Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 400-29, Basic Care Program. This manual also incorporates IM 5186.

Par.2. **Effective Date** – Changes in Service Chapter 400-29 are effective July 1, 2016, and the changes to IM 5186 were effective October 1, 2013.

Payment to Licensed Basic Care Facilities 400-29-75

1. **400-29-75 –** Payment to Licensed Basic Care Facilities. Decreased the maximum number of hospital days allowed from 30 to 15.

The Basic Care Assistance Program payment shall be authorized by the county through the Resident Payment System for room and board services received in a licensed basic care facility. The county authorizing the case shall send the "Notice of Action" to the basic care provider and to the recipient.

The Basic Care Assistance Program policy for hospital days is similar to the policy used by the Medicaid Program. A maximum of ~~30~~ 15 days per occurrence will be allowed for payment for basic care during a time a recipient requires a level of care higher than basic care, including days in a hospital, swing bed, hospice care, or nursing facility, if the care plan provides that the resident will return to the basic care facility and the facility holds the bed until the resident returns. Payment for therapeutic days, or days when the resident is on personal leave, will be limited to 28 days per year. Basic care facilities will receive payment for room and board for leave days but not the payment for personal care services. A facility may charge to hold a bed for a period in excess of the maximums stated in this paragraph if the resident or a person acting on behalf of the resident has requested the bed be held, the facility informs the person making the request the amount of the charge, and the payment comes from a source other than the recipient's monthly income (75-02-07.1-04).

The basic care provider uses the Medical Management Information System (MMIS) billing codes to record and bill all resident in days and resident leave days, the date of entry into the basic care facility, and the date the individual left the basic care facility. The payment will be made directly to the provider by the Department based on the provider's billing. The Department will not pay for billings for services from a basic care provider that are over a year old.

Allowable Gross Income Deductions 400-29-60-05

1. **400-29-60-05 –** Allowable Gross Income Deductions, manual was updated to reflect IM5186 which increased the personal needs allowance to $100.

Only specific deductions are allowed for a resident in a basic care facility. Countable income is the remainder of gross income minus any of the following allowable deductions:

1. Personal needs allowance of ~~$85.00~~ $100.00;
2. Sixty-five plus one-half of the remaining monthly gross earned income;
3. The cost of guardianship or conservatorship fees actually charged, but not to exceed 5% of gross monthly income;
4. Court-ordered child support payments or alimony payments actually paid on behalf of a minor child or ex-spouse who is not a member of the person's Medicaid unit;
5. The Medicare or health insurance premium will be allowed as a deduction for all individuals residing in a basic care facility if the premium is not paid by another source such as Qualified Medicare Beneficiaries (QMB) or Special Low-Income Beneficiaries (SLMB);
6. Co-payments for Medicaid may be deducted for individuals not eligible for Medicare or if the service is not covered by Medicare;

7. A disregard of recipient liability expense under the Medicaid program; and

8. Income actually deemed to the community spouse from the recipient in a basic care facility.

In the month of entry into a basic care facility, the medically needy income level size of the family in which the person was a member at the beginning of the month (NDAC 75-02-10-01. 4(d)) and reasonable living expenses. Necessary living expenses are items such as rent, utilities, health insurance premium, etc. Deeming income to the community spouse at the Medicaid level for one is allowed for Medicaid budgeting.

In the second month, following the month of entry, count the income minus applicable disregards to determine the recipient responsibility towards room and board costs.

Individuals moving from a basic care facility to another living arrangement such as home, apartment, assisted living, etc., will be allowed the same household expense deduction that they are allowed in the month of entry into a basic care facility as long as the expenses are actually paid and not just incurred.

NOTES:

Note - Medicaid transportation to medical appointments is not an allowable expense under this program.

Clothing and Personal Needs Allowance 400-29-45

1. **400-29-45 –** Clothing and Personal Needs Allowance, manual was updated to reflect IM5186 which increased the personal needs allowance to $100

Each recipient of the Basic Care Assistance Program shall retain ~~$85.00~~ $100.00 per month for clothing and personal needs.

Definitions 400-29-15

1. **400-29-15 -** Definitions, manual was updated to reflect IM5186 which increased the personal needs allowance to $100

1. "Activities of daily living" means bathing, dressing, toileting, transferring, eating, bed mobility, medication management, and individual hygiene.

2. "Aged" means at least sixty-five years of age.

3. "Alzheimers and related dementia facility" means a licensed basic care facility which primarily provides services specifically for individuals with Alzheimer's disease or related dementia.

4. "Applicant" means an individual or proper person, seeking Basic Care Assistance benefits on behalf of another person, to a county agency.

5. "Assisted living" means an environment where a person lives in an apartment-like unit and receives services on a twenty-four-hour basis to accommodate that person's needs and abilities to maintain as much independence as possible.

6. "Assisted living facility" means any building or structure containing a series of living units operated as one business entity to provide services for five or more individuals who are aged or disabled adults and who are not related by blood or marriage to the owner or manager of the entity and which is kept, used, maintained, advertised, or held out to the public as a place that takes available individualized support services to accommodate an individual's needs and abilities to maintain as much independence as possible. It does not include a facility that is licensed as a basic care facility or a congregate housing facility.

7. "Basic Care Facility" means a residence, not licensed under NDCC § 23-16 by the Department, that provides room and board to five or more individuals who are not related by blood or marriage to the owner or manager of the residence and who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four hour medical or nursing services and

    a. Makes response staff available at all times to meet the twenty-four hour per day scheduled and unscheduled needs of the individual; or,

    b. Is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility.

8. "Blind" has the same meaning as the term used by the Social Security Administration for the Supplemental Security Income Program under Title XVI of the Social Security Act. [42 U.S.C. 1381 et seq.]

9. "Congregate housing" means housing shared by two or more individuals not related to each other and receive services not provided in an institution.

10. "Countable income" means gross income reduced by

    a. The cost of guardianship or conservatorship fees actually charged, but no more than five percent of the monthly gross income;

b. All health insurance premiums including but not limited to Medicare health insurance supplements, cancer insurance, etc. If the deduction is allowed for Medicaid in TECS, it must be allowed as a deduction for the Basic Care Assistance Program;

c. Court-ordered child support payments actually paid on behalf of a minor child who is not a member of the person's Medicaid unit; and,

d. For persons receiving Basic Care Assistance:

1. The month the person enters the basic care facility, the medically needy income level of the size of family in which the person was a member before entering the basic care facility; and

2. Sixty-five dollars plus one-half of the remaining monthly gross earned income.

e. Medicaid recipient liability.

f. The Personal clothing allowance of ~~$60.00~~ $100.00 per month.

11. "County agency" means the county social service board.

12. "Department" means the Department of Human Services.

13. "Disabled" has the same meaning as the term has when used by the Social Security Administration in the supplemental security income program under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

14. "Eligible beneficiary" means a resident of this State who:

a.

1. Is aged; or

2. Is at least eighteen years of age and is disabled or blind:

b. Has applied for and is eligible to receive benefits under Medicaid provided that an individual who was eligible to receive benefits under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] and who was receiving benefits under Title XVI before January 1, 1995, is not ineligible because that individual is not eligible to receive benefits under Title XIX:

c. Based on functional assessment, is not severely impaired in any of the activities of daily living of toileting, transferring to or from a bed or chair, or eating and:

1. Has health, welfare, or safety needs, including a need for supervision or a structured environment, which requires care in a licensed adult family foster care home or a licensed basic care facility; or

2. Is impaired in three of the following four instrumental activities of daily living: preparing meals, doing housework, taking medicine, and doing laundry; and

d. Is determined to be eligible pursuant to rules adopted by the Department.

15. "Functional assessment" means an evaluation process based on the person's ability or inability to live independently. The evaluation process is completed by the Home and Community Based Service case manager before entering a basic care facility.

16. "Functional status" means a redetermination of the recipient's functional status at the time of redetermination for Medicaid eligibility.

17. "Functional Status Report" is a report of recipients who may need a review of functional status at the same time as the Medicaid redetermination eligibility. The functional status is reported on SFN 21 under the functional assessment section.

Basic Care policy requires a functional assessment be completed annually. Personal care assessment is required to be updated every six months. If a redetermination and the functional assessment do not coincide, the most recent functional assessment or personal care assessment may be used as long as the assessment is not older than six months.

18. "Gross income" includes any income at the disposal of an applicant, recipient, or responsible relative; any income with respect to which an applicant, recipient, or responsible relative has a legal interest in a liquidated sum and the legal ability to make the sum available for support or maintenance; or any income an applicant, recipient, or responsible relative has the lawful power to make available or to cause to be made available. It includes any income that would be applied in determining eligibility for benefits; any income, except occasional small gifts, and interest income from liquid assets that would be disregarded in determining eligibility for benefits; annuities, pensions, retirement, and disability benefits to which an applicant or recipient, or spouse of an applicant or recipient, may be entitled including veteran's compensation and pensions of any type, old-age survivors benefits, and disability insurance benefits; railroad retirement benefits; and unemployment benefits.

19. "Individualized support services" means services designed to provide assistance to adults who may have physical or cognitive impairments and who require at least a moderate level of assistance with one or more activities of daily living.

20. "Institution" means an establishment that makes available some treatment or services beyond food or shelter to four or more persons who are not related to the proprietor.

21. "Instrumental activities of daily living" means activities to support independent living including housekeeping, shopping, laundry, transportation, and meal preparation.

22. "Living independently" includes living in congregate housing. The term does not include living in an institution.

23. "Living unit" means a portion of an assisted living facility occupied as the living quarters of an individual who has entered into a lease agreement with the assisted living facility.

24. "Medical leave day" means a day a resident is not in the basic care facility due to a medical condition.

25. "Necessary benefits" means those benefits:

    1. Provided under this program;

    2. Identified by the department (or a county agency under the direction and supervision of the department) as appropriate to meet the needs of an applicant or recipient; and,

    3. Which, when provided in coordination and conjunction with benefits available from any other source, represent the means least costly to the department of meeting the needs of the applicant or recipient.

26. "Personal Care Services" means services consisting of a range of human assistance, provided to an individual with disabilities or conditions that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands on assistance or curing so that the individual can perform a task without direct assistance.

27. "Proprietor" means an individual responsible for day-to-day administration and management of a facility.

28. "Proper individual" means any individuals of sufficient maturity and understanding to act responsibly on behalf of the applicant.

29. "Qualified service provider" means a county agency or independent contractor who agrees to meet standards for services and operations established by the department.

30. "Recipient responsibility" means the amount a recipient of the Basic Care Assistance Program is responsible for to the basic care facility.

The recipient responsibility cannot be offset by outstanding medical bills.

31. "Related by blood or marriage to the owner or manager" means an individual who is a spouse or former spouse of the owner or manager or is a parent, stepparent, grandparent, step grandparent, child, stepchild, grandchild, step grandchild, brother, sister, half-brother, half-sister, stepbrother, or stepsister of the owner or manager of the owner or manager's spouse or former spouse.

32. "Related by the proprietor" means an individual who is a proprietor's spouse or former spouse, or a parent, stepparent, grandparent, step grandparent, child, stepchild, grandchild, step grandchild, brother, sister, half-brother, half-sister, stepbrother, or stepsister, of a proprietor or proprietor's spouse or former spouse.

33. "Remedial care" means services that produce the maximum reduction of an eligible beneficiary's physical or mental disability and the restoration of an eligible beneficiary to the beneficiary's best possible functional level.

34. "Resident" means an individual who has been admitted to the facility, but not discharged.

35. "Resident day" in a facility means any day for which service is provided or for which payment in any amount is ordinarily sought, including medical care leave and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day.

36. "Tenant" means an adult individual who has entered into a lease agreement with an assisted living facility.

37. "Therapeutic day leave" means any day that a resident is not in the facility or in a licensed health care facility other than a medical leave day.

38. "Total income" means countable income.

39. "Would be eligible to receive the cash benefits except for income" refers to an individual whose countable income, less the cost of necessary remedial care that may be provided under this chapter, does not exceed an amount equal to the cash benefit under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] which the individual would receive if the individual had no income, plus sixty dollars.

Income (BCAP) 400-29-60

1. **400-29-60** – Income, manual was updated to reflect IM5186 which increased the personal needs allowance to $100.

Income is the gain or benefit, earned or unearned, derived from labor, business, capital or property that is received or is available to the individual.

Earned income is defined as income earned through the receipt of wages, salaries, commissions, or profit from activities in which an individual is engaged through employment or self-employment. Earned income must entail personal involvement and effort on the part of the applicant or recipient. The household must verify all income.

Unearned income is income not gained by current labor, service, or skill. The types of unearned income include but are not limited to Social Security benefits (Social Security Income (SSI), Social Security Disability benefits, Social Security Survivors benefits), Veterans benefits, private pensions, Workman's Compensation, rental income, and dividends. Interest income from liquid assets will be disregarded.

All income under the Basic Care Assistance program must be counted.

NOTE: This policy differs from Medicaid which states, "The following types of income must be disregarded in determining Medicaid eligibility: Interest or dividend income from liquid assets;" Refer to Medicaid policy – 510-05-85-30, Disregarded Income.

Deemed income actually received is considered countable unearned income.

When there is an SSA or SSI overpayment deducted from the SSI or SSA benefit, follow Medicaid policy Section 510-05-85-05 Income Considerations, "Income that is withheld because of garnishment or to pay a debt or other legal obligation is still considered available. Title II and SSI overpayments being deducted from Title II benefits are normally considered to be available because the applicant or recipient can pursue a waiver of the overpayment. Only if the waiver has been denied after a good faith effort, can the Title II or SSI overpayment deductions be considered unavailable. Occasionally other delinquent debts owed to the federal government may be collected from an individual's Title II benefits. These other reductions of Title II benefits are NOT allowed to reduce the countable benefit amount. The award amount of the Title II benefit is counted as available."

VA – Aid and Attendance payment follows Medicaid policy, Section Unearned Income 510-05-85-15, "Veteran's Administration aid and attendance, Veteran's Administration reimbursements for unusual medical expenses, and Veteran's Administration homebound benefits intended for medical expenses is not considered as income the month it is received. These payments are considered to be medical payments which must be applied towards the recipient's medical cost.

VA – Improved Pension, Medicaid allows the individual to keep $90. Basic Care Assistance, the Improved Pension is counted as income but the

resident can only retain the maximum of ~~$85~~ $100.00 for personal needs per state law.

The policy that Basic Care will follow is below:

Individual Indian Monies (IIM) - Income received from Individual Indian trust or restricted lands will be counted as income. This includes leases on individually owned or restricted Indian lands. The income generally comes from interests in lands allotted to individual Indians many years ago. Income to individual Indians generated by these interests are likely to be small because many of the original interests are allotted lands which have been fractionalized due to the inheritance of multiple heirs over several generations. Incomes included in the accounts are payments from range unit leasing, farm leases, oil leases, oil rental, gravel pit contract, sales, royalties etc.

The Omnibus Budget Reconciliation Act of 1993 provides that up to $2,000 per year of this income must be disregarded. Funds in the IIM accounts that do not have a specific exclusion must be counted for Basic Care. Other moneys deposited in the accounts, such as inheritances, VA, SSA, SSI, gaming profits, etc. are not part of the $2,000 exclusion.

Beginning January 1, 2003, client statement is an accepted verification of the amount in an IIM account unless one of the following applies:

1. The amount is more than $2000 for the year;
2. The client statement information is questionable; or
3. The IIM account includes countable income such as inheritance, bonuses, and other income that is not derived from leases, trust, or restricted land.

Verification Options

There are three options by which verification may be obtained:

1. Request for verification of IIM account information using form SFN 413, Individual Indian Monies Account. This form will need to be notarized per requirements of the United States Department of the Interior, Office of the Special Trustee for American Indians, Office of Trust Funds Management. These releases are valid for one (1) year and must be renewed annually.

2. Individuals with IIM accounts receive statements from the Office of Trust Funds Management on a quarterly basis. A copy of this form may be requested from the recipient. However, the recipient will not receive the statement if the Office of Trust Funds Management does not have a current address.

3. The individual may obtain a statement of their IIM account directly from the Office of Trust Funds Management through the Bureau of Indian Affairs (BIA) by requesting the information in person or by making a telephone request. In both cases, the individual will need to know their account number and provide at least two forms of identification.

At the time of application, verification of the deposits into the IIM account for the 12 month period prior to the month of application must be obtained. Deposits such as inheritances, VA, SSA, SSI, gaming profits, etc. must be deducted and the remaining amount divided by 12 to determine the monthly countable income for the next 12 months.

New Source Income

When new source income is deposited into an individual's IIM account, the countable amount for Basic Care will be determined as follows:

Verification of the IIM account must be obtained for the most recent FULL 12 month period through one of the three options identified above. Once verification of the IIM account is received, any deposits that will not be counted as IIM income will be subtracted (inheritances, VA, SSA, SSI,

gaming profits, etc.). The most current month's countable new source income (or an average if received for multiple months) will be multiplied by 12 and added to all countable deposits for the 12-month period (excluding the new source income deposited into the IIM account). The $2000 disregard will be subtracted and the remaining balance divided by 12 to determine the monthly countable unearned income.

Example #1: In 02/2009, the Eligibility Worker learns that the individual began receiving a new source income in 02/2009 through their IIM account. The Eligibility Worker will request verification of the IIM account for the period of 02/01/2008 thru 02/28/2009 (the most recent FULL 12 month period, plus the current month of 02/2009) to capture the amount of the new source income.

Reviewing the ledger, the Eligibility Worker would determine which income is countable. The new source income deposited in February was $850. Multiplying $850 by 12 equals $10,200. The countable income, not including the new source income, for the FULL 12 month period (02/01/2008 thru 01/31/2009) totals $1,500. The total of income to be considered for the 12 month period is $11,700 ($10,200 plus $1,500). After deducting the $2000 disregarded amount from $11,700, $9,700 must be annualized and the monthly amount of $808.33 counted as unearned income.

Example #2: A new application is received in 07/2009 and the Eligibility Worker requests verification of the IIM account for the period of 07/01/2008 thru 06/30/2009, the most recent FULL 12 month period.

Reviewing the ledger, the Eligibility Worker determines a new source income began to be deposited in 04/2009. The Eligibility Worker would first determine which income is countable. The new source income deposited in April was $850, in May was $790 and in June was $825. The three months of the new source income would be totaled and divided by 3 and the average would be projected for a 12

month period ($2,465 divided by 3 equals $821.67). Multiplying $821.67 by 12 equals $9,860.04. The countable, not including the new source income, for the 12 month period totals $87.29. The total of income to be considered for the 12 month period is $9,947.33 ($9860.04 plus $87.29). After deducting the $2000 disregard from $9,947.33, $7,947.33 must be annualized and the monthly amount of $662.28 counted as unearned income.

Once a determination of the countable income has been made, Basic Care must begin counting the income when received and budgeted consistent with the individual's budget methodology.

Reasonable Payable Rates 400-29-90-05-10

1. **400-29-90-05-10 –** Reasonable Payable Rates, manual was updated to reflect IM5186 which increased the personal needs allowance to $100.

North Dakota Administrative Code 75-02-07.1 requires the Department to establish payable rates for licensed basic care facilities. The Department's Provider Audit Unit conducts an annual review or audit of basic care facility costs. The types of costs are similar to those recognized in nursing facilities.

Each facility's rate is adjusted forward to the beginning of the basic care rate year, July 1. Adjustments include cost of living adjustments to the basic care facility's audited costs. Prior to July 1, the Department establishes the reasonable rate for each facility that chooses to participate in this process.

The payable rate is expressed in terms of a daily rate for personal care and a daily rate for room and board which does not include the provision for a resident's personal needs requirement of ~~$60.00~~ $100.00 per month. This

allowance from a resident's gross income is determined in the budgeting process as set forth in Service Chapter 400-29.

The Department makes all payments on behalf of eligible residents through the Medicaid Management Information System (MMIS). Only those licensed basic care facilities for whom the Department has determined a payable rate may receive a payment.

Resident Payment System 400-29-40-05

2. **400-29-40-05 –** Residential Payment System, manual was updated to reflect IM5186 which increased the personal needs allowance to $100.

The county shall determine the recipient's responsibility for payment toward the room and board expense in a licensed basic care facility. This is accomplished by completing the appropriate screens in the Resident Payment System.

The county must use the Resident Payment System screen(s) each time there is a change in the amount the recipient is required to pay toward the room and board costs in a licensed basic care facility. Notification of any change in recipient responsibility is sent to the basic care facility and to the recipient.

BUDGETING EXAMPLE -- MONTH OF ENTRY INTO A

BASIC CARE FACILITY

Scenario – Mr. Jones entered the basic care facility on August 13th. For the month of August, he had rent expense of $325.00. The deductions in the month of entry are clothing **allowance** of ~~$85.00~~ $100.00, Medicaid level

for one of $750.00, rent expense of $325.00, and the Medicaid Recipient Liability disregard in this case of $128.00. Total deductions for Mr. Jones in the month of entry into the basic care facility equals $1288.00. Mr. Jones has income of $700.00. Following is the example as it would appear in the resident payment system:

GROSS INCOME:		**DEDUCTIONS:**	
SSI:		Clothing/Personal:	~~85.00~~ 100.00
SSA:	700.00		
VA:		MA Level for One:	750.00
OTHER:		Rent:	325.00
		MA RL Deduction:	128.00
TOTAL:	$700.00	Total:	~~$1,288.00~~ $1303.00
Resident Payment Amt:			00.00

Computation: $700.00 income minus ~~$1,288.00~~ $1303.00 deductions equals $0 recipient responsibility towards room and board expense.

In the month of entry, allow the deduction of Medicaid level for one and reasonable living expenses.

BUDGETING EXAMPLE OF AN INDIVIDUAL IN A

BASIC CARE FACILITY

Scenario -- Ongoing case for George Dakota who entered the basic care facility August 29, and the benefit month is December. George receives SSA of $1,033.00 monthly. The deduction allowed is ~~$85.00~~ $100.00 clothing **allowance** (zero Medicaid recipient liability). Following is an example of how the system would budget this situation.

GROSS INCOME:		**DEDUCTIONS:**	
SSI:		Clothing/Personal:	~~85.00~~ 100.00
SSA:	1,033.00		
VA:			
OTHER:			
TOTAL:	$1,033.00	Total:	~~$85.00~~ $100.00

Computation: Income is $1,033.00, minus the allowable deduction of ~~$85.00~~ $100.00 equals the basic care recipient responsibility of ~~$948.00~~ $933.00. The resident is responsible for paying ~~$948~~ $933 to the basic care facility for room and board.

BUDGETING EXAMPLE – TEMPORARY STAY OF LESS THAN SIX MONTHS

Scenario -- Tom Jones is in a licensed basic care facility recovering from surgery. He will return home within six months. Mr. Jones' stay is temporary; therefore, he is allowed additional deductions such as rent, utilities, and the Medicaid level for one. The additional deductions are

allowed in these cases so the individual can maintain their residence while residing temporarily in a basic care facility.

GROSS INCOME:		**DEDUCTIONS:**	
SSI:	129.00	Clothing/Personal:	~~85.00~~ 100.00
SSA:	450.00	MA Level:	750.00
VA:		BC/BS Prc:	319.00
OTHER:			
TOTAL:	579.00	Total:	~~$1,154.00~~ $1169.00

Computation: Monthly Income $579.00, a deduction of ~~$1,154.00~~ $1169.00 leaving a recipient responsibility of $0 for room and board.