medical Assistance for people receiving services from the Center for Victims of Torture (MA-CVT) must have eligibility redetermined every 12 months. ~~Renewing eligibility means redetermining eligibility.~~ The first annual renewal is 12 months from the month of application and renewals occur annually thereafter as long as the enrollee remains eligible for MA. Eligibility for retroactive coverage months do not affect when an enrollee's annual renewal occurs.

MA-CVT enrollees receive a renewal form. Enrollees must complete, sign and return the renewal form to their county, tribal or state servicing agency. They must include proof they are continuing to receive CVT services. The proof must be dated within 30 days of the date of renewal.

Annual Renewal Month

The annual renewal month is the month in which eligibility is redetermined for the next 12 months. The first annual renewal month after application is 12 months from the month of application and occurs annually thereafter as long as the enrollee remains eligible for MA-CVT.

When Eligibility Ends at Renewal

Changes reported during an enrollee's renewal may affect an MA enrollee's basis of eligibility. Enrollees who lose eligibility under one basis must be redetermined for all health care programs they are potentially eligible for, without interruption in their coverage. See EPM 1.3.2.1 Change in Circumstances for more information.

Legal Citations

Code of Federal Regulations, title 42, section 435.916

Minnesota Statutes, section 256B.06, subdivision 4

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AA. 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.

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 an employee's spouse and dependents 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.

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

Employee-only Affordability Standard

An employer-sponsored health plan is affordable for the employee if the employee's portion of the annual premiums for employee-only coverage does not exceed 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.~~

Family Affordability Standard

An employer-sponsored health plan is affordable for the employee's spouse and dependents if the employee's portion of the annual premiums for family coverage does not exceed 9.12 percent of their annual household income for the tax year.

"Family coverage" means the lowest-cost plan offered by the employer that covers all members of the family, which may include any combination of the employee, the employee's spouse if filing taxes jointly, and the employee's tax dependents. The cost of family coverage is used when determining affordability for spouses and dependents.

The calculation used to determine employer-sponsored coverage affordability for the family is separate from the calculation used to determine affordability for the individual employee.

- If the ESC premium is not affordable for the employee and also not affordable for the spouse and dependents, the entire household is eligible for MinnesotaCare if they meet all other eligibility criteria.
- If the premium is affordable for the employee, but not affordable for the spouse and tax dependents, only the spouse and tax dependents may qualify for MinnesotaCare.

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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BB. 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, 2023 to June 30, 2024	$740
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

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, 2023 to June 30, 2024	$2,466
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

IRS Mileage Rate

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

Effective Dates	IRS Mileage Rate
January 1, 2023 to December 31, 2023	65.5 cents
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

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, 2023 to June 30, 2024	$1,215
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, 2023 to June 30, 2024	$1,256
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

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

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
July 1, 2023 to December 31, 2023	$271
January 1, 2023 to June 30, 2023	$244
~~July 1, 2022 to December 31, 2022~~	~~$234~~

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

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, 2023 to June 30, 2024	$9,526
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

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

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

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	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
Single	No	No	Earned Income	$12,400	$12,950
Single	No	No	Unearned Income	$1,100	$1,150
Single	No	No	Gross Income	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	$14,050	$14,700
Single	Yes	No	Unearned Income	$2,750	$2,900
Single	Yes	No	Gross Income	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	$14,050	$14,700
Single	No	Yes	Unearned Income	$2,750	$2,900
Single	No	Yes	Gross Income	Larger of $2,750 or Earned Income Reported up	Larger of $2,900 or Earned Income Reported up to

Marital Status	Age over 65?	Blind?	Income Type	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
				to $12,050 + $2000	$12,550 + $2,150
Single	Yes	Yes	Earned Income	$15,700	$16,450
Single	Yes	Yes	Unearned Income	$4,400	$4,650
Single	Yes	Yes	Gross Income	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	$12,400	$12,950
Married	No	No	Unearned Income	$1,100	$1,150
Married	No	No	Gross Income	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	$13,700	$14,350
Married	Yes	No	Unearned Income	$2,400	$2,550
Married	Yes	No	Gross Income	Larger of $2,400 or Earned Income Reported up to $12,050 + $1,650	Larger of $2,550 or Earned Income Reported up to

Marital Status	Age over 65?	Blind?	Income Type	2021 Tax Year Threshold Amount	2022 Tax Year Threshold Amount
					$12,550 + $1,800
Married	No	Yes	Earned Income	$13,700	$14,350
Married	No	Yes	Unearned Income	$2,400	$2,550
Married	No	Yes	Gross Income	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	$15,000	$15,750
Married	Yes	Yes	Unearned Income	$3,700	$3,950
Married	Yes	Yes	Gross Income	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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