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House Research Department
December 2009

Minnesota Family Assistance

A Guide to Public Programs Providing Assistance to Minnesota Families

This publication describes the federal and state programs that provide assistance to Minnesota families in the form of income, health care, child care, food purchasing, and housing. Programs covered in this guide are General Assistance, Minnesota Family Investment Program, Minnesota Supplemental Aid, Supplemental Security Income, General Assistance Medical Care, Medical Assistance, MinnesotaCare, Child Care, Food Support, and Group Residential Housing.

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Introduction

This guide is intended to help legislators understand the following public programs that provide assistance to Minnesota families:

- General Assistance (GA)
- Minnesota Family Investment Program (MFIP)
- Minnesota Supplemental Aid (MSA)
- Supplemental Security Income (SSI)
- General Assistance Medical Care (GAMC)
- Medical Assistance (MA)
- MinnesotaCare
- Child Care
- Food Support (FS)
- Group Residential Housing (GRH)

The first four programs, GA, MFIP, MSA, and SSI, provide income assistance to eligible needy families and individuals.

The GAMC, MA, and MinnesotaCare programs cover the cost of health care for eligible low-income families and individuals.

The Child Care assistance programs subsidize the child care costs of eligible MFIP and other low-income families.

The Food Support program provides food purchasing assistance to eligible low-income households.

The GRH program subsidizes the housing costs of certain low-income individuals who live in community-based group residences.

This guide includes basic information about how each of these programs works and includes information on each program's administration, eligibility, benefits, funding, and recipients.

Assistance Programs Originating in Federal Law

Some of the programs described in this guide began with federal legislation:

- Supplemental Security Income (SSI)
- Medical Assistance (MA)
- Minnesota Family Investment Program (MFIP)
- Child Care
- Food Support (FS)

SSI, MA, and MFIP have their origins in the federal Social Security Act. The Food Support program began as the result of separate federal legislation in 1964. The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 also made fundamental changes to the Social Security law, the Food Support law, and child care assistance that have had a significant effect on these programs.

The Social Security Act

Prior to 1935, relief for the poor had been the responsibility of state and local governments and private charities. During the Depression, however, local governments and private agencies no longer had enough resources to help the growing number of families and individuals who were in need of direct financial assistance. In 1935, Congress passed the Social Security Act as a response to the economic hardship created by the Great Depression.

The Social Security Act includes two types of programs: social insurance programs and assistance programs. The assistance programs are the focus of this guide.

Social Insurance

Social insurance is a system to protect people with a work history, and their dependents, who experience an abrupt loss of income due to temporary unemployment, disability, retirement, or death. Eligibility for social insurance programs in the Social Security Act is not based on an applicant's financial need. The social insurance component of the act includes Old Age, Survivors' and Disability Insurance Program, Unemployment Compensation, and the Medicare program. Program benefits are funded by mandatory employer/employee contributions to special program trusts. Eligibility for benefits under these programs is based on an individual's work history and contributions to the trust funds. Some state agencies play a limited role in the social insurance programs; county agencies have no administrative responsibility for any of the social insurance programs.

Assistance Programs

Eligibility for the assistance programs created in the Social Security Act is based on individual or family financial need and on whether or not an applicant/recipient is a member of a federally authorized category. Through the provisions of the original Social Security Act and its successive amendments, Congress has authorized programs that provide cash and medical assistance to aged, blind, and disabled individuals and families with dependent children. Program benefits are financed by federal and state general funds. Funding formulas vary among programs. There are no special trusts (like the Social Security trust fund) to finance the costs of these assistance programs.

Title IV-A of the act created the Aid to Families with Dependent Children (AFDC) program, which was an entitlement program intended to provide financial support to needy families where a dependent child in the family was deprived of the support of one of his or her parents. Title XIX created the Medicaid entitlement program to provide health care assistance to certain categories of low-income persons. Title XVI created the Supplemental Security Income (SSI) entitlement program to provide monthly cash assistance to needy aged, blind, and disabled persons. Title XXI created the State Children's Health Insurance Program (SCHIP) to fund health care coverage for uninsured low-income children and some parents, by providing an enhanced federal match to states.[1]

With the exception of the federally administered SSI program, the other assistance programs of the Social Security Act are administered in Minnesota by the counties under the supervision of the state Department of Human Services (DHS). Overall program requirements are set by Congress and the responsible federal agency.

The various titles of the Social Security Act remain the basis of the national public assistance system in America today. Most changes in federal welfare policy are established as amendments to the Social Security Act.

PRWORA: The Federal Welfare Reform Law

In 1996 Congress enacted landmark welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA; Pub. L. No. 104-193). PRWORA marked a fundamental shift in the direction and design of the public assistance programs. This welfare reform law amended the Social Security Act to abolish the AFDC entitlement program, replacing it instead with a totally rewritten Title IV-A that established the block grant program of Temporary Assistance for Needy Families (TANF).

Under TANF states receive a federal block grant to provide time-limited assistance to needy families with minor children. PRWORA has a strong focus on moving welfare recipients into

[1] States can administer SCHIP through their Medicaid programs, a separate program, or a combination of both. Minnesota uses SCHIP funding to pay for health care services for certain MA and MinnesotaCare eligibility groups (see the MA and MinnesotaCare chapters for details).

work and self-sufficiency. TANF families are required to participate in work activities, and states must ensure that the federally established work participation requirements are met. Minnesota's TANF program is the Minnesota Family Investment Program (MFIP).

The welfare reform legislation also made significant changes in the eligibility requirements for the SSI, MA, and Food Support programs, and in the design and funding of the Child Care assistance programs. Some of the most noticeable changes were provisions that created categories of legal noncitizens who were ineligible for SSI or Food Support benefits, or were eligible for those benefits for only a limited time. However, the 2002 Farm Bill restored Food Support eligibility to certain categories of legal noncitizens. Another significant change was the repeal of the child care assistance entitlement, under federal law, for AFDC recipients who needed child care to get or keep a job.

TANF was reauthorized in February 2006 under the Deficit Reduction Act of 2005 through fiscal year 2010.

Food Stamp Act

Congress established the Food Support (Stamp) Program in 1964. This entitlement program increases the food purchasing power of low-income households. Eligibility for this program is based on an applicant's financial need. Over time Congress has amended the Food Stamp Act and has added work requirements that some categories of Food Support recipients must also meet as a condition of receiving food support benefits. PRWORA has also limited the eligibility of many legal noncitizens for Food Support. The Food Support program is administered by county agencies under the supervision of the state DHS.

Assistance Programs Originating in State Law

The remaining programs described in this guide are programs that originated in state rather than federal legislation:

- General Assistance (GA)
- Minnesota Supplemental Aid (MSA)
- General Assistance Medical Care (GAMC)
- MinnesotaCare
- Group Residential Housing (GRH)

Benefits for these programs are financed by the state general fund, or in the case of MinnesotaCare, the state-created Health Care Access Fund. Overall program requirements are set by the state legislature and the programs are administered by the counties under the supervision of DHS, or in the case of MinnesotaCare, by DHS itself.

Financing Minnesota's Family Assistance Programs

The program costs of the principal public programs that assist Minnesota families are financed by a combination of federal and state money as follows:

	Source of Financing	
Program	**Federal**	**State**
Minnesota Family Investment Program (MFIP)	X	X
Medical Assistance (MA)	X	X
MinnesotaCare	X	X[2]
Child Care Assistance	X	X[3]
Supplemental Security Income (SSI)	X	
Food Support (FS)	X	
General Assistance (GA)		X
General Assistance Medical Care (GAMC)		X
Minnesota Supplemental Aid (MSA)		X
Group Residential Housing (GRH)		X

Beginning January 1, 1991, the state assumed responsibility for, or "took over," the historic county share of expenditures for public assistance benefits. From that point on counties were not responsible for paying a share of the program costs of certain state-mandated assistance programs.[4] Counties have continued to administer most programs (with the exception of MinnesotaCare), and they are expected to follow state guidelines in administering the programs.

Unless otherwise noted, all citations are to Minnesota Statutes 2008.

[2] MinnesotaCare is also financed with premiums paid by the program's enrollees.

[3] Child Care Assistance programs are also financed with county funds and participant copayments.

[4] Certain exceptions apply. For example, a county share is required for certain MA services (see discussion of the nonfederal share in the MA chapter).

Appendices

This guide includes several appendices:

- Appendix I: Asset Limits for Assistance Programs
- Appendix II: Income Limits for Assistance Programs
- Appendix III: GAMC Enrollee Characteristics
- Appendix IV: Program Expenditures and Caseload Data
- Appendix V: Laws and Regulations Governing Assistance Programs for Families
- Appendix VI: Federal TANF Work Requirements
- Appendix VII: Mille Lacs Band Tribal TANF Program
- Appendix VIII: Federal Earned Income Tax Credit and Minnesota Working Family Credit
- Appendix IX: Federal and Minnesota Dependent Care Tax Credits

The first five appendices provide comparative information for all the assistance programs included in the guide. Appendices VI and VII relate to specific aspects of MFIP, the state's welfare reform program for families.

Finally, both the federal and state governments provide some assistance to Minnesota families through tax credit programs. Tax provisions are outside the scope of this guidebook. However, appendices VIII and IX provide some basic information about two of the best known tax credits that assist Minnesota families: earned income tax credits and dependent care tax credits.

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General Assistance

General Assistance (GA) is a state program that provides cash assistance to needy persons who fall into specified statutory categories and who meet the GA eligibility requirements, including income and asset requirements.

Administration

GA provides aid to individuals or couples who are not eligible for federally funded assistance programs, but who are unable to provide for themselves.

Minnesota State Legislature

The legislature established GA in 1973 when it abolished county "Poor Relief" programs and the "Township Relief System." The original GA program provided assistance to needy persons who did not qualify for federal programs. In 1985 the legislature changed the GA program to allow assistance only for those people who meet certain standards of "unemployability." The state law includes: minimum statewide standards for assistance, general eligibility requirements (including resource limitations), provisions for program funding and administration, and guidelines for determining the county financially responsible for GA grants.

State Department of Human Services (DHS)

DHS supervises program administration. DHS rules govern GA administration in Minnesota. DHS also issues a detailed program manual for county caseworkers, which includes specific eligibility criteria and schedules for determining benefits.

Counties

The counties administer GA. The county human services agency, with the assistance of the state agency through the MAXIS computer system, determines if an applicant meets the state's eligibility requirements and determines the amount of assistance.

Eligibility Requirements

The GA program provides aid to individuals or couples who are not eligible for federally funded assistance programs, but who are unable to provide for themselves (Minn. Stat. § 256D.01). An applicant qualifies for GA if he or she meets the eligibility standards set by state law and has income and assets below the limits established by the state legislature and DHS.

Income Limits

The legislature mandates that DHS limit eligibility for GA based on maximum income levels. The limit applies to earned and unearned income. If the current net income of an individual or couple is below the applicable need standard, that person or couple may be eligible for GA.

GA eligibility is based on income and assets.

An applicant's net income is calculated in two steps. First, all of the applicable allowed disregards and deductions are subtracted from the applicant's gross monthly earned income, to get the applicant's net earned income amount. These disregards and deductions include the following:

- a $50 earned income disregard[5]
- a work expense deduction
- a deduction for actual unreimbursed dependent care costs, if there are no caregivers in the home, or if all caregivers are working or in school and incurring dependent care costs

Second, all unearned income that is not otherwise excluded is added to the applicant's net earned income amount, in order to arrive at the applicant's net income. Some types of unearned income are excluded from this calculation. Examples of excluded unearned income are certain types of federal assistance payments received by the person or couple, such as the value of food support and low-income home energy assistance.

The net income limit represents the state's determination of the minimum monthly income individuals need to provide themselves with "a reasonable subsistence compatible with decency and health"

[5] For residents of licensed facilities for mentally ill persons or chemically dependent persons, supervised apartments, and all other group residential housing settings, an additional earned income disregard of up to $150 per month, up to a maximum accumulated total of $1,000, is allowed if this money is kept in a separate account for use after discharge, and discharge and work are part of the resident's treatment plan.

(Minn. Stat. § 256D.02, subd. 4). For this reason the net income limit is also known as the standard of assistance or the "need standard."

Asset Limits

State regulations also set the maximum value of assets an applicant may possess and be eligible for GA. GA recipients can have no more than $1,000 in net counted assets after all allowable exclusions. Certain assets are excluded from the $1,000 limit:

- Ownership of a homestead, without regard to value
- Ownership of one car with an equity value no greater than $1,500 (A car's value in excess of this amount is counted as part of the $1,000 asset limit.)
- Assets needed to get or keep suitable employment
- One burial space (or up to $1,000 for a prepaid burial account, burial plan, or trust) for each person whose assets are considered in determining eligibility

Other items are excluded from the $1,000 asset limit:

- proceeds from the sale of the home (excluded for six months if another home will be purchased)
- the value of corrective payments (excluded for two months only)
- disaster relief funds
- tax refunds and credits (excluded for two months only)
- nondeferred student loans
- reverse mortgages
- special funds to replace or repair real or personal property
- amounts escrowed for real estate taxes and insurance

The total value of other personal property is subject to the $1,000 limit. Certain property, such as household goods, furniture, and clothing, is automatically excluded from the limit. The county agency must also exclude assets for certain reasons, for example, if the asset is determined to be essential to the individual, if the applicant is expected to receive GA for less than 30 days, or if forced disposal of property would result in "undue hardship." Applicants are prohibited from transferring ownership of property for less than reasonable compensation less than 12 months before applying for GA in order to

establish eligibility for GA. Such asset transfers can make the applicant ineligible for GA.

Additional GA Eligibility Requirements

Among other criteria, GA recipients must be Minnesota residents, U.S. citizens, or eligible noncitizens, and ineligible for cash assistance from federally funded programs.

In addition to having financial need, a GA applicant must also:

- be a resident of Minnesota;
- be ineligible for aid from any cash assistance program that uses federal funds (i.e., MFIP or SSI);
- be a citizen of the United States; and
- meet other eligibility requirements.

A GA applicant must be a resident of Minnesota. A resident is a person who intends to make his or her home in Minnesota and has been in the state for at least 30 days. Exceptions to the 30-day requirement are made for migrant workers who meet certain criteria and for persons in situations of unusual hardship. Time spent in a battered women's shelter also counts towards meeting the requirement.

A GA applicant must be ineligible for aid from any cash assistance program that uses federal funds (i.e., MFIP or SSI).

A GA applicant must be a citizen of the United States. Legal noncitizens who are lawfully residing in the United States are eligible for GA. Undocumented noncitizens and nonimmigrant noncitizens[6] are not eligible for GA benefits.

The income and assets of sponsors of noncitizens are deemed available for GA applicants and recipients as provided under federal law. In order to receive GA, legal adult noncitizens who are under age 70 and have lived in the United States for at least four years must also meet certain requirements relating to English literacy or application for U.S. citizenship.

A GA applicant must be unable to work because the person:

1. Has a professionally certified illness, injury, or incapacity expected to continue for more than 30 days and that prevents the person from getting or keeping a job

[6] A nonimmigrant is a person who is lawfully present in the United States, but who is not lawfully residing in the United States (because the person maintains a residence outside the United States). Nonimmigrants are generally admitted temporarily and for a limited purpose (e.g., tourists, foreign students).

2. Has diagnosed mental retardation or mental illness
3. Is of advanced age
4. Is needed in the home to care for a person whose age or medical condition requires continuous care
5. Is placed in a licensed or certified facility for care or treatment under a plan approved by the local human services agency
6. Resides in a shelter facility for battered women that has a contract with the Department of Corrections
7. Or is one of the following:
   - (a) a person who has an application pending for or is appealing a termination of Social Security disability payments, as long as the person has a professionally certified illness or disability
   - (b) a person who is assessed as not employable
   - (c) a person under age 18 in certain specified circumstances and with consent of the local agency
   - (d) a person who is eligible for displaced homemaker services and is enrolled as a full-time student
   - (e) a person who lives more than four hours round-trip traveling time from any potential suitable employment
   - (f) a person involved with protective or court-ordered services that prevent working at least four hours per day
   - (g) a person over the age of 18 whose primary language is not English and who is attending high school at least half time
   - (h) a person who is learning disabled and, if a rehabilitation plan is developed or approved by the local agency, the person is following the plan

GA Ineligibility

GA is not provided to:

- fugitive felons and parole and probation violators; or
- persons who have fraudulently misrepresented residency to obtain assistance in two or more states (GA is not provided for ten years).

Special requirements apply to persons convicted of a felony drug offense after July 1, 1997. The person is not eligible for GA for five years after completing his or her sentence, unless the person has successfully completed a drug treatment program or is assessed as not needing such a program. Once eligible for GA, these individuals are subject to random drug testing and are subject to losing GA eligibility for another five years after either a positive test result or completing their sentence for a subsequent drug felony conviction.

Benefits

GA recipients are not required to participate in employment and training services as a condition of receiving benefits.

GA Grants

GA recipients receive a monthly cash assistance payment, called a grant. The amount of a recipient's grant is determined by subtracting the recipient's net income from the applicable monthly GA assistance standard.

Monthly GA Standards for Single Persons and Childless Couples

Eligible Units	Monthly Standard
One adult	$203
Emancipated minor	203
One adult, living with parent(s) who have no minor children	203
Minor not living with parent, stepparent, or legal custodian (with social service plan approval)	250
Married couple with no children	260
One adult, living in a medical facility or in group residential housing	84 (plus add $12 for those in GRH)

Unlike MFIP, the GA program does not include an employment and training component. GA recipients are not required to participate in employment and training services as a condition of receiving benefits.

Emergency General Assistance

Applicants with insufficient income or resources may be eligible for a GA grant for emergency needs, not to exceed 30 days, as long as the applicant is not a recipient of MFIP benefits. An individual or family may not receive EGA more than once in any 12-month period. Persons or families in need who are not state residents may also receive assistance to meet emergency needs. In the case of

nonresidents, state law provides that the 30-day residency requirement is not waived when a person applies for EGA (Minn. Stat. § 256D.02, subd. 12a, para. f). EGA grants may be made to the extent that funds are available. However, the governor has unallotted funds for EGA effective November 1, 2009, through June 30, 2011.

Group Residential Housing

Individuals who are eligible for GA can also be eligible for residence in community group residential housing facilities paid for by the state or county under Minnesota Statutes, chapter 256I. Group residential housing is a group living arrangement that provides at a minimum room and board to unrelated individuals. (The GA grant for a recipient who resides in a group residential housing facility is a personal needs allowance of $96 per month.)

Eligibility for Other Programs

GA recipients are automatically eligible for health care benefits through the General Assistance Medical Care (GAMC) program.

GA recipients may also be eligible for GAMC, Food Support, and MFAP.

GA recipients who are citizens, and some who are legal noncitizens, are also generally eligible for the federal Food Support program but must make separate application for those benefits. A GA recipient who also receives food support is exempt from the Food Stamp Employment and Training (FSET) program, but may volunteer for FSET services.

Legal noncitizen recipients of GA who are not eligible for federal food support solely because of their citizenship status may be eligible for the state-financed Minnesota Food Assistance Program. (See box on page 148.)

Payment of Benefits

GA grants are generally issued once per month on the first day of the month subsequent to the initial grant. For persons without a verified address, the county may issue checks on a weekly basis. Grants are paid directly to program recipients or to legally appointed guardians. In other circumstances, such as evidence of continual mismanagement of funds or drug dependency, the county may institute vendor payments. Vendor payments are payments made directly to the providers of goods and services (such as the landlord or the utility company). The county may also issue the GA grant as a "protective payment," i.e., the grant can be given to another individual to be spent on behalf of the recipient.

Funding and Expenditures

The state pays for the costs of GA benefits.

In state fiscal year 2008 the state paid out $41,999,363 in benefits to GA recipients. This figure does not include those residing in Group Residential Housing.

Recipient Profile

Most GA recipients are single persons (99 percent of GA recipients are single adults). Childless couples may also be eligible for GA. In state fiscal year 2008 the average monthly number of GA cases was 17,702.[7]

[7] Most GA cases consist of one person. However, GA data is available from DHS by cases only, not by the number of individual GA recipients.

Minnesota Family Investment Program

The Minnesota Family Investment Program (MFIP) is a jointly funded, federal-state program designed to provide income assistance for eligible low-income families. MFIP replaces the Aid to Families with Dependent Children (AFDC) program, which was repealed by Congress in 1996.

Administration

Congress

MFIP is the state's response to federal welfare reform.

With passage of the 1996 federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (Public Law 104-193), Congress eliminated the federal AFDC entitlement program and replaced it with Temporary Assistance for Needy Families (TANF), a block grant program to states. Under TANF each state receives a block grant of federal funds that it must use to assist its needy families. Each state has the authority to design its own program to assist these families, although there are specific requirements in the federal TANF law that apply to all state programs.

U.S. Department of Health and Human Services (DHHS)

DHHS administers the TANF block grant program. DHHS approves state TANF plans and monitors states' compliance with the various requirements of the federal law.

Minnesota State Legislature

The Minnesota Legislature authorized MFIP in the 1997 session. MFIP is Minnesota's TANF program; it is Minnesota's response to the welfare reform authority granted by Congress. The program uses the state's annual federal TANF block grant[8] and state appropriations to provide income assistance, employment and training services, and support services to eligible Minnesota families.

[8] Minnesota's annual TANF block grant amount is $267.985 million. Of this total, $4,550,816 goes directly to the Mille Lacs Band of Ojibwe for the operation of that tribe's separate TANF program. The remainder is available for the state to help fund its welfare reform activities, which include MFIP.

State Department of Human Services (DHS)

DHS directs the operation of MFIP throughout the state by issuing implementation instructions to counties, providing training for county staff, providing other technical support to counties, and assisting in eligibility and benefits determination through its centralized MAXIS computer system.

Counties

Counties administer MFIP. The county agency conducts intake and eligibility screenings, including orientations to the program. It also provides case management and assists MFIP participants in their employment and training efforts and meeting the other program requirements.

Mille Lacs Band of Ojibwe – Separate TANF Program

The federal TANF law authorizes American Indian tribes to apply for federal TANF funds to operate a Tribal TANF family assistance program that is separate from the state's program. One Minnesota tribe, the Mille Lacs Band of Ojibwe, applied for and received federal approval to operate a separate Tribal TANF program. The program serves TANF-eligible families where one or more of the eligible adults is a member of the Band (or in the case of the Tribal TANF program in the counties of Anoka, Hennepin, and Ramsey, a member of the Minnesota Chippewa Tribe). See Appendix VII for information about the unique features of the band's program.

Eligibility Requirements

MFIP provides cash and food assistance, employment and training services, and related support services and transitional services to eligible low-income Minnesota families.

In order to be eligible for MFIP, a family must:

- have income and assets under the program's limits; and
- satisfy the other eligibility requirements of the federal and state laws that govern the program.

Who's Who in an MFIP Household

An MFIP **caregiver** is a person who lives with, and provides care and support to, a minor child. Some caregivers must be included in the assistance unit (e.g., parents, stepparents); other caregivers may choose not to be included in the assistance unit (e.g., grandparents, other adult relatives, legal custodians).

The MFIP **assistance unit** is the group of people receiving MFIP benefits together.

An MFIP **participant** is a person who is currently receiving cash assistance or the food portion available through MFIP and may also be required to participate in employment and training services.

Income Limits

MFIP uses two different income standards to determine eligibility: the transitional standard and the shared household standard.

For an initial applicant to be eligible for MFIP, family income, after all allowable deductions are made, must be below the program's applicable income standard (See **Applicable MFIP Standards**, in box) for a family of like size. To make the eligibility determination, the county agency calculates an applicant's net income in two steps. First, the county subtracts all allowable disregards and deductions from the applicant's gross monthly earnings, to determine the applicant's net monthly earned income amount. These disregards and deductions include:

- 18 percent of gross earned income;
- actual dependent care costs paid by the applicant caregiver, up to a maximum of $200 per month for each child under age two, and $175 per month for each child age two or older;
- child support payments made by the applicant caregiver for the support of children not in the assistance unit; and
- an allocation for the unmet need of an ineligible spouse or child under age 21 who lives with the applicant caregiver and for whom the caregiver is financially responsible.

Second, the county adds all of the family's unearned income that is not otherwise excluded. The county compares the result to the applicable MFIP standard. If the result is at or below the standard, the family is eligible for MFIP.

Applicable MFIP Standards

Since January 1999, MFIP has used two different income standards to determine eligibility. The **transitional standard** is the program's basic income standard; it applies to households that do not include an unrelated member.

The **shared household standard** is used instead of the transitional standard when an MFIP household includes an unrelated member, and that person does not meet one of several exceptions that are specified in the MFIP law (for example, a roomer or boarder).

The shared household standard is lower than the transitional standard because the cash portion of the shared household standard equals 90 percent of the cash portion of the transitional standard for a given family size. (See **MFIP Monthly Income Standards** table, below.)

An eligible family's MFIP benefit is calculated by subtracting the net earned income amount from a family wage level that is 110 percent of the transitional standard for the same size family.

An eligible family's MFIP benefit is calculated by subtracting the net earned income amount from the family wage level.

If an eligible applicant family has only earned income, the county agency subtracts the net earned income amount from the family wage level for the same size family. The family's MFIP benefit is the difference between the family wage level and the net earnings, up to a maximum amount that is equal to the applicable standard for the same size family.

If an eligible family has both earned and unearned income, the county takes all unearned income that is not otherwise excluded and subtracts it, either (1) from the difference calculated under the preceding paragraph if the difference is less than the applicable standard, or (2) from the applicable standard, if the difference is equal to or greater than that standard's amount. The calculated result is the family's total MFIP benefit.

If an eligible family has only unearned income, the county agency subtracts all unearned income that is not otherwise excluded from the applicable standard. The family's MFIP benefit is equal to the resulting amount.

If an eligible family has no income, the family's MFIP benefit is equal to the applicable standard.

MFIP Monthly Income Standards
Effective April 1, 2009

Family Size	Transitional Standard	Shared Household Standard	Family Wage Level
1	$428	$403	$471
2	764	720	840
3	1,005	952	1,106
4	1,217	1,155	1,339
5	1,393	1,323	1,532
6	1,602	1,525	1,762
7	1,748	1,663	1,923
8	1,934	1,842	2,127
9	2,119	2,021	2,331
10	2,298	2,195	2,528
over 10	add $178 for each additional member	add $173 for each additional member	add $196 for each additional member

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$50 Subsidized Housing Provision

Effective July 1, 2003, MFIP families who receive rental housing assistance through the federal Department of Housing and Urban Development (e.g., Section 8 assistance) will have up to $50 of the housing subsidy amount counted as unearned income when the family's MFIP benefit is calculated. The following families are permanently exempt from the $50 housing provision:

- families where the caregiver is exempt from MFIP work requirements because the person is age 60 or over, or is certified to be ill, injured, or incapacitated
- families where the caregiver is exempt from MFIP work requirements because the person is needed in the home to care for a disabled or ill household member
- families where the parental caregiver receives federal Supplemental Security Income benefits

For an ongoing participant to continue to be eligible for MFIP, the county calculates net family income as follows.

When calculating a family's net income, a percentage of a participant's gross income is disregarded. Currently, the earned income disregard is 39 percent.

Until October 1, 1999, the county agency disregarded 36 percent of the participant's gross earnings. The amount of earnings remaining was the participant's net earned income amount. The county subtracted these net earnings from the appropriate family wage level amount. The family's MFIP benefit was the difference between the family wage level and the net earnings, up to a maximum amount that equaled the applicable standard.

In 1999, the legislature authorized an increase in the percentage of the earned income disregard used to calculate net family income on October 1, 1999, and again on October 1, 2001. Under this legislation, policymakers intended to ensure that a family of three would not become ineligible for MFIP until its income reaches at least 120 percent of the federal poverty guidelines. The 2001 Legislature made this adjustment permanent. Each October 1, the disregard will be adjusted to ensure that most MFIP families do not lose eligibility until their income reaches 115 percent of the federal poverty guidelines.

MFIP imposes asset limits of $2,000 for new applicants and $5,000 for ongoing MFIP participants.

Asset Limits

To be eligible for MFIP, the equity value of all nonexcluded assets must not exceed:

- $2,000 for an MFIP applicant; and
- $5,000 for an ongoing MFIP participant.

Certain items are excluded from these asset limits:

- ownership of a homestead, without regard to value
- up to $15,000 total loan value for all vehicles[9]
- assets used to produce income for self-support
- one burial space for each member of the MFIP assistance unit
- the value of ordinary household goods

[9] If a vehicle is essential to operating a self-employment business, its entire value is excluded.

- assets owned by a person receiving federal Supplemental Security Income (SSI) benefits
- the value of life insurance policies for members of the assistance unit

Other items are excluded from these asset limits:

- the value of corrective payments in the month received and in the following month
- proceeds from the sale of the home (excluded for six months if another home will be purchased)
- disaster relief funds
- tax refunds and credits (excluded in the month received and in the following month)
- savings from a minor's earnings that are set aside for future educational or employment costs
- payments excluded under federal law (for example, low-income home energy assistance (LIHEAP) or Americorps benefits)
- school loans and scholarships
- special funds to replace or repair assets (excluded for three months)
- amounts escrowed for business expenses
- amounts escrowed for real estate taxes and insurance
- value of gift cards

Among other requirements, an MFIP participant must have a minor child and assign rights to child support.

Additional Eligibility Requirements for MFIP

To receive MFIP, families who meet the program's income and asset limits must also:

- have a minor child in the home (or be pregnant);
- be residents of Minnesota;
- be U.S. citizens, qualified noncitizens, or noncitizens otherwise lawfully residing in the United States;
- assign rights to child support;
- have received fewer than 60 months of assistance; and
- satisfy any other eligibility requirements of the program.

This section provides more information about each of these additional requirements.

Eligible families must have a minor child. To receive MFIP assistance, a family must include at least one minor child or a pregnant woman.

Eligible families must be residents of Minnesota. A resident is defined as an individual who has been domiciled in Minnesota for at least 30 days, with the intent to remain here. As long as one member of an MFIP assistance unit meets this 30-day residency requirement, the entire unit is considered to have met it. Time spent in a battered women's shelter counts towards this requirement.

Families facing an unusual hardship because they are without alternative shelter or without resources for food are exempt from the 30-day residency requirement. Migrant workers and their immediate families are also exempt from this requirement if the worker verifies that the migrant family earned at least $1,000 in Minnesota within the last 12 months.

Eligible families must be citizens of the United States, qualified noncitizens, or noncitizens otherwise lawfully residing in the United States. Undocumented noncitizens and nonimmigrant[10] noncitizens are not eligible for MFIP.

The state is prohibited by the federal TANF law from using its federal block grant to pay for MFIP benefits to legal noncitizen families, unless they fall into one of the categories specified as eligible in the federal law. However, under the MFIP law the state opted to make legal noncitizen families who meet all other MFIP requirements eligible for the program, and to use only state monies to pay for those families' cash assistance.[11] The effect of this decision is that for some legal noncitizen participants, their MFIP cash assistance is paid entirely with state dollars, and no federal TANF funds are used.

Noncitizen Eligibility for MFIP Cash Benefits. The following table identifies the categories of noncitizens who are not eligible for MFIP, the categories for whom the state may use federal funds to provide MFIP cash benefits, and the categories for whom the state may not use

[10] A nonimmigrant is a person who is lawfully present in the United States, but who is not lawfully residing in the United States (because the person maintains a residence outside the United States). Nonimmigrants are generally admitted temporarily and for a limited purpose (e.g., tourists, foreign students).

[11] Laws 1997, ch. 203, art. 9, § 21, as amended by Laws 1998, ch. 407, art. 6, § 111; Laws 2000, ch. 488, art. 10, § 28; Laws 2001, 1st spec. sess., ch. 9, art. 10, § 21; and Laws 2003, 1st spec. sess., ch. 14, art. 1, § 105.

federal funds, but instead uses only state funds to provide MFIP cash assistance. The entry "N/A" in the table indicates categories where using state monies to provide cash assistance is not applicable, since federal TANF funds may be used to pay for the MFIP cash benefits of participants in those categories.

MFIP Cash Benefits: Noncitizen Eligibility by Source of Funds

Category of Noncitizen	Eligible for federally funded cash portion?	Eligible for state-funded cash portion?
Undocumented noncitizens	No	No
Nonimmigrant noncitizens	No	No
Refugees; Asylees; Persons granted withholding of deportation; Cuban/Haitian entrants; Amerasians from Vietnam; and victims of a severe form of trafficking[12]	Yes	N/A
Veterans or persons on active military duty, along with their spouses and dependent children	Yes	N/A
Lawful permanent residents[13] who entered U.S. before 8/22/96	Yes	N/A
Lawful permanent residents who entered U.S. on or after 8/22/96	Only after have been in U.S. for five years	Yes, if federal funds can't be used
Battered noncitizen who is the spouse or child of a citizen or lawful permanent resident, and who entered U.S. before 8/22/96	Yes	N/A
Battered noncitizen who is the spouse or child of a citizen or lawful permanent resident, and who entered U.S. on or after 8/22/96	Only after have been in U.S. for five years	Yes, if federal funds can't be used
Noncitizens paroled into U.S.[14] for at least one year, before 8/22/96	Yes	N/A
Noncitizens paroled into U.S. for at least one year, on or after 8/22/96	Only after have been in U.S. for five years	Yes, if federal funds can't be used
Noncitizens paroled into U.S. for less than one year; Persons granted temporary permission to remain in U.S. (e.g., temporary protected status,[15] lawful temporary residents); Noncitizens applying for asylum	No	Yes

[12] A victim of severe forms of trafficking is a noncitizen who is forced into the international sex trade, prostitution, slavery, and forced labor through coercion, threats of physical violence, psychological abuse, torture, and imprisonment. The federal Trafficking Victims Protection Act of 2000 provides that victims of severe forms of trafficking are eligible for federal public assistance benefits to the same extent as a noncitizen who is admitted into the United States as a refugee.

[13] A lawful permanent resident is generally a person who has a "green card," which means the person has permission to live and work permanently in the United States and can apply for naturalization after living for five continuous years in the United States.

[14] A person is "paroled into the U.S." when the U.S. Justice Department uses its discretion to grant temporary admission to the United States for humanitarian, legal, or medical reasons.

[15] Temporary protected status is granted to a person living in the United States who is from a designated country where conditions make it unsafe for the person to return.

Noncitizen Eligibility for MFIP Food Benefits. MFIP benefits also include a food portion that is funded with federal Food Support dollars. (See Benefits, page 32.) As part of the 1996 federal welfare reform act, noncitizen eligibility for the federal Food Support program was severely limited; however, the 2002 Farm Bill restored eligibility for many noncitizens. Because MFIP uses federal Food Support funding, these noncitizen eligibility restrictions apply to MFIP. However, when the MFIP law was originally enacted the state opted to make legal noncitizen families who meet all other MFIP requirements eligible for the food portion, and to use only state monies to pay for the MFIP food portion for those families for whom federal Food Support funds may not be used.

The decision to use state funds to provide the MFIP food portion to noncitizen families who were not eligible for federally funded food assistance was originally enacted for limited time periods and was scheduled to sunset on June 30, 1999. However, the 1999 Legislature made permanent the provision of state-funded food assistance to noncitizen MFIP families who are not eligible for federally funded food assistance (Minn. Stat. § 256J.11, subd. 2).

The following table identifies the categories of noncitizens who are not eligible for the food portion of MFIP, the categories for whom the state may use federal Food Support funds to provide MFIP food assistance, and the categories for whom the state may not use federal funds, but instead uses only state funds to provide MFIP food assistance.

MFIP Food Portion: Noncitizen Eligibility by Source of Funds

Category of Noncitizen	Eligible for federally funded food portion?	Eligible for state-funded food portion?
Undocumented noncitizens	No	No
Nonimmigrant noncitizens	No	No
Refugees; Asylees; Persons granted withholding of deportation; Cuban/Haitian entrants; Amerasians from Vietnam; and victims of a severe form of trafficking	Yes	No
Veterans or persons on active military duty, along with their spouses and dependent children	Yes	No
Immigrants who are lawfully residing in U.S.[16] and who are receiving federal assistance payments for blindness or disability (i.e., SSI or SSDI)	Yes	No
Immigrants who were lawfully residing in U.S. on 8/22/96 who were age 65 or older on that date	Yes	No
Immigrant children lawfully residing in U.S. who are currently under age 18	Yes	No
American Indians born in Canada who have at least 50% Indian blood and other noncitizen American Indian applicants who are members of a tribe that is eligible for U.S. programs	Yes	No
Persons lawfully residing in U.S. who were members of a Hmong or highland Laotian tribe who assisted U.S. armed forces during the Vietnam era and their spouses, dependent children, and unremarried widows/widowers	Yes	No
Lawful permanent residents, regardless of date admitted, who don't meet one of above qualifications	Only if lawfully residing in the U.S. for at least five years or have 40+ quarters of work history in U.S.	Yes, if federal funds can't be used
Battered noncitizen who is the spouse or child of a citizen or lawful permanent resident, and who doesn't meet one of above qualifications, regardless of date admitted	No	Yes
Noncitizens paroled into U.S. for at least one year, who don't meet one of above qualifications, regardless of date admitted	No	Yes
Noncitizens paroled into U.S. for less than one year; Persons granted temporary permission to remain in U.S. (e.g., temporary protected status, lawful temporary residents); Noncitizens applying for asylum	No	Yes

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[16] The category of "lawful permanent residents" is not the same as the category of immigrants "who were lawfully residing in the U.S." The first category covers a smaller group than the second category, because an immigrant can be lawfully residing in the United States, but not have lawful permanent resident immigration status.

The state MFIP law has two other requirements that affect a legal noncitizen's eligibility for MFIP. First, if the noncitizen has a sponsor who executed an affidavit of support, the county must deem, or count as if it were the noncitizen's, the income and assets of the noncitizen's sponsor and the sponsor's spouse in determining the noncitizen's eligibility for MFIP.

Second, in cases where a noncitizen's benefits are funded entirely with state money, the MFIP law also requires that, unless exempted, a legal adult noncitizen receiving MFIP who has been a lawful permanent resident for at least four years must make specified efforts to pursue English literacy, English as a Second Language proficiency, or U.S. citizenship in order to remain eligible for MFIP.

Eligible families must assign rights to child and spousal support, child care support, and medical support. MFIP participants must assign all rights to child support, spousal support, and child care support, if applicable, to the state. Families who fail to assign these rights are not eligible for MFIP.[17] The state distributes, or passes-through, all current child support and maintenance collections to MFIP participants. The child support payments are treated as unearned income when calculating MFIP eligibility and benefit amounts. This means that the family's MFIP grant will be reduced, dollar-for-dollar, by the amount of the child support payment. (For more information about child support, see *Minnesota's Child Support Laws: An Overview*, House Research Department, June 2007.)

MFIP participants must also cooperate with county child support enforcement efforts. Unless the participant has a good cause exemption from cooperating, noncooperation makes the participant subject to sanctions. (See Sanctions, page 44.)

Eligible families must have received fewer than 60 months of AFDC or MFIP assistance since July 1, 1997. The federal TANF law sets a **lifetime limit of 60 months** for assistance units that include an adult who receives assistance using federal TANF money. Minnesota began counting participants' time on assistance towards this 60-month limit in July 1997. Most of the first families started to reach this time limit in July 2002.[18]

[17] If an MFIP participant fails to assign rights to medical support, if applicable, to the state, the participant is not eligible for Medical Assistance (MA) benefits.

[18] Some families may have reached the time limit before July 2002 because they accrued months of TANF assistance in a state that implemented time limits earlier than Minnesota.

MFIP has a 60-month lifetime limit for receiving assistance.

The state MFIP law specifies several situations where time spent on MFIP does not count towards the 60-month lifetime limit on assistance. MFIP caregivers who are age 60 or over are exempt from the 60-month lifetime limit on assistance. For an adult who is receiving MFIP and lives in Indian country,[19] months when at least 50 percent of the adults in Indian country are not employed do not count towards the 60-month limit. Months when a family receives payments provided to meet short-term needs under the MFIP consolidated fund or diversionary work benefits also do not count towards the 60-month limit. (See Eligibility for Other Programs, page 34.)

For an MFIP caregiver who is a victim of family violence, months when the person is complying with a modified employment plan do not count towards the 60-month limit. (See Special Provisions for Victims of Family Violence, page 43.) Participants extended for this reason are required to participate in Family Stabilization Services and meet that program's requirements. (See below.)

For custodial parents who are under age 20, time spent on MFIP as a teen caregiver does not count towards the 60-month limit, as long as the teen complies with the program's special requirements for teen caregivers. (See Special Requirements for Caregivers Under Age 20, page 39.)

Some families may be eligible for MFIP after they reach the 60-month limit. An extension is when assistance is provided to families who are subject to and who reach the time limit if the family meets certain criteria. Under the federal TANF law, a state may provide TANF-funded assistance to families who have reached the 60-month limit, for up to 20 percent of the state's caseload on the basis of hardship, or if the family includes someone who has been subject to domestic violence. A state may also provide assistance to more than 20 percent of its caseload if it uses state-only funds.

The 2001 Legislature authorized the extension of assistance to certain groups of hardship cases.[20] Families that reach the time limit and meet the following criteria are eligible for an extension:

- **Ill or incapacitated**. Participants who are ill or incapacitated; are needed in the home to care for a household member who is ill or incapacitated; or have a household member who meets certain disability or medical criteria. Participants extended for

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[19] Indian country is a term that is generally defined under federal law as including Indian reservations, dependent Indian communities, and Indian allotments (18 U.S.C. § 1151).

[20] Amended by Laws 2003, 1st spec. sess., ch. 14, art. 1, §§ 54 to 60.

this reason are required to participate in Family Stabilization Services and meet that program's requirements. (See below.)

- **Hard to employ**. Participants who are diagnosed as having mental retardation or mental illness, and that condition severely limits the person's ability to obtain or retain suitable employment; are considered unemployable or are employable, but employability is limited due to a low IQ; or have a learning disability. Participants extended for this reason are required to participate in Family Stabilization Services and meet that program's requirements. (See below.)

- **Employed participants**. A one-parent family in which the parent is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week are spent in employment; a two-parent family if the parents are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week are spent in employment. To qualify, the parent in a one-parent family or both parents in a two-parent family must not have been sanctioned for at least ten out of the 12 months before reaching the 60-month time limit, including the 60th month.

In general, families who receive an extension may continue to receive MFIP assistance until the family no longer meets the extension criteria or the MFIP eligibility requirements. Families who receive an extension for the hard-to-employ or employed participants must continue to meet the MFIP employment and training requirements. Families who do not comply with the requirements are subject to a sanction.

Counties may request an extension for a category of participants that are not already extended, as long as the extension is for participants who are unable to meet MFIP requirements due to other statutory requirements or obligations. An example of such a category might be a group of participants who are required by the court to attend a chemical dependency treatment program and attendance would prevent the participant from meeting the hourly work requirements for an extension. DHS must approve a county's request to extend a category of participants and the commissioner must report the extensions to the legislature by January 15 of each year. The legislature must act in order for the extensions to continue.

For more information on the 60-month time limit, see *The 60-month Time Limit on TANF Assistance*, House Research Department, January 2002.

Other Special Requirements for and Prohibitions Against Eligibility

In a few special cases, the MFIP law imposes additional conditions for eligibility or prohibits eligibility altogether.

MFIP assistance is not available for minor custodial parents, unless they and their child live in the household of a parent, legal guardian, or other adult relative, or in adult-supervised supportive living arrangements.

MFIP is not provided to:

- fugitive felons and parole and probation violators; or
- persons who have fraudulently misrepresented residency to obtain assistance simultaneously in two or more states (MFIP is not provided for ten years).

Benefits

MFIP benefits are vendor paid or come in the form of an electronic debit card, with portions for cash and food.

MFIP benefits are based on family size, with the MFIP grant composed of a cash portion and a food portion.[21] Counties issue both the cash and the food portion of an MFIP family's grant in electronic debit card form, called EBT (Electronic Benefits Transfer). However, the two kinds of benefits are electronically segregated on the family's EBT card. This ensures that the family can only use the food portion of their MFIP benefit to purchase food items that are approved under the federal Food Support program, from a retailer that has been approved under that program. There are no such restrictions on the cash portion of the MFIP benefit; the family accesses these benefits through automatic teller machines (ATMs).

However, **MFIP benefits are vendor paid**[22] for all new applicants, for the first six months they receive assistance. The only exception is for MFIP households where the caregiver is not the parent of the child receiving assistance, and this nonparental caregiver is receiving MFIP assistance only on behalf of the child, but not for themselves.

[21] MFIP families receive the food portion of assistance as a part of the MFIP grant, instead of receiving a separate benefit through the federal Food Support program. The MFIP food portion uses the same EBT mechanism to deliver the food benefits as the Food Support program does.

[22] Vendor payments are cash assistance benefits that are paid directly to a provider of goods or services. For a new applicant, the county vendor pays the applicant's shelter costs up to the amount of the cash portion of the MFIP grant.

MFIP Assistance Standards Effective April 1, 2009

Family Size	Full Transitional Standard	Food Portion	Cash Portion
1	$428	$178	$250
2	764	327	437
3	1,005	473	532
4	1,217	596	621
5	1,393	696	697
6	1,602	829	773
7	1,748	898	850
8	1,934	1,018	916
9	2,119	1,139	980
10	2,298	1,263	1,035
over 10 (add for each additional member)	178	125	53

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When a household includes a person who is unrelated to the members of the MFIP assistance unit, the household's MFIP benefit is calculated based on the **shared household standard** instead of the transitional standard. The shared household standard is equal to 90 percent of the cash portion of the transitional standard for a given family size, plus the full food portion for the same family size.[23]

"Opting Out" of the Cash Portion of MFIP Grant

The 1998 Legislature amended the MFIP law to allow an MFIP family to choose to discontinue receiving the cash portion of their MFIP grant. Once a family does not receive a cash portion of the MFIP grant, their subsequent months on MFIP do not count towards the family's 60-month lifetime limit on assistance. However, the family still receives the other benefits of MFIP, such as the MFIP food portion and MFIP child care assistance; the other requirements of MFIP still apply to the family.

[23] The MFIP law specifies several exceptions when the shared household standard does not apply (Minn. Stat. § 256J.24, subd. 9).

MFIP benefits are vendor paid for persons convicted of a felony drug offense after July 1, 1997. These individuals are also subject to random drug testing and are subject to sanctions in the month after a positive test result.

MFIP benefits are issued in the form of protective payments for minor custodial parents on MFIP; that is, the grant is paid to another individual on behalf of the minor MFIP caregiver and the minor caregiver's child.

Eligibility for Other Programs

Under the old AFDC rules, MFIP participants were automatically eligible for MA benefits. However, the federal TANF law changed the eligibility requirements so that eligibility for MA is not automatic. As of July 1, 2002, MFIP participants have had MA eligibility determined separately from MFIP eligibility. MFIP participants are eligible for MA if they meet income, asset, and other eligibility requirements that apply to families and children under MA. Families who do not meet the criteria for MA can apply for MinnesotaCare.

MFIP participants are also eligible for MA and MFIP Child Care Assistance, or may be eligible for MFIP consolidated fund short-term assistance.

MFIP participants who are working or otherwise involved in the employment and training services component of MFIP are eligible for assistance with their child care costs through the MFIP Child Care Assistance program.[24]

Counties also screen MFIP applicants to see if they are eligible for the Diversionary Work Program or other short-term assistance.

Diversionary Work Program (DWP)

The 2003 Legislature established the DWP to provide short-term diversionary benefits to eligible recipients; the benefits are designed to lead to unsubsidized employment, increase economic stability, and reduce the risk of families needing longer-term assistance. Families who meet the DWP eligibility requirements are prohibited from receiving MFIP assistance. However, counties may provide supportive and other allowable services funded by the MFIP consolidated fund. Eligibility for DWP is limited to a maximum of four consecutive months once in a 12-month period.

[24] Families who leave MFIP due to either an increase in income from earnings or an increase in child or spousal support payments may be eligible for 12 months of child care assistance through the Transition Year Child Care Assistance program.

All families who apply and are eligible for MFIP must first participate in the DWP, with certain exceptions. To be eligible for DWP, participants must:

- cooperate with child support enforcement;
- provide the Social Security numbers of all family members; and
- develop an employment plan or family stabilization plan.

All DWP caregivers must participate in a DWP employment plan, except caregivers who meet certain criteria.

A family's eligibility for DWP cash benefits is based on the number of persons in a family unit, the family maintenance needs, personal needs allowance, and countable income. Housing and utilities must be vendor paid. The minimum cash benefit amount is $10 per month. Counties must convert or refer participants to MFIP if the county determines that a participant is unlikely to benefit from DWP.

The goal of DWP is to divert families from MFIP by providing short-term assistance and intensive employment services. A family receiving DWP may also receive Food Support, but is ineligible for MFIP during the period of time covered by DWP.

MFIP Consolidated Fund Short-Term Benefits

The MFIP consolidated fund allows for short-term nonrecurring shelter and utility needs to be expended for eligible families. Eligibility requirements include presence of a minor child in the household and income below 200 percent of the federal poverty guidelines. Counties must give priority to families currently receiving MFIP, DWP services, or Family Stabilization Services.

Family Stabilization Services

In 2007, the legislature established the Family Stabilization Services program to stabilize and improve the lives of families at risk of long-term welfare dependency who are not making significant progress within MFIP. Participants in MFIP or DWP may be eligible for Family Stabilization Services if the participant meets the hardship extension requirements for MFIP (but is not approaching the 60th month of MFIP participation), has applied for Supplemental Security Income or Social Security disability insurance, is a noncitizen in the United States for 12 or fewer months, or is age 60 or older.

Family Stabilization Services are provided through a case management model. If a participant already has a case manager through social services, disability services, or housing services, that case manager may also be the case manager for family stabilization services. A family stabilization plan must be established for each participating family by the case manager in conjunction with the participant. This plan must include:

- a long-term plan for self-sufficiency for each participant;
- an assessment of each participant's strengths and barriers; and
- an identification of the supports, education, training, and services needed to reduce or overcome these barriers.

Transitional Assistance

Effective October 1, 2009, a work participation bonus is available for employed participants leaving the MFIP or DWP. Families may be eligible for a transitional assistance payment of $50 per month to assist them in meeting their family's basic needs. Transitional assistance payments are available for up to 24 consecutive months and do not count towards the MFIP 60-month time limit.

To be eligible for transitional assistance payments, a participant must:

- not receive MFIP cash assistance or DWP assistance; and
- be single caregivers with children under six and working at least 87 hours per month;
- be single caregivers without a child under six and working at least 130 hours per month; or
- be a two-parent family with at least one parent employed an average of 130 hours per month.

Other MFIP Features and Requirements

Employment and Training

MFIP participants must spend a specified number of hours every week in work or other work activity.

MFIP is designed to be a welfare program that "expects, supports, and rewards work."[25] MFIP caregivers are required to spend a specified number of hours per week engaged in work or other work activity.[26] For example, a caregiver who is in the initial job search step of MFIP's employment and training component is expected to spend an average of 30 hours per week, for six weeks, in job search activities.

During the other steps of the MFIP employment and training process, a single-parent family with at least one child under age six must participate in at least 87 hours of work activities per month; a single-parent family with no children under age six must participate at least in 130 hours of work activities per month; and a two-parent family must participate in at least 55 hours per week (hours are combined).

Both single- and two-parent families are required to meet the program's work requirements within one month of receiving the first MFIP grant.

MFIP has special requirements for custodial parents who are under age 20 and lack a high school diploma or its equivalent. These requirements begin when a teen parent receives the first MFIP monthly grant. (See Special Requirements for Caregivers Under Age 20, page 39.)

Employment and Training Services Providers

Counties provide employment and training services to MFIP participants.

The MFIP law allows counties to choose from among three types of employment and training services providers: agencies with which a county has contracted to provide employment and training services; a county agency that has opted to provide employment and training services as its own provider; and a local public health department that a county has designated to provide employment and training services.

Each county, or group of counties working cooperatively, must offer MFIP employment services participants a choice of at least two employment and training providers, unless doing so would be a financial hardship for a county. A county may choose to provide services on its own as one of these providers. A county can also meet

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[25] From the DHS flyer Statewide Minnesota Family Investment Program (publication DHS-3179).

[26] Some caregivers are exempt from employment and training services requirements.

this provider choice requirement by using a workforce center[27] that uses multiple employment and training services and offers multiple service options as its employment and training services provider.

In two-parent MFIP families, each parent must choose the same employment and training services provider, unless a parent has an identified special need that is not available through the provider being used by the other parent.

Employment and Training Services Process for MFIP Participants

MFIP participants must participate in MFIP employment and training activities or face the possibility of a sanction.

The county's employment and training service provider (whose staff are generally called "job counselors") first provides an overview of the employment and training component of MFIP. The job counselor then conducts an assessment of an MFIP participant's ability to obtain and retain employment. If the job counselor's opinion is the person is likely to be able to obtain unsubsidized employment, the person is required to conduct up to six weeks of job search, at 30 hours per week,[28] and accept any offer of suitable employment.[29] Employment plan activities and hourly requirements may be adjusted, as necessary, to accommodate the personal and family circumstances of participants. Employment plans must be reviewed every three months.

Family Cap

The 2003 Legislature limited MFIP cash benefits for MFIP recipients who have additional children.[30] MFIP assistance units are prohibited from receiving an increase in the cash portion of the transitional standard as a result of the birth of a child, unless:

- for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

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[27] A workforce center brings together state, county, and private nonprofit employment and training-related services under one roof, to provide a seamless and comprehensive system for job seekers and employers. There are 50 workforce centers throughout the state.

[28] In a two-parent family, the job search requirement is 30 hours per week for each parent.

[29] MFIP defines "suitable employment" as work that is within the person's physical and mental abilities, pays at least minimum wage, meets applicable health and safety standards, and complies with antidiscrimination laws.

[30] Minn. Stat. § 256J.24, subd. 6.

- for families who apply for DWP or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;
- the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;
- the child's mother is a minor caregiver and the child, or children, are the mother's first birth; or
- the adult parent or parents have not received DWP benefits or MFIP assistance in the previous ten months. This applies to any child previously excluded in determining family size.

An excluded child must be included in determining family size for the purposes of determining the food portion of the transitional standard and is deemed an MFIP recipient for purposes of child care eligibility.

The income and resources of an excluded child, except child support received or distributed on behalf of the child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit. The caregiver must assign support and cooperate with child support enforcement to establish paternity and collect child support on behalf of the excluded child.

County agencies are required to inform applicants of this provision at the time of application and at recertification.

Special Requirements for Caregivers Under Age 20

In most cases, education is the first priority for teen MFIP caregivers.

Individual Assessment Required

The employment and training requirements are different if the MFIP caregiver is a custodial parent under age 20. Within a month of receiving MFIP benefits the county must document the teen caregiver's educational level. If the teen has not obtained a high school diploma or its equivalent, the county must also assess the teen's educational progress and needs, unless the caregiver is exempt from attending school or has chosen to have an employment plan. The purpose of this individual assessment is to identify an appropriate educational option for the teen. If the teen caregiver is a minor, the county social services agency conducts this assessment. If the teen caregiver is 18 or 19 and chooses to have an employment plan with an education option, the job counselor conducts this assessment (or, at a

county's option, the county social services agency may also conduct this assessment for these older teens).

Education Is Teen's First Option

If the individual assessment identifies an appropriate educational option for the teen, the teen caregiver's employment plan must require the teen to complete the educational option as the teen's first goal.

The MFIP law requires an MFIP caregiver who is a custodial parent under age 20 and who has not yet obtained a high school diploma or its equivalent to attend high school or another equivalent training program. If this is the case, the 60-month MFIP limit stops while the teen pursues his or her education. A teen caregiver who does not attend school faces the possibility of a sanction, unless one of a limited number of exemptions applies:

- transportation to attend school is unavailable
- appropriate child care is unavailable
- the teen caregiver is ill or incapacitated seriously enough to prevent attending school
- the teen caregiver is needed to care for an ill or disabled household member

Employment and Training When Education Is Not Appropriate

The individual assessment may indicate that an MFIP teen caregiver does not have an appropriate educational option, even though the teen lacks a high school diploma. If the teen is age 18 or 19, the general MFIP employment and training services requirements apply, and the job counselor and teen must develop an employment plan. If the teen is under age 18, the teen must be referred to the county's social services agency, where a plan for the teen parent and child must be developed.[31]

If an MFIP caregiver is a custodial parent who is under age 20 and has a high school diploma or its equivalent, the general MFIP employment and training services requirements apply. However, a county may opt to have a social services agency conduct the required initial assessment and complete the job search support or employment plan.

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[31] An 18- or 19-year-old custodial parent who has been receiving services from a social services agency, and who does not yet have a high school diploma, may choose whether to continue to receive services from the social services agency or to instead use an employment and training services provider (Minn. Stat. § 256J.54, subd. 2).

What Counts as Work

In MFIP, a work activity is "any activity in a participant's approved employment plan that leads to employment" (Minn. Stat. § 256J.49, subd. 13). The statute also specifies that this includes activities that meet the definition of work activity under the participation requirements of TANF. (See Appendix VI for a discussion of the federal work requirements.)

Job search activities, and all of the activities in a person's employment plan, count as work activities for the purpose of meeting the MFIP hourly work requirements. The MFIP definition of work activity includes, but is not limited to, any of the following nine activities:

1. Unsubsidized employment, including work study and paid apprenticeships or internships
2. Subsidized private or public sector employment, including grant diversion, on-the-job training, the self-employment investment demonstration program, paid work experience, and supported work
3. Unpaid work experience, including the community work experience program and community service
4. Job search, including job readiness assistance and job-related counseling
5. Job readiness education, including English as a second language, general educational development course work, high school completion, and adult basic education
6. Job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment
7. Providing child care services to a participant who is working in a community service program
8. Activities included in the employment plan
9. Pre-employment activities, including chemical and mental health assessments, treatment, and services, or other programs designed to enhance employment

Generally, MFIP is designed to give the job counselor a great deal of discretion in approving activities for inclusion in a participant's job search support plan or employment plan. However, the 2003 Legislature limited that discretion by providing that adult basic education is an approved work activity only for participants who are proficient in reading or math below a ninth grade level, with the

exception of classes related to obtaining a GED. The 2003 Legislature also provided that English as a second language classes are an approved work activity only for participants who are below a specified level on a nationally recognized test (Minn. Stat. § 256J.531, subds. 1 and 2).

Postsecondary Education as a Work Activity

Postsecondary education, included under item six on the list of work activities, is not routinely available to MFIP participants. In order for a postsecondary education program to be an approved activity in an employment plan, the participant must be working in unsubsidized employment at least 20 hours per week and the education program must meet criteria specified in the law. These criteria include documentation about: the value of the program in obtaining significantly higher paying employment; the availability of suitable employment that requires the training or education provided by the program; and the participant's ability to meet the admission requirements and complete the program.

In order for an education program to be included in a participant's employment plan, the person must also fit into one of the following categories:

1. At the initial assessment the person has presented a plan for an education or training program that lasts 24 months or less and meets the required criteria for education or training programs
2. At the initial assessment the job counselor determines that the person needs refresher courses for professional certification or licensure. These courses must be included in the person's job search support plan or employment plan
3. The job counselor and the person have included specific goals in the person's employment plan that can only be met with the additional education or training
4. The person is already involved in training or education activities, the activities are modified with job counselor approval as needed to meet the MFIP criteria for education or training programs, and the person's hours spent in those activities, either alone or combined with hours spent in employment, meet the MFIP hourly work participation requirements

The MFIP law also requires a participant for whom a postsecondary education or training program has been approved to maintain satisfactory progress in the program.

Post-secondary education under MFIP is limited to 24 months.

Under MFIP, postsecondary education is limited to 24 months (Minn. Stat. § 256J.53).

A person who has completed a post-secondary education or training program and does not meet the work participation requirements must complete six weeks of job search. If at the end of six weeks the person has not found a job that is consistent with the person's employment goal, the person must accept any offer of suitable employment, or meet with the job counselor to revise the employment plan to include additional work activities necessary to meet hourly requirements.

Exception from Employment and Training Requirements

There is only one exception from the requirement to participate in the MFIP work requirements. This exception applies to families with a child under 12 months of age. The exception is available only once in a lifetime and applies to any child born to the family.

All MFIP caregivers must participate in employment services (Minn. Stat. § 256J.561). Employment plans must meet specified requirements, contain allowable work activities, and include a specified number of participation hours. Minor caregivers and caregivers who are under age 20 who have not completed high school or obtained a GED must meet specified requirements. A participant who has a family violence waiver shall develop and comply with an employment plan that may address safety, legal, or emotional issues, and other demands on the family as a result of the family violence. Employment plans for participants who meet certain other criteria must be tailored to recognize the special circumstances of these caregivers and families.

Special Provisions for Victims of Family Violence

An MFIP caregiver who is a victim of family violence may have the regular MFIP work requirements waived if the county agency has approved the person's employment plan and the person is complying with the plan.

The primary purpose of an employment plan for a victim of violence is "to ensure the safety of the caregiver and children." It may address safety, legal, or emotional issues and other demands on the family as a result of the family violence. A victim of family violence is not automatically deferred or exempt from regular MFIP work requirements. It is up to the job counselor and a person trained in domestic violence to determine whether participation in work

requirements would compromise the safety of the caregiver and children.

Sanctions

MFIP participants who do not comply with program requirements may be sanctioned through reduction of their monthly grant.

Another important feature of MFIP is its sanctions. The program has requirements that participants are expected to follow, such as attending the MFIP orientation, cooperating with child support enforcement efforts, developing and following the job search support plan or employment plan, and accepting an offer of suitable employment. A participant who does not follow a program requirement faces a sanction for noncompliance until one month after the participant comes into compliance with the requirements.

In general, for the first occurrence of noncompliance, the family's monthly grant is reduced by an amount that is equal to 10 percent of the transitional standard[32] for a family of that size. (See page 33 for a table listing the MFIP transitional standard by family size.) For a second, third, fourth, fifth, or sixth occurrence of noncompliance, the family's shelter costs are vendor paid up to the amount of the family's cash portion of their MFIP grant. (A county may opt to also vendor pay the family's utilities as part of this sanction.) Any remaining cash portion of the grant, and the food portion of the family's MFIP grant, is reduced by an amount equal to 30 percent of the applicable standard for a family of that size. Once a family's cash portion is being vendor paid as a result of a sanction, the vendor payments stay in effect until six months after the participant returns to compliance with MFIP requirements.

For a seventh occurrence of noncompliance by a participant in an assistance unit, or when the participants in a two-parent assistance unit have a total of seven occurrences of noncompliance, the county agency is required to close the MFIP case, both the cash and food portions and redetermine the family's continued eligibility for food support payments. The case must remain closed for a minimum of one full month.

Sanctions for participants who are receiving an extension follow the same sequence, except the family is disqualified for a fourth occurrence of noncompliance. The disqualified family may reapply for MFIP after the participant is in compliance for up to one month, but no assistance is paid during that month. If a disqualified participant reapplies for MFIP and has a second occurrence of noncompliance, the participant is permanently disqualified.

[32] Or 10 percent of the shared household standard, if that is the standard that applies to the family.

The MFIP law provides for slightly different levels of sanctions if the participant is being sanctioned for refusing to cooperate with child support requirements, or if the participant faces a dual sanction for refusing to cooperate with child support requirements as well as failing to comply with other program requirements. In all cases, each month that a participant does not follow a program requirement is considered a separate occurrence of noncompliance.

Funding and Expenditures

MFIP is funded with a combination of federal funds and state appropriations. The TANF block grant for each state is based on the state's historical expenditures for AFDC, JOBS (the old AFDC work and training program), and AFDC emergency assistance. Minnesota received approximately $268 million[33] annually in TANF block grant funding in federal fiscal years 1998 to 2008. The state legislature must appropriate federal TANF funds before the state can spend them.

Under the federal TANF law, a state must also spend its own resources to provide assistance to needy families. The federal law includes a maintenance of effort (MOE) provision that requires a state to spend 75 percent to 80 percent of the amount it spent in federal fiscal year 1994 under its old AFDC and related programs, including child care assistance to eligible families.[34]

In 2001, the legislature placed two-parent MFIP families in a separate state program, which means that assistance paid to these families is paid for using state-only dollars. Previous to TANF's reauthorization under the Deficit Reduction Act (DRA) of 2005, these two-parent families were not included in the federal two-parent family work participation rate of 90 percent. This resulted in a reduction of the state's required MOE to 75 percent. With the passage of the DRA, these two-parent families were included in work participation rates. In response, the legislature in 2006 moved two-parent families to a new program that is no longer used for TANF/MOE purposes. In state fiscal year 2008, the required minimum MOE amount was $176.7 million per year. The state currently uses general fund spending on MFIP cash assistance benefits, MFIP and Basic Sliding Fee Child Care, and noncitizen MA expenditures, as well as general fund

[33] Minnesota's TANF block grant amount is $267.985 million each year. Of this amount, $4,550,816 is allocated directly to the Mille Lacs Band of Ojibwe for the band's Tribal TANF program. This leaves the state with an effective annual block grant of $263.434 million.

[34] 42 U.S.C. § 609 (a) (7).

spending on state and county administrative costs and employment services, to meet its TANF/MOE requirement.

According to DHS, for state fiscal year 2008, total expenditures for MFIP and DWP were $262.8 million. Expenditures were $113.2 million for the cash portion of the grants and $116.6 million for the food portion. $74.6 million was financed with federal TANF funds, $116.6 million was from federal Food Support funds, and $71.6 million was from state appropriations.

The federal American Recovery and Reinvestment Act of 2009, Public Law 111-5, included a new emergency contingency fund for the TANF program. Funds are made available in fiscal year 2009 and 2010 to make grants to states in three areas: cash assistance caseload increases, nonrecurring short-term benefits, and expenditures for subsidized jobs. The fund reimburses states for 80 percent of the increased expenditures on basic assistance, nonrecurring short-term benefits, and/or subsidized employment. There is no state match or new MOE requirement for this fund. In addition, there is a two-year hold harmless to the caseload reduction credit to assist states in meeting work participation rates.

Recipient Profile

In fiscal year 2008, a monthly average of 98,028 people were receiving MFIP assistance. According to DHS, about 59 percent of these MFIP cases had one eligible parent, about 9 percent had two eligible parents, and about 32 percent were cases with no eligible parent in the household.[35]

The average family size among MFIP participants is about three people. About 73 percent of MFIP families have two or fewer children.

A large majority of MFIP caregivers are 20 years old or older. In December 2008, about 10 percent of MFIP families were headed by an eligible parent who is under age 20.

Most MFIP families (about 67 percent) live in the Twin Cities metropolitan area. And most MFIP caregivers (about 59 percent) have at least a high school education.

[35] Examples of situations where no eligible parent is included in an MFIP case are: the parent receives Supplemental Security Income (SSI) and is not included in the MFIP grant; it is a child-only case where MFIP benefits are paid only for a child in the household.

Minnesota Supplemental Aid

Minnesota Supplemental Aid (MSA) is a state program that provides supplemental cash assistance to aged, blind, and disabled persons who are SSI recipients, or who would qualify for SSI except for excess income.

Administration

Congress

MSA provides a required income supplement to the needy aged, blind, and disabled people who previously received higher benefits from various federal programs.

When Congress established the Supplemental Security Income (SSI) program (see SSI, page 54), it mandated that states supplement the payments of SSI recipients who had previously received higher benefits under the former Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Disabled (AD) programs. The MSA program delivers this mandated supplement to Minnesota recipients of SSI. Congress also offered states the option of supplementing the income of two other groups: (1) SSI recipients who had not received OAA, AB, or AD and (2) those who would have qualified for the former programs but are ineligible for SSI due to excess income or resources. Minnesota offers both optional supplements to Minnesota residents through the MSA program.

Congress has set general SSI program requirements for citizenship, disability determinations, and resource limits.[36] States with state-administered supplement programs, such as Minnesota, set their own eligibility requirements within the general framework of the federal requirements.

Minnesota State Legislature

The legislature established the MSA program in the Laws of Minnesota 1974, chapter 487. The state law was revised in 1989 as the Minnesota Supplemental Aid Act and is codified at Minnesota Statutes, sections 256D.33 to 256D.54. The state law includes:

- application procedures;
- eligibility requirements such as real and personal property limitations and income limits; and
- standards of assistance and methods of payment.

[36] States with federally administered supplement programs must adhere strictly to these requirements.

State Department of Human Services (DHS)

DHS supervises program administration. DHS maintains MAXIS, which is the centralized computer system for determining an applicant's eligibility for MSA and MSA grant amounts. DHS also assists counties in MSA administration by providing them with technical assistance on eligibility requirements and other program components.

Counties

The counties administer the MSA program. The county human services agency, through the MAXIS computer system, determines if an individual meets the state's eligibility requirements and calculates the amount of each recipient's MSA cash grant.

Eligibility Requirements

An elderly, blind, or disabled individual qualifies for MSA if his or her income and assets are below the limits established by the state legislature and DHS.

MSA helps the aged, blind persons of all ages, and disabled persons age 18 or older, whose income and resources are insufficient to meet the costs of their basic needs. An aged, blind, or disabled individual qualifies for MSA if his or her income and assets are below the limits established by the state legislature and DHS.

Income Limits

Under the direction of the Minnesota Legislature, DHS limits eligibility based upon maximum income levels for MSA recipients. The limits apply both to earned and unearned income.

To be financially eligible for MSA an individual must meet both a gross monthly income test and a net monthly income test. ("Gross monthly income" means a household's total nonexcluded income, before any deductions have been made. "Net monthly income" means gross income minus all deductions allowed by the program.)

To be eligible for MSA, the applicant must have **gross** income no greater than 300 percent of the SSI federal benefit rate (600 percent for a married couple). In calculating an applicant's gross income, state law also specifies that the MSA program excludes the same sources of income that the federal SSI program excludes in determining SSI eligibility (for example, the value of food support is excluded).

In addition, the applicant's **net** income must also be below the MSA benefit standards in order for the applicant to be eligible for MSA. (See assistance standards under Benefits, below.) The applicant's net monthly income is calculated by subtracting all of the applicable allowed income disregards and deductions from the applicant's gross monthly income.

In calculating net income for individuals who are SSI recipients, the county agency counts the full amount of their SSI federal benefit rate as gross unearned income. The county then allows for a $20 general income disregard.

For individuals who are not SSI recipients, the net monthly income calculation depends upon whether the individual lives in a long-term care facility where the Medical Assistance program (see MA, page 75) pays the cost of care. For these applicants the following disregards and deductions are calculated:

- a deduction for guardianship fees to a legally appointed guardian or conservator, up to 5 percent of the person's monthly gross income to a $100 maximum
- allocations allowed under the MA program for long-term care facility residents

For all other MSA applicants the county disregards or deducts the following amounts to calculate the applicant's net monthly income:

- for blind and disabled students under age 22, an earned income disregard of up to a maximum of $1,550 a month, not to exceed $6,240 in a calendar year
- a $20 general income disregard
- $65 of earned income; if both spouses are recipients, the disregard is $65 of the couple's combined earned income
- an impairment-related work expense deduction for disabled individuals
- one-half of the remaining earned income
- income set aside by a disabled or blind recipient (for up to 36 months) under an approved plan to achieve self-support (PASS)
- a limited work expense deduction for disabled or blind recipients

Asset Limits

Federal and state law and regulations also set the value of assets an individual may possess and be eligible for the MSA program. A single MSA recipient can have no more than $2,000 in net counted assets after all allowable exclusions. A married couple can have $3,000 in net counted assets.[37] Certain assets are excluded from consideration in calculating the value of an applicant's assets. Examples of excluded assets are the following:

- the value of the homestead, if it is owned and occupied by the recipient or the recipient's spouse
- the value of one vehicle per household is totally excluded
- certain assets used for self-support
- one burial space for each eligible person and each member of that person's immediate family; up to $1,500 in burial funds for recipient and recipient's spouse

In addition to being financially needy and aged, blind, or disabled, MSA recipients must live in Minnesota and be U.S. citizens or eligible noncitizens.

State regulation also excludes household goods and personal effects up to a value of $2,000. For a complete list of asset limits, see Appendix I.

If an applicant's net countable assets exceed the limits, he or she is not eligible for MSA. State regulations prohibit an applicant from transferring property for less than adequate compensation in order to qualify for MSA. Property thus transferred is presumed available for the applicant's support.

Additional Eligibility Requirements

In addition to financial need, the following conditions must be present to establish eligibility. An MSA recipient must also be:

- a recipient of SSI; or be eligible for SSI except for excess income and be:
  - aged—defined as those age 65 or older;
  - blind—defined as having vision no better than 20/200 with glasses or a limited visual field of 20 degrees or less. There is no age requirement for this basis of eligibility; or

[37] For persons who reside in a long-term care facility where the MA program pays the cost of care, the MA program's asset provisions and limits apply.

- disabled—a person must have a disability within the meaning of the federal Social Security Act, Title II. The person must be 18 years of age or older, and must be unable to work and support him or herself because of a permanent and total physical or mental impairment.

- a citizen of the United States

  Noncitizens may be eligible under some circumstances. However, undocumented immigrants, and noncitizens who are in the United States legally on a temporary basis and are not immigrants, are not eligible for MSA. Persons who are not eligible for the federal SSI program because of their noncitizen status are also not eligible for MSA.

- reside in Minnesota

  The MSA grant is canceled whenever a recipient is absent from the state for one calendar month or more.

Benefits

MSA Monthly Cash Grant

MSA recipients receive a monthly cash grant to supplement their income.

MSA recipients receive a monthly cash grant to supplement their income. The amount of the MSA grant is computed by subtracting an individual's net countable income from the MSA assistance standard that applies to the recipient. A county may set higher standards than the state, as long as the county pays the additional costs.

Certain MSA recipients are only eligible for a monthly personal needs allowance of $89. MSA recipients who receive this personal needs allowance are the following:

- individuals who receive a monthly SSI benefit of $30 because they live in a long-term care facility
- individuals who live in a nursing facility or other medical facility where the MA program (see MA, page 75) pays the cost of care
- blind children who meet certain requirements

2009 MSA Assistance Standards
(Before income deductions)

Type of Recipient	Monthly Assistance Standard
Individual recipient living alone	$735
Individual recipient living with others	$542
Married couple, both receiving MSA prior to 1/1/94	
- living with others	$1,001
- not living with others	$1,117
Married couple, both found eligible for MSA after 1/1/94 -	
living with others	$738
- not living with others	$1,102
Individual eligible for personal needs allowance only	$89

For some MSA recipients with special needs, their MSA assistance standard also includes amounts for these ongoing special needs.

Examples of ongoing "special needs" that are recognized by the program are prescribed diets, guardian or conservator service fees, representative payee service fees, and restaurant meals. Disabled recipients who are under age 65, are otherwise eligible for MSA; are relocating into the community from a residential facility; and are considered "shelter-needy"[38] receive an additional amount to help cover housing costs. However, the governor eliminated funds for special needs diets through unallotment effective November 1, 2009, through June 30, 2011.

Nonrecurring Special Needs

The MSA program also makes available additional cash payments for a recipient's nonrecurring special needs such as necessary home repairs and necessary repairs or replacement of essential furniture or appliances.

Emergency MSA (EMSA)

MSA recipients and individuals presently residing in Minnesota who meet all MSA eligibility requirements may receive a special MSA grant to meet emergency needs. Receipt of EMSA is limited to once in a 12-month period. "Emergency need" is defined as a need that threatens the person's health or safety. Individuals must apply all available resources, even those normally excluded, toward the

[38] Shelter-needy means that the recipient's monthly housing costs are more than 40 percent of his or her gross income.

MSA recipients may also be eligible for MA and other social services.

emergency. EMSA pays the minimum amount needed to resolve the emergency. EMSA grants are limited to available funding. However, the governor has unalloted funds for EMSA effective November 1, 2009, through June 30, 2011.

Eligibility for Other Assistance Programs

- Medical Assistance (also called Medicaid or MA). All MSA recipients are eligible for services available through the state's MA program. (See MA, page 75)

- Social Services. State laws mandate that certain social services be available to MSA recipients.

Monthly MSA cash grants are paid directly to program recipients, except for persons in institutional settings. The county may also make payments to a protective "representative payee" instead of the recipient if the recipient cannot manage his or her funds. The representative payee may be any person or agency concerned with the recipient's welfare.

Funding and Expenditures

The state finances MSA grants with general fund appropriations.

In state fiscal year 2008, the state spent $30,829,796 to supplement the income of aged, blind, and disabled persons through the MSA program. A monthly average of 28,009 individuals received MSA in state fiscal year 2008.

Recipient Profile

An estimated 81 percent of MSA recipients also receive federal SSI benefits. Of all MSA recipients, about 21.4 percent are aged, 0.5 percent are blind, and 78.1 percent are disabled.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program that provides cash assistance to needy aged, blind, and disabled persons.

Administration

Congress

SSI replaced individual federal programs that provided assistance to the elderly, blind, and disabled.

Congress established SSI as Title XVI of the Social Security Act. The program went into effect on January 1, 1974. SSI replaced the former federal-state programs for Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Disabled (AD) authorized by Titles I, X, and XIV of the Social Security Act. Title XVI sets uniform, nationwide standards for administration of SSI. The law defines "old age," "blindness," and "disability," establishes income and resource limits, sets income exclusions and disregards, mandates certain state supplementation and allows other optional supplements, and provides a process for the hearing, appeal, and review of disputed cases.

Social Security Administration (SSA)

The SSA became an independent agency on March 31, 1995. It has responsibility for administering the Old Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs. SSA also administers the Medicare and Black Lung programs.

The SSA sets uniform, nationwide standards for administration of SSI. The law establishes specific program regulations, including residence and citizenship requirements. These regulations are contained in the Code of Federal Regulations (CFR) Title XX.

The local offices of the SSA administer SSI in the states. The local offices determine if an applicant is eligible for benefits, determine the amount of the grant, and authorize the payment.

Eligibility Requirements

SSI assists aged, blind, or disabled adults and blind or disabled children whose income and resources are insufficient to meet the costs of their basic needs. An individual qualifies for SSI if his or her income and assets are below the limits established by Congress.

Income Limits

In order to qualify for SSI, an individual's net income, after all allowed income disregards and exclusions are applied, must be below the maximum monthly SSI benefit. (Refer to the Benefits section on page 61 for these maximums.) The maximum monthly benefit is uniform nationwide and is increased each January based upon a formula in the Social Security Act.

In determining eligibility, both income received as a direct result of work activities (called "earned income") and income obtained from other sources (e.g., gifts or pensions, called "unearned income") are counted against the maximum monthly benefit. When counting income, the government disregards the first $20 of most income received in a month and the first $65 of earned income, plus half of remaining earnings received in a month. Income received from certain sources, such as most scholarship funds and certain federal housing payments, is exempt from the limits.

Disabled recipients who work and who lose eligibility for regular SSI and Medical Assistance (MA) because of increased earnings may, in most instances, receive MA and cash benefits under special provisions designed to assist working persons with a disability.

Asset Limits

Federal law also sets the value of assets an individual may possess and be eligible for SSI. "Assets" include the following:

Real property. The value of a homestead is excluded.

Personal property. An individual may own a car and have its value totally excluded as long as it is used for transportation of the recipient or a member of the recipient's household.

Liquid assets. The value of liquid assets, such as cash-on-hand, savings, stocks, trusts, and other investments cannot exceed $2,000 for a single individual and $3,000 for a married couple.

The value of household goods and personal effects (up to an equity value of $2,000) is excluded from the resource limits. Federal law allows an individual to sell excess resources to qualify for SSI.

Additional Eligibility Requirements

In addition to financial need, the following conditions must be present to establish eligibility. An SSI recipient must:

In addition to being financially needy, SSI recipients must be U.S. citizens or noncitizens meeting certain criteria and cannot reside in public institutions.

- **be a citizen residing in the United States or a lawful permanent resident who has, or can be credited with, 40 qualifying quarters of work;**[39]

The federal welfare reform act placed limitations on the provision of SSI benefits to legal noncitizens. These limitations were partially offset by provisions passed in the Balanced Budget Act of 1997. Together, the two acts provide that:

1. Legal noncitizens who received SSI benefits on August 22, 1996, will continue to receive SSI benefits. Legal noncitizens residing in the United States on that date who later become disabled will be eligible for SSI; and

2. Refugees, asylees, and aliens whose deportation has been withheld, Cuban or Haitian entrants, victims of trafficking, or Amerasian immigrants will be eligible for SSI and MA for seven years after entering the United States. Under a new law effective October 2008, those humanitarian immigrants who have been cut off or denied SSI after the seven years have an extension of two years. If after the two years, the immigrant is not a citizen but has applied for citizenship, that person is eligible for an additional year. This extension is set to expire in 2011.

- **not reside in a public institution;**

Certain health and publicly operated community facilities covered by the Medicaid program are exempt from this provision.

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[39] The exceptions to this requirement are: (1) active duty members of the U.S. Armed Forces or an honorably discharged veteran; or a spouse or dependent child of an active duty member or an honorably discharged veteran; (2) American Indians born in Canada or American Indians who are members of a federally recognized tribe; (3) legal noncitizens who received SSI benefits on August 22, 1996; and (4) refugees, asylees, aliens whose deportation has been withheld, Cuban or Haitian entrants, victims of trafficking or Amerasian immigrants.

- **be one of the following:**

Aged. Federal law defines the "aged" as those age 65 or older.

Blind. Federal law defines "blindness" as vision no better than 20/200 with glasses or tunnel vision—a limited visual field of 20 degrees or less.

Disabled. For adults, federal law defines "disability" as a physical or mental impairment that prevents a person from engaging in any "substantial gainful activity." For adults, the condition must have lasted or be expected to last at least 12 months or result in death.

The welfare reform act established a new, more stringent definition of disability for children. Under this definition, a child is considered to be disabled if he or she has a medically determined physical or mental condition that "results in marked and severe functional limitations" and "can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The act also required related changes in the federal rules specifying the methodology used to determine whether a child meets the definition of disability.

Benefits

SSI Monthly Benefit

SSI recipients receive monthly cash payments from the federal government. The monthly cash payment is calculated by subtracting the individual's net available income (i.e., after applying the SSI income disregards and exclusions noted in the Eligibility Requirements section) from the maximum monthly SSI benefit. The maximum monthly SSI benefit is reduced by one-third for persons living in the household of another.

Maximum Monthly SSI Benefit, Effective January 2009

Type of recipient	Maximum monthly benefit
Individual recipient living alone	$674
Individual recipient living with others	449.34
Married couple living alone	$1,011
Married couple living with others	674

In September 2008, the average monthly SSI benefit paid to SSI recipients in Minnesota was $491.50.

Minnesota Supplemental Aid (MSA)

Some SSI recipients receive supplemental payments from the MSA program.

Some SSI recipients receive supplemental payments from the MSA program. MSA fulfills the congressional mandate that states supplement the grants of persons who had received higher benefits from former state Old Age Assistance, Aid to the Blind, and Aid to the Disabled programs in December 1973. MSA also supplements the grants of SSI recipients who became eligible for program benefits after SSI was implemented in January 1974. In Minnesota, SSI recipients apply for MSA through the local human services agency. (See MSA, page 47.)

Emergency Payments

If an SSI applicant is in desperate financial need and can demonstrate probable program eligibility, the SSA can issue emergency payments of up to $674 to an eligible individual and $1,011 to a couple (these are payment levels in effect as of January 1, 2009).

Eligibility for Other Assistance Programs

SSI recipients may also be eligible for MA, Food Support, and other social services.

Medical Assistance (MA—also called "Medicaid"). In Minnesota, SSI recipients apply for MA through the local human services agency. The vast majority of SSI recipients are eligible for MA. A person who is blind or who has a severe disability and who engages in substantial gainful employment despite severe medical impairments may continue on MA even when earned income makes the person ineligible for SSI benefits. (See MA page 75.)

An SSI recipient who enters a nursing home, hospital, or other institution on MA receives only limited cash assistance, in the form of a personal needs allowance. The personal needs allowance as of January 1, 2009, is $89 a month. SSI contributes $30 of this amount, with the remainder paid out of MSA.

Social Services. SSI recipients may be eligible for a variety of social services. State law requires that social services be provided for certain groups of persons with disabilities.

Food Support. SSI recipients may be eligible to receive food support; in cases where all household members receive SSI, Food Support eligibility is automatic. (See Food Support, page 141.)

Reinstatement of MA Benefits

Children who lose SSI eligibility due to the change in the definition of disability made by the welfare reform act also lose their MA coverage, unless they are found eligible for MA on some other basis (e.g., by qualifying as part of a low-income family). The Balanced Budget Act of 1997 restored Medicaid coverage for children who were on SSI as of the date of enactment of the welfare reform act (August 22, 1996), and who became ineligible for SSI due to the change in the definition of disability made by the welfare reform act. This reinstatement does not apply to persons applying for SSI after August 22, 1996.

The monthly SSI cash grant is paid directly to program recipients. However, the SSA may appoint a "representative payee" if the recipient cannot manage his or her own funds. The representative payee may be any person or agency concerned with the recipient's welfare.

Funding and Expenditures

SSI expenditures in fiscal year 2008 were $454 million.

Funds for the SSI program come solely from the general revenues of federal government. SSI utilizes no state or local funds for financing program benefits or administration.

In fiscal year 2008, the federal government spent $453,986,000 to assist SSI recipients in Minnesota.

Recipient Profiles

In state fiscal year 2008, an average of 78,880 individuals per month in Minnesota received SSI payments. Most of those SSI recipients were disabled.

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General Assistance Medical Care

General Assistance Medical Care (GAMC) is a state-funded program that pays for certain health care services for Minnesota residents whose income and resources are insufficient to cover their expenses and who are not eligible for other health care programs. This section describes eligibility, covered services, and other aspects of the program. The section also provides information related to the line-item veto and unallotment of GAMC funding.

Administration

Minnesota State Legislature

The legislature established GAMC in 1975. The state law includes provisions for funding and administration and gives certain program authority to the Minnesota Department of Human Services (DHS). The program was implemented on January 1, 1976.

State Department of Human Services

State law gives DHS authority to fund and administer the program. DHS administrative policy sets requirements related to eligibility, the provision of heath care services, state and county duties, and provider payments.

Counties

County human services agencies determine eligibility for GAMC. The counties are responsible for the costs of administering the GAMC program at the local level.

Eligibility Requirements

General Requirements

In order to be eligible for GAMC, an individual must:

- reside in Minnesota;
- meet GAMC asset and income limits;
- not be eligible for Medical Assistance (MA) benefits;
- meet one of the following GAMC qualifying statuses:

    - receive General Assistance (GA) or Group Residential Housing (GRH) payments;
    - be awaiting a disability determination from the Social Security Administration or the State Medical Review Team;
    - be unable to meet the MinnesotaCare six-month durational residency requirement;
    - be homeless;
    - be entitled to Medicare due to end-stage renal disease;
    - be enrolled in private health coverage;
    - be detained by law for less than one year in a county correctional or detention facility or admitted to a hospital on a criminal hold order, and meet other criteria;
    - receive treatment funded through the Consolidated Chemical Dependency Treatment Fund; or
    - reside in the Minnesota sex offender program;
- not be a parole violator or a fleeing felon and meet certain criteria if convicted of a drug offense (see Minn. Stat. § 609B.425);
- cooperate with the local agency in determining whether the applicant meets MA eligibility requirements; and
- assign any medical support and insurance benefit rights to DHS.

GAMC eligibility must be redetermined every 12 months for those on a fixed income and every six months for all others.

Eligibility Groups

GAMC is available for the following groups of individuals:

1. Individuals receiving GA or GRH payments if they are not otherwise eligible for MA

2. Individuals who do not receive GA or GRH, but who meet the GAMC income limit (75 percent of the federal poverty guidelines or FPG) and asset limit ($1,000 per household, excluding specified assets), and meet one of the GAMC qualifying statuses

3. Individuals with incomes greater than 75 percent but not exceeding 175 percent of FPG, who meet the asset limit used by MA for families and children ($10,000 for a household of one and $20,000 for a household of two or more, excluding specified assets), and who apply during a hospital stay. These individuals receive GAMC hospital-only coverage.

Covered services and cost-sharing requirements for these groups vary and are summarized in the table below.

GAMC Eligibility Groups

Eligibility Group	Income Limit	Asset Limit	Covered Services	Cost-Sharing
1. GA and GRH recipients	GA limit ($203/month for one person; $260 for married couple) or GRH limit[40]	GA limit ($1,000 per assistance unit) or GRH limit[41]	All covered services	Copayments
2. Other individuals eligible for full coverage	75 percent of FPG	$1,000 per household	All covered services	Copayments
3. Individuals eligible for hospital-only coverage	Greater than 75 percent but not exceeding 175 percent of FPG	$10,000 per household of one/$20,000 per household of two or more	Inpatient hospital services and physician services provided during inpatient stay	$1,000 deductible for each hospitalization

House Research Department

Enrollment in MinnesotaCare

Since September 1, 2006, certain GAMC applicants and recipients eligible for full coverage have been required to enroll in the MinnesotaCare program as adults without children. These individuals are exempt for up to six months from MinnesotaCare premiums,[42] income and asset limits, and eligibility criteria related to lack of health coverage and lack of access to employer-subsidized health insurance.

[40] GRH is a state program that provides payments for room and board and related housing services to persons who are aged, blind, or disabled, or who are potentially eligible for GA. GRH recipients must have net incomes that are less than the GRH assistance standard, which, effective July 1, 2009, is $846 per month plus any applicable supplemental rate.

[41] The GRH asset limit is $2,000 for all recipients who are aged, blind, or disabled and $1,000 for all other recipients, after applicable asset exclusions.

[42] County agencies are required to pay the enrollee share of premiums for these individuals for six months and have the option of continuing to pay these premiums beyond this period.

GAMC applicants and recipients are exempt from the MinnesotaCare enrollment requirement if they are any of the following:

1. Eligible for GAMC as GA or GRH recipients
2. Awaiting a determination of blindness or disability
3. Unable to meet the MinnesotaCare residency requirement
4. Homeless
5. End-stage renal disease beneficiaries in the Medicare program
6. Persons enrolled in private health coverage
7. Certain persons detained by law for less than one year in a county correctional or detention facility or admitted to a hospital on a criminal hold order
8. Persons who receive treatment funded through the Consolidated Chemical Dependency Treatment Fund
9. Persons residing in the Minnesota sex offender program

Residency

To be eligible for GAMC, an individual must be a resident of Minnesota. A "resident" is defined as a person living in the state for 30 days, with the intention of making a home here and not for any temporary purpose. County agencies are required to waive the 30-day residency requirement in cases of medical emergencies. Migrant workers who have worked in Minnesota within the last 12 months and have earned at least $1,000 in wages from this employment are exempt from the 30-day residency requirement.

Asset Limits

To be eligible for GAMC, the assets of applicants with incomes not exceeding 75 percent of FPG cannot exceed $1,000 per household, excluding exempt assets. The assets of applicants with incomes greater than 75 percent but not exceeding 175 percent of FPG (i.e., those applying for GAMC hospital-only coverage) cannot exceed $10,000 for a household of one and $20,000 for a household of two or more persons, excluding exempt assets. Asset exemptions are determined using the standards of the MA program.

Certain items are not considered assets when determining GAMC eligibility for individuals with incomes not exceeding 75 percent of FPG, including the following:

- The homestead
- Household goods and personal effects
- Personal property used as a regular abode
- A burial plot for each member of the household
- Life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- Capital and operating assets of a business necessary for the person to earn an income
- Insurance settlements for damaged, destroyed, or stolen property, which are excluded for nine months and may be excluded for up to nine additional months under certain conditions
- One automobile that is used for transportation of the enrollee or a household member of the enrollee

Certain items are not considered assets when determining eligibility for individuals with incomes greater than 75 percent but not exceeding 175 percent of FPG eligible for hospital-only coverage, including the following:

- The homestead
- Household goods and personal effects
- A burial plot for each member of the household
- Life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- Capital and operating assets of a business up to $200,000
- Insurance settlements for damaged, destroyed, or stolen property, which are excluded for three months if held in escrow
- A motor vehicle for each person who is employed or seeking employment
- Court-ordered settlements of up to $10,000
- Individual retirement accounts and funds
- Assets owned by children

Income Limits

To be eligible for GAMC, an applicant must have gross income that is equal to or below the income limit set by the state legislature. The income limit for GAMC full coverage is 75 percent of FPG. Individuals with incomes greater than 75 percent but not exceeding 175 percent of FPG are eligible for GAMC hospital-only coverage. (See table on page 71.)

In determining whether an applicant meets the program income limits, specified types of income, such as federal and state tax refunds and food support benefits, are excluded from gross income.

Benefits

Covered Services

GAMC enrollees eligible for full coverage (those receiving GA or GRH payments, or with incomes not exceeding 75 percent of FPG who meet the program asset limit and one of the program qualifying statuses) receive most, but not all, of the services provided to MA recipients. The following health care services are available under the GAMC program to enrollees eligible for full coverage:

- Ambulance services
- Care coordination and patient education services provided by a community health worker
- Chemical dependency services
- Chiropractic services as covered under the MA program
- Dental services[43]
- Eyeglasses and eye examinations
- Family planning
- Hearing aids and prosthetic/orthotic devices
- Inpatient hospital services
- Laboratory and x-ray services
- Medical supplies and equipment

[43] GAMC covers the dental services covered under Medical Assistance (MA). Effective January 1, 2010, MA coverage of dental services for adults who are not pregnant (and therefore GAMC coverage of dental services) will be limited to specific services (see Minn. Stat. § 256B.0625, subd. 9 (Supp. 2009)).

- Mental health services
- Outpatient hospital services
- Physician services, including services provided by a nurse practitioner
- Podiatric services
- Prescription drugs
- Psychological services
- Public health nursing services provided by a unit of government
- Services provided by Medicare-certified rehabilitation agencies
- Vision care

Enrollees with incomes greater than 75 percent but not exceeding 175 percent of FPG are covered only for inpatient hospital services, including physician services provided during an inpatient stay.

The following services are not covered under GAMC:

- Home health care services
- Nursing facility services
- Therapy services provided by independently enrolled providers
- Pregnancy and related services[44]
- Services in an intermediate care facility for persons with mental retardation and related conditions (ICF/MR)

Cost-Sharing

Enrollees who are GA recipients, or have incomes not exceeding 75 percent of FPG, are subject to the following copayments:[45]

- $25 for nonemergency visits to an emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $12-per-month limit. Antipsychotic

[44] GAMC enrollees who are pregnant qualify for coverage of these services under Medical Assistance and/or Emergency Medical Assistance.

[45] The $3 copayment for nonpreventive visits was eliminated January 1, 2006. The monthly limit on prescription drug copayments was reduced from $20 to $12, effective January 1, 2006, and further reduced to $7 effective July 1, 2009. A copayment of $25 for eyeglasses and a 50-percent coinsurance requirement for basic restorative dental services were eliminated July 1, 2009.

drugs are exempt from copayments when used for the treatment of mental illness.

Health care providers are responsible for collecting the copayment; GAMC reimbursement to a provider is reduced by the amount of the copayment. A provider cannot withhold services from an enrollee who does not pay the copayment.[46]

Enrollees with incomes greater than 75 percent but not exceeding 175 percent of FPG who qualify for hospital-only coverage are subject to a $1,000 deductible for each hospitalization.

GAMC Managed Care

GAMC enrollees receive services under either a fee-for-service system, through prepaid health plans under the prepaid GAMC program, or through a county-based purchasing initiative. Prepaid GAMC has been implemented since the mid-1980s in coordination with the Prepaid Medical Assistance Program (PMAP). County-based purchasing was authorized by the legislature in 1997. Counties implementing county-based purchasing are responsible for providing all covered services to enrollees, either through their own provider networks or by contracting with prepaid health plans and providers. DHS payments to counties under county-based contracting cannot exceed GAMC payment rates to prepaid health plans.

As of July 2009, 19,928 GAMC recipients were enrolled in either prepaid GAMC or a county-based purchasing initiative.

Fee-for-Service Provider Reimbursement

Under fee-for-service GAMC, the individuals and institutions that provide medical services to GAMC recipients are reimbursed for those services directly by DHS. Generally, GAMC reimburses providers at the same rates used by the MA program.

[46] Minnesota Statutes, section 256B.0631, subdivision 4, allowed providers who routinely refused services to individuals with uncollected debt to include uncollected copayments as bad debt and deny services to enrollees. The Ramsey County District Court in *Dahl et al. v. Goodno*, court file number C9-04-7537, ruled that this provision was preempted by federal law. This provision was repealed January 1, 2009.

Funding and Expenditures

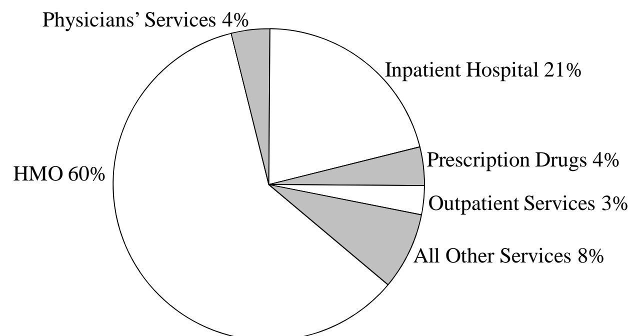
The GAMC program is funded solely by state dollars. There is no federal funding for GAMC. Beginning January 1, 1991, the state assumed responsibility for the historic county share of 10 percent of GAMC costs.

During state fiscal year 2008, the state spent $262,835,029 in payments to health care providers for GAMC services.

Recipients

In fiscal year 2008, an average of 28,165 persons were eligible to receive GAMC services each month.

GAMC Spending on Services
FY 2008



Source: DHS November 2008 Forecast

Information on the characteristics of GAMC recipients is provided in Appendix III.

GAMC Income Limit – Federal Poverty Guidelines[47]
for 7/1/09 through 6/30/10 – 12-month period

Household Size	75% of FPG	175% of FPG
1	$8,124	$18,960
2	10,932	25,512
Each Additional Person	2,808	6,552

House Research Department

[47] Federal poverty guidelines are updated every year, usually in February. New DHS income standards based on updated guidelines are effective July 1 of each year.

Elimination of GAMC Funding

On May 14, 2009, the governor line-item vetoed the $378,000,000 fiscal year 2011 general fund appropriation for GAMC in the health and human services finance bill (Laws 2009, ch. 79/H.F. 1362). The fiscal note[48] for the line-item veto assumes that coverage for GAMC services will need to be terminated April 1, 2010, due to the lag in provider billing for services and the need to pay program expenditures out of the fiscal year 2010 appropriation. Coverage would be eliminated for the regular GAMC program; DHS is currently determining whether coverage would need to be eliminated under the MinnesotaCare transition program described earlier.

In June 2009, the governor announced that he would reduce the fiscal year 2010 general fund appropriation for GAMC by $15,000,000 through unallotment. DHS projects that the GAMC program, given this action, will have sufficient funding available to pay for coverage up to March 1, 2010, and is examining whether the GAMC appropriation, after unallotment, will be sufficient to continue the program until April 1, 2010.

DHS is assessing and analyzing options under current law (subject to any action by the legislature) to provide health care services to current GAMC enrollees and individuals who otherwise would have been eligible for the program. Final decisions on a number of issues have not been made at the time of writing.

MinnesotaCare for Persons Otherwise Eligible for GAMC

The MinnesotaCare program is a potential coverage option for individuals who would otherwise be covered under GAMC. One reason is that the MinnesotaCare income and asset limits are higher than the respective limits for GAMC. However, some MinnesotaCare program features may make that program less than an ideal fit for the former GAMC population, in part because MinnesotaCare: (1) requires enrollees to pay premiums; (2) does not allow coverage from the date of application as does GAMC; and (3) applies a $10,000 annual limit on inpatient hospital services provided to adults without children.

The fiscal note for the line-item veto of GAMC funding states that

[48] Consolidated Fiscal Note – 2009-10 session, H.F. 1362-4E, May 15, 2009, Omnibus HHS Line-Item Veto Provision.

more than 90 percent of GAMC enrollees will be eligible for MinnesotaCare. The fiscal note projects that about 75 percent of GAMC managed care capitation payments will shift to MinnesotaCare. The fiscal note assumes that most of the 25-percent reduction in capitation payment is due to former GAMC enrollees failing to pay MinnesotaCare premiums (mainly because they are unable to afford the premiums or unable to complete the MinnesotaCare application process). The estimate of a 25-percent reduction assumes that counties and other entities will assist individuals who would otherwise have been eligible for GAMC in paying MinnesotaCare premiums. To the extent that this does not occur, the percentage of individuals in this group who do not switch to MinnesotaCare will probably increase. Also, about 2 percent of former enrollees are projected as being unable to meet the MinnesotaCare 180-day residency requirement, and a small number of additional individuals will not enroll in MinnesotaCare because they are eligible for Medicare, have other health coverage, or are ineligible for the program due to incarceration.[49]

The table below summarizes some of the differences between the GAMC and MinnesotaCare programs.

Comparison of the GAMC and MinnesotaCare Programs

	GAMC (full coverage)	**MinnesotaCare (adults without children)**
Income limit	75% FPG	250% FPG
Asset limit, after exclusions	$1,000 ($2,000 for Group Residential Housing recipients)	$10,000 household of 1/$20,000 household of 2 or more
Durational residency requirement	30 days	180 days
Premiums	None	Sliding scale[50]

[49] Individuals who apply for GAMC or MinnesotaCare while residing in a correctional facility are not eligible for those programs. GAMC enrollees who are incarcerated after GAMC enrollment can remain on that program if they are expected to be detained for less than one year and continue to meet program requirements, but would not be eligible for MinnesotaCare if they apply for that program (due to GAMC termination) while residing in a correctional facility.

[50] At 75 percent of FPG (the GAMC income limit for full benefits), the MinnesotaCare premium for one individual is $11 per month. At 25 percent of FPG, the MinnesotaCare premium for one individual is $4 per month (92 percent of GAMC enrollees have income under 25 percent of FPG, according to a DHS analysis of individuals enrolled in GAMC for at least one month in fiscal year 2008). County agencies and other entities have the option of paying the MinnesotaCare sliding scale premiums for MinnesotaCare enrollees.

	GAMC (full coverage)	MinnesotaCare (adults without children)
Effective date of coverage	Date of application (allows limited retroactive coverage, e.g. if individuals apply as part of an inpatient stay)	First day of month following month in which premium payment received; limited retroactive coverage[51] for persons terminated from GAMC
Other health coverage	May have other health coverage; program pays enrollee premiums, deductibles, and cost-sharing for cost-effective coverage	May not have other health coverage; four-month uninsured requirement; no current access to employer-subsidized insurance and no access through current employer in past 18 months
Covered services	No inpatient hospital annual limit Covered by GAMC but not MinnesotaCare: • Common carrier transportation/mileage reimbursement • Limited orthodontia	$10,000 inpatient hospital annual limit Covered by MinnesotaCare but not GAMC: • Certain home care services • Hospice care
Cost-sharing	• $25 nonemergency visit to ER • $3 brand-name, $1 generic prescriptions/$7 monthly limit	• $6 nonemergency visit to ER • $3 all prescriptions, no monthly limit • $25 eyeglasses • $3 nonpreventive visits • 10% coinsurance for inpatient hospital charges, up to $1,000 per adult

House Research Department

[51] MinnesotaCare provides limited retroactive coverage for individuals who are terminated from GAMC or MA. For these individuals, coverage is effective the first day of the month following termination, if the individual submits a written request for retroactive MinnesotaCare coverage and a completed application, within 30 days of the mailing of the termination notice. The applicant must provide all required verifications within 30 days of submitting the written request for retroactive coverage, and must pay premiums for the retroactive month, current month, and next month within 30 days of the premium billing.

Medical Assistance

Medical Assistance (MA) is a jointly funded, federal-state program that pays for health care services provided to low-income individuals. It is also called Medicaid. This chapter describes eligibility, covered services, and other aspects of the program.

Administration

Congress

MA is Minnesota's version of Medicaid, a federal program established by Congress to offer basic health care services to certain low-income individuals.

Medicaid was established by the U.S. Congress in 1965 as Title XIX of the Social Security Act. This federal law requires all states to offer basic health care services to certain categories of low-income individuals. States are reimbursed by the federal government for part of the cost of providing the required services. The federal law also gives states the option to cover additional services, and additional categories of low-income individuals, in their Medicaid programs. States that provide optional coverage receive federal reimbursement for part of the cost of this coverage.

U.S. Department of Health and Human Services (DHHS)

Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS), an agency within DHHS. CMS issues regulations and guidelines for Medicaid that states are required to follow. These regulations and guidelines are found in Title 42 of the Code of Federal Regulations, in the state Medicaid Manual, and in State Medicaid Director letters from CMS.

States establish operating and administrative standards for their own Medicaid programs. All Medicaid programs must stay within the scope of federal rules and regulations, but state programs can and do vary widely, due to differences in coverage of optional services and eligibility groups.

Minnesota State Legislature

Medical Assistance (MA), Minnesota's Medicaid program, was established by the legislature and implemented in January 1966. The MA law in Minnesota is found primarily in chapter 256B of Minnesota Statutes, which contains the following:

- eligibility requirements, including specific income and asset limits for MA recipients
- administrative requirements, such as the duties of the state Department of Human Services and the counties, and provisions for the central disbursement of MA payments to providers
- a listing of services provided under MA
- requirements for managed care and county-based purchasing plans providing services to MA recipients
- provisions for establishing payment rates for MA providers (Provisions relating to hospital payment rates are found in Minnesota Statutes, chapter 256.)

Minnesota Department of Human Services (DHS)

DHS is responsible for administering the MA program at the state level and for supervising the implementation of the program by the counties. DHS has adopted administrative rules and policies that govern many aspects of the MA program.

Counties

County human services agencies and tribal governments choosing to participate are responsible for determining if applicants meet state and federal eligibility standards.[52] Individuals apply for MA by contacting their county human services agency. Agencies are required to complete eligibility determinations for most individuals within 45 days of receiving an application. (This time limit is 60 days in the case of disabled individuals and 15 days in the case of pregnant women.)

[52] The DHS central office determines MA eligibility for some individuals who lose MinnesotaCare coverage due to failure to pay the premium and who want to apply for MA without submitting a new application.

Eligibility Requirements

MA pays for the cost of medical services provided to eligible needy persons who cannot afford the cost of health care.

MA pays for the cost of medical services provided to eligible needy persons who cannot afford the cost of health care. MA can retroactively pay for the cost of health care services provided to an individual up to three months before the month of application, if the individual would have been eligible for MA at the time the services were provided. Generally, MA is available to families, children, pregnant women, the elderly, and persons with disabilities, who meet the program's income and asset standards.

Determining eligibility for MA is a complex task. The following discussion provides only an overview of the topic. More detailed information can be obtained from intake staff at county human services agencies or by referring to the DHS *Health Care Programs Manual* (available on the DHS web site).

To be eligible for MA, an individual must meet the following criteria:

- be a citizen of the United States, a qualified noncitizen, or otherwise residing lawfully in the United States
- be a resident of Minnesota
- be a member of a group for which MA coverage is required or permitted under federal or state law
- meet program income and asset limits, or qualify on the basis of a "spenddown"
- not reside in a public institution, or in a public or private Institution for Mental Diseases (IMD), if age 21 through 64

Eligibility for most enrollees must be redetermined every six to 12 months.

Citizenship

To be eligible for MA, an individual must be a citizen of the United States or a noncitizen who meets specified immigration criteria (see MA Eligibility for Noncitizens table on page 78). The state has chosen to provide MA coverage for all groups of noncitizens for which MA eligibility is mandatory or optional under federal welfare law. The state has also chosen to provide MA coverage for noncitizens who would have been eligible for MA except for passage of federal welfare reform legislation. MA coverage for this group of individuals is funded solely by state dollars, and the coverage is referred to as MA without federal financial participation (FFP). Nonimmigrants and

undocumented persons are eligible only for MA coverage of emergency and pregnancy-related services.

MA Eligibility for Noncitizens

Immigration Status	MA with FFP	MA without FFP	Emergency MA with FFP[53]
Refugees, asylees, persons granted withholding of deportation, veterans/active duty military personnel and families, Cuban/Haitian entrants, Amerasians, American Indians born in Canada, American Indians born outside of the U.S. who are members of a federally recognized tribe, certain Iraqi and Afghani special immigrants, victims of trafficking	Yes	N/A	N/A
Following individuals residing in the U.S. prior to 8/22/96: lawful permanent residents,[54] noncitizens paroled into the U.S.[55] for at least one year, conditional entrants, battered noncitizens and their children	Yes	N/A	N/A
Following individuals who entered the U.S. on or after 8/22/96: lawful permanent residents,[56] noncitizens paroled into the U.S. for less than one year, conditional entrants, battered noncitizens and their children	No, until five years after entry[57]	Yes, if not eligible for MA with FFP	Yes
Others lawfully residing in the U.S.[58] on 8/22/96 and receiving SSI	Yes	N/A	N/A
Others lawfully residing in the U.S.	No[59]	Yes	Yes

[53] Emergency MA with FFP covers MA services necessary to treat an emergency medical condition, including labor and delivery. For noncitizens eligible for MA with FFP, the emergency MA with FFP category is not applicable because emergency services are included in the regular set of MA services for which FFP is received.

[54] A lawful permanent resident is generally a person who has a "green card," which means the person has permission to live and work permanently in the United States and can apply for citizenship after living for five continuous years in the United States.

[55] A person is "paroled into the United States" when the U.S. Justice Department uses its discretion to grant temporary admission for humanitarian, legal, or medical reasons.

[56] Until 40 quarters of work are completed, a noncitizen's income and resources are deemed to include the sponsor's income and resources.

[57] Beginning July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present will be eligible for MA with FFP.

[58] Includes lawful temporary residents, family unity beneficiaries, persons whose enforced departure has been deferred, persons with temporary protected status, persons paroled for less than one year, and applicants for asylum.

[59] The federal Children's Health Insurance Program (CHIP) provides an enhanced federal match for prenatal care and labor and delivery for uninsured pregnant women not eligible for federally funded MA. Beginning July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present will be eligible for MA with FFP for all MA-covered services.

Immigration Status	MA with FFP	MA without FFP	Emergency MA with FFP[53]
Nonimmigrants[60] and undocumented persons	No, except for prenatal care, labor and delivery, and postnatal care for uninsured pregnant women[61]	No	Yes

Source: Department of Human Services

Residency

To be eligible for MA, an individual must be a resident of Minnesota, as determined under federal law,[62] or a migrant worker as defined in Minnesota Statutes, section 256B.06, subdivision 3.

Eligible Categories of Individuals

To be eligible for MA, an individual must be a member of a group for which MA eligibility is either required by the federal government or mandated by the state under a federal option. In Minnesota, those groups eligible for MA coverage include the following:

- parents or caretakers of dependent children
- pregnant women
- children under age 21
- persons age 65 or older
- persons with a disability or who are blind, as determined by the Social Security Administration or the State Medical Review Team (This category includes most persons eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs.)
- children eligible for or receiving state or federal adoption assistance payments

[60] A nonimmigrant is a person who is lawfully present in the United States, but who is not permanently residing in the United States (because the person maintains a residence outside the United States). Nonimmigrants are generally admitted temporarily and for a limited purpose (e.g., tourists, foreign students).

[61] The federal Children's Health Insurance Program (CHIP) provides an enhanced federal match for these services.

[62] Generally, federal law defines residency in terms of being present in a state with an intent to remain and specifically prohibits durational residency requirements (see 42 C.F.R. § 435.403).

Certain disabled children who would normally not be eligible for MA because of parental income are also covered under Minnesota's MA program. MA also pays for Medicare premiums and cost-sharing for certain groups of Medicare beneficiaries.

Individuals with excess income belonging to a group eligible for MA coverage may be able to qualify by spending down their income (see page 84).

Income Limits

To be eligible for MA, an applicant's net income must not exceed program income limits. Different income limits apply to different categories of individuals. For example, the MA income limit for most children is higher than the MA income limit for parents. This means that not all members of a family may be covered under MA.

MA income limits are based on the federal poverty guidelines (FPG). The federal poverty guidelines vary with family size and are adjusted annually for inflation.

In determining whether an applicant meets the program income limits, specified types of income such as federal and state tax refunds and Food Stamp benefits are excluded from gross income. Work and dependent care expenses, a specified amount of earned income, a monthly personal needs allowance for persons residing in certain health care facilities, and other specified items may be deducted or disregarded from gross income.

The tables on pages 65 and 71 lists the income standard, asset standard, and covered benefits for each of the principal eligibility groups. (Eligibility criteria for other eligibility groups such as disabled adult children and disabled widows and widowers can be found in Minnesota Statutes, sections 256B.055 and 256B.057.) Tables showing allowable income by household size for the various eligibility groups are included at the end of this report.

MA Income Limit – Federal Poverty Guidelines[63]
for 7/1/ 09 through 6/30/ 10 – 12-month Standard

Household Size	100%	135%	150%	200%	275%	280%
1	$10,836	$14,868	$16,248	$21,900	$29,784	$ 30,324
2	14,580	19,920	21,864	29,388	40,080	40,800
3	18,324	24,972	27,480	36,876	50,376	51,276
4	22,068	30,024	33,096	44,364	60,672	61,752
5	25,812	35,076	38,712	51,852	70,968	72,228
6	29,556	40,128	44,328	59,340	81,264	82,704
7	33,300	45,180	49,944	66,828	91,560	93,180
8	37,044	50,232	55,560	74,316	101,856	103,656
9	40,788	55,284	61,176	81,804	112,152	114,132
10	44,532	60,336	66,792	89,292	122,448	124,608
Each Additional Person	3,744	5,052	5,616	7,488	10,296	10,476

Transitional MA[64]

Individuals who lose MA eligibility (under the 100 percent of FPG income limit) due to increased earned income or the loss of an earned income disregard, or due to increased child or spousal support, may be able to retain MA coverage for a transitional period, if: (1) the individual's income did not exceed 100 percent of FPG for at least three of the past six months; and (2) the household contains a dependent child and a caretaker. Individuals who lose eligibility due to earned income or loss of an earned income disregard remain eligible for an initial period of six months and can continue to receive MA coverage for up to six additional months if their income does not exceed 185 percent of FPG. Individuals who lose eligibility due to increased child or spousal support remain eligible for four months.

[63] Federal poverty guidelines are updated every year, usually in February. New DHS income standards based on updated guidelines are effective July 1 of each year.

[64] Transitional MA is contingent on federal funding. Federal funding is scheduled to expire on January 1, 2011, unless reauthorized by the U.S. Congress.

Extended Coverage for Children

On October 31, 2008, the federal Centers for Medicare and Medicaid Services (CMS) denied a request by the state to allow children age one through 18 who become ineligible for MA due to excess income to be eligible for two additional months of MA (in addition to transitional MA coverage) and be automatically eligible for MinnesotaCare until the next MinnesotaCare renewal. The coverage extension was authorized by the 2007 Legislature. DHS resubmitted the request on September 30, 2009.

Asset Limits

MA has two main asset limits. One applies to persons who are aged, blind, or disabled and the other to parents in MA-eligible families.[65] Children under age 21 and pregnant women are exempt from any asset limit. In addition, different asset limits apply to some of the smaller MA eligibility groups (see table on pages 78 and 83).

Aged, blind, or disabled. Persons who are aged, blind, or disabled need to meet the asset limit specified in Minnesota Statutes, section 256B.056, subdivision 3. This asset limit is $3,000 for an individual and $6,000 for two persons in a household, with $200 added for each additional dependent. Certain assets are excluded when determining MA eligibility for persons who are aged, blind, or disabled, including the following:

- the homestead
- household goods and personal effects
- personal property used as a regular abode
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program[66]
- capital and operating assets of a business necessary for the person to earn an income

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[65] The Minnesota Long-term Care Partnership (LTCP) program allows individuals with qualified long-term care insurance policies to qualify for MA payment of long-term care services, while retaining assets above the regular MA asset limit equal in value to the amount paid for care by the policy. For more information on the LTCP program, see DHS Bulletin 08-21-08, “DHS Introduces Long-Term Care Partnership (LTCP),” August 8, 2008.

[66] The SSI program allows recipients to set aside, or designate, up to $1,500 in assets to cover certain burial expenses.

- funds for damaged, destroyed, or stolen property, which are excluded for nine months, and may be excluded for up to nine additional months under certain conditions
- motor vehicles to the same extent allowed under the SSI program[67]

Parents in MA-eligible families. A uniform asset limit, identical to that used for the MinnesotaCare program, applies to parents and caretakers in MA-eligible families (see Minnesota Statutes, section 256B.056, subdivision 3c). This asset limit is $10,000 in total net assets for a household of one person, and $20,000 in total net assets for a household of two or more persons. Certain items are excluded when determining MA eligibility for parents in MA-eligible families, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- capital and operating assets of a business up to $200,000
- funds received for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children

The governor announced that he will temporarily reduce, through unallotment, the asset limit for parents to the lower asset limit that applies to persons who are aged, blind, or disabled, for the period January 1, 2011, through June 30, 2011.

Minnesota law also has provisions governing the treatment of assets and income for persons residing in nursing homes whose spouses reside in the community. These provisions are found in Minnesota Statutes, sections 256B.0575 to 256B.0595.

[67] The SSI program excludes as an asset one vehicle per household, regardless of value, if it is used for transportation by the recipient or a member of the recipient's household.

Eligibility on the Basis of a Spenddown

Individuals who, except for excess income, would qualify for coverage under one of the MA categories described above can qualify for MA through a "spenddown." Under a spenddown, an individual reduces his or her income by incurring medical bills in amounts that are equal to or greater than the amount by which his or her income exceeds the relevant spenddown standard for the spenddown period (see table below for the spenddown standards). Unpaid medical bills incurred before the time of application for MA can be used to meet the spenddown requirement.

There are two types of spenddowns. Under a six-month spenddown, an individual can become eligible for MA for up to six months, beginning on the date his or her total six-month spenddown obligation is met. Under a one-month spenddown, individuals spend down their income during a month in order to become eligible for MA for the remainder of that month.

MA Spenddown

Eligibility Group	Spenddown Standard
Families and children	100% of FPG
Aged, blind, or disabled	75% of FPG

MA Eligibility – Income and Asset Limits – Benefits

Eligibility Category	Income Limit	Asset Limit	Benefits
Children under age two [68]	$\leq$ 280% of FPG	None	All MA services
Children two through 18 years of age	$\leq$ 150% of FPG	None	All MA services
Children 19 through 20 years of age	$\leq$ 100% of FPG	None	All MA services
Pregnant women	$\leq$ 275% of FPG	None	All MA services
Parents or relative caretakers of dependent children on MA	$\leq$ 100% of FPG	Uniform MA/ MinnesotaCare asset standard ($10,000 for households of one and $20,000 for households of two or more)	All MA services
Aged, blind, disabled	$\leq$ 100% of FPG	MA asset standard ($3,000 for households of one and $6,000 for households of two, with $200 for each additional dependent)	All MA services
Qualified Medicare Beneficiaries (QMBs)	$\leq$ 100% of FPG	$10,000 for households of one and $18,000 for households of two or more	Premiums, coinsurance, and deductibles for Medicare Parts A and B
Service Limited Medicare Beneficiaries (SLMBs)	> 100% but < 120% of FPG	$10,000 for households of one and $18,000 for households of two or more	Medicare Part B premium only
Qualifying Individuals (QI)–Group 1[69]	$\geq$ 120% but < 135% of FPG	$10,000 for households of one and $18,000 for households of two or more	Medicare Part B premium only
Qualified Working Disabled Adults	$\leq$ 200% of FPG	Must not exceed twice the SSI asset limit	Medicare Part A premium only
Disabled children eligible for services under the TEFRA children's home care option[70]	$\leq$ 100% of FPG[71]	None	All MA services
Employed persons with disabilities	No income limit	$20,000	All MA services

House Research Department

[68] Children with incomes > 275% and $\leq$ 280% of FPG are funded through the federal State Children's Health Insurance Program (SCHIP) with an enhanced federal match.

[69] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on January 1, 2011, unless reauthorized by the U.S. Congress.

[70] Authorized by section 134 of the federal Tax Equity Fiscal Responsibility Act (TEFRA) of 1982.

[71] Only the income of the child is counted in determining eligibility. Child support and Social Security disability payments paid on behalf of the child are excluded.

Institutional Residence

Individuals living in public institutions, such as secure correctional facilities, are not eligible for MA. Individuals living in Institutions for Mental Diseases (IMDs) are also not eligible, unless they are under age 21 and reside in an inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or they are age 65 or older, or otherwise qualify for an exception. An IMD is a hospital, nursing facility, or other institution of 17 or more beds that primarily provides diagnosis, treatment, and care to persons with mental illness.

Benefits

MA reimburses health care providers for health care services furnished to eligible recipients. The federal government requires every state to provide certain services. States may choose whether to provide other optional services.

MA benefits include federally mandated services and services provided at state option.

Federally Mandated Services Are Available to All MA Recipients

The following services are federally mandated and therefore available to all MA recipients in Minnesota:

- Early periodic screening, diagnosis, and treatment (EPSDT) services for children under 21
- Family planning services and supplies
- Federally qualified health center services
- Home health services and medical equipment and supplies
- Inpatient hospital services
- Laboratory and X-ray services
- Nurse midwife services
- Certified family and certified pediatric nurse practitioner services
- Outpatient hospital services
- Physician services
- Rural health clinic services
- Nursing facility services

- Medical and surgical services of a dentist
- Pregnancy-related services (through 60 days postpartum)

Optional Services Are Also Provided to Minnesota's MA Recipients

The following services have been designated "optional" by the federal government but are available by state law to all MA recipients in Minnesota:

- Audiologist services
- Care coordination and patient education services provided by a community health worker
- Case management for seriously and persistently mentally ill persons and for children with serious emotional disturbances
- Case management and directly observed therapy for people with tuberculosis
- Chiropractor services
- Clinic services
- Dental services[72]
- Other diagnostic, screening, and preventive services
- Emergency hospital services
- Extended services to women
- Hearing aids
- Home and community-based waiver services
- Hospice care
- Some Individual Education Plan (IEP) services provided by a school district to disabled students
- Some services for residents of Institutions for Mental Diseases (IMDs)
- Inpatient psychiatric facility services for persons under age 22
- Intermediate care facility services, including services provided in an intermediate care facility for persons with mental retardation (ICF/MR)
- Medical equipment and supplies

[72] Effective January 1, 2010, coverage of dental services for adults who are not pregnant will be limited to specified services (see Minn. Stat. § 256B.0625, subd. 9 (Supp. 2009))

- Medical transportation services
- Mental health services
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services[73]
- Physical therapy services
- Podiatry services
- Private duty nursing services
- Prosthetics and orthotics
- Public health nursing services
- Rehabilitation services, including day treatment for mental illness
- Speech therapy services
- Vision care services and eyeglasses

Copayments

MA enrollees are subject to the following copayments:[74]

- $6 for nonemergency visits to a hospital emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $7 per-month limit. Antipsychotic drugs are exempt from copayments when used for the treatment of mental illness.

Children and pregnant women are exempt from copayments; other exemptions also apply. Since January 1, 2009, total monthly copayments for persons with incomes not exceeding 100 percent of

[73] Since January 1, 2006, MA has not covered prescription drugs covered under the Medicare Part D prescription drug benefit for individuals enrolled in both MA and Medicare (referred to as "dual eligibles"). These individuals are instead eligible for prescription drug coverage under Medicare Part D. MA continues to cover certain drug types not covered under the Medicare prescription drug benefit, such as over-the-counter drugs for cough and colds and certain vitamin and mineral products.

[74] The per-month limit for prescription drug copayments was reduced from $12 to $7 on January 1, 2009. Copayments of $3 per nonpreventive visit and $3 for eyeglasses were eliminated January 1, 2009.

FPG have been limited to 5 percent of family income.

Health care providers are responsible for collecting the copayment from enrollees; MA reimbursement to a provider is reduced by the amount of the copayment. Providers cannot deny services to enrollees who are unable to pay the copayment.[75]

Some Services Are Provided in Minnesota Under a Federal Waiver

States can seek approval from the federal government to provide services that are not normally covered and reimbursed under the Medicaid program. These services are referred to as "waivered services." Minnesota has federal approval for the following community-based waivered service programs.

The Elderly Waiver (EW) provides community-based care for elderly individuals who are MA eligible.

Minnesota also has a solely state-funded program, the **Alternative Care (AC)** program, which provides community-based care for elderly individuals who are not eligible for MA, but who would become eligible for MA within 135 days of entering a nursing home.

The Home and Community Based Waiver for Persons with Mental Retardation or Related Conditions (MR/RC) provides community-based care to persons diagnosed with mental retardation or related conditions who are at risk of placement in an ICF/MR.

The Community Alternative Care (CAC) waiver provides community-based care for chronically ill individuals who are under age 65 and are either residing in a hospital or at risk of inpatient hospital care.

The Community Alternatives for Disabled Individuals (CADI) waiver provides community-based care to disabled individuals under age 65 who are residing in, or are at risk of placement in, a nursing home.

The Traumatic Brain Injury (TBI) waiver provides community-based care to persons under age 65 diagnosed with traumatic or

[75] Minnesota Statutes, section 256B.0631, subdivision 4, allowed providers who routinely refused services to individuals with uncollected debt to include uncollected copayments as bad debt and deny services to enrollees. The Ramsey County District Court in *Dahl et. al. v. Goodno*, court file number C9-04-7537, ruled that this provision was preempted by federal law. The provision was repealed January 1, 2009.

acquired brain injury who are residing in, or are at risk of placement in, a nursing home.

For each of the federally approved waiver programs, the costs of caring for an individual in the community cannot exceed the cost of institutional care.

Medicaid Managed Care

MA enrollees receive services under a fee-for-service system (described in the next section) or through a managed care system. Some managed care programs require federal waivers from CMS, others may be operated under the Medicaid State Plan which outlines the MA services states are providing under agreement with CMS.

Under the managed care system, MA enrollees who are families and children receive services from prepaid health plans through the Prepaid Medical Assistance Program (PMAP) or through county-based purchasing initiatives. Enrollees who are elderly (age 65 and over) receive services from prepaid health plans through Minnesota Senior Care Plus and have the option of receiving services through Minnesota Senior Health Options (MSHO). Enrollees with disabilities have the option of receiving services through the Minnesota Disability Health Options program if they reside in the seven-county metropolitan area or the Special Needs BasicCare (SNBC) program, a statewide program for persons with disabilities.

Programs for Families and Children

Under PMAP, prepaid health plans contract with DHS to provide services to MA enrollees. Plans receive a capitated payment from DHS for each MA enrollee, and in return are required to provide enrollees with all MA covered services, except for some home and community-based waiver services, some nursing facility services, and intermediate care facility services for persons with mental retardation. PMAP operates under a federal waiver; one of the terms of the waiver allows the state to require certain MA enrollees to receive services through managed care.

Enrollees in participating counties select a specific prepaid health plan from which to receive services, obtain services from providers in the plan’s provider network, and follow that plan’s procedures for seeing specialists and accessing health care services. Enrollees are allowed to switch health plans once a year during an open enrollment period.

PMAP has contracts with prepaid health plans to provide services in all 87 counties.

County-based purchasing provides an alternative method of health care service delivery. County boards that elect to implement county-based purchasing are responsible for providing all PMAP services to enrollees, either through their own provider networks or by contracting with prepaid health plans. DHS payments to counties cannot exceed PMAP payment rates to prepaid health plans. As of July 2009, three county-based purchasing initiatives involving 28 counties were operational.

Programs for the Elderly

The Minnesota Senior Care waiver replaced PMAP for elderly enrollees effective June 1, 2005. This federal waiver provides continued authority for mandatory enrollment of people age 65 or older into managed care. Minnesota Senior Care covered all the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare were covered by Medicare Part D (see footnote 75 on page 89).

The Minnesota Senior Care benefit package was replaced by a broader Minnesota Senior Care Plus benefit package, effective January 1, 2009. Minnesota Senior Care Plus began providing services on June 1, 2005, to elderly enrollees enrolled in county-based purchasing initiatives. It was expanded to 80 nonmetro counties in January 2008 and was further expanded to include the seven metro-area counties in January 2009. In addition to covering all basic Minnesota Senior Care services, Minnesota Senior Care Plus also covers elderly waiver services and 180 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment.

Elderly enrollees in Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, elderly enrollees also have the option of receiving managed care services through the Minnesota Senior Health Options (MSHO), rather than Minnesota Senior Care Plus. MSHO includes all Medicare and MA prescription drug coverage under one plan. Since 1997, MSHO provided a combined Medicare and MA benefit as part of a federal demonstration project; the program now operates under federal Medicare Advantage Special Needs Plan (SNP) authority.[76] DHS also contracts with SNPs to

[76] A Medicare Special Needs Plan is a Medicare-managed care plan that is allowed to serve only certain Medicare populations, such as institutionalized enrollees, dually eligible enrollees, and enrollees who are severely chronically ill and disabled. SNPs must provide all Medicare services, including prescription drug coverage.

provide MA services. Enrollment in MSHO is voluntary. As is the case with Minnesota Senior Care Plus, MSHO also covers elderly waiver services and 180 days of nursing home services. MSHO was available in 83 counties as of January 1, 2009. Most elderly MA enrollees are enrolled in MSHO rather than Minnesota Senior Care Plus because of the integrated Medicare and MA prescription drug coverage. As of July 2009, MSHO enrollment was 36,820, compared to enrollment in Minnesota Senior Care Plus of 11,208.

Programs for Persons with Disabilities

The Minnesota Disabilities Health Options (MnDHO) program is a voluntary managed care program for persons with disabilities under age 65 that also operates under combined Medicare SNP and MA managed care authority. MnDHO provides all Medicare primary, acute, and long-term care services and also includes all Medicare and MA prescriptions drugs under one plan. MnDHO has been operating since 2001 and as of July 2009, served 1,273 enrollees in the seven-county metropolitan area.

Special Needs BasicCare (SNBC) is a new voluntary integrated Medicare and Medicaid plan for persons with disabilities that was implemented statewide beginning January 2008. The program also works through contracts with Medicare SNPs and provides all Medicare and Medicaid prescription drugs under one plan. SNBC does not include long-term care services. The program served 3,414 individuals as of July 2009. DHS continues to work with a stakeholders' advisory group on implementation of the program.

Managed Care Enrollment

Generally, MA recipients in participating counties who are in families with children are required to enroll in PMAP or county-based purchasing. As noted above, recipients who are elderly are required to enroll in Minnesota Senior Care or Minnesota Senior Care Plus, but a majority have chosen to participate instead in the voluntary MSHO program.

Most persons who are blind or disabled, and persons belonging to other specific groups, are exempt from managed care enrollment.

As of July 2009, 363,154 MA enrollees received services through PMAP, county-based purchasing, Minnesota Senior Care Plus, MSHO, MnDHO, or SNBC.

Managed Care Reimbursement Rates

Prepaid health plans and county-based purchasing initiatives receive a capitation rate for each enrollee. Fifty percent of the PMAP capitation rate is based upon the enrollee's age, sex, Medicare status, institutional status, basis of eligibility, and county of residence. The remaining 50 percent of the rate is risk-adjusted to reflect the overall health status of a plan's enrollees.

MnDHO and SNBC rates are based on historical fee-for-service costs and are paid through a separate risk adjustment system designed for people with disabilities. MSHO, Minnesota Senior Care, and Minnesota Senior Care Plus rates are adjusted for age, sex, institutional status, and geographical area and are identical across programs.[77] Rates for elderly waiver services are based on historical fee-for-service costs.

DHS does not regulate prepaid health plan and county-based purchasing payment rates to health care providers under contract to serve MA enrollees. These payment rates are a matter of negotiation between the health care provider and the prepaid health plan or county boards.

Fee-for-Service Provider Reimbursement

Under fee-for-service MA, health care providers and institutions (sometimes called "vendors") bill the state and are reimbursed by the state at a level determined by state law for the services they provide to MA recipients.

Under the fee-for-service system, MA recipients, with some exceptions, are free to receive services from any medical provider participating in the MA program. As a condition of participating in the MA program, providers agree to accept MA payment (including any applicable copayments) as payment in full. Providers in Minnesota are prohibited from requesting additional payments from MA recipients, except when the recipient is incurring medical bills in order to meet the MA spenddown (discussed earlier in the eligibility section).

DHS has established a central system for the disbursement of MA

[77] Rates for elderly recipients enrolled in Minnesota Senior Care, Minnesota Senior Care Plus, and MSHO are determined using historical data and are not risk-adjusted, since most of the services used to determine risk-adjustment values are covered by Medicare.

payments to providers. DHS uses different methods to reimburse different types of providers; the reimbursement methods for major provider groups are described below.

The 2009 Legislature reduced payment rates for basic care services by 3 percent, effective July 1, 2009, and made proportional reductions in managed care and county-based purchasing plan capitation rates. This reduction does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, and medical transportation. The governor, as part of unallotment, increased this reduction by an additional 1.5 percentage points (to a total of 4.5 percent) for fiscal years 2010 and 2011.

Physicians and Other Medical Services

Physician services and many other medical services are paid for at the lower of (1) the submitted charge or (2) the prevailing charge. The prevailing charge is defined as a specified percentile of all customary charges statewide for a procedure during a base year. The prevailing charge for physicians is the 50th percentile of 1989 submitted charges, minus either 20 percent or 25 percent depending upon the type of service. The legislature has at times changed the specified percentile and base for different provider types and different procedures. All geographic regions within the state are subject to the same maximum reimbursement rate.

MA services reimbursed in this manner include services from a mental health clinic, rehabilitation agency, physician, physician clinic, optometrist, podiatrist, chiropractor, nurse midwife, physical therapist, occupational therapist, speech therapist, audiologist, community/public health clinic, optician, dentist, and services for children with handicaps.

Other MA services are reimbursed at the lesser of the submitted charge or the Medicare maximum allowable rate. Services reimbursed using the Medicare rate include those for costs relating to a laboratory, a hospice, medical supplies and equipment, prosthetics, and orthotics. (DHS uses other payment rates for certain laboratory services and medical supplies and equipment if a Medicare rate does not exist.)

The 2009 Legislature reduced physician and professional service payment rates for specialty services by 5 percent effective July 1, 2009, and made proportional reductions in managed care and county-based purchasing plan capitation rates. The reductions do not apply to office and outpatient services, preventive medicine, and family

planning services provided by certain primary care providers. The governor, as part of unallotment, increased the percentage reduction by an additional 1.5 percent points (to a total of 6.5 percent) for fiscal years 2010 and 2011.

Prescription Drug Reimbursement

Under the MA fee-for-service program, pharmacies are reimbursed for most drugs at the lower of: (1) average wholesale price (AWP) minus 15 percent[78] plus a fixed dispensing fee; (2) the maximum allowable cost set by the federal government or DHS plus a fixed dispensing fee; or (3) the pharmacy's usual and customary price charged to the public. The fixed dispensing fee in most cases is $3.65 per prescription; higher dispensing fees are allowed for intravenous solutions compounded by a pharmacist, cancer chemotherapy products, and total parenteral nutritional products (see Minn. Stat. § 256B.0625, subd. 13e).

1. **AWP formula.** The MA program uses the AWP minus 15 percent formula to reimburse pharmacies for most brand-name drugs. AWP is generally a drug wholesaler's list price to pharmacies for a prescription drug. (In practice, most pharmacies purchase prescription drugs for an amount less than AWP, at a percentage above the wholesaler's cost.) The AWP is based on national pricing data compiled by drug price publishing companies, using data self-reported by drug manufacturers. A recent federal district court class action settlement[79] has modified the formula used to calculate AWP for many brand-name drugs. The settlement ruling lowered the AWP for many brand-name prescription drugs effective September 26, 2009, and thereby reduced the reimbursement pharmacies receive from MA for those brand-name drugs.

[78] MA reimbursement based on the AWP was reduced from AWP minus 14 percent to AWP minus 15 percent, effective July 1, 2009 (Laws 2009, ch. 79, art. 5, § 30).

[79] See *New England Carpenters Health Benefits Fund, et al., v. First DataBank, Inc. and McKesson Corporation*, Civil Action No. 05-11148-PBS, U.S. District Ct. (Mass.), Final Order and Judgment, March 30, 2009. The settlement ruling in part required First DataBank and Medi-Span (two publishers of drug pricing information), beginning September 26, 2009, to calculate AWP for a large number of brand-name drugs at the level of wholesale acquisition cost (WAC) plus 20 percent, rather than WAC plus 25 percent as had been their recent practice. (WAC is generally a drug manufacturer's price charged to drug wholesalers for a product.) This has the effect of reducing the AWP for those brand-name drugs. Minnesota's MA program uses First DataBank as its source for AWP data. DHS has calculated AWP using the revised lower values since September 29, 2009 (see Provider Update PRX-09-02, August 27, 2009). A complaint has been filed in federal court by several pharmacy groups seeking an injunction to enjoin the use of the lower AWP value, and also requesting the court to overturn the July 1, 2009, rate change that reduced reimbursement based on AWP from AWP minus 14 percent to AWP minus 15 percent. (See *Minnesota Pharmacists Ass'n et al. v. Pawlenty et al.*, complaint for injunctive and declaratory relief filed with the U.S. District Ct. (Minn.), October 2, 2009.)

The two drug pricing companies involved in the settlement have also voluntarily agreed to stop publishing AWP price data within two years of the date of the settlement. The practical effect of this will be to require Minnesota, and other states that use AWP in their Medicaid drug reimbursement formulas, to modify these formulas by incorporating a measure of drug costs that is not based on AWP.

2. **Maximum allowable cost.** MA reimbursement to pharmacies for multiple source drugs (drugs for which at least one generic exists) may be subject to a maximum allowable cost (MAC). The purpose of a MAC price is to set the reimbursement rate closer to the actual acquisition cost of the generic drug. Federal law requires CMS to set a MAC (referred to as a federal upper limit or FUL) for certain multiple-source drugs. Each state's Medicaid program must meet an aggregate FUL for all drugs for which CMS has set a FUL. States can also set state MACs for multiple-source drugs that are lower than any FUL and for drugs for which CMS has not set a FUL. Minnesota has chosen to set state MACs for a large number of multiple-source drugs.

3. **Usual and customary price.** MA reimburses pharmacies at the usual and customary price charged to the public, if this is lower than the payment rate under the AWP formula or the MAC price. This provision allows the MA program to reimburse large chain pharmacies for generic drugs provided to MA recipients at their discounted price for the general public (e.g., $4.00 per prescription).

In addition, the MA program has negotiated payment rates lower than those described above for specialty pharmacy products, defined as those used by a small number of recipients or by recipients with complex and chronic diseases requiring expensive and challenging drug regimens (see Minn. Stat. § 256B.0625, subd. 13e, para. (e)).

Hospitals

MA uses a prospective payment system to reimburse hospitals for inpatient hospital services. Hospitals are paid per admission, but the amount of payment varies depending on the medical diagnosis of the patient.

The MA payment to a hospital for an admission is based on the reimbursement amount for the diagnosis-related group (DRG) into which the patient has been classified. The reimbursement for each

DRG is hospital-specific and is intended to represent the average cost to a hospital of caring for a patient in that particular DRG classification. Hospitals benefit financially from patient stays that cost less than the DRG reimbursement amount. (The DRG reimbursement level is increased for hospital stays that exceed the average length of stay by a certain margin; these stays are referred to as day outliers.)

Hospital payment rates are not automatically adjusted for inflation, but under Minnesota law are required to be rebased (recalculated using more current cost data) at least every two years. Rebasing has the effect of adjusting payment rates for inflation. The legislature, in response to budget shortfalls, has at times delayed rebasing. The 2008 Legislature delayed the rebasing scheduled for January 1, 2009, by 24 months. The 2009 Legislature extended this delay by an additional three months, through March 30, 2011, and also provided that rates would be rebased at 39.2 percent of full value for the period April 1, 2011, to March 31, 2012, with rebasing at full value beginning April 1, 2012.

In addition to this change in the timing and value of rebasing, the 2009 Legislature also made a number of other changes in hospital reimbursement, including but not limited to reducing inpatient hospital payment rates by 1 percent, effective July 1, 2009, and delaying a portion of inpatient hospital payments to the next fiscal year (the governor, through unallotment, delayed the full amount of the payments).

The hospital prospective payment system is described in Minnesota Statutes, sections 256.9685 to 256.9695; it is also described in Minnesota Rules, parts 9500.1090 to 9500.1140.

Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD)

ICFs/DD are reimbursed by MA under a contract system that was implemented on October 1, 2000. Under this system, reimbursement to a facility is based on the facility's current rate, plus any inflation adjustments authorized by the legislature in law. When first implemented, the system provided a floor for property reimbursement that was the greater of $8.13 per person per day or the facility's existing property reimbursement rate. Property reimbursement rates can be adjusted annually for inflation if an appropriation is made specifically for that purpose. Facilities can request variable rate adjustments if the care needs of a resident change and can also request temporary rate adjustments when there is a vacancy in the facility.

The reimbursement system for ICFs/DD is described in Minnesota Statutes, sections 256B.5011 to 256B.5015.

The 2009 Legislature reduced ICF/DD payments rates by 2.58 percent, effective July 1, 2009. The governor, through unallotment, prohibited the granting of new variable rate adjustments for fiscal year 2010, and will suspend existing variable rate adjustments for fiscal year 2011.

Nursing Facilities

Nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUGS) case-mix system to reflect the varying care needs of residents. RUGS classifies nursing facility residents into 34 groups based on information collected using the federally required minimum data set. The RUGS case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

MA rates and private pay rates do not vary within a facility. This is due to Minnesota’s equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

Since October 1, 2006, all nursing facilities participating in MA have been reimbursed under the alternative payment system (APS), sometimes referred to as the contract system. APS was developed as an alternative to an existing cost-based system (sometimes referred to as Rule 50). Under the cost-based system, reimbursement to facilities was based upon their reported costs, and at times, certain limits applied to the rate of increase in operating costs. Under APS, facilities are exempt from certain requirements of the cost-based system and are reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner. These payment rates are adjusted annually for inflation, subject to limitations specified in law. Effective July 1, 1999, through September 30, 2013, the automatic inflation adjustment has been or will be applied only to the property-related rate; inflation adjustments for operating costs must be authorized by the legislature.

The 2007 Legislature required DHS to rebase nursing facility rates. Rebasing will allow nursing facilities to have new or currently unreimbursed expenditures recognized in the facility payment rate, subject to certain limits. The rebased operating cost payment rates took effect October 1, 2008, and will be phased in over eight years,

through the rate year beginning October 1, 2015. Property rates will be rebased beginning October 1, 2014. During the phase-in period, facilities will be held harmless—a facility cannot receive an operating cost payment rate that is less than what the facility would have received without rebasing.

The 2008 Legislature set a rebasing floor for the rate year beginning October 1, 2008, of 1 percent, funded by setting a limit on the maximum increase a facility can receive under rebasing. The 2008 Legislature also increased nursing facility operating payment rates by 1 percent effective October 1, 2008, and also provided a temporary rate increase of an additional 1 percent that applies only for the period October 1, 2008, through September 30, 2009.

The 2009 Legislature suspended the phase-in of rebased rates October 1, 2010, through September 30, 2013, but retained (and did not delay) the phase-in formula currently in law, so that rebasing will resume October 1, 2013, with 65 percent of the payment rate reflecting rebased costs. The governor, through unallotment, suspended the phase-in of rebasing for fiscal year 2010. This has the effect of eliminating an increase of 1 percent (from 13 percent to 14 percent) in the proportion of a nursing facility's payment rate that uses rebased costs.

Funding and Expenditures

The federal and state governments jointly finance MA.

In fiscal year 2008, total MA expenditures for services were $6.265 billion.

Federal Share

The federal share of MA costs for each state, referred to as the federal medical assistance percentage (FMAP), is usually determined by a formula included in Title XIX of the Social Security Act. The formula is based on the state's per capita income and is recalculated annually.

However, for the period October 1, 2008, through December 31, 2010, the American Recovery and Reinvestment Act (ARRA)—the federal stimulus bill—has provided Minnesota with a higher FMAP. For the period October 1, 2008, through March 31, 2009, Minnesota's FMAP was 60.19 percent, rather than 50 percent as calculated under the regular formula. For the period April 1, 2009, through December 31, 2010, Minnesota's FMAP is 61.59 percent. Minnesota's FMAP is projected to return to 50 percent beginning January 1, 2011.

Nonfederal Share

The state, with some exceptions, has been responsible for the nonfederal share of MA costs since January 1991.[80]

MA Expenditures – State Fiscal Year 2008

In fiscal year 2008, total MA expenditures for services were $6.265 billion. This total was distributed between the levels of government as follows:

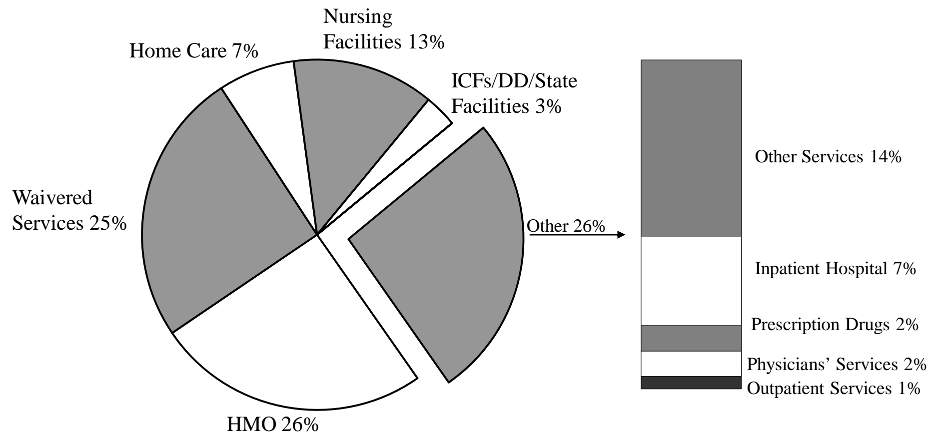
Actual Expenditures — SFY 2008	
Federal	$3.130 billion
Nonfederal	$3.135 billion

The following chart shows the percentage of MA spending in fiscal year 2008 on the major service categories.

- HMO and waivered services were the largest single expenditure categories (each representing about one-fourth of MA spending).
- Community-based long-term care (waivered services and home care services) accounted for 32 percent of MA spending.
- Long-term institutional care (care provided in nursing homes, ICFs/DD, and state facilities) accounted for 16 percent of MA spending.

[80] Through December 1990, the state paid 90 percent of the nonfederal share and the counties the remaining 10 percent. Counties are currently responsible for the nonfederal share of MA costs for selected services, as follows: 50 percent of the nonfederal share for the cost of placement of severely emotionally disturbed children in regional treatment centers, 20 percent for the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days, 10 percent of the cost of placements in ICFs/DD with seven or more beds that exceed 90 days, and 20 percent of the costs of placements in nursing facilities that are institutions for mental diseases (IMDs) that exceed 90 days.

MA Spending on Services – SFY 2008



Note: The waivered services category includes waiver payments to HMOs.
Source: Department of Human Services

Recipient Profile

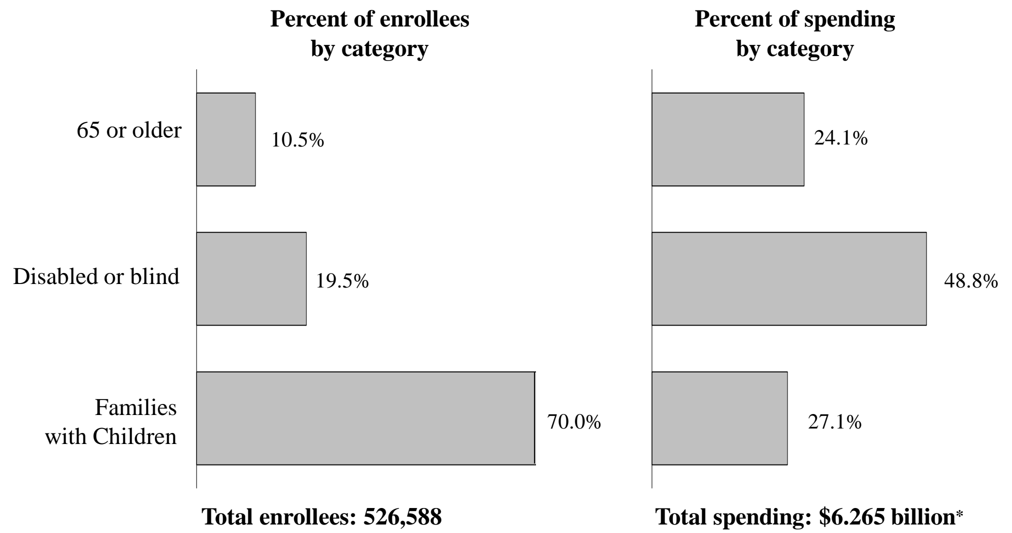
In fiscal year 2008, an average of 526,588 persons were eligible for MA services each month.

During fiscal year 2008, an average of 526,588 persons were eligible for MA services each month.

The graph below shows the percentage of MA eligibles in each of the major eligibility groups. The table also shows the percentage of MA spending accounted for by individuals from each eligibility group.

- Families with children make up the largest eligibility group, constituting 70.0 percent of eligibles. However, this group accounted for only 27.1 percent of MA spending.
- The elderly, and the disabled or blind, accounted for 72.9 percent of MA spending, although only 30.0 percent of eligibles are in these two groups.

Minnesota Medical Assistance Eligibles – SFY 2008



*does not include special funding items and adjustments

Source: Department of Human Services

MinnesotaCare

MinnesotaCare is a jointly funded, federal-state program administered by the Minnesota Department of Human Services that provides subsidized health coverage to eligible Minnesotans. This section describes eligibility requirements, covered services, and other aspects of the program.

Administration

MinnesotaCare is administered by the Minnesota Department of Human Services (DHS). DHS is responsible for processing applications and determining eligibility, contracting with managed care plans, monitoring spending on the program, and developing administrative rules. County human services agencies are responsible for determining Medical Assistance (MA) and General Assistance Medical Care (GAMC) eligibility for applicants for those programs. County human services agencies are also responsible for determining MinnesotaCare eligibility and managing MinnesotaCare cases for GAMC enrollees who transition to MinnesotaCare (see page 109). Some county human services agencies have elected to process additional MinnesotaCare applications and manage additional MinnesotaCare cases.

Eligibility Requirements

To be eligible for MinnesotaCare, individuals must meet income limits and satisfy other requirements related to residency and lack of access to health insurance. MinnesotaCare eligibility must be renewed every 12 months.[81]

Income Limits

Children[82] and parents, legal guardians, foster parents, or relative caretakers residing in the same household are eligible for

[81] The statutory change increasing the renewal period from six to 12 months was effective July 1, 2007; the change codified existing practice. Effective upon federal approval, which has not yet been received, children with family incomes that do not exceed 275 percent of FPG who fail to submit renewal forms and related documentation in a timely manner shall remain eligible. The commissioner is still required to verify income and determine premiums based on income, and to disenroll children for nonpayment of premiums.

[82] A child is defined in the law as an individual under 21 years of age, including the unborn child of a pregnant woman and an emancipated minor and that person's spouse.

MinnesotaCare, if their gross household income does not exceed 275 percent of the federal poverty guidelines (FPG) and if other eligibility requirements are met. The 2009 Legislature allowed children with incomes greater than 275 percent of the FPG to be eligible for MinnesotaCare if they meet all other eligibility requirements. This elimination of the income limit for children is effective upon federal approval, which has not yet been received. Parents, legal guardians, foster parents, and relative caretakers are not eligible if their gross annual income exceeds $50,000, regardless of whether their income exceeds 275 percent of FPG. This annual income cap will increase to $57,500, effective July 1, 2010, or upon federal approval, whichever is later. Different eligibility requirements and premiums apply to children from households with gross incomes that do not exceed 150 percent of FPG.

Single adults and households without children are eligible for MinnesotaCare if their gross household incomes do not exceed 250 percent of FPG[83] and they meet other eligibility requirements.

Extended Coverage for Children

On October 31, 2008, the federal Centers for Medicare and Medicaid Services (CMS) denied a request by the state to allow children age one through 18 who become ineligible for Medical Assistance (MA) due to excess income to be eligible for two additional months of MA[84] and be automatically eligible for MinnesotaCare until the next MinnesotaCare renewal. These children would have been exempt until renewal from the MinnesotaCare income limit and from the requirement that MinnesotaCare enrollees have no current access to employer-subsidized coverage, no access to employer-subsidized coverage through the current employer for 18 months prior to application or reapplication, and no other health coverage while enrolled or for at least four months prior to application or renewal. These children would have been required to pay the standard MinnesotaCare sliding scale premiums to enroll and remain enrolled.

The coverage extension was authorized by the 2007 Legislature in Laws 2007, chapter 147, article 13, and was to have been effective October 1, 2008, or upon federal approval, whichever was later. The Minnesota Department of Human Services resubmitted the request on September 30, 2009.

Enrollees whose incomes rise above program income limits after initial enrollment are disenrolled from the program. Children are exempt from this requirement and can remain enrolled in MinnesotaCare if 10 percent of their gross annual household income is less than the annual premium of the $500-deductible policy offered by

[83] The income limit for adults and households without children was increased from 200 percent to 250 percent of FPG on July 1, 2009.

[84] These two additional months would have been in addition to the transitional MA coverage that is available to persons who lose MA eligibility due to increased earned or unearned income.

the Minnesota Comprehensive Health Association (MCHA).[85]

Table 1 lists categories of persons eligible for MinnesotaCare, eligibility criteria, and enrollee cost (see table on page 114 for sample sliding scale premiums). The second table below lists program income limits for different family sizes.

Eligibility for MinnesotaCare[86]

Eligible Categories	Household Income Limit	Other Eligibility Criteria	Cost to Enrollee
Lower income children	150% of FPG	Not otherwise insured or insurance is considered underinsured; residency requirement	$4 per child per month
Other children	151% - 275% of FPG[87]	No access to employer-subsidized coverage; no other health coverage; residency requirement	Premium based on sliding scale
Pregnant women	275% of FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement	Premium based on sliding scale
Parents and relative caretakers	275% of FPG or $50,000,[88] whichever is less	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale
Single adults, households without children	250% of FPG	No access to employer-subsidized coverage; no other health coverage; residency requirement; asset limit	Premium based on sliding scale

[85] The MCHA offers health insurance to Minnesota residents who have been denied private market coverage due to pre-existing health conditions.

[86] Exceptions to these requirements are noted in the text.

[87] The 2009 Legislature allowed children with household incomes greater than 275 percent of FPG to be eligible, effective upon federal approval, which has not yet been received. These children must pay the maximum premium.

[88] The 2008 Legislature increased the income limit for parents and relative caretakers to $57,500, effective upon federal approval, which has not yet been received.

Annual Household Income Limits for MinnesotaCare
(Effective July 1, 2009)

Household Size[89]	Lower Income Children 150% of 2009 FPG	Adults Without Children 250% of 2009 FPG	Families and Children 275% of 2009 FPG[90]
1	$16,248	$27,084	$29,784
2	21,864	36,444	40,080
3	27,480	Not eligible	50,376
4	33,096	Not eligible	60,672
Each Additional Person	Add $5,616	Not applicable	Add $10,296

Asset Limits

MinnesotaCare adult applicants and enrollees who are not pregnant are subject to an asset limit, identical to the Medical Assistance program's asset limit for parents. This asset limit is $10,000 in total net assets for a household of one person, and $20,000 in total net assets for a household of two or more persons. Certain items are not considered assets when determining MinnesotaCare eligibility, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- capital and operating assets of a business up to $200,000
- insurance settlements for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children

[89] Pregnant women are households of two.

[90] Parents are not eligible once income exceeds $50,000.

- workers' compensation settlements received due to a work-related injury[91]

Pregnant women and children are exempt from the MinnesotaCare asset limit.

No Access to Subsidized Coverage

A family or individual must not have access to employer-subsidized health care coverage. A family or individual must also not have had access to employer-subsidized health care coverage through a current employer for 18 months prior to application or re-application. Employer-subsidized coverage is defined as health insurance coverage for which an employer pays 50 percent or more of the premium cost. This requirement applies to each individual. For example, if an employer contributes 50 percent or more towards the cost of coverage for an employee but does not contribute 50 percent or more towards the cost of covering that employee's dependents, the employee is not eligible for MinnesotaCare but the employee's dependents are eligible.

The requirement of no current access to employer-subsidized coverage does not apply to the following:

1. Children from households with incomes that do not exceed 150 percent[92] of FPG
2. Children enrolled in the Children's Health Plan as of September 30, 1992 (the precursor program to MinnesotaCare) who have maintained continuous coverage
3. Children who enrolled in the Children's Health Plan during a transition period following the establishment of MinnesotaCare

Children referred to in clauses (1) and (2) are, in some cases, also exempt from the no-other-health-coverage requirement (see section below).

Families or individuals whose employer-subsidized coverage was lost because an employer terminated health care coverage as an employee benefit during the previous 18 months are also not eligible for MinnesotaCare.

[91] This asset exclusion was approved by the federal government on October 31, 2008, and became effective January 1, 2009.

[92] The 2009 Legislature increased this income limit to 200 percent of FPG, effective upon federal approval, which has not yet been received.

A family or individual disenrolled from MinnesotaCare because of the availability of employer-subsidized health coverage, who reapplies for MinnesotaCare within six months of disenrollment because the employer terminates health care coverage as an employee benefit, is exempt from the 18-month enrollment restriction related to access to subsidized coverage.

No Other Health Coverage

Enrollees must have no other health coverage and must not have had health insurance coverage for the four months prior to application or renewal. For purposes of these requirements:

1. MA, GAMC, and CHAMPUS (Civilian Health and Medical Program of the Uniformed Service, also called TRICARE) are not considered health coverage for purposes of the four-month requirement; and

2. Medicare coverage is considered health coverage, and an applicant or enrollee cannot refuse Medicare coverage to qualify for MinnesotaCare.

Children from households with incomes that do not exceed 150 percent[93] of FPG and children enrolled in the original Children's Health Plan who have maintained continuous coverage are not subject to the four-month uninsured requirement and may have other health coverage, if the children are considered "underinsured." A child is underinsured if:

1. The coverage lacks two or more of the following:

    - basic hospital insurance
    - medical-surgical insurance
    - major medical coverage
    - prescription drug coverage
    - preventive and comprehensive dental coverage
    - preventive and comprehensive vision coverage

[93] The exemption from the four-month uninsured requirement is found only in rule. See Minnesota Rules, part 9506.0020, subpart 3, item A. The 2009 Legislature expanded the exemption from the four-month uninsured requirement to include children from families with incomes less than 200 percent of FPG, and also increased to this level the income limit below which children can have other health coverage if they are uninsured. These changes are effective upon federal approval, which has not yet been received.

2. The coverage requires a deductible of $100 or more per person per year; or

3. The child lacks coverage because the maximum coverage for a particular diagnosis has been exceeded, or the policy of coverage excludes coverage for that diagnosis.

Individuals who are receiving a state premium subsidy for COBRA continuation coverage for unemployed individuals, and their qualified beneficiaries, are exempt from the four-month uninsured requirement, if the individual or qualified beneficiaries apply for MinnesotaCare coverage after COBRA continuation coverage ends (see Laws 2009, chapter 79, article 5, section 78).

Residency Requirement

Pregnant women, families, and children must meet the residency requirements of the Medicaid program. The Medicaid program requires an individual to demonstrate intent to reside permanently or for an indefinite period in a state, but it does not include a durational residency requirement (a requirement that an individual live in a state for a specified period of time before applying for the program).

In contrast, enrollees who are adults without children must have resided in Minnesota for 180 days prior to application and must also satisfy other criteria relating to permanent residency.

Enrollment of Certain GAMC Applicants and Recipients

Since September 1, 2006, certain GAMC applicants and recipients have been enrolled in the MinnesotaCare program as adults without children, immediately following approval of GAMC coverage. These individuals are exempt from MinnesotaCare premiums, income and asset limits, and eligibility requirements related to not having other health coverage and not having access to employer-subsidized health insurance for up to six months until their next six-month renewal. County agencies are required to pay the enrollee share of MinnesotaCare premiums for these individuals up to the six-month renewal and have the option of continuing to pay for these premiums beyond this period. At the six-month renewal, all MinnesotaCare eligibility criteria apply.

GAMC applicants and recipients are exempt from the MinnesotaCare enrollment requirement if they are any of the following:

- eligible for GAMC as General Assistance or Group Residential Housing recipients
- awaiting a determination of blindness or disability
- unable to meet the MinnesotaCare residency requirement
- homeless
- end-stage renal disease beneficiaries in the Medicare program
- persons enrolled in private health coverage
- certain persons detained by law for less than one year in a county correctional or detention facility or admitted to a hospital on a criminal hold order
- persons who receive treatment funded through the Consolidated Chemical Dependency Treatment Fund
- persons residing in the Minnesota sex offender program

Elimination of GAMC Funding

On May 14, 2009, the governor line-item vetoed the $378,000,000 fiscal year 2011 general fund appropriation for the GAMC program in the health and human services finance bill (Laws 2009, ch. 79/H.F. 1362). In June 2009, the governor announced that he would reduce the fiscal year 2010 general fund appropriation for GAMC by $15,000,000 through unallotment. More information on these actions, and the use of MinnesotaCare as a potential coverage option for individuals who would otherwise be covered under GAMC is provided in the GAMC chapter of this guide.

Automatic Eligibility for Certain Children

Effective upon federal approval, which has not yet been received, children who resided in a foster care or juvenile residential correctional facility at the time of their 18th birthday are automatically eligible for MinnesotaCare upon termination or release until the age of 21. These children are exempt from the MinnesotaCare income limit, insurance barriers, and premiums.

Benefits

MinnesotaCare enrollees are covered by several different benefit sets. Pregnant women and children have access to the broadest range of services and are not required to pay copayments. Parents and adults without children are covered for most services, but are subject to benefit limitations and copayments. These differences are summarized in the table below and are described in more detail in the text.

Overview – MinnesotaCare Covered Services and Cost-Sharing

Eligibility Category	Covered Services[94]	Inpatient Hospital Limit	Cost-Sharing
Pregnant women and children	MA benefit set	None	None
Parents ≤ 215% of FPG	Most MA services	None	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $6 nonemergency visit to hospital ER
Parents > 215% and ≤ 275% of FPG	Most MA services	$10,000 annual limit for inpatient hospital services[95]	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $6 nonemergency visit to hospital ER
Adults without children	Most MA services	$10,000 annual limit for inpatient hospital services	• $25 eyeglasses • $3 prescriptions • $3 nonpreventive visit • $6 nonemergency visit to hospital ER • 10% inpatient hospital, up to $1,000

Covered Services and Benefit Limitations

Pregnant women and children up to age 21 enrolled in MinnesotaCare can access the full range of MA services without enrolling in MA, except that abortion services are covered as provided under the MinnesotaCare program.[96] These individuals are exempt from

[94] See Table 5 for a list of covered services.

[95] The state recently received federal approval to raise the income limit above which patients are subject to this annual limit.

[96] Under MinnesotaCare, abortion services are covered "where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest" (Minn. Stat. § 256L.03, subd. 1). Under MA, abortion services

MinnesotaCare benefit limitations and copayments,[97] but still must pay MinnesotaCare premiums. Pregnant women and children up to age two are not disenrolled for failure to pay MinnesotaCare premiums and can avoid MinnesotaCare premium charges altogether by enrolling in MA.

Parents and adults without children, who are not pregnant, are covered under MinnesotaCare for most, but not all, services covered under MA.[98] Parents with household incomes greater than 215 percent of FPG, and all adults without children, are subject to an annual benefit limit for impatient hospital services of $10,000.[99]

Covered Services Under MinnesotaCare

Service	Children; Pregnant Women	Parents; Adults without children[100]
Adult mental health rehab/crisis	x	x
Alcohol/drug treatment	x	x
Child and teen checkup	x	
Chiropractic	x	x
Common carrier transportation	x	

are covered to save the life of the mother and in cases of rape or incest (see Minn. Stat. § 256B.0625, subd. 16) and, as a result of a Minnesota Supreme Court decision, for "therapeutic" reasons (*Doe v. Gomez*, 542 N.W.2d 17 (1995)). MinnesotaCare enrollees must enroll in the MA program in order to obtain abortion services under the MA conditions of coverage. Nearly all MinnesotaCare enrollees who are pregnant women are eligible for MA.

[97] This change in MinnesotaCare was approved by the federal government in April 1995 as part of the state's health care reform waiver (now referred to as the Prepaid Medical Assistance Project Plus or PMAP+ waiver). The waiver, and subsequent waiver amendments, exempt Minnesota from various federal requirements, give the state greater flexibility to expand access to health care through the MinnesotaCare and MA programs, and allow the state to receive federal contributions (referred to as "federal financial participation" or FFP) for services provided to MinnesotaCare enrollees who are children, pregnant women, or parents and relative caretakers of children under age 21. After protracted negotiations, the PMAP+ waiver was reauthorized by the federal Centers for Medicare and Medicaid Services for the period October 31, 2008, through June 30, 2011.

[98] Effective October 1, 2003, through December 31, 2007, adults without children with incomes greater than 75 percent but not exceeding 175 percent of FPG received coverage under MinnesotaCare for a limited benefit set. The limited benefit set covered inpatient hospital services (subject to a $10,000 annual limit), physician services, outpatient hospital and ambulatory surgical center services, chiropractic services, lab and diagnostic services, diabetic supplies and equipment (added January 1, 2006), and prescription drugs. This coverage was subject to a $5,000 annual limit on outpatient services, which was eliminated January 1, 2006. The limited benefit set was eliminated by the 2007 Legislature, effective January 1, 2008. Prior to January 1, 2008, outpatient mental health coverage for parents and adults without children was limited to diagnostic assessments, psychological testing, explanation of findings, day treatment, partial hospitalization, psychotherapy, and medication management. This restriction was eliminated January 1, 2008, except that coverage for mental health case management did not take effect until January 1, 2009.

[99] The increase in the income limit at or above which the annual inpatient hospital benefit limit applies (from 200 percent to 215 percent of FPG) took effect July 1, 2009.

[100] Benefit limitations and cost-sharing requirements apply.

Service	Children; Pregnant Women	Parents; Adults without children[100]
Dental[101]	x	x
Emergency room	x	x
Eye exams	x	x
Eyeglasses	x	x
Family planning	x	x
Hearing aids	x	x
Home care	x	X[102]
Hospice care	x	x
Hospital stay	x	x
Immunizations	x	x
Interpreters (hearing, language)	x	x
Lab, x-ray, diagnostic	x	x
Medical equipment and supplies	x	x
Mental health	x	x
Mental health case management	x	x
Nursing home/ICF/MR	x	
Outpatient surgical center	x	x
Physicians and clinics	x	x
Physicals/preventive care	x	x
Prescriptions	x	x
Rehabilitative therapies	x	x
School-based services	x	
Transportation: emergency	x	x
Transportation: special	x	

Copayments for Adults

Parents and adults without children, who are not pregnant, are subject to the following copayments:

- Copayment of 10 percent of paid charges for inpatient hospital services, up to an annual maximum of $1,000 per adult. (This

[101] MinnesotaCare covers the dental services covered under Medical Assistance (MA). Effective January 1, 2010, MA coverage of dental services for adults who are not pregnant (and therefore MinnesotaCare coverage of dental services for this category of individuals) will be limited to specified services (see Minn. Stat. § 256B.0625, subd. 9 (Supp. 2009)).

[102] Personal care attendant and private duty nursing services are covered for children and pregnant women, but are not covered for parents and adults without children.

copayment does not apply to parents and relative caretakers of children under age 21.)
- $3 copayment per prescription
- $25 copayment per pair of eyeglasses
- $3 per nonpreventive visit (does not apply to mental health services)
- $6 for nonemergency visits to a hospital emergency room

Enrollee Premiums

Minimum Premium

Children enrolling in MinnesotaCare are charged a minimum monthly premium of $4 per child, if they are from households with incomes that do not exceed 150 percent of FPG.

Effective upon federal approval, which has not yet been received, children with family incomes at or below 200 percent of FPG will not be charged premiums.

Adults enrolling in MinnesotaCare are charged a subsidized premium based upon a sliding scale.

Sliding Premium Scale

MinnesotaCare enrollees who are not children eligible for the minimum premium pay premiums equivalent to the percentages of gross monthly income specified in the table below. This premium scale became effective July 1, 2009, and replaced a premium scale under which the enrollee contribution ranged from 1.8 percent to 8.8 percent of monthly gross household income.

Sliding Premium Scale

Federal Poverty Guideline Range	Average Percentage of Gross Monthly Income Paid as Premium
0% - 45%	Minimum premium of $4/month
46 - 54	$4/month or 1.1%, whichever is greater
55 - 81	1.6%
82 - 109	2.2
110 - 136	2.9
137 - 164	3.6
165 - 191	4.6
192 - 219	5.6
220 - 248	6.5
249 - 275	7.2

Premium Exemption

Members of the military and their families who are determined eligible for MinnesotaCare within 24 months of the end of the member's tour of active duty are exempt from premiums for 12 months.[103]

Nonpayment of Premiums

Unless an exemption applies, nonpayment of premiums results in disenrollment from MinnesotaCare effective the calendar month for which the premium was due.[104] If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage continues until the last day of the month in which 60 days postpartum occurs. If the premium is not paid for an enrollee who is a child under age 2, MinnesotaCare coverage continues to the last day of the month following the month in which the child turns 2 years old.

Prepaid MinnesotaCare

The legislature has authorized the Commissioner of Human Services to contract with health maintenance organizations and other prepaid health plans to deliver health care services to MinnesotaCare enrollees. All MinnesotaCare enrollees receive health care services through prepaid health plans and not through fee-for-service.

Prepaid health plans (sometimes referred to as managed care plans) receive a capitated payment from DHS for each MinnesotaCare enrollee, and in return are required to provide enrollees with all covered health care services for a set period of time. A capitated payment is a predetermined, fixed payment per enrollee that does not vary with the amount or type of health care services provided. A prepaid health plan reimbursed under capitation does not receive a higher payment for providing more units of service or more expensive services to an enrollee, nor does it receive a lower payment for providing fewer units of service or less expensive services to an enrollee.

Under prepaid MinnesotaCare, enrollees select a specific prepaid plan

[103] Federal approval for this provision was obtained on October 31, 2008. The provision took effect February 1, 2009, and will expire June 30, 2010.

[104] The 2008 Legislature provided a grace month extending the enrollment of a person who fails to pay the premium to the first day of the calendar month following the calendar month for which the premium was due. This provision is effective upon federal approval, which has not yet been received.

from which to receive services, obtain services from providers in that plan's provider network, and follow that plan's procedures for seeing specialists and accessing health care services. Enrollee premiums, covered health care services, and copayments are the same as they would have been under fee-for-service MinnesotaCare.

Funding and Expenditures

Total payments for health care services provided through MinnesotaCare were $463 million in fiscal year 2008. Sixty-six percent of this amount was paid for through state payments from the health care access fund. Enrollee premiums (this category also includes enrollee cost-sharing) and federal funding received under the Prepaid Medical Assistance Project Plus (PMAP+) waiver and Minnesota's Children's Health Insurance Program (CHIP)[105] allotment pay for the remainder.

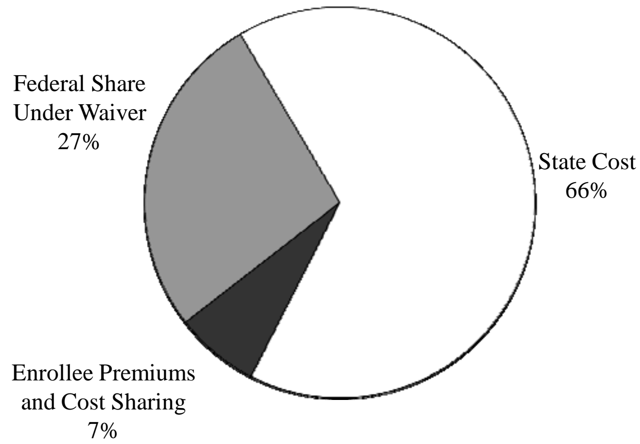
Funding for the state share of MinnesotaCare costs, and for other health care access initiatives, is provided by:

- A 2-percent tax on the gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors (sometimes referred to as the "provider tax"); and
- A 1-percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.

Medicare payments to providers are excluded from gross revenues for purposes of the gross revenues taxes. Other specified payments, including payments for nursing home services, are also excluded from gross revenues.

[105] The PMAP+ waiver is described in footnote 97 on page 112. The state may make a claim against its CHIP allotment for the difference between the CHIP federal matching rate for Minnesota (65 percent) and the Medicaid federal matching rate for Minnesota, for the cost of services provided to children under age 21 whose family income equals or exceeds 133 percent of FPG but does not exceed 275 percent of FPG. Minnesota had a CHIP waiver until January 31, 2009, that provided an enhanced federal match of 65 percent for parent and relative caretakers enrolled in MinnesotaCare with family incomes greater than 100 percent but not exceeding 200 percent of FPG. Parents and relative caretakers now receive the regular MA federal match of 50 percent. There is no federal match for adults without children.

MinnesotaCare Funding
(FY 2008)

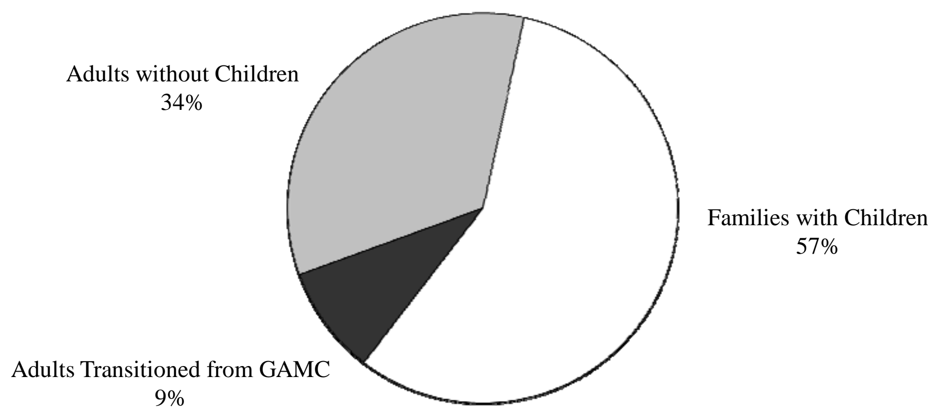


Source: DHS Reports and Forecasts Division

Recipient Profile

As of June 2009, 121,722 individuals were enrolled in the MinnesotaCare program. Just over three out of five MinnesotaCare enrollees are children, parents and caretakers, or pregnant women.

MinnesotaCare Enrollment
(June 2009)



Source: DHS Reports and Forecasts Division

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Child Care

Child Care assistance programs receive federal, state, and county funds to subsidize the child care expenses of eligible families, including families participating in the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP) with household incomes less than or equal to 67 percent of the state median income, and working families or students who receive no cash assistance and have incomes at or below 47 percent of the state median income, adjusted for family size, at program entry and up to 67 percent of the state median income, adjusted for family size, at program exit.

Administration

Congress

The federal government supports child care assistance through the Child Care and Development Fund (CCDF) established by Congress in 1996 as part of federal welfare reform. Previous federal child care programs were repealed by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which created CCDF as a unified child care fund.

The federal government supports child care assistance through the Child Care and Development Fund established by Congress in 1996.

In addition to appropriating money for the CCDF, Congress authorized states to transfer up to 30 percent of the annual federal Temporary Assistance for Needy Families (TANF) block grant to the CCDF to be used for child care assistance and the development of child care.

U.S. Department of Health and Human Services (DHHS)

The CCDF is administered by the Administration for Children and Families in the DHHS. Federal legislation requires states to submit a plan to the secretary of DHHS. The plan must provide for parental choice of providers, unlimited parental access to children in child care, provisions to record parental complaints, consumer education, compliance with state licensing requirements, compliance with health and safety requirements to protect children, and provisions to meet the needs of certain groups including families attempting to transition off of cash assistance programs through work. DHHS issued final CCDF rules in July 1998. Eligibility criteria and payment methods are set in the federal rules which also direct the governor to appoint a lead agency to administer the child care fund. The lead agency in Minnesota is the Department of Human Services (DHS).

Minnesota State Legislature

Minnesota subsidizes the cost of child care for welfare recipients and other low-income families.

The Minnesota Legislature established a statewide child care assistance program to subsidize the cost of child care for welfare recipients and other low-income families in 1985. In 1989, the legislature separated the funding for the basic sliding fee child care assistance program from the funding that provided child care assistance as an entitlement for eligible families receiving welfare. Working families who did not receive cash assistance were eligible for the basic sliding fee program under a limited and capped funding allocation.

Minnesota child care assistance law is primarily found in Minnesota Statutes, chapter 119B, which:

- authorizes the commissioner of DHS to receive, administer, and expend funds from the CCDF;
- establishes the MFIP child care assistance program for MFIP or DWP families who are engaged in authorized activities and families who are transitioning off MFIP or DWP;
- establishes the basic sliding fee child care assistance program for non-MFIP families who are income-eligible and employed, actively seeking employment, or are students;
- establishes a program that provides continuing child care assistance for families who move;
- defines priorities for funding;
- establishes parental choice of provider;
- establishes child care rates;
- authorizes the commissioner to adopt rules for the child care assistance programs; and
- establishes a formula to allocate federal and state money to counties to provide assistance through the basic sliding fee program.

The legislature appropriates money for both MFIP child care assistance and basic sliding fee child care assistance.

Minnesota Department of Human Services (DHS)

Each Minnesota county must adopt written policies on child care assistance, provide information on child care programs, and maintain a waiting list for basic sliding fee assistance.

The Minnesota Department of Human Services (DHS) is responsible for coordinating child care assistance appropriations and maximizing the use of federal child care assistance funds. DHS establishes standards for county boards to provide child care assistance to eligible families. The standards are found in Minnesota Rules, chapter 3400, which:

- defines family eligibility for all child care assistance programs;
- provides for payment methods and procedures for child care subsidies; and
- establishes administrative responsibilities for counties.

DHS supervises county administration of child care assistance programs, provides training and technical support services, and reimburses counties for the cost of child care assistance. DHS allocates funding to the counties for the basic sliding fee program. The allocation for each county is based on formulas in Minnesota Statutes, chapter 119B, and is limited by state and federal appropriations.

DHS is also authorized to contract with Indian tribes that have a reservation in Minnesota to operate child care assistance programs.

Counties

In Minnesota, counties administer child care assistance programs. Counties must accept applications for child care assistance and determine a family's eligibility for assistance. Counties must make assistance payments to the provider or to the family if using an in-home child care provider. Each county must adopt written policies on child care assistance, provide information on child care programs, and maintain a waiting list for basic sliding fee assistance if funding is not sufficient to meet the need for assistance.

Counties must determine if child care providers are eligible to receive a subsidized payment through the child care assistance programs. Counties must register participating legal nonlicensed child care providers and must refer parental health and safety complaints about registered providers to the appropriate agency.

Counties are required to use local funding sources to make a financial contribution to child care assistance programs. Each county must submit a child care fund plan to DHS. The plan must certify that the county has not used money from the child care fund to supplant other

available federal and state funding sources, but has maintained a comparable level of effort.

Eligibility Requirements

Child care assistance programs reduce child care expenses for eligible families according to a sliding fee scale.

Child care assistance programs reduce child care expenses for eligible families according to a sliding fee scale. The purpose of the assistance is to enable families to seek or retain employment, or to participate in education or training that leads to employment. A family must apply for child care assistance. To be eligible, a family must:

- have income within the income guidelines based on family size;
- have all parents participating in an authorized activity;
- choose a legal child care provider (licensed family or center child care, or legal nonlicensed family, individual, or center care); and
- cooperate with child support enforcement for all children in the assisted household and assign the child care portion of child support to the state.

Maximum subsidies are established by a market rate survey administered by DHS and are based on the age of the child, type of child care, and the county of residence.

Eligible Children, Families, and Caregivers

The child care assistance programs provide a child care subsidy for the care of children in eligible families who are under the age of 12 or for the care of disabled children in eligible families up to the age of 14.

"Family" for the child care assistance programs includes:

- family members living in the same home including parents, stepparents, guardians and their spouses, other eligible relative caregivers and their spouses, and dependent children under the age of 18 who are related by blood or adoption;

- dependent children under age 18 who are temporarily absent from the home for school, foster care, or residential treatment;

- parents, stepparents, guardians and their spouses, and other relative caregivers and their spouses temporarily absent from

the home for school, military service, or rehabilitation programs; and

- adults age 18 or older who meet the definition of family, are attending high school or postsecondary school, and receive 50 percent or more of their income from family members living in the same household.

For a minor parent living with relatives, "family" includes only the minor parent or parents and their children.

MFIP Child Care Eligibility

MFIP child care is a fully funded program that provides a child care subsidy to eligible MFIP families.

MFIP child care is a fully funded program that provides a child care subsidy to eligible MFIP or DWP families who participate in authorized education and employment activities. Family members must be participating in an authorized activity. MFIP families who choose to forego the cash assistance grant are also eligible for child care assistance for authorized activities.

MFIP families with an employment or job search plan are eligible for child care assistance for activities provided in their plan, including the following:

- orientations to employment services
- employment
- assessments
- participation in work, training, or education activities
- appeals or hearings for cash assistance programs
- job search
- social services activities

MFIP families without an employment plan are eligible for child care assistance for:

- employment earning at least the minimum wage for an average of 20 hours per week or more;
- job search, as authorized, for up to 240 hours per year;
- orientation to MFIP financial assistance; and
- appeals or hearings for cash assistance.

A family required to participate in social services activities in the family's employment plan may be eligible for subsidized child care through the MFIP child care program. Social services activities include parent education, chemical dependency counseling or treatment, or mental health counseling or treatment.

Transition Year Child Care Eligibility

Transition year child care assistance is a fully funded program that provides one year of child care assistance to families who leave MFIP or DWP. Eligibility for transition year assistance begins the first month that a family is ineligible for MFIP or DWP and continues for 12 consecutive months.

Eligible families are provided transition year child care assistance for employment or job search activities.

If, after the transition year has ended, the family continues to be eligible for child care assistance, but cannot be moved to Basic Sliding Fee because the county lacks funds and there is a waiting list, the family will be moved to the Transition Year Extension program for the length of time needed to be moved from the Basic Sliding Fee waiting list to the program.

Annual income limits for participation in Minnesota's child care assistance programs are based on the federal poverty guidelines.

Basic Sliding Fee Child Care Eligibility

Basic sliding fee child care assistance provides child care assistance for families who are not participating in MFIP or receiving transition year child care assistance. Eligible families must meet income requirements and participate in authorized activities. Assistance to eligible families is limited by the availability of federal and state funding.

Income Limits for Child Care Assistance

Families receiving assistance through the MFIP child care program must be income eligible for the MFIP cash assistance program (see page 17). Families receiving assistance through the MFIP transition year or basic sliding fee program must have incomes at or below 47 percent of the state median income, adjusted for family size, at program entry and up to 67 percent of state median income, adjusted for family size, at program exit.

Annual income limits for participation in Minnesota's child care assistance programs are based on the state median income. The state

median income for a family of four is $81,477 for state fiscal year 2009. Families with incomes at or below 47 percent of the state median income are eligible for child care assistance at program entry and within incomes up to 67 percent of the state median income at program exit. The chart below shows income eligibility for families with two to six members for state fiscal years 2008 and 2009. Prior to fiscal year 2004, the maximum income eligibility level was set at 75 percent of state median income. The state briefly converted to the federal poverty guidelines as the income standard between 2004 and 2008, but then converted back to state median income effective July 2008.

Exit Income Limits for Basic Sliding Fee and Transition Year Child Care Assistance

Family Size	Exit Income Limit	
	FY 2008	**FY 2009**
2	$34,224	$37,120
3	42,924	45,854
4	51,624	54,589
5	60,324	63,323
6	69,024	72,058

Source: Department of Human Services

Annual gross income is the basis for determining income eligibility for child care assistance. Gross income includes earned income, self-employment income, unearned income, and lump sum payments received by all family members. Income excludes payments of health insurance premiums, Supplemental Security Income, scholarships, education grants and work-study income, tuition loans and reimbursements, earned income tax credits, in-kind assistance including, but not limited to child care assistance, foster care assistance, earned income of student family members up to the age of 19 without a high school diploma or GED, family subsidy program grants, lump sum payments used for a directed purpose, and child care support assigned to the state.

Earned income for wage and salary employees is the total amount of income from employment before any payroll deductions. It includes the following:

- salaries and wages
- tips and gratuities

- commissions and incentive payments
- employer payments for accrued vacation and sick leave
- profits earned by an individual
- uniform and meal allowances if federal taxes are deducted
- flexible employer benefits selected by an employee in place of cash
- fair market value of housing included in compensation

Unearned income includes the following:

- assistance payments including cash assistance
- interest and dividends
- benefit payments including unemployment compensation, disability, and veterans
- pension payments
- support payments for child support and spousal support
- insurance or severance payments
- RSDI-Social Security survivor's benefits

Self-employment income is earned income equal to the difference between gross receipts and authorized expenses. Farm income and rental income are self-employment income. Authorized expenses exclude the following:

- the purchase of capital assets or payment of principal for capital loans
- depreciation and amortization
- the value of inventory for sale
- transportation costs above the federal allowance or for the cost of travel from home to work
- salaries and deductions for family members
- monthly expenses above the allowance for roomers, boarders, or roomer-boarders or upkeep and repair of rental property
- expenses not allowed by the federal tax code for self-employment

Lump sum payments are treated as earned or unearned income depending on the source of the payment. Rental income is treated as

self-employment or unearned income depending on the amount of time the owner spends on property maintenance or management.

Additional Eligibility Requirements

To be eligible for child care assistance, families must:

- apply for child care assistance in the county where they live;
- document income eligibility, residence, relationship of child to parent, and the authorized activities that require child care assistance;
- select a legal child care provider, including legal nonlicensed providers;
- notify the county, within ten days, of any change in household size, status, income, and residence;
- cooperate with the establishment of paternity and enforcement of child support obligations for all children in the family and assign the child care portion of support to the state; and
- pay a family copayment as required by law.

Family Copayments

Families with incomes at or above 75 percent of FPG must pay a family copayment to receive child care assistance through the MFIP, transition year, or basic sliding fee programs. The amount of the copayment is based on family size and annual gross family income. The number of children requiring child care and the parent's choice of child care provider do not influence a family's copayment.

The 2005 Legislature reduced copayments beginning on January 1, 2006, for families with incomes above 75 percent of the poverty guidelines. The table below shows family copayments beginning on January 1, 2009. Under the changes effective July 2008, copayments are calculated based on federal poverty guidelines up to 100 percent of federal poverty guidelines. Thereafter, copayments are based on state median income.

Copayment Schedule for Child Care Assistance
Effective July 1, 2009

Family Size	Annual Income		Bi-weekly Copayment	
	75% of FPG	**67% SMI**	**Minimum**	**Maximum**
2	$10,928	$38,017	$2	$205
3	13,733	46,962	2	253
4	16,538	55,907	2	301
5	19,343	64,853	2	349
6	22,148	73,798	2	397
7	24,953	75,475	2	407
8	27,758	77,152	2	415
9	30,563	78,830	2	425
10	33,368	80,507	2	433
11	36,173	82,184	2	443
12	38,978	83,861	2	451
13	41,783	85,538	2	461

Source: Department of Human Services

Basic Sliding Fee Waiting Lists

When funds are unavailable for child care assistance through the Basic Sliding Fee program, a county must maintain and periodically update a waiting list of eligible applicants. As funds become available, families receive child care assistance according to three statutory priorities:

1. The child care needs of eligible non-MFIP families who do not have a high school diploma or GED or who need remedial and basic skill courses in order to pursue employment and who need child care assistance to participate in the education program
2. Families who have completed their MFIP transition year
3. Families who have moved to a county with a waiting list from a county where they received Basic Sliding Fee

Benefits

Maximum benefits under the child care assistance programs cannot exceed 120 hours of subsidized care in a two-week period for each eligible child.

Benefit amounts under the child care assistance programs depend on the caretaker's activities, the selection of a child care provider, where the child care is provided, and the amount of the family copayment. Maximum benefits under the child care assistance programs cannot exceed 120 hours of subsidized care in a two-week period for each eligible child. A family may also be reimbursed for up to two child care registration fees per year for each eligible child.

Under state law, the maximum reimbursement rate for child care assistance must be equal to or less than the 75th percentile of the cost of similar care in the county. DHS establishes maximum child care reimbursement rates for each county based on a survey of child care providers. The cost of child care varies throughout the state. It also varies by the age of the child and the type of child care provider—family- or center-based. Infant child care in a child care center in the Twin Cities area is the most expensive child care in Minnesota. The following table shows established maximum weekly rates by provider type and age of the child in each of the development regions. DHS establishes a maximum rate for each type of care in each county of the state.

The 2003 Legislature froze the maximum rates paid to child care providers that were implemented on July 1, 2002, through June 30, 2005. The 2005 Legislature extended the rate freeze through December 31, 2005. Beginning on January 1, 2006, the maximum rate for child care assistance in any county or multi-county region is the lesser of the 75th percentile rate for like-care arrangements in the county or region as surveyed by the commissioner, or the previous year's rate for like-care arrangements, increased by 1.75 percent. Beginning July 1, 2006, the maximum reimbursement rate for child care assistance is increased by 6 percent over the rate established on January 1, 2006, in each county or multicounty region.

Range of Maximum Weekly Child Care Rates (standard hours) by Region, Provider Type, and Age of Child
Effective January 2007

	Infant		Toddler		Pre-school		School age	
	Family	**Center**	**Family**	**Center**	**Family**	**Center**	**Family**	**Center**
Region 1	$94.37-107.86	$107.86-134.82	$94.37-107.86	$102.46-113.25	$94.37-107.86	$91.68-107.86[S]	$94.37-106.00	$107.86-119.25
Region 2	106.00-119.78	212.00	106.00-116.60	121.90-212.00	106.00-116.60	113.25[R]-151.05[R]	106.00-116.60	80.89[R]-159.00
Region 3	121.34-134.82	145.60[S]-194.14	119.25-134.82	124.03[S]-161.79	107.86-134.82	134.82[R]-148.30	107.86-134.82	118.65[R]-153.70
Region 4	94.37-121.34	140.22-151.00	94.37-107.86	113.25[R]-145.60	94.37-107.86	115.94-129.43	94.37-107.86	98.42-129.43
Region 5	113.25-132.50	92.75-134.82	106.00-132.50	121.34-134.82	106.00-132.50	118.65-134.82	106.00-121.34	121.34-134.82
Region 6E	107.86-121.34	142.04[R]-212.00	107.86-121.34	118.65[R]-145.60	107.86-115.94	113.25[R]-127.27	106.00-121.34	107.86[S]-127.20
Region 6W	99.77-107.86	119.25[R]-121.34	97.07-107.86	108.65[R]	94.37-107.86	108.65[R]	94.37-107.86	108.65-113.25
Region 7E	107.86-134.82	145.60[S]-185.51	106.00-132.50	124.03-155.31	106.00-132.50	107.86[S]-144.53	97.07-121.34	107.86[S]-134.82
Region 7W	107.86-134.82	163.94-183.36	107.86-118.65	145.60-160.71	102.46-107.86	133.74-145.60	97.07-107.86	112.17-124.03
Region 8	92.75-121.34	136.17[R]-169.88	92.75-119.25	129.43[R]-153.69	92.75-119.25	124.03[R]-134.82	92.75-119.25	116.60[R]-134.82
Region 9	97.07-134.82	129.43-161.79	94.37-121.34	121.34-144.53	94.37-121.34	108.94-140.22	94.37-121.34	108.94-132.50
Region 10	121.34-151.00	146.28-237.28	107.86-138.05	128.26-196.30	107.86-134.82	107.06-167.17	107.86-132.50	110.24[R]-161.79
Region 11	134.82-167.17	230.82-277.19	124.03-160.17	200.62-226.50	113.25-145.60	177.96-203.85	107.86-134.82	167.17-190.91

Source: Department of Human Services CCAP Policy Manual November 2008[106]
R = Regional Rates
S = Statewide Rates

[106] DHS establishes maximum rates for each county based on a market rate survey. Weekly rates, if not established by the survey, are calculated based on 50 hours of care at the established hourly rate or on five days of care at the established daily rate. If hourly, daily, or weekly rates are not established due to insufficient information, regional rates are substituted. When a region has an insufficient number of providers responding to establish regional rates, statewide rates are substituted.

Provider Payments

The subsidy payment is the maximum rate or the provider's charge, whichever is lower. Counties may request approval from the commissioner for reimbursement rates that exceed the maximum rate for the care of children with special needs. The amount of a family's actual benefit is the subsidy payment less the family copayment fee. Families may select care arrangements with a rate higher than the maximum allowable rate, however, the family is responsible for any amount over the approved maximum rate plus the family copayment fee.

Child care providers who are accredited by certain national organizations or who meet specified educational requirements are eligible to receive a 15-percent rate differential above the maximum reimbursement rates established in the provider's county or multi-county region (Minn. Stat. § 119B.13, subd. 3a).

Continuation of Benefit

Families may continue to receive MFIP child care assistance as long as they are participating in MFIP and engaged in authorized activities. Families may receive 12 consecutive months of transition year child care assistance as long as the family is income-eligible and engaged in an authorized activity. After the 12 months if the family remains on the waiting list for the Basic Sliding Fee program, the family can receive a transition year extension as long as the family remains eligible for assistance. Families may receive assistance through the Basic Sliding Fee program as long as the family is income-eligible and engaged in an authorized activity. Student assistance under the Basic Sliding Fee program is limited to the amount of time necessary to complete a degree program. Child care assistance for job search activities for families without an employment plan is limited to 240 hours per year.

Limits on the amount of child care assistance by activity are presented in the following table.

Child Care Assistance by Work Activity

	Requirements	Benefits
Hourly Wage Employment Nonstudents Full-time students	Paid wages equal to the minimum wage or greater Work an average of 20 hours per week Work an average of 10 hours per week, if seeking child care assistance for employment	Child care for: • hours of employment • breaks during employment • maximum two hours of daily travel • maximum of 120 hours in two weeks Students may receive basic sliding fee assistance for the time necessary to complete the credit requirements for the degree program
Employment – No Hourly Wage	Self-employed or other employment without hourly wages	Hours of child care equal to the lesser of: • gross earned income divided by the minimum wage, plus one hour for breaks and meals per eight-hour day, plus one hour for travel per day; or • the actual amount of care for employment, breaks, and meals plus up to two hours daily for travel
Job Search	Must be included in employment plan or activities supporting job search for families without a plan	Up to 240 hours per calendar year for basic sliding fee and MFIP child care without an employment plan

Child Care Assistance for Specific Populations

At-Home Infant Child Care Program

State law authorizes DHS to use a portion of the state basic sliding fee appropriation for a subsidy for parents to provide care in their home for their infant child under the age of one year. To be eligible, a family must be participating in the Basic Sliding Fee program or meet the program's income and authorized activity requirements. Participation in the At-Home Infant Child Care Program is limited to a lifetime total of 12 months per family. The subsidy amount is equal to 90 percent of the maximum rate for licensed family child care in the family's county of residence less the applicable parent fee. A family is ineligible for other child care assistance while receiving an at-home infant child care subsidy. As of July 1, 2007, this program has not been funded and all applications are denied.

Migrant Care Program

DHS administers the migrant child care program through a contract with the Tri-Valley Opportunity Council. The program provides full-day child care for the children of migrant workers. Some migrant child care programs coordinate with migrant Head Start programs. In fiscal year 2008, migrant child care was funded with $193,000 in federal Title XX funds and $200,000 in state funds.

Higher Education Child Care Grant Program

The Office of Higher Education administers a grant program to subsidize the cost of child care for eligible students attending Minnesota postsecondary institutions. Postsecondary students apply for a grant through the financial aid office at participating colleges, universities, or technical institutions. To be eligible, the student must be a Minnesota resident with one or more children ages 12 or under, have demonstrated financial need, meet the family income guidelines, and be enrolled at least half-time in a nonsectarian program leading to an undergraduate degree, diploma, or certificate. Most public and nonprofit postsecondary schools in Minnesota are eligible to participate in the grant program. Students at private, for-profit, postsecondary schools that do not offer a baccalaureate degree are ineligible to participate.

Family income ranges and corresponding per child care grant amounts are set in rule. Income ranges are based on federal poverty levels, adjusted for family size. For academic year 2009-2010, the maximum incomes to qualify for a child care grant were $43,000 for a two-person family, $48,000 for a three-person family, and $53,000 for a four-person family. The incomes to qualify for the maximum grant amount were $18,000 for a two-person family, $23,000 for a three-person family, and $28,000 for a four-person family. MFIP participants are not eligible for a postsecondary child care grant.

Child care grants are awarded for the nine-month academic year based on the maximum set in state statute for each child receiving regular care. In 2009-2010, the maximum child care grant is $2,600 per child. Actual grant awards are based on the number of children eligible for care, the amount and cost of care, family income, and the availability of funding. Grants for infant care can exceed the statutory maximum by 10 percent. A child care grant award cannot exceed the student's amount of financial need. If a student receives other forms of child care assistance (including assistance from the Basic Sliding Fee program) the amount of the child care grant is reduced. Students

attending summer school are eligible for a separate child care grant award.

The state appropriates $6.184 million per year to the Office of Higher Education for child care grants. The office is authorized to use any remaining appropriations after the first year of the biennium to increase the maximum child care grant in the second year of the biennium. In fiscal year 2007, $4.934 million was awarded in child care grants to 2,832 recipients. The average award was $1,796.

Funding and Expenditures

Federal, state, and county governments fund child care assistance programs.

Federal funding for child care is distributed to the states through CCDF, which includes three funding streams:

Federal funding for child care is distributed to the states through CCDF.

- **Mandatory funds** provide funding to the states for subsidized child care. A state's base allocation is equal to the greater of the state's share of federal child care expenditures for fiscal years 1994 or 1995; or the average of the federal child care expenditures for fiscal years 1992 through 1994. A state is not required to match or meet a maintenance of effort level for mandatory funding. Federal fiscal year 1995 is the base year for Minnesota's mandatory funds under the CCDF.

- **Matching funds** provide federal funding in addition to the mandatory funds. To be eligible for matching funds, a state must first spend the maintenance of effort that is equal to the state's base year child care expenditures. State expenditures above the maintenance of effort level are matched at the federal medical assistance percentage (FMAP) up to a state's maximum allocation for that year.

- **Discretionary funds** are authorized by Congress and distributed to states according to a formula. Under the formula, half of a state's allotment is based on its share of children under the age of five, and half on its share of children eligible for free and reduced price meals. Both formula components are adjusted by the ratio of U.S. per capita income to the state's per capita income. The federal government does not require a state match or maintenance of effort expenditure for discretionary funding.

For state fiscal year 2007, the CCDF contributed 61 percent of Minnesota expenditures for subsidized child care. The contribution of federal funds, including TANF, in Minnesota varies by child care program—for fiscal year 2007, the federal funds made up 68 percent of MFIP child care and 51 percent of the basic sliding fee child care costs.

- **TANF block grant funds** under the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 may be transferred to the CCDF. Federal law limits transfers up to a 30 percent maximum of the annual TANF grant. The 1999 Minnesota Legislature authorized the transfer of a portion of the available TANF funds to the child care programs for assistance for eligible families.

The federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) included additional CCDF funding. The funds were awarded on a formula basis to states. These funds are supplemental CCDF discretionary funds, allocated in addition to the fiscal year 2009 discretionary fund appropriation amount. There is no match required for these funds. The federal act specified that a portion of these funds be used for quality activities and that the funds be used to supplement, not supplant, state general funds for child care assistance to low-income families. Minnesota received $26.1 million in additional CCDF funding in fiscal year 2009 due to this federal legislation.

Nonfederal Funding

State general fund appropriations and county general funds are used for child care assistance programs.

- **State appropriations** provide a substantial share of the funding for subsidized child care programs. The state's share of funding varies with the child care assistance program. In fiscal year 2007, the state funded 45 percent of MFIP child care assistance and 45 percent of the basic sliding fee assistance.

- **County funds** are also used for basic sliding fee child care assistance. The county contribution for fiscal years 2007 and 2008 averaged about 2 percent of all direct service child care expenditures. Some counties choose to provide additional funding for child care programs through their general funds. All counties contribute approximately half of the total administrative costs of the child care assistance programs. However, DHS has no statistical data to support the level of county contributions toward administrative costs.

Expenditures

In state fiscal year 2008, the total cost of child care assistance programs, including county administration, was $184.2 million. Expenditures in state fiscal year 2009 are projected to be $211.1 million. Expenditures for each level of government on child care assistance programs are as follows:

In state fiscal year 2008, the total cost of child care assistance programs was $184.2 million.

Actual Costs of Child Care Assistance Programs SFY 2008

Federal	$96,283,520
State	$85,019,141
County	$2,941,235
Total	$184,243,896

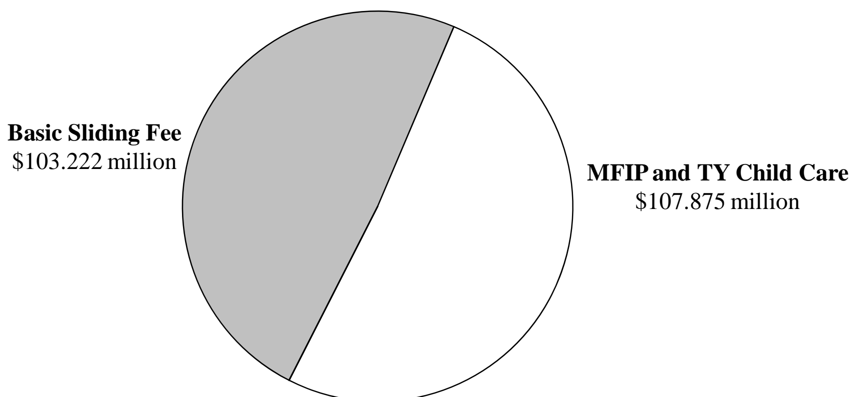
Forecasted Costs of Child Care Assistance Programs SFY 2009

Federal	$111,103,260
State	$97,052,501
County	$2,941,235
Total	$211,096,996

Source: Department of Human Services

The graph below shows total costs by child care program for fiscal year 2009.

Child Care Assistance Programs Total Cost (Projected FY 2009)



Recipient Profile

The majority of families receiving assistance through the child care assistance programs are working families who need child care for employment.

The majority of families receiving assistance through the child care assistance programs are working families who need child care for employment. In fiscal year 2008, approximately 62 percent of the families who received child care assistance through MFIP had an employment plan. Forty-five percent of the families with an employment plan received child care assistance only for activities that are defined as employment. In fiscal year 2008, the monthly average total amount of child care subsidy for a participating family ranged from $811 for basic sliding fee assistance to $1,083 for MFIP and transition year assistance.

In fiscal year 2008, the child care assistance programs subsidized the care of approximately 29,922 children in an average month. In 2008, most of the subsidized care was for children under the age of six—61.6 percent of the children were ages five or younger. Fifty-six percent of the children were cared for in a family setting (including the child's own home)—32 percent in a licensed family child care facility. The tables below have profiles of recipients of the child care assistance programs.

Families Receiving Child Care Assistance
(State Fiscal Year 2008)

	Families	**Children**
Basic Sliding Fee Child Care		
Average Monthly Direct Service Cost per Family*	$811	
Average Number of Children*	8,977	15,780
Number Served in Month**	8,695	15,174
Employed	83.3%	
Employment and Training	11.7%	
Students	5.0%	
MFIP/DWP/Transition Year/TYE Child Care		
Average Monthly Direct Service Cost per Family*	$1,083	
Average Number of Children*	7,789	14,142
Number Served in Month**	8,096	14,317
Employment Only	44.9%	
Education and Training Only	10.2%	
Employment, Education, and Training	7.4%	
Social Service Only	0.7%	
Appeals and Orientation	3.0%	

* State Fiscal Year 2008 ** Month ending November 2008.

Type of Child Care Providers and
Ages of Children in Subsidized Care
(Federal Fiscal Year 2008)

Type of Child Care Providers	Number of Children	Percent
Legal Unlicensed (Registered) Providers		
In Provider's or Child's Home	7,301	24.4%
In Child Care Center (primarily operated by school district)	1,496	5.0%
Licensed Providers		
In Provider's Home	9,425	31.5%
In Child Care Center	11,700	39.1%
Age of Children in Subsidized Care (State Fiscal Year 2008)		
Ages 0 - 1	3,770	12.6%
Ages 1 - 3	7,570	25.3%
Ages 3 - 6	7,092	23.7%
Ages 6 - 13	11,191	37.4%
Ages 13+	299	1.0%
Total Number of Children	29,922	100.0%

Note: The number of children by age is estimated based on the total number of children served as reported by Department of Human Services. The percentages are from FFY 2008 data from the U.S. Department of Health & Human Services Child Care Bureau.

Food Support

Food Support[107] is a federal program that increases the food purchasing power of low-income households. It is also called "Food Stamps."

Administration

Congress

Congress established the Food Support program in 1964 after a series of pilot projects (including one conducted in St. Louis County) demonstrated the program's feasibility. The federal Food Support law establishes eligibility criteria, benefit calculations, work requirements, and other provisions for program funding, administration, and fraud detection.

U.S. Department of Agriculture Food and Nutrition Service (FNS)

The Food and Nutrition Service of the U.S. Department of Agriculture supervises the administration of the Food Support program nationwide. FNS establishes specific program rules and regulations, such as certification standards, the development of application forms, and the elements of the program's work requirements. FNS also must approve any request from a state agency for a waiver from program requirements.

Minnesota State Legislature

The legislature has assigned the administration of the Food Support program to the county welfare boards under the supervision of the state Department of Human Services. The legislature has also defined what constitutes food support theft (Minn. Stat. § 393.07).

[107] In Minnesota, the program is referred to as Food Support. The federal program was still called Food Stamps until October 1, 2008, when its new name became effective: SNAP – Supplemental Nutrition Assistance Program.

State Department of Human Services (DHS)

DHS supervises the administration of the Food Support program in Minnesota, including required quality control and management evaluations.

Counties

Counties administer the Food Support program. The county agency determines if a household meets federal eligibility requirements and enables DHS to issue food support benefits directly to eligible recipients.

Eligibility Requirements

Food support assists households composed of eligible single individuals and families. Generally speaking, the basic "food support household" consists of individuals living together who purchase and prepare meals in common. (For a more detailed definition of food support household, see Additional Eligibility Requirements, on page 146.) A household qualifies for the Food Support program if it satisfies certain eligibility requirements or if its income and assets are below the program's established limits.

Categorical Eligibility

A household composed entirely of GA or SSI recipients is generally categorically eligible for food support, regardless of the household's income or assets.

A household composed entirely of GA or SSI recipients is generally categorically eligible for food support, regardless of the household's income or assets. A categorically eligible household may, however, receive zero food support benefits if its income available for food purchases under the program's guidelines exceeds the maximum allowable food support benefit. (See the maximum allotment chart on page 149.)

A household composed entirely of Minnesota Family Investment Program (MFIP) recipients is also generally eligible for federally funded food support assistance. However, because MFIP combines cash assistance and food assistance in one program, MFIP recipients receive their food assistance benefits as a "food portion" of their total monthly MFIP grant, rather than receiving a cash grant and a separate food support monthly allotment (see MFIP, page 32).

Income Limits

Except for "categorically eligible" households, a household must have income below the maximum income limits established by Congress to qualify for food support. The income limits apply both to earned income and unearned income. Income that is received from certain sources, such as a minor child's earnings, low-income home energy assistance payments, or irregular income that is less than or equal to $30 per calendar quarter, is excluded from the income limits.

Except for "categorically eligible" households, a household must have income below the maximum income limits established by Congress to qualify for food support.

To be financially eligible for food support, a household that is not categorically eligible and that has no elderly or disabled member must meet both a gross monthly income test and net monthly income test. ("Gross monthly income" means a household's total nonexcluded income, before any deductions have been made. "Net monthly income" means gross income minus all deductions allowed by the program.) To qualify for food support, such a household must have gross income that is at or below 130 percent of the federal poverty guidelines (FPG) and net income that is at or below 100 percent of those guidelines. A household that includes someone who is elderly or disabled must meet only the net income test.

The gross and net income limits are based on family size. The limits in effect for the 48 contiguous states and the District of Columbia beginning October 1, 2009, are shown in the table below.

Income Limits

Household Size	Maximum Gross Monthly Income 130% of FPG	Maximum Net Monthly Income 100% of FPG
1	$1,174	$903
2	1,579	1,215
3	1,984	1,526
4	2,389	1,838
5	2,794	2,150
6	3,200	2,461
7	3,605	2,773
8	4,010	3,085
Each additional member	406	312

A household's net monthly income is calculated by subtracting all of the applicable allowed deductions from the household's gross monthly income. The Food Support program permits the following deductions from gross income:

- 20 percent of any earned income
- a standard disregard of $144 for a household size of one to three people
- out-of-pocket dependent care expenses, when the care is related to a household member's employment, job search, or job training
- regularly recurring medical expenses over $35 per month (applicable only in households with an elderly or disabled member)
- an excess shelter cost deduction for families who must pay more than 50 percent of their monthly income for shelter, including utilities. The maximum monthly shelter deduction is $446 for households without an elderly or disabled member; there is no maximum for households with an elderly or disabled member.
- legally owed child support payments

Asset Limits

To be eligible for food support, households may have no more than $2,000 in countable assets.[108] Households with at least one member who is age 60 or older may have up to $3,000 in countable assets. "Countable assets" include the following:

- cash-on-hand, savings, stocks and bonds
- property and vehicles used for recreational purposes
- the loan value of each nonexcluded licensed vehicle, that is greater than $7,500. Some vehicles may be totally excluded, if they are: used for income-producing purposes; annually producing income consistent with their fair market value; used for long-distance travel (other than daily commuting) for work; used as the home; needed for the transportation of a physically disabled household member; or needed to carry fuel or water to

[108] The asset limit for those meeting the Domestic Violence Brochure requirements is $7,000. The Domestic Violence Brochure provides information about certain public assistance program requirements that may be waived for eligible applicants due to domestic violence.

the household. If the vehicle has an equity value of no more than $1,500, it is not counted as a resource.

"Countable assets" do not include the following:

- the value of the household's residence; property that produces income or that is essential to the employment of a household member (such as rental homes or farm land)
- business assets
- property that is directly related to the maintenance or use of an excluded vehicle
- household goods and personal effects
- the cash value of life insurance policies
- burial plots
- disaster relief payments
- resources that have cash value that is not accessible to the household (for example, irrevocable trust funds)
- resources such as those of students or self-employed persons that have been prorated as income
- the value of certain Indian lands
- state and federal earned income tax credits
- energy assistance payments
- resources of a household member who receives Supplemental Security Income (SSI) or public assistance benefits
- certain types of retirement accounts including: 401(a) (employer-sponsored retirement plans for state and local government and some other tax-exempt entities including 401(k)s and Keogh plans); 403(a); 403(b); 408; 408(a) (including IRAs and Roth IRAs); 457(b); 501(c)(18)
- the value of gift cards
- certain IRS tax-preferred education accounts

The federal Food Support law prohibits households from transferring ownership of their assets in order to qualify for food support. Households that do so are ineligible for program benefits for a period of up to one year.

For a complete list of asset limits, see Appendix I.

Additional Eligibility Requirements

In addition to financial need, the following conditions must be met in order for a person to be eligible for food support benefits. Food support recipients must also meet the following criteria:

- be citizens of the United States (some noncitizens may qualify for food support if they meet certain criteria)
- reside in a "household"
- register for work and fulfill job search requirements
- furnish their Social Security number to the state agency
- comply with monthly reporting requirements

Food support recipients must be citizens of the United States. Most noncitizens, including those legally present in the country, were initially made ineligible for the Food Support program by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform act). Congress subsequently restored food support eligibility for many legal noncitizens in the Agriculture Research, Extension, and Education Reform Act of 1998 and in the 2002 Farm Bill. Legal noncitizens may be eligible to receive food support benefits if they fall into one of the following categories:

- persons lawfully residing in the United States for five or more years
- persons lawfully residing in the United States who are receiving payments or assistance for blindness or disability
- persons lawfully residing in the United States on August 22, 1996, who were 65 or older at that time
- children lawfully residing in the United States who are currently under age 18 (when a child becomes 18, the child is no longer eligible for food support under this provision)
- asylees
- refugees
- people whose deportation was withheld
- American Indians born in Canada
- other noncitizen American Indian applicants who are members of a tribe whose members are eligible for programs provided by the United States
- Cuban and Haitian entrants

- Amerasians from Vietnam
- veterans or persons on active military duty (this category also includes their spouses and dependent children)
- persons who are lawfully residing in the United States and who were members of a Hmong or Highland Laotian tribe at the time the tribe assisted U.S. personnel by taking part in a Vietnam-era military or rescue operation (this category may also include their spouses or unremarried surviving spouses and dependent children)
- victims of a severe form of trafficking[109]
- lawful permanent residents who have, or can be credited with, 40 qualifying quarters of coverage under Social Security (8 U.S.C. § 1612 (2001))

Food support recipients must reside in a "household." The Food Support program generally defines a "household" as an individual or group of individuals who live together and who customarily purchase food and prepare meals together for home consumption. The program also requires certain groups to be considered to be in the same household even if they purchase food and prepare meals separately. Spouses who live together, children under the age of 22 who live with their parents, and children under the age of 18 who are under the parental control of another household member must be included in the same food support household.

There are, however, certain exceptions to these requirements. Elderly or disabled individuals can be separate households if they purchase and prepare food separately. Also, under certain circumstances, elderly persons who are unable to purchase or prepare food separately are nonetheless deemed to be separate households. Boarders and residents of most institutions are not eligible for food support regardless of how their food is purchased and prepared.

Food support recipients must register for work and fulfill job search requirements. Certain persons are exempt from work requirements.

[109] A victim of a severe form of trafficking is a noncitizen who is forced into the international sex trade, prostitution, slavery, and forced labor through coercion, threats of physical violence, psychological abuse, torture, and imprisonment. The federal Trafficking Victims Protection Act of 2000 provides that victims of severe forms of trafficking are eligible for federal public assistance benefits to the same extent as a noncitizen who is admitted into the United States as a refugee. The Trafficking Victims Protection Reauthorization Act of 2003 also expanded eligibility for food support to the minor children and spouses of victims of trafficking and, in some cases, their parents and siblings.

Food support recipients must furnish their Social Security number to the state agency. This requirement is intended to help in the prevention of fraud and abuse.

Food support recipients must comply with monthly reporting requirements. Most households that receive food support must submit a monthly income report in order to continue to receive benefits.

In addition, federal restrictions make the following persons ineligible for food support:

- postsecondary students between the ages of 18 and 50 who are physically and mentally fit and who are enrolled at least half-time in an institution of higher education, unless they are receiving assistance through MFIP
- the head of a household who has voluntarily quit a job (ineligible for 90 days)
- households containing members who are on strike, unless the household was eligible before the strike
- undocumented immigrants or temporary residents
- most persons in institutional settings
- persons who have committed intentional program violations
- a person in a household that has been disqualified because one or more members of the household failed to comply with work requirements

State-purchased Food Support Benefits for Certain Legal Noncitizens

The 1998 Legislature acted to provide food assistance from July 1, 1998, to June 30, 1999, to certain legal noncitizen state residents who are not eligible for federal food support. Utilizing an option made available to states in the federal 1997 Emergency Supplemental Appropriations Act, the legislature created the Minnesota Food Assistance Program (MFAP), which provides state-funded food support benefits to legal noncitizens who are ineligible for the federal Food Support program solely because of their citizenship status (Minn. Stat. § 256D.053). MFAP recipients must meet all applicable Food Support work requirements (discussed below), or they will be subject to sanctions for failure to participate.

The 1999 Legislature made MFAP permanent. It also modified the eligibility for the program, so that effective July 1, 2000, the program would be limited to eligible legal noncitizen residents who are age 50 or older. The 2000 and 2001 Legislatures each delayed the implementation of this provision, so that legal noncitizen residents under age 50 remained eligible for MFAP until July 1, 2003.

Benefits

Food Support Allotment

Food support is used to purchase food and food products, excluding alcohol, tobacco, and pet food, in approved stores. Individuals over 60 (and their spouses), blind and disabled persons, and homeless individuals can also use food support to purchase meals in authorized restaurants. In addition, food support can be used to purchase hot foods or hot food products through nonprofit meal delivery services, at communal dining facilities, and at institutions serving meals to drug addicts, alcoholics, and battered women and children.

Food support households receive a certified allotment based on the calculation of their monthly net income.

Food support households receive a certified allotment based on the calculation of their monthly net income. Each household's allotment is based on the "Thrifty Food Plan"—a plan developed by the U.S. Department of Agriculture that estimates the minimum amount of food a household needs to maintain an adequate diet. Food support benefits are issued on a monthly basis.[110]

Maximum monthly food support allotments are set annually by the federal government and vary by household size. Effective April 1, 2009, there was a 13.6 percent increase to the maximum food support benefit level as part of the federal American Recovery and Reinvestment Act. There were no changes to the gross or net income limits for the food support program. The maximum allotments effective April 1, 2009, are shown below.

Household Size	Maximum Allotment
1	$200
2	367
3	526
4	668
5	793
6	952
7	1,052
8	1,202
Each additional member	150

[110] The Food Stamp Act of 1977 eliminated an original requirement that eligible households pay cash for the food stamps.

Emergency Aid

Households in "immediate need" must be issued food support on an expedited basis. County agencies must issue food support within 24 hours to the following households:

- households with less than $150 gross monthly income and no more than $100 in liquid assets
- destitute migrant or seasonal farmworker households with no more than $100 in liquid assets
- households whose actual monthly housing and utility costs are greater than the total of their gross monthly income plus their liquid assets

There is no limit to the number of times a household can receive expedited benefits, as long as the household provides the county agency with certain required information before they again receive expedited benefits.

Issuance of Food Support

Food support benefits are issued directly to program recipients. Since October 1998 benefits have been issued to all Minnesota recipients in an electronic debit card format known as Electronic Benefits Transfer (EBT). Household members use their EBT card to access their food support benefits electronically at the point of sale (i.e., the grocery store). As part of the 1996 federal welfare reform, all states were required to move to EBT systems by October 1, 2001.

Other Food Support Program Features

Work Requirements

Like the federal welfare reform law, the Food Support program has some work requirements for recipients.

The federal Food Support law requires that people receiving food support benefits must register for work and participate in Food Support Employment and Training (FSET) activities unless they are exempt.

The following food support recipients are exempt from mandatory registration and participation in FSET (Minn. Stat. § 256D.051, subd. 3a):

- a person who also receives assistance under the General Assistance (GA), MFIP, Minnesota Supplemental Aid (MSA), or Refugee Cash Assistance[111] programs
- a child under age 18
- a person age 55 or older
- a person who is ill, injured, or incapacitated and certified as unable to work
- a person whose presence in the home is required to care for a child under age six, or for an injured, ill, or incapacitated household member
- a person who receives or has applied for unemployment insurance and who is required to register for work with the state Department of Employment and Economic Development
- a person who is participating regularly in a chemical dependency treatment and rehabilitation program
- a self-employed person who is either working at least 30 hours per week, or who receives earnings that are at least equal to 30 hours a week at the minimum wage
- a student who is enrolled at least half-time in a recognized education program
- a person providing homeschooling to a child and in compliance with state reporting requirements for homeschooling

Each nonexempt adult member in a food support household must participate in FSET for each month that the household is eligible for food support. Persons who are exempt may volunteer for FSET and receive FSET services to the extent that funds are available.

FSET participants receive an orientation and an employability assessment. An employability development plan is created for each participant that is based on the participant's assessment. The employability development plan must include referrals to available remedial or skills training programs, if needed, and to available programs that provide subsidized or unsubsidized employment. A participant must spend at least eight hours per week, but cannot be required to spend more than 32 hours per week, in FSET activities.

Food support recipients who are required to participate in FSET but who do not cooperate with FSET requirements without good cause

[111] Refugee Cash Assistance (RCA) is a program that provides cash assistance and employment services to needy refugee single adults and childless couples who are ineligible for SSI during their first eight months in the United States.

lose eligibility for the Food Support program for themselves and, if they are the principal wage earner, for the entire food support household. The disqualification period is between one and six months, depending upon whether it is the first, second, or third failure to meet FSET requirements. (Minn. Stat. § 256D.051, subd. 1a.)

Under the 1996 federal welfare reform law, an otherwise eligible able-bodied adult who is between the ages of 18 and 50 and is without dependents (ABAWD) is only eligible to receive food support for three months in a 36-month period, unless the person is exempt from the time limit or is meeting the monthly work requirements. After using up these "three free months" of eligibility, in order to "earn" additional months of eligibility for food support the ABAWD must work at least 20 hours per week (averaged monthly), or must participate in employment and training activities.

The 1997 federal Balanced Budget Act amended the ABAWD requirement to allow states to exempt 15 percent of the state's ABAWDs who have used up their three free months of food support eligibility, so that they may continue to be eligible for food support. DHS has implemented this ABAWD exemption provision in two steps. First, effective December 1, 1997, the state exempted ABAWDs who receive assistance under the GA program from the three-out-of-36-month time limit. Second, effective September 1, 1998, the state also exempted ABAWDs who receive assistance under the RCA program from this time limit.

Funding and Expenditures

In state fiscal year 2008, food support expenditures in Minnesota were $318 million.

The federal government finances food support benefits.

During state fiscal year 2008 the federal government spent $318,182,427 on food support benefits to eligible households in Minnesota.

Recipient Profile

Most food support households also receive some form of public income assistance.

There were an average of 130,188 Minnesota households receiving food support benefits each month during state fiscal year 2008. Each household received an average monthly allotment of $203.67 in food support benefits.

Group Residential Housing

Group Residential Housing (GRH) is a state program that provides payments on behalf of eligible persons to pay for room and board and related housing services.

Administration

Minnesota State Legislature

The legislature established GRH in Laws of Minnesota 1992, chapter 513, as the Group Residential Housing Act (Minn. Stat. §§ 256I.01-256I.06). The GRH act was a revision of existing law known as the Negotiated Rate Act. The GRH program pays for housing and related services that had been paid for under the Negotiated Rate Act by the Minnesota Supplemental Aid (MSA) and General Assistance (GA) programs.

The GRH program pays for housing and related services that had been paid for by MSA and GA.

State Department of Human Services (DHS)

DHS supervises program administration. The agency assists counties in GRH administration by providing them with technical assistance on eligibility requirements and other program components.

Counties

The counties administer the GRH program. County human services agencies are responsible for determining if individuals are eligible for GRH and calculating GRH payment levels for those individuals. Counties are also responsible for setting rates for GRH settings and for making payments to these settings.

Eligibility Requirements

In order to be eligible for GRH payments, an individual must have county approval for residence in a GRH setting and must: (1) be aged, blind, or over 18 years of age and disabled, and meet specified income and asset standards; or (2) belong to a category of individuals potentially eligible for GA and meet specified income and asset standards.

An individual who is aged, blind, or over 18 years of age and disabled

according to the criteria used by the Social Security program, is eligible for GRH if he or she:

- meets the asset standard of the Supplemental Security Income (SSI) program; and
- has an income that is less than the monthly rate specified in the county's agreement with the GRH provider, after deducting: (1) the income exclusions and disregards of the SSI program; (2) the Medical Assistance (MA) personal needs allowance; and (3) for elderly waiver recipients, any income actually made available to a community spouse as part of the community spouse monthly income allowance.

A person who belongs to a category of individuals potentially eligible for GA is eligible for GRH if he or she: (1) has countable income under the GA program, minus the MA personal needs allowance, that is less than the monthly rate specified in the county agency's agreement with the GRH provider; and (2) meets the GA asset standard.

In order to receive GRH payments, a residential setting must have an agreement with the county and be licensed.

Eligible Residential Settings

Counties make GRH payments directly to eligible GRH settings. In order to receive GRH payments, a residential setting must have an agreement with the county agency to provide GRH services and must be: (1) licensed by the Minnesota Department of Health (MDH) as a board and lodging establishment, supervised living facility, or boarding care home; (2) licensed by DHS as an adult foster home (family or corporate); or (3) registered with MDH as a housing with services establishment under Minnesota Statutes, chapter 144D, and provide three meals a day.

County agencies are prohibited from entering into agreements for new GRH beds with total rates that exceed the GRH basic room and board rate (see description on page 156)[112], unless:

- the facility is needed to meet regional treatment center census reduction targets;
- the beds are needed to comply with federal alternative disposition plan requirements for inappropriately placed persons;
- the beds are part of an 80-bed facility in Hennepin County for chronic inebriates;

[112] The 2007 Legislature authorized several new GRH beds specifically in the statute.

- the beds are part of supportive housing initiatives in Anoka, Dakota, Hennepin, or Ramsey counties for homeless adults with mental illness, a history of substance abuse, or HIV or AIDs;
- the beds are used exclusively for MA home and community-based waiver recipients who had resided in a nursing facility for the six months immediately prior to the month of entry into the GRH setting; or
- the beds replace beds with rates in excess of the GRH basic room and board rate that are no longer available due to facility closure, change in licensure or certification, or downsizing.

As of January 2009, there were over 4,900 residential settings receiving GRH payments.[113]

Types of GRH Settings
As of January 2009

House Research Graphics

Adult mental health residential treatment centers provide intensive rehabilitative treatment under section 256B.0622. Noncertified boarding care homes are licensed as boarding care homes by MDH but are not certified to provide services to MA recipients.

[113] Information on the number and type of settings that received GRH payments was provided by DHS using data from the MAXIS vendor system.

Benefits

Nearly all GRH recipients qualify for the GRH basic room and board rate of $846 per month.[114] Recipients in certain GRH settings may also qualify for a supplemental payment that is in addition to this base rate. The table on page 157 summarizes the different GRH payment rates.

A. GRH basic room and board rate. The GRH basic room and board rate, also referred to as the "MSA equivalent rate," is $846 per month, for the fiscal year beginning July 1, 2009. This rate is the sum of:

Nearly all GRH recipients qualify for the GRH basic room and board rate of $846 per month. Recipients in certain GRH settings may also qualify for a supplemental payment.

1. The MSA basic need standard for an individual living alone ($735/month); and
2. The maximum food stamp allotment for one person ($200/month); minus
3. The MA personal needs allowance ($89/month).

The basic room and board rate is increased each July 1 to reflect changes in any of the component rates listed in clauses (1) to (3) above.

B. Supplementary service rate. Counties are also allowed to negotiate a room and board rate that exceeds the GRH basic room and board rate by up to $496.87 per month for other services necessary to provide room and board, if the provider is not also receiving MA funding for waivered services or personal care services, or funding under Minnesota Rules, parts 9535.2000 to 9535.3000 (Rule 12) for residential services for the adult mentally ill. This rate is available mainly to board and lodging with special services and noncertified boarding care home settings, and applies to all recipients in the setting. However, this rate was reduced by 2.58 percent effective July 1, 2009, and then by an additional 5 percent by the governor through unallotment effective November 1, 2009, through June 30, 2011.

C. Difficulty of care payment. Counties are also allowed to negotiate higher rates for recipients residing in adult foster care homes, based upon an assessment of an individual's supervision and care needs. The additional payment cannot exceed the supplementary service rate of $496.87 per month and applies to specific individuals in a facility. Rate approval by the commissioner is not required. Difficulty of care payment rates for GRH recipients in the same setting

[114] A few counties have GRH basic room and board rates of under $790 per month.

may vary based upon their assessments. However, this rate was reduced by 5 percent for adult foster care providers receiving difficulty of care payments by the governor through unallotment effective November 1, 2009, through June 30, 2011.

D. Facilities with higher historical rates. Some GRH settings were receiving payment rates under the negotiated rate system that were higher than the GRH base rate. Facilities receiving these higher rates prior to 1991 had these rates "grandparented" into the GRH payment system.

E. Statutory exceptions. Some GRH settings qualify for payment rates higher than the GRH base rate as a result of specific statutory provisions.

Rate increases. Counties are prohibited from increasing GRH rates for existing facilities above those in effect on June 30, 1993, except to:

- increase the GRH basic room and board rate to reflect cost-of-living increases, as described on page 156;
- increase rates for residents in family adult foster care whose difficulty of care has increased (subject to the overall maximum rate of $1,141.36 per month); or
- comply with other exceptions in law.

GRH Payment Rates

Type of Payment	Monthly Payment	Eligible Setting	Other Requirements
A. GRH Basic Room and Board Rate	$846	All GRH settings	
B. Supplementary Service Rate	Up to $496.87	Board and Lodging with Special Services; Noncertified Boarding Care Homes	Recipient must not also be eligible to receive or receiving MA waiver services, MA personal care services, or funding under Rule 12 for adult mentally ill
C. Difficulty of care	Up to $496.87	Adult Foster Care	Recipient must qualify based upon an assessment of supervision and care needs, and must not be eligible for MA waiver services
D. Facilities with Higher Historical Rates	May exceed maximum	GRH settings that are not corporate adult foster care	Facility must have been receiving a payment rate higher than the GRH base rate prior to 1991 under the negotiated rate system

Type of Payment	Monthly Payment	Eligible Setting	Other Requirements
E. Statutory Exceptions	As specified in statute	GRH settings that are not corporate adult foster care	Higher facility rate must be authorized in statute

Payment of Benefits

Counties make GRH payments directly to the operator of the residential setting, using state general fund dollars. Counties can supplement GRH payments using their own financial resources.

The financial responsibility of the state for GRH payments is usually offset by a contribution from the recipient's income (e.g., SSI or Social Security Disability income). Recipients are required to contribute all income except that excluded by state or federal law. This amount can vary depending upon the recipient:

- An SSI recipient who is not working is allowed to keep the personal needs allowance of $89, a community living adjustment of $12.
- An SSI recipient who is working is allowed to keep the personal needs allowance of $89, a community living adjustment of $12, plus the first $65 from employment and one-half of any additional earned income.
- Other adults, such as GA recipients, who are not working are allowed to keep the $89 personal needs allowance and a community living adjustment of $12.
- A recipient who does not receive SSI and who is working is allowed to keep the first $50 of earned income and can deduct work expenses.

Funding and Expenditures

The GRH program is funded with state general fund dollars and receives no federal funding.

The GRH program is funded with state general fund dollars, using in part that portion of general fund dollars that had been used by the GA and MSA program to make payments to negotiated rate facilities to provide housing and related services under the Negotiated Rates Act. The GRH program receives some federal funding for food and nutrition costs.[115]

In state fiscal year 2008, an average of 15,699 persons received GRH payments each month. The total GRH expenditure for that year was $85,504,943, and the average monthly GRH payment per person in June 2009 was $498.35.

[115] The Commissioner of Human Services was directed to seek federal approval, by October 1, 2009, for expansion of a demonstration project to obtain federal reimbursement of food and nutritional costs currently paid by GRH.

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Appendix I

Asset Limits for Assistance

Program	Cash and Liquid Assets	Car - A recipient may own a car valued at no greater than	
SSI & MSA	$2,000 for single person; $3,000 for married couple, after all allowable exclusions	1 vehicle per household is excluded	For SSI and MSA, MA, GAMC, and FS, the entire value may be excluded under certain circumstances (e.g., the car is needed for transportation of a physically disabled household member)
MA – Aged, Blind, or Disabled	$3,000 for one person; $6,000 for two people; $200 for each additional person		
GAMC	$1,000 per assistance unit	1 vehicle per household is excluded for regular GAMC. For hospital-only coverage, a motor vehicle is allowed for each person who is employed or seeking employment.	
MA - Families[116] **MinnesotaCare**	$10,000 for a household of one; $20,000 for a household of two or more persons	No limit. A motor vehicle is allowed for each person who is employed or seeking employment.	
FS	$2,000 per household; $3,000 per household when at least one person is over 60 years of age; $7,000 if at least one member meets the Domestic Violence Brochure requirements	$7,500 (loan value) for each nonexcluded licensed vehicle	
GA	$1,000 per assistance unit (including excess equity value of the automobile), excluding certain items	$1,500 (equity value); excess equity value is applied to the asset limit	
MFIP	$2,000 per applicant assistance unit; $5,000 per ongoing recipient assistance unit	$7,500 (equity value)/ $15,000 (loan value); excess equity value is applied to the asset limit	
MFIP Child Care	Uses MFIP asset limits		
Transition Year Child Care	No asset limits		
Basic Sliding Fee Child Care	No asset limits		
GRH	Uses GA or SSI asset limits, depending on the characteristics of the individual		

[116] There is no asset test under MA or MinnesotaCare for pregnant women and children under age 21.

Programs (for programs in FY 2008)

<table>
<tr><th>Life Insurance</th><th>Prepaid Burial Contracts</th><th>Household Goods and Personal Effects</th><th>Burial Plot</th><th>Homestead</th></tr>
<tr><td colspan="2" rowspan="2">Up to $1,500 in the cash surrender value of life insurance policies, burial funds, or a combination of both</td><td>$2,000</td><td rowspan="2">Exempt</td><td rowspan="5">Exempt, regardless of value</td></tr>
<tr><td rowspan="4">Such items as furniture, clothing, jewelry, appliances, tools, and equipment used in the home are exempt</td></tr>
<tr><td>Exempt</td><td>$1,500 for each member of unit</td><td rowspan="2">One burial space for each person whose assets are considered is exempt</td></tr>
<tr><td>The cash surrender value of a life insurance policy is included in the cash and liquid asset limit</td><td>$1,000 for each member of assistance unit</td></tr>
<tr><td>Exempt</td><td>Not exempt</td><td>One burial space for each assistance unit member is exempt</td></tr>
</table>

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Appendix II

Income Limits for Assistance Programs

(For programs in FY 2009)

Program	Income Basis*	Eligible Group	Annual Income by Family Size			
			1	2	3	4
MFIP (FY 2008)	As specified in statute	Eligible family w/no unrelated household members	$5,136	$9,168	$12,060	$14,604
	As specified in statute	Eligible family w/one unrelated household member	4,836	8,640	11,424	13,860
GA	As specified in law ($203/month)	Single adult	2,436	N/A	N/A	N/A
	As specified in rule ($260/month)	Married couple w/no children	N/A	3,120	N/A	N/A
MSA	As specified in statute and rule	Single adult living alone	8,820	N/A	N/A	N/A
	As specified in statute and rule	Married couple living alone	N/A	13,404	N/A	N/A
	As specified in statute and rule	Individual eligible for personal needs allowance only	1,068	N/A	N/A	N/A
SSI (CY 2009)	Does not exceed maximum monthly SSI benefit	Individual living alone	8,088	N/A	N/A	N/A
	Does not exceed maximum monthly SSI benefit	Married couple living alone	N/A	12,132	N/A	N/A
	Does not exceed maximum monthly SSI benefit	Individual living with others	5,392	N/A	N/A	N/A
	Does not exceed maximum monthly SSI benefit	Married couple living with others	N/A	8,088	N/A	N/A
GAMC	75% of federal poverty guidelines (FPG)	Household with one or more GAMC eligibles	8,124	10,932	N/A	N/A
MA	100% of FPG	Adults with children; children 19 through 20 years of age; aged, blind, or disabled	10,836	14,580	18,324	22,068
	280% of FPG	Children under age two	30,324	40,800	51,276	61,752
	150% of FPG	Children two through 18 years of age	16,248	21,864	27,480	33,096
MinnesotaCare	275% of FPG	Family with one or more eligible children	29,784	40,080	50,376	60,672**

Program	**Income Basis***	**Eligible Group**	**Annual Income by Family Size**			
			1	**2**	**3**	**4**
Food Support	Net income at or below 100% FPG	Household with disabled or elderly (age 60+) member	10,836	14,580	18,312	22,056
	Gross income at or below 130% FPG **and** net income at or below 100% FPG	Household	14,088 - - - - - - 10,836	18,948 - - - - - - 14,580	23,808 - - - - - - 18,312	28,668 - - - - - - 22,056
MFIP Child Care	See MFIP income basis	Eligible MFIP family (these are MFIP exit levels using 39% income disregard on FWL)	NA	34,225	42,925	51,625
Basic Sliding Fee & Transition Year Child Care	47% SMI at program entry and 67% at program exit	Family with one or more children eligible for care	NA	37,120	45,854	54,589
GRH	An individual's income, after exclusions, must be less than the monthly rate for the GRH setting	Individual	NA	NA	NA	NA

* Many programs apply income disregards or exclusions.

** Parents and other caretakers are not eligible for MinnesotaCare if their gross annual household income exceeds $50,000.

Appendix III

GAMC Enrollee Characteristics

This appendix provides information on the demographics, income, and health status of GAMC enrollees.

Unless otherwise noted, the information on GAMC enrollees in the tables that follow is from an analysis by the Department of Human Services of 34,722 individuals with at least one month of GAMC eligibility in fiscal year 2008. Individuals covered under transitional MinnesotaCare were not part of the analysis. GAMC hospital-only enrollees are included in the analysis.

A. Demographics

1. Gender

- About two-thirds of GAMC enrollees are men.

Gender	Number of Enrollees	Percentage of Total Enrollment
Male	22,787	65.63%
Female	11,935	34.37

2. Age

- GAMC enrollees are fairly evenly distributed across age cohorts between ages 21 and 60.

Age	Number of Enrollees	Percentage of Total Enrollment
0-20	4	0.01%
21-30	9,153	26.36
31-40	7,172	20.66
41-50	10,323	29.73
51-60	6,800	19.59
61-65	1,267	3.65
66-70	3	0.01
Total	34,722	100.00%
Note: Recipients below age 21 and over age 65 are mainly due to incorrect coding and unusual eligibility situations.		

3. Race/ethnicity

- About four out of ten GAMC enrollees are from populations of color.

Race/Ethnicity	Number of Enrollees	Percentage of Total Enrollment
Asian/Pacific Islander	695	2.00%
African American	10,805	31.12
Native American	2,686	7.74
White	19,545	56.29
Multiple race codes	270	0.78
Not listed/no data on file	721	2.07
Total	34,722	100.00%

4. Status as homeless

- About one out of four GAMC enrollees report being homeless.

Homeless Status	Percentage of Total Enrollment
Yes	27.166%
No	74.16
Blank	0.19
Note: Figures do not include enrollees coded as being homeless who had a general delivery address. Inclusion of this group would bring the percentage of homeless to 33.22 percent. DHS has noted that the indicator for being homeless may be error prone—eligibility workers may not always remove the indicator when an individual obtains a permanent address.	

B. Income

1. Total income

- More than nine out of ten GAMC enrollees have incomes less than 25 percent of the federal poverty guidelines (about $226/month for a household of one).

Income Level	Percentage of Total Enrollment
< 25% of FPG	92.0%
25 – 50% FPG	2.0
>50% FPG	6.0

Source: October 2008 data, DHS Reports and Forecasts Division.

2. Earned income

- 10 percent of GAMC enrollees (3,363 individuals) reported earned income.

  For these individuals:

  - the median range of hours worked per month was between 61 and 80
  - the median monthly earned income range was $601 to $700

- 46.8 percent of enrollees with earned income had started a job within two months prior to the reporting month

3. Unearned income

- About one-half of GAMC enrollees (17,375 individuals) were receiving General Assistance. This program provides a cash grant of $203 per month.

- 4 percent of GAMC enrollees (1,506 individuals) reported receiving unearned income other than GA (these individuals may also have been receiving GA). For these individuals, the most common sources of unearned income included:

Type of Unearned Income Received	Percentage of All Individuals Receiving Unearned Income
Social Security – retirement or survivor's benefits	18.8%
Unemployment benefits	17.2
VA benefits	13.0
Social Security disability or SSI	12.0
Other	19.7
Note: Individuals may be receiving more than one type of unearned income. The table does not include all income categories and therefore does not total to 100 percent.	

4. Potential eligibility for other benefits

- About four out of ten GAMC enrollees are potentially eligible for benefits from other programs.

More than a third, 38.5 percent, of GAMC enrollees (13,367 individuals) were determined by caseworkers to be potentially eligible for benefits from other programs in their most recent month of eligibility in fiscal year 2008. The most common programs for which enrollees were potentially eligible were SSI (95 percent of potentially eligible individuals) and Social Security disability and nondisability-related programs (58 percent of potentially eligible individuals).

The status of the eligibility determination for other benefits, for those 15,616 cases for which information was available, was as follows:

- 65 percent – determination pending

- 16 percent – eligibility denied

- 14 percent – decision on appeal

C. Health Status

1. Chemical or mental health diagnosis

- About six out of ten GAMC enrollees have a mental health and/or chemical health diagnosis.

Diagnosis	Number of Enrollees	Percentage of Total Enrollment
Mental health only	4,607	13.3%
Chemical health only	5,593	16.1
Mental health and chemical health	10,771	31.0
No mental or chemical health	13,751	39.6
Total	34,722	100.0%

2. Chronic medical illness

- About three out of ten GAMC enrollees have a chronic medical illness.

Diagnosis Category	Number of Enrollees	Percentage of Total Enrollment
One diagnosis category	6,696	19.3%
Two diagnoses categories	2,820	8.1
Three or more diagnoses categories	1,061	3.1
No diagnosis categories	24,145	69.5
Total	34,722	100.0%
Note: A chronic medical illness is defined as specified ICD-9 codes related to diabetes, heart disease, hypertension, asthma, chronic liver disease, and chronic kidney disease.		

Appendix IV

Program Expenditures and Caseload Data
(State Fiscal Year 2008)

Program	Program Expenditures*	Funding Sources	Federal Expenditures	State Expenditures	Average Monthly Recipients or Enrollees
MFIP plus DWP	$262,784,839	Federal – 73% State – 27%	$191,272,718	$71,512,121	98,028
GA	41,999,363	State – 100%	0	41,999,363	17,798 17,702 (cases)
MSA	30,829,796	State – 100%	0	30,829,796	28,009
SSI	453,986,000	Federal – 100%	453,986,000	0	78,880
GAMC	262,835,029	State – 100%	0	262,835,029	28,165
MA	6,265,200,244	Federal – 50% State – 48% County – 2%	3,130,167,280	2,990,613,827	526,588
MNCare	463,313,412	Enrollee premiums – 7% Federal – 27% State – 66%	126,974,075	303,929,498	114,350
Food Support	318,182,427	Federal – 100%	318,182,427	0	130,188 (households)
MFIP/TY/TYE Child Care	96,674,578	Federal – 55% State – 45%	52,808,887	43,865,691	7,789 families; 14,142 children
Basic Sliding Fee Child Care	87,569,318	Federal – 50% State – 47% County – 3%	43,474,633	41,153,450	8,977 families; 15,780 children
GRH	85,504,943	State – 98% County – 2%	0	83,983,947	15,699 (individuals)

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* For program costs or direct benefits only.

Appendix V

Laws and Regulations Governing Assistance Program for Families

	Federal Law			State Law	
Program	**Congress**	**U.S. Dept. of Health & Human Services**	**U.S. Dept. of Agriculture**	**MN State Legislature**	**MN Dept. of Human Services**
MFIP	42 USC 601 *et seq.* Title IV-A Social Security Act	45 CFR Parts 260-265		MN Stat. Ch. 256J	
GA				MN Stat. §§ 256D.01-.21	MN Rules 9500.1200-.1272
MSA	42 USC 1382 Title XVI Social Security Act	20 CFR Part 416, Subpart T		MN Stat. §§ 256D.33-.54	
SSI	42 USC 1381 Title XVI Social Security Act	20 CFR Part 416			
GAMC				MN Stat. Ch. 256B and § 256D.03	MN Rules Chapter 9505
MA	42 USC 1396 *et seq.* Title XIX Social Security Act	42 CFR Parts 430-456		MN Stat. Ch. 256B	MN Rules Chapters 9505, 9549, and 9553
MNCare				MN Stat. Ch. 256L	MN Rules Chapter 9506
Food Stamp	7 USC 2011 *et seq.* Food Stamp Act		7 CFR Parts 271-285	MN Stat. § 256.01; §§ 256D.051-.052; and § 393.07	

	Federal Law			State Law	
Program	**Congress**	**U.S. Dept. of Health & Human Services**	**U.S. Dept. of Agriculture**	**MN State Legislature**	**MN Dept. of Human Services**
Child Care Assistance	42 USC 9858 *et seq.*	45 CFR Parts 98 - 99		MN Stat. Ch. 119B	MN Rules Chapter 3400
GRH				MN Stat. Ch. 256I	

CFR=Code of Federal Regulations
USC=United States Code

Appendix VI

Federal TANF Work Requirements

The federal Temporary Assistance for Needy Families (TANF) law (PRWORA, Public Law No. 104-193) sets strict work participation requirements for the families who receive assistance under state welfare programs, such as the Minnesota Family Investment Program (MFIP), that are paid for in part with federal TANF funds.

MFIP participants must work for at least the number of hours per week that are specified in the federal law. The federal minimum weekly work requirements are slightly different than the minimum weekly work requirements that are in the MFIP state law. The federal TANF law also specifies percentages of all families and of two-parent families on a state's program who must meet the federal weekly work requirements.

The federal work participation requirements are listed in the following tables.

Federal Work Participation Requirements for All Families

	All participant families		
	Required hours of work per week		
Federal Fiscal Year	**If all children are over six**	**If at least one child is under six**	**Percentage of MFIP families who must meet requirement**
1998	20	20	30%
1999	25	20	35%
2000	30	20	40%
2001	30	20	45%
2002 +	30	20	50%

The percentage of families who must meet the work requirement is also called the "participation rate." Under the federal law, a state's required participation rate is reduced by 1 percent for each 1 percent reduction in the number of cases on the state's welfare program in the year compared to the average monthly number of AFDC cases in federal fiscal year 2005.[117] This "caseload reduction credit" can result in a state's target work participation rates being lower than the percentages shown in the tables on this page and the following page.

[117] The caseload reduction credit used to be calculated based on the number of AFDC cases in federal fiscal year 1995. However, the Deficit Reduction Act of 2005 changed the base year to 2005. Since many AFDC and MFIP cases were closed prior to 2005, this makes the required work participation rates (which remained the same) harder to achieve.

Federal Work Participation Requirements for Two-parent Families

Federal Fiscal Year	Required weekly hours of work (both parents combined) if **don't** utilize federally funded child care assistance	Percentage of MFIP families who must meet requirement	Required weekly hours of work (both parents combined) if **do** utilize federally funded child care assistance	Percentage of MFIP families who must meet requirement
1998	35	75%	55	75%
1999-present	35	90%	55	90%

If a state does not meet the federal work participation requirements, it is subject to losing a portion of its federal TANF block grant funds. The state MFIP law specifies that in the event the federal HHS imposes a fiscal sanction on Minnesota for failing to meet the federal work requirements, the state must pay 88 percent of the sanction. Counties must pay the remaining 12 percent of the sanction, each county in proportion to its percentage of the average monthly MFIP caseload (Minn. Stat. § 256J.751).

In federal fiscal year 2007 (October 1, 2006, to September 30, 2007), Minnesota's target work participation rate for all MFIP families, after the allowable caseload reduction credits were applied, was 32.22 percent. Minnesota's caseload reduction rate was 17.78 percent. Much of this caseload reduction was a result of two-parent families no longer being funded with TANF funds. Therefore, the expected caseload reduction rate for 2008 is much lower at 10.2 percent. However, both these caseload reduction credits are expected to be revised to account for excess MOE spending that Minnesota may count towards increasing the caseload reduction credit. Minnesota's actual 2006 family participation rate was 30.3 percent.

Note: The federal TANF work requirements are current as of November 2008.

Appendix VII

Mille Lacs Band Tribal TANF Program

The Mille Lacs Band of Ojibwe's tribal Temporary Assistance for Needy Families (TANF) program follows some of the same basic framework as the Minnesota Family Investment Program (MFIP), using the same grant amounts, and following some of the other MFIP requirements. The band also imposes a 60-month limit on assistance, but uses non-TANF funds to provide assistance to families beyond the time limit.

Some of the features of the band's program are different from MFIP:

- The band does not have a post-60-month program.
- The band's Tribal TANF program has some additional types of sanctions: for failure to achieve negative results on an employer-administered drug test; for failure to keep a minor child in school; and for abuse, neglect, or domestic violence in the family.
- The state must release child support collections, except for medical and child care support, to a Tribal TANF recipient who has assigned the support rights to the state and who is cooperating with child support requirements.
- The band's Tribal TANF program disregards up to $400 of child support income per month in calculating the amount of a recipient family's grant, if the family is in compliance with employment services requirements.[118]
- Tribal TANF appeals are heard by the band.
- The band's Tribal TANF program does not use the shared household standard used by MFIP.

The band's Tribal TANF program began operating January 1, 1999, in a six-county area covering Aitkin, Crow Wing, Morrison, Benton, Mille Lacs, and Pine counties. The program has expanded to serve Minnesota Chippewa tribal members residing in Anoka, Hennepin, or Ramsey counties on a voluntary basis.

[118] MFIP does not allow any disregard for child support that is paid to the family receiving MFIP.

Appendix VIII

Federal Earned Income Tax Credit and Minnesota Working Family Credit

The federal earned income tax credit (EITC) provides a wage supplement equal to a percentage of the income earnings of low-income individuals. The credit is fully refundable; if the credit exceeds a filer's tax liability, the rest is paid as a refund. The following table shows the maximum credit, income at which the credit begins to phase out, and maximum income eligible for the credit for tax year 2010.

Federal Earned Income Tax Credit, 2010

	Maximum credit	Income at which credit begins to phase out	Income at which credit is fully phased out
No Dependents	$457	$7,480	$13,460
One Dependent	3,050	16,450	35,535
Two or More Dependents	5,036	16,450	40,363
Note: The income at which the credit begins to phase out and at which the credit is fully phased out is increased by $3,000 for married couples filing joint returns.			

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The Minnesota working family credit (WFC) is also calculated as a percentage of earnings. Before 1998, the WFC was set as a percentage of the federal EITC. Legislation enacted in 1998 restructured the WFC, with the goal of reducing work disincentives caused by interactions with income and payroll taxes and MFIP. Like the EITC, the WFC is refundable. The following table shows the maximum credit, income at which the credit begins to phase out, and maximum income eligible for the credit for tax year 2010.

Minnesota Working Family Credit, 2010

	Maximum credit	Income at which credit begins to phase out	Income at which credit is fully phased out
No Dependents	$115	$7,480	$13,470
One Dependent	914	19,540	35,487
Two or More Dependents	1,762	23,180	40,287
Note: The income at which the credit begins to phase out and at which the credit is fully phased out is increased by $3,000 for married couples filing joint returns.			

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For a more thorough description of these credits, see also *The Federal Earned Income Tax Credit and the Minnesota Working Family Credit*, House Research, December 2007.

Appendix IX

Federal and Minnesota Dependent Care Tax Credits

Federal Dependent Care Income Tax Credit

The federal dependent care tax credit is equal to a percentage of qualifying dependent care expenses. Qualifying expenses are amounts paid for household services and care of a dependent while the taxpayer works or looks for work. The credit is not refundable; that is, it may only be used to offset income tax liability. Filers with no federal income tax liability may not claim the credit. The maximum qualifying expenses are $3,000 for one dependent, and $6,000 for two or more dependents. The credit equals 35 percent of expenses for filers with gross incomes under $15,000, for a maximum credit of $1,050 for one child and $2,100 for two or more children. The credit percentage decreases by one percentage point for each $2,000 of income over $15,000, down to a minimum of 20 percent for filers with incomes over $43,000. These filers are eligible for a maximum credit of $600 for one child and $1,200 for two or more children.

Minnesota Dependent Care Income Tax Credit

The Minnesota dependent care credit is tied to the federal credit, with three significant differences. First, the Minnesota credit is refundable. A filer with no state income tax liability but who otherwise qualifies for the credit receives the credit as a refund from the state. Second, while the federal credit phases down to 20 percent of qualifying expenses, the Minnesota credit is targeted at lower income filers and subject to an income-based phaseout. Third, the maximum Minnesota credit is $720 for one child and $1,440 for two or more children, the maximum amounts in effect at the federal level before tax year 2003. Since the state credit is tied to the federal credit, filers with incomes under $15,000 are eligible for the maximum credit of $720 for one dependent, and $1,440 for two or more dependents. For those with incomes over $15,000 but less than the state phase-out floor ($23,380 in 2010), the state credit is reduced on the same schedule as the federal credit. For those with incomes over the state phase-out threshold, the credit is reduced by $18 for each $350 of income over the threshold for filers claiming the credit for one dependent, and by $36 for those with qualifying expenses for two dependents. The phase-out threshold is adjusted upwards each year for inflation; as a result the maximum income eligible for the credit increases as well. For tax year 2010, the maximum income eligible for the state credit was $37,030.

Minnesota also allows all married couples with a dependent under age one to claim a credit equal to the maximum dependent care credit for one child. Couples may claim this credit, which is sometimes called the "young child credit," or the "at-home credit," regardless of whether or not they have any child care expenses.

For a more thorough description of the Minnesota dependent care credit, see also *The Minnesota and Federal Dependent Care Tax Credits*, House Research, December 2008.

Glossary

Terms and concepts used in the Minnesota Family Assistance Guide

AFDC: Aid to Families with Dependent Children. AFDC is the old federal-state cash assistance program that was originally authorized by Title IV-A of the Social Security Act. AFDC was an entitlement program that provided cash assistance to families with children who were deprived of support as the result of a parent's death, incapacity, continued absence, or unemployment. It was replaced in the 1996 federal welfare reform law by the TANF block grant program.

Alternative Employment Plan: An employment plan based on an assessment of need and developed by a victim of domestic violence, or a person at risk of domestic violence, and a person trained in domestic violence. A person who is complying with an alternative employment plan is exempt from the 60-month assistance limit, but is not automatically exempt from MFIP work requirements.

Assistance Unit: The group of people who are applying for or receiving benefits and whose needs are included in a cash grant. In MFIP the assistance unit is the group of mandatory or optional people who are applying for or receiving MFIP benefits together.

At-Home Infant Child Care Program: A component of the Basic Sliding Fee program. The program allows a parent to receive a small subsidy to stay home with a child under 12 months of age.

Basic Sliding Fee Program: A child care assistance program that assists eligible low-income families with their child care costs. The number of eligible families that participate is limited by the amount of state appropriations.

Blindness: For the purpose of establishing eligibility for SSI and MSA, the federal government defines blindness as vision no better than 20/200 with glasses or tunnel vision—a limited visual field of 20 degrees or less.

Caregiver: In MFIP, an adult in the assistance unit who cares for a dependent child. With a few exceptions, a child must reside with a caregiver to qualify for MFIP. The needs of the caregiver are usually included in the assistance unit's grant. The caregiver must comply with program requirements or face a sanction.

Categorical Assistance: Public assistance programs for needy persons who fit into particular categories: e.g., the aged, blind, and disabled (SSI, MSA), needy families (MFIP), households composed entirely of MFIP or SSI recipients (Food Support).

Categorically Needy: A term used in the MA program. The "categorically needy" are people who are eligible for MA because they belong to a group for which MA coverage is required by either the federal government or by the state under a federal option.

CFR: Code of Federal Regulations. The regulations for TANF are found in Title 45; those for Supplemental Security Income (SSI) are found in Title 20; those for Medicaid (MA) are found in Titles 42 and 45; those for Food Stamps are found in Title 7.

Child Care and Development Fund (CCDF): Federal funding mechanism for child care assistance programs. Congress created the CCDF in the PRWORA as a unified fund for all federal child care assistance. Final regulations are in Title 45 CFR, Parts 98 and 99.

Child Care Assistance Programs: Programs that provide subsidies to assist eligible low-income families to pay for child care costs. Child care assistance programs include: MFIP Child Care, Transition Year Child Care, and the Basic Sliding Fee program.

Child Care Fund: The funding mechanism for the child care assistance programs, the child care fund also provides grants to develop, expand, and improve the access and availability of statewide child care services.

Child Care Providers: Providers of child care that may participate in the child care assistance programs. An eligible provider must be licensed under DHS rules for family child care or child care centers, or be exempt from licensure. Unlicensed providers must be registered with the county to receive payments through the child care assistance programs.

Child Care Resource and Referral Program (CCR&R): Agencies that help parents find quality child care, provide consumer education, train child care providers, and assess child care needs in communities.

CMS: Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration or HCFA). The division of DHHS that administers the MA program.

DHS: The state Department of Human Services. DHS is the state agency that supervises the administration of assistance programs in Minnesota.

DHHS: The U.S. Department of Health and Human Services. DHHS is the federal agency that administers federal and joint state-federal human services programs.

Disability: For the purpose of establishing eligibility for SSI and MSA, “disability” is defined as the inability to engage in any substantial gainful activity as the result of any medically determinable physical or mental impairment. The condition must be expected to last at least 12 months or result in death, except that for children the test is one of functional impairment.

Disabled: In the Food Support program, a “disabled” household member is generally someone who is receiving some type of disability-based assistance.

Disregard: Earned income that is not counted when determining eligibility and calculating the amount of the assistance payment.

DRA: The Deficit Reduction Act of 2005 reauthorized TANF until 2010, making important technical changes to TANF requirements for the states.

DWP: Diversionary Work Program. Provides short-term, necessary services and supports to families that will lead to unsubsidized employment, increase economic stability, and reduce the risk of families needing longer term assistance under MFIP. A family is eligible for DWP assistance for a maximum of four months once in a 12-month period.

Earned Income: Income that is received as the direct result of legal work activity, effort, or labor. Examples of earned income include wages, salaries, tips, and commissions.

Earned Income Tax Credit: The federal tax credit program for low-income individuals.

EBT: Electronic Benefits Transfer. A method of providing food and cash assistance benefits, under the Food Support program and MFIP, in electronic debit card form.

EGA: Emergency General Assistance. A state program that provides short-term cash assistance (paid for one 30-day period in a consecutive 12-month period) to applicants who have emergency needs.

Employment Plan: A plan developed by a job counselor and an MFIP caregiver that identifies the caregiver's employment goal, activities needed to reach the goal, and a time line for accomplishing each activity. The similar plan in FSET is known as an "employability development plan."

Employment and Training Services: Activities and services, such as assessments, job search, job placements, and training that are designed to assist an individual to obtain and retain employment.

Employment and Training Services Provider: A public, private, or nonprofit employment and training agency that a county uses to provide employment and training services to MFIP, MFAP, or Food Support recipients.

Exempt Income: Income from certain sources that is not used in determining program eligibility and/or benefit levels.

Family: People who live together or are temporarily absent from the household. For child care assistance programs family includes parents, stepparents, guardians and their spouses, other relative caregivers, and children.

Family Cap: Prohibits an increase in the cash portion of the MFIP grant as a result of the birth of a child while participating in MFIP unless certain conditions are met.

Family Copayment: The amount a family that receives child care assistance must pay for the child care. The amount—also known as a parent fee—is based on family income adjusted for family size according to a sliding fee scale.

Family Stabilization Services: Programs, activities, and services that provide MFIP participants and their family members with certain assistance to achieve economic self-sufficiency and family well-being.

Family Violence Waiver: A waiver of the 60-month time limit for victims of family violence who meet certain criteria and are complying with an employment plan.

Family Wage Level: The MFIP standard of assistance that is used for calculating the amount of a family's MFIP grant when the family has earned income. The family wage level is equal to 110 percent of the MFIP transitional standard.

Federal Poverty Guidelines (FPG): The federal measure, updated annually, below which a household is considered to be living in poverty. The guidelines are published annually in the *Federal Register* by the DHHS to determine eligibility for certain programs. Published guidelines are identical for all states except Alaska and Hawaii.

Federal Work Requirements: The work participation standards specified in PRWORA that Minnesota must meet with MFIP families. Beginning October 1, 2001, the work participation rate that must be met by MFIP is 50 percent for all families and 90 percent for two-parent families. Each MFIP caregiver must work a minimum number of hours, averaged over a month, to be counted toward meeting the work participation rate.

FFP: Federal Financial Participation. Federal monies, matched by state funds, that are used to pay for health care services provided to MA enrollees. The FFP is calculated as a percentage; it determines the extent of the federal government's share of the costs of the MA program.

FMAP: Federal Medical Assistance Percentage. The federal share of Medicaid costs for each state, usually recalculated annually based on a formula that takes into account state per capita income.

Food Support (formerly Food Stamps): Federal assistance, issued in EBT form, that recipients can use to purchase food and food products in approved stores. The federal program is now called the Supplemental Nutrition Assistance Program (SNAP), but Minnesota's program is still called Food Support.

FSET: Food Support Employment and Training. The employment and training program for the Food Support and the MFAP programs. FSET participation is required of some Food Support and MFAP recipients who are not otherwise employed.

GA: General Assistance. A state program that provides cash assistance to needy persons who do not qualify for any of the federal programs (MFIP, SSI, or MSA) and who meet one of the GA eligibility criteria.

GAMC: General Assistance Medical Care. A state program that pays for health care services provided to persons who cannot afford the cost of these services and who are not eligible for other medical programs.

General Relief: (1) County programs that provide for certain needs of persons not eligible for other public assistance. General relief responsibilities include general hospitalization, university hospitals, and burials. (2) A term used interchangeably with "Poor Relief." (See "Poor Relief")

Group Residential Housing (GRH): A state program that provides subsidized community-based housing for persons on GA or MSA. GRH settings were formerly known as negotiated rate facilities.

HCAF: Health Care Access Fund. A fund that is the source of financing for the MinnesotaCare program and related activities. HCAF revenues are primarily taxes paid by health care providers, nonprofit health plan companies, and MinnesotaCare enrollee premiums.

Household: People who live together. In the Food Stamp program, a "household" is generally defined as those individuals living together who purchase and prepare meals in common.

Income Assistance Programs: Programs providing cash assistance to needy people (e.g., MFIP, GA, SSI, and MSA).

In-Kind Assistance Programs: Programs providing noncash benefits to eligible recipients (e.g., MA, GAMC, MinnesotaCare, Food Stamps, and child care assistance).

Income Disregard: Income that is not considered in the calculations when an applicant's eligibility and/or benefit level for an assistance program is determined.

Income: Payment received from any source, whether in money, goods, or services. Income may be earned or unearned, and recurring or nonrecurring.

Job Counselor: A staff person employed by an employment and training services provider who delivers services to participating MFIP, Food Stamp, and MFAP recipients.

Job Search Support Plan: A plan developed by an MFIP caregiver and job counselor that specifies the activities required and services to be provided to the caregiver while the caregiver is involved in job search activities.

Legal Noncitizen: A person who is not a U.S. citizen, but who has permission from the USCIS to live in the United States.

LIHEAP: Low-Income Home Energy Assistance Program. A program that helps low-income individuals pay heating costs.

MA: Medical Assistance or Medicaid; Title XIX of the Social Security Act. MA is a federal-state program that provides assistance to eligible persons who cannot afford the cost of necessary medical services.

MAXIS: Minnesota AXIS. The statewide centralized computer system run by DHS that counties use for eligibility determinations for the MFIP, GA, FS, MA, and GAMC programs, and for benefit payments for the MFIP, GA, and FS programs.

Medicaid: A jointly funded federal-state health care program established under Title XIX of the Social Security Act to provide for the health care needs of certain low-income individuals. Minnesota's Medicaid program is called MA (see above).

Medically Needy: Individuals with incomes too high to qualify for MA as a member of a group for which MA coverage is made available (see "categorically needy"), who have high medical expenses and qualify for MA by subtracting incurred medical expenses from their income (see "spenddown").

MFAP: Minnesota Food Assistance Program. A state program that provides state-funded food assistance to legal noncitizens who would be eligible for the federal Food Support program, except that their immigration status bars them from Food Support eligibility. MFAP recipients must follow all the rules of the Food Support program, including FSET requirements.

MFIP: Minnesota Family Investment Program. The state program begun in January 1998 that replaces the old AFDC entitlement program. MFIP is Minnesota's TANF program; it is designed to promote family self-sufficiency. It combines cash assistance and Food Support in a single grant, and also provides employment and training services.

MFIP Child Care Assistance: A child care assistance program for MFIP families who are participating in an authorized education and employment activity. This is a fully funded child care assistance program.

MFIP Consolidated Fund: Consists of funds used for MFIP and other assistance programs. Expenditures are limited to the benefits and services allowed under Title IV-A of the federal Social Security Act. Examples of allowable expenditures include: short-term, nonrecurring shelter and utility needs, transportation needed to obtain or retain employment, services to parenting and pregnant teens, supported work, and wage subsidies. Families with a minor child, pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guidelines are eligible for services funded under the consolidated fund.

MinnesotaCare: A state health care insurance program for eligible uninsured families and adults.

Minor Custodial Parent: An MFIP caregiver under the age of 18 who is the parent of a dependent child, and who receives MFIP assistance on behalf of herself or himself and her or his child.

MSA: Minnesota Supplemental Aid. A state program that supplements the income of needy aged, blind, and disabled persons who (1) are recipients of SSI or (2) would qualify for SSI except for excess income.

PMAP: Prepaid Medical Assistance Program. Provides health care services to MA enrollees through contracts with health maintenance organizations (HMOs) and other prepaid health plans.

Poor Relief: Also known as "General Relief," Poor Relief refers to the aid programs formerly administered and funded solely by the counties and townships prior to the institution of the GA program in 1974. State law abolished Poor Relief when it created GA.

Portability Pool: Provides Basic Sliding Fee child care assistance to eligible families who move between counties in Minnesota.

Poverty Guidelines: See Federal Poverty Guidelines.

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law Number 104-193). The federal welfare reform law that eliminated the AFDC entitlement program for needy families and replaced it with the TANF block grant program of time-limited assistance.

Qualified Noncitizen: Any of several categories of noncitizens defined in PRWORA as being eligible for federally funded public assistance if all other program eligibility requirements are also met.

Real Property: Any real estate such as a house, buildings, and/or land. Ownership of real property can affect an applicant's eligibility for a public assistance program.

Sanction: Reduction of a recipient's assistance benefit by a specified percentage or amount that is imposed because the recipient is not cooperating with a program requirement.

SCHIP: State Children's Health Insurance Program. A program that provides states with federal matching funds to provide health care coverage to uninsured children and some parents. SCHIP was established as Title XXI of the Social Security Act and authorized by the Federal Balanced Budget Act of 1997.

Shared Household Standard: The standard of assistance used in MFIP when unrelated people live in the same household as the assistance unit.

Shelter Costs: In MFIP, shelter costs include any of the following: rent, manufactured home lot rentals, monthly principal, interest, and insurance premiums and property taxes due for mortgages or contracts for deed costs.

Social Services: Counties provide "social services" to individuals who need assistance other than (or sometimes in addition to) income or health care assistance. Social services are designed to help people achieve or maintain self-support and self-sufficiency and prevent the abuse or neglect of children and adults. Social services include, but are not limited to, child and adult protection, foster care, adoption, chemical dependency services, day care, and services for seniors, persons with developmental disabilities, and persons with mental illness. Counties

receive block grant funds from the federal government (through the Social Services Block Grant program, Title XX of the Social Security Act) and from the state (through the Children and Community Services Act block grant program); counties also use other state or local sources to pay for the social services they provide. (The state Children and Community Services Act, CCSA, is found in Minnesota Statutes, chapter 256M.) Social services activities are not an authorized activity for child care assistance through the child care fund.

Spenddown: A term used in the MA program. Under a spenddown, an individual with income in excess of the program maximum qualifies for MA by incurring medical bills in amounts that are equal to or greater than the amount by which his or her income exceeds the program maximum for a specific time period.

SSA: The federal Social Security Administration, located within DHHS. SSA administers the SSI program, as well as the various Social Security insurance programs.

SSI: Supplemental Security Income. A federal program begun in 1974 that provides cash assistance to needy aged, blind, and disabled persons.

Standard of Need: The level of income the government has determined is sufficient for an individual to provide for his or her basic maintenance needs, such as shelter, food, clothing, and utilities.

Standard of Assistance: The amount of the standard of need that is paid by an income assistance program.

TANF: Temporary Assistance for Needy Families. The federal program created by the 1996 federal Welfare Reform Act which replaced the AFDC entitlement program with block grants to states, to assist states in providing time-limited assistance to needy families. In Minnesota, MFIP is the state's TANF program.

Title IV-A of the Social Security Act: authorizes the federal Temporary Assistance for Needy Families (TANF) block grant program of assistance to states.

Title IV-D of the Social Security Act: authorizes measures to (1) enforce child support obligations by absent parents, (2) locate absent parents, (3) establish paternity, and (4) obtain child support.

Title IV-E of the Social Security Act: authorizes a state-federal program of foster care payments and adoption assistance payments.

Title XVI of the Social Security Act: authorizes the federal Supplemental Security Income (SSI) program for the aged, blind, and disabled.

Title XVII of the Social Security Act: authorizes the federal medical insurance program for the aged and disabled that is known as Medicare.

Title XIX of the Social Security Act: authorizes the joint federal-state MA program. MA is also known as Medicaid.

Title XX of the Social Security Act: authorizes the federal Social Services Block Grant program of assistance to states to help fund social services.

Title XXI of the Social Security Act: authorizes SCHIP.

Transition Year Families: Families who have received MFIP for at least three of the last six months, but who have lost eligibility for MFIP due to increased hours of employment, increased child support income, or the loss of income disregards due to time limitations.

Transition Year Child Care: A program that assists transition year families with child care expenses for up to 12 months after leaving MFIP.

Transitional Standard: In MFIP, a combination of a cash assistance portion and food assistance portion for a family of a specific size. It is the basic standard of assistance for a family with no earned income.

Undocumented Noncitizen: An immigrant who enters or stays in the United States without the knowledge or authorization of the USCIS. Also known as an "illegal immigrant."

Unearned Income: Income a person receives without having performed any work activity, effort, or labor. Unearned income includes pensions, benefits, dividends, interest, insurance compensation, and other types of payments.

USCIS: Bureau of U.S. Citizenship and Immigration Services. The federal agency responsible for admitting noncitizens into the United States; formerly known as the Immigration and Naturalization Services (INS).

USDA: U.S. Department of Agriculture. The USDA is responsible for administering the Food Support program.

Vendor Payments: Payments made directly to a provider of goods and services on behalf of a recipient. Vendor payments can be instituted in MFIP and GA.

Waiting List: A list of unserved families who have applied for child care assistance through the Basic Sliding Fee program. A county is required by law to maintain a list of unserved applicants who are eligible for the Basic Sliding Fee program. The county must update the list at least every six months. County funding allocations are partially based on the number of families on the waiting list.

Work Activity: Any activity in an MFIP recipient's approved job search support plan or employment plan that is tied to the recipient's employment goal and is considered work for the purposes of meeting the federal work requirements.

Working Family Credit: A state program that provides refundable tax credits to low-income families who work.

For more information about family assistance, visit the health and human services area of our web site, www.house.mn/hrd/hrd.htm