



Minnesota Health Care Programs

Eligibility Policy Manual

This document provides information about additions and revisions to the Minnesota Department of Human Service's Minnesota Health Care Programs Eligibility Policy Manual.

Manual Letter #17.4

September 1, 2017

Manual Letter #17.4

This manual letter lists new and revised policy for the Minnesota Health Care Programs (MHCP) Eligibility Policy Manual (EPM) as of September 1, 2017. The effective date of new or revised policy may not be the same date the information is added to the EPM. Refer to the Summary of Changes to identify when the Minnesota Department of Human Services (DHS) implemented the policy.

I. Summary of Changes

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

A. [EPM Home Page](#)

The change to the EPM home page adds a link to this manual letter.

Additionally, a hyperlink to DHS Bulletin #17-21-01, DHS Explains Policy and Procedures for MA Cost Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEGAs Are Not CEHI, is replaced with a hyperlink to the corrected version of that bulletin, [Corrected #17-21-01C](#), which was published on August 9, 2017.

B. [Section 1.2.7 MHCP Applications for Incarcerated People Preparing for Release](#)

The language in this section incorrectly noted that the Individual Discharge Information Sheet (IDIS) (DHS-3443) could not be submitted later than 10 calendar days after the date a person is released. This language is removed to reflect the correct policy.

Additional changes are made to this section to better state the policy, including clearly defining who may use a shortened application process and who must submit a new application.

C. [Section 2.1.1.2.1.3.1 MA Cost Effective Insurance](#)

The changes to this section complement the publication of DHS Bulletin Corrected #17-21-01C, DHS Explains Policy and Procedures for MA Cost Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEGAs Are Not CEHI, by removing information that is contrary to the bulletin or no longer applicable.

The changes do **not** incorporate the corrected bulletin. Continue to refer to the corrected bulletin for current policy.

D. Section 2.1.1.2.1.3.2 MA Medical Support

Information is added to this section to clarify that a pregnant woman, or a parent or relative caretaker who is pregnant, is not required to cooperate with medical support for the child she is expecting or for any other child during pregnancy or during the postpartum period.

An additional change clarifies that a medical support referral is not required if one parent in a two-parent household has a temporary absence.

E. Appendix F

The annual updates for the standard utility allowances are added to Appendix F. The new standards are effective October 1, 2017.

II. Documentation of Changes

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

- A. [EPM Home Page](#)
- B. [Section 1.2.7 MHCP Applications for Incarcerated People Preparing for Release](#)
- C. [Section 2.1.1.2.1.3.1 Cost Effective Insurance](#)
- D. [Section 2.1.1.2.1.3.2 MA Medical Support](#)
- E. [Appendix F](#)

A. EPM Home Page

Minnesota Health Care Programs

Eligibility Policy Manual

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

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

Manual Letters

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

MHCP EPM Manual Letter #17.1, April 1, 2017

MHCP EPM Manual Letter #17.2, June 1, 2017

MHCP EPM Manual Letter #17.3, August 1, 2017

[MHCP EPM Manual Letter #17.4, September 1, 2017](#)

2016 Manual Letters

MHCP EPM Manual Letter #16.1, June 1, 2016

MHCP EPM Manual Letter #16.2, August 1, 2016

MHCP EPM Manual Letter #16.3, September 1, 2016

MHCP EPM Manual Letter #16.4, December 1, 2016

Bulletins

DHS bulletins provide information and direction to county and tribal health and human services agencies and other DHS business partners. According to DHS policy, bulletins more than two years old are obsolete. Anyone can subscribe to the Bulletins mailing list.

A DHS Bulletin supersedes information in this manual until incorporated into this manual. The following bulletins have not yet been incorporated into the EPM:

- Corrected Bulletin #17-21-01C, DHS Explains Policy and Procedures for MA Cost-Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEBAs Are Not CEHI
- Bulletin #17-21-02, DHS Explains: Changes to MA Estate Recovery Resulting from CMS Approval of a Revised State Plan Amendment; and a New Statewide Funeral Expenses Policy
- Bulletin #17-21-05, DHS Explains How Unified Cash Asset Policy Affects Medical Assistance (MA) Eligibility
- Bulletin #17-21-06, DHS Clarifies the Medical Assistance MAGI Based Income Calculation
- Bulletin #17-21-07, DHS Clarifies use of SAVE for Minnesota Health Care Programs
- Bulletin #17-21-08, DHS Explains Changes to the Minnesota Health Care Programs (MHCP) Application for Medical Assistance for Long-Term Care Services (MA-LTC)

Archives

This manual consolidates and updates eligibility policy previously found in the Health Care Programs Manual (HCPM) and Insurance Affordability Programs Manual (IAPM). Prior versions of policy from the HCPM and IAPM are available upon request.

Refer to the EPM Archive for archived sections of the EPM.

Contact Us

Direct questions about the Minnesota Health Care Programs Eligibility Policy Manual to the DHS Health Care Eligibility and Access (HCEA) Division, P.O. Box 64989, 540 Cedar Street, St. Paul, MN 55164-0989, call (888) 938-3224 or fax (651) 431-7423.

Health care eligibility workers must follow agency procedures to submit policy-related questions to HealthQuest.

Legal Authority

Many legal authorities govern Minnesota Health Care Programs, including but not limited to: Title XIX of the Social Security Act; Titles 26, 42 and 45 of the Code of Federal Regulations; and Minnesota Statutes chapters 256B and 256L. In addition, DHS has obtained waivers of certain federal regulations from the Centers for Medicare & Medicaid Services (CMS). Each topic in the EPM includes applicable legal citations at the bottom of the page.

DHS has made every effort to include all applicable statutes, laws, regulations and other presiding authorities; however, erroneous citations or omissions do not imply that there are no applicable legal citations or other presiding authorities. The EPM provides program eligibility policy and should not be construed as legal advice.

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Manual Letter #17.2, June 1, 2017

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Manual Letter #16.3, September 1, 2016

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B. Section 1.2.7 MHCP Applications for Incarcerated People Preparing for Release

Minnesota Health Care Programs

1.2.7 Applications for Incarcerated People Preparing for Release

A person who is incarcerated and applying for Minnesota Health Care Programs (MHCP) in advance of their release from a state prison, county detention facility, or city jail must apply using a paper application. Applying with a paper application ensures that eligibility dates for health care coverage are correct.

Health Care Application

People who are incarcerated preparing for release may receive application assistance from a discharge planner or facility staff when applying for MHCP. There are two special application procedures for people who are incarcerated so health care coverage can begin when they reenter the community on the day they return to the community. This helps ensure continued treatment of chronic health conditions and successful transition to community life.

1. Some incarcerated people may use a shortened application process for Medical Assistance (MA).
2. Others may complete a new application and an Individual Discharge Information Sheet (IDIS) (DHS-3443) receive application assistance from a discharge planner or facility staff when applying for MHCPs.

Incarcerated people who do not apply for MHCPs prior to release follow all standard policies when applying for health care. These procedures help ensure continued treatment of chronic health conditions and successful transition to community life.

Shortened Application Process

People who are incarcerated for less than 12 months and who were MA enrollees at the time of their incarceration may have their MA coverage reopened without a new application by submitting their Request to Re-Open MA (DHS-5038) to their county or tribal servicing agency. DHS-5038 must not be submitted earlier than 45 days prior to release and no later than 10 calendar days after release.

Application Assistance New Application

Incarcerated people may receive assistance from discharge planners or facility staff when applying for health care prior to release.

An incarcerated person may apply and have eligibility approved prior to release so they can have health care coverage on the day they return to the community.

People who are incarcerated for 12 months or more must complete the appropriate health care application and the IDIS (DHS-3443). Refer to Section 1.2 MHCP Application Forms for more information. Discharge planners and facility staff may help incarcerated people complete these forms ~~the appropriate health care application and the Individual Discharge Information Sheet (IDIS) (DHS-3443).~~ See the ~~MHCP Application Forms~~ policy for more information.

The completed application and DHS-3443 are submitted to the county or tribal servicing agency where the person lived before entering the correctional system. If the previous county of residence is unknown or the person came from another state, the completed forms are sent to the county or tribal servicing agency where the person plans to live.

DHS-3443 must not be submitted earlier than 45 days prior to release ~~and no later than 10 calendar days after release.~~

~~Shortened Application Process~~

~~Incarcerated people who were MA enrollees at the time of their incarceration may have their MA coverage reopened without a new application by submitting the Request to Re-Open MA (DHS-5038) to their county or tribal servicing agency. DHS-5038 must not be submitted earlier than 45 days prior to release and no later than 10 calendar days after release.~~

Incarcerated people who do not apply for MHCP prior to release follow all standard policies when applying for health care after release.

Legal Citations

Minnesota Statute 256B.055, subdivision 14

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C. Section 2.1.1.2.1.3.1 MA Cost Effective Insurance

Medical Assistance

2.1.1.2.1.3.1 Cost Effective Insurance

A Medical Assistance (MA) enrollee with access to a group or individual health insurance plan from another source may be eligible for assistance in paying the premiums, deductibles, and copays, if it is cost effective. Cost effective means that paying for the other plan would be less costly than the amount for an equivalent set of services paid for by MA. If a plan is cost effective, MA reimburses the premium for the enrollee's health plan and provides coverage for all MA benefits not included in the plan.

~~When the other available health insurance plan is determined by the county, tribal or state servicing agency to be cost effective, the enrollee may receive a reimbursement for premiums paid for the policy or they may have the cost of the premium paid directly to the employer or insurance provider. The county, tribal or state servicing agency must process the reimbursement or premium payment within 30 days of receiving verification from the enrollee or employer. Only the portion of the premium payment that covers MA enrollees is reimbursed.~~

~~Cost effective coverage could include, but is not limited to, coverage through:~~

- ~~• Group health care coverage, including COBRA~~
- ~~• Individual health care coverage~~
- ~~• Long term care insurance (group or individual coverage)~~
- ~~• Medicare~~

MA Cooperation Requirement to Enroll in a Cost Effective Group Health Plan

As a condition of ongoing MA eligibility, an adult enrollee with access to a group health plan must cooperate by enrolling in the plan and maintaining enrollment when the plan is determined to be cost effective. An MA enrollee may have access to a cost effective group health plan through their own employer, or through a family member's employer.

An MA enrollee who has an individual health plan may request a cost effective determination but is not required to enroll or maintain enrollment in the plan as a condition of MA eligibility. If the individual health plan is determined to be cost effective, the enrollee may receive premium reimbursement.

Enrollee responsibilities MA Enrollee Cost Effective Cooperation Requirements

MA enrollees must:

- Report access to a group health plan upon request at the time of application or any time access to a group health plan becomes available
- Maintain or enroll in a group health plan, if when determined to be notified of a determination that it is cost effective and premiums are paid by the county, tribal or state servicing agency or if there is no cost to the enrollee.
- ~~An MA enrollee currently enrolled in a group health plan is not required to maintain enrollment during the cost effective evaluation process.~~
- ~~Adult enrollees who choose to disenroll from the group health plan during the evaluation process must reenroll in the group health plan at the earliest opportunity if the coverage is determined to be cost effective.~~
- ~~Children who disenroll from the group health plan during the evaluation process must be reenrolled in the coverage the next possible month if the coverage is determined to be cost effective.~~
- Cooperate in determining the cost effectiveness of ~~Medicare supplemental policies or group health care coverage.~~ Enrollees have 10-days notice to provide information about other group health care coverage to maintain MA eligibility. MA coverage ends when the enrollee fails to cooperate.
- Enroll in cost effective ~~Medicare~~ or group health care coverage at the earliest possible date.
- Report when the cost effective insurance ends or changes.
- ~~Enrollees are not required to cooperate with cost effective coverage determinations when they are Safe at Home (SAH) Address Confidentiality program participants and the policyholder is their probable assailant.~~

Exceptions to Cost Effective Cooperation Requirements

MA enrollees who cannot enroll in cost effective group health care coverage on their own behalf, do not have MA coverage end due to non-cooperation. See the MA Cooperation policy for more information.

~~MA enrollees may choose to enroll in or maintain individual health care coverage that is cost effective, with premiums reimbursed or paid directly to the insurance provider. MA enrollees are not required to enroll in or maintain individual policies.~~

Pregnant women, who are eligible for CHIP-funded MA, are not required to pursue other health care coverage.

Infants who are funded under CHIP cannot have other health insurance. If a CHIP funded infant gains access to group health coverage or other health insurance they are moved to MA and the cost effective information in this section will apply.

Enrollees are not required to cooperate with cost effective coverage determinations when they are Safe at Home (SAH) Address Confidentiality program participants and the policyholder is their probable assailant.

Premiums not reimbursable

The following policies are not cost effective:

- ~~Medicare Supplements~~
- ~~Medicare Part C (Medicare Advantage)~~
- ~~Long term care and hospital indemnity policies that provide cash payments for each day in a hospital or nursing facility and the MA enrollee is not currently collecting benefits~~

Managed care exclusions

Enrollees with cost effective ~~private group or individual~~ health care coverage are excluded from participation in managed care. These enrollees receive health care through fee-for-service (FFS). Refer to the Prepaid Minnesota Health Care Programs Manual for more information.

Enrollees with non-cost effective private health care coverage through a Health Maintenance Organization (HMO) licensed under Minnesota Statutes §62D may enroll on a voluntary basis if they select the same MHCP managed care organization as their private HMO.

Legal Citations

Code of Federal Regulations, title 42, section 435.1015

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

Minnesota Rules, part 9505.0430

Minnesota Statutes, section 256B.056, subdivision 8

Minnesota Statutes, section 256B.0625, subdivision 15

Social Security Act, title 19, section 1905(a)

Social Security Act, title 19, section 1906

~~United States Code, title 26, section 5000~~

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D. Section 2.1.1.2.1.3.2 MA Medical Support

Medical Assistance

2.1.1.2.1.3.2 Medical Support

The Medical Assistance (MA) program requires parents or relative caretakers to help provide health care for their children. When one parent does not live with the child, a referral for medical support may be required.

Medical support is health insurance coverage or cash payments that a parent, who is not living with the child, provides or is court-ordered to provide to meet the medical needs of their child. For MA eligibility, the parent or relative caretaker who lives with the child is required to cooperate with medical support referral requirements for children younger than age 19 on MA.

Assignment of Rights and Cooperation

A parent or relative caretaker assigns the child's right to medical support by signing a paper or online health care application or renewal form.

County, tribal or state servicing agencies are required to mail a medical support referral packet to the parent or relative caretaker. The MA enrolled parent or relative caretaker must return the form within 30 days of the date on the referral packet. Regardless of whether the forms are returned or not, the county, tribal or state servicing agency must initiate a referral to the county or tribal child support agency, also called the IV-D agency.

For medical support, cooperation may include:

- Establishing paternity
- Establishing an order for medical support, or enforcing an existing order
- Providing information about non-custodial parents
- Forwarding any medical support payments received directly from the non-custodial parent to the Department of Human Services (DHS)

A pregnant woman, or a parent or relative caretaker who is pregnant, is not required to cooperate with medical support for the child she is expecting or for any other child during pregnancy or during the postpartum period.

Non-Cooperation

The county or tribal child support office determines non-cooperation with medical support requirements and notifies the county, tribal or state servicing agency. The parent or relative caretaker's MA coverage is closed with 10-day notice.

If MA is closed for non-cooperation, MA coverage cannot be reopened until the parent or relative caretaker cooperates with medical support requirements. If the parent or relative caretaker cooperates, MA may reopen the first day of the month in which cooperation occurs.

The child's MA coverage is not impacted by their parent or relative caretaker's non-cooperation with medical support requirements.

Good Cause

A parent or relative caretaker may request "good cause" when there are circumstances beyond their control which keeps them from cooperating with medical support requirements. Information about good cause is included in the medical support referral packet sent to parents who are referred to medical support. A good cause committee reviews the good cause request.

When Medical Support Referrals are Made

A medical support referral is made when a child younger than age 19 resides with one parent or a relative caretaker, both the child and the parent or relative caretaker are eligible for MA, and none of the Referral Not Required criteria below applies.

Referral Not Required

A medical support referral is not made in any of the following circumstances:

- ~~The One parent in a two-parent household has a temporary absence is temporarily absent.~~ Refer to Section 1.4.4 Minnesota Health Care Programs Temporary Absence for more information.
- The parent is deceased.
- The parent or relative caretaker is pregnant.
- The parent is a minor child under age 18 or is an emancipated minor.
- The child receives Northstar Adoption Assistance.
- The child receives Northstar Foster Care or Kinship Assistance.
- A parent is involuntarily out of the household because he or she is being detained by U.S. Immigration and Customs Enforcement (ICE) or is waiting for immigration authorization from U.S. Citizenship and Immigration Services (USCIS) from outside of the United States.

Voluntary Referral

A parent or relative caretaker may request voluntary medical support or child support referral services from the county or tribal IV-D agency when a referral for MA eligibility purposes is not required. The county or tribal IV-D agencies can assist people in getting the medical or child support referral services.

Legal Citations

Code of Federal Regulations, title 42, section 435.610

Code of Federal Regulations, title 42, section 433.145

Code of Federal Regulations, title 42, section 433.146

Code of Federal Regulations, title 42, section 433.147

Code of Federal Regulations, title 42, section 433.148

Minnesota Statutes, section 256.741

Minnesota Statutes, section 256B.056, subdivisions 6 and 8

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E. Appendix F

Appendix F

Standards and Guidelines

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

Community Spouse Allowances

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

Basic Shelter Allowance

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

Effective Dates	Basic Shelter Allowance
July 1, 2017 to June 30, 2018	\$609
July 1, 2016, to June 30, 2017	\$602

Maximum Monthly Income Allowance

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

Effective Dates	Maximum Monthly Income Allowance
January 1, 2017, to December 31, 2017	\$3,022.50
January 1, 2016, to December 31, 2016	\$2,980.50

Minimum Monthly Income Allowance

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

Effective Dates	Minimum Monthly Income Allowance
July 1, 2017 to June 30, 2018	\$2031
July 1, 2016 – June 30, 2017	\$2,005

Utility Allowance

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

Effective Dates	Utility Allowance
October 1, 201 <u>6</u> <u>7</u> to September 30, 201 <u>7</u> <u>8</u>	\$ <u>532</u> <u>556</u>
October 1, 201 <u>5</u> <u>6</u> to September 30, 201 <u>6</u> <u>7</u>	\$ <u>454</u> <u>532</u>

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

Effective Dates	Electricity Allowance
October 1, 201 <u>6</u> <u>7</u> to September 30, 201 <u>7</u> <u>8</u>	\$ <u>144</u> <u>172</u>
October 1, 201 <u>5</u> <u>6</u> to September 30, 201 <u>6</u> <u>7</u>	\$141

Effective Dates	Telephone Allowance
October 1, 201 <u>6</u> <u>7</u> to September 30, 201 <u>7</u> <u>8</u>	\$ <u>38</u> <u>41</u>
October 1, 201 <u>5</u> <u>6</u> to September 30, 201 <u>6</u> <u>7</u>	\$38

Federal Poverty Guidelines

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

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

Home Equity Limit

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

Effective Dates	Home Equity Limit
January 1, 2017, to December 31, 2017	\$560,000

Effective Dates	Home Equity Limit
January 1, 2016, to December 31, 2016	\$552,000

IRS Mileage Rate

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

Effective Dates	IRS Mileage Rate
January 1, 2017, to December 31, 2017	53.5 cents
January 1, 2016, to December 31, 2016	54 cents

Long-Term Needs Allowances

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

Clothing and Personal Needs Allowance

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

Effective Dates	Clothing and Personal Needs Allowance
January 1, 2017, to December 31, 2017	\$97
January 1, 2016, to December 31, 2016	\$97

Home Maintenance Allowance

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

Effective Dates	Home Maintenance Allowance
July 1, 2017 to June 30, 2018	\$1,005
July 1, 2016, to June 30, 2017	\$990

Special Income Standard for Elderly Waiver Maintenance Needs Allowance

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

Effective Dates	Maintenance Needs Allowance
July 1, 2017 to June 30, 2018	\$990
July 1, 2016, to June 30, 2017	\$988

Maximum Asset Allowance

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

Effective Dates	Minimum	Maximum
January 1, 2017, to December 31, 2017	No minimum	\$120,900
June 1, 2016 to December 31, 2016	No minimum	\$119,220
January 1, 2016, to May 31, 2016	\$33,851	\$119,220

MinnesotaCare Premium Amounts

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

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

Pickle Disregard

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

Effective Date	Pickle Disregard
January 1, 2017, to December 31, 2017	1.003
January 1, 2016, to December 31, 2016	1

Remedial Care Expense

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

Effective Dates	Remedial Care Expense
July 1, 2017 to December 31, 2018	\$186
January 1, 2017 to June 30, 2017	\$196

Roomer and Boarder Standard Amount

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

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

Special Income Standard

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

Effective Dates	SIS
January 1, 2017, to December 31, 2017	\$2,205
January 1, 2016, to December 31, 2016	\$2,199

Statewide Average Payment for Skilled Nursing Facility Care

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

Effective Dates	SAPSNF
July 1, 2017, to June 30, 2018	\$7,106
July 1, 2016, to June 30, 2017	\$6,280

Student Earned Income Exclusion

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

Effective Date	Monthly	Annual
January 1, 2017, to December 31, 2017	\$1,790	\$7,200
January 1, 2016, to December 31, 2016	\$1,780	\$7,180

Supplemental Security Income Maximum Payment Amount

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

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

Effective Date	Individual
January 1, 2017, to December 31, 2017	\$735
January 1, 2016, to December 31, 2016	\$733

Effective Date	Couple
January 1, 2017, to December 31, 2017	\$1,103
January 1, 2016, to December 31, 2016	\$1,100

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