

**NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BISMARCK, NORTH DAKOTA
January 20, 2016**

IM 5264

TO: County Social Service Directors
Economic Assistance Policy Regional Representatives
Economic Assistance Policy Quality Control Reviewers

FROM: Carol Cartledge, Director, Economic Assistance Division

SUBJECT: ACA Policy Clarifications and Changes due to
Implementation of SPACES

PROGRAMS: Medicaid and Healthy Steps

EFFECTIVE: February 1, 2016

RETENTION: Until Manualized

**SECTIONS
AFFECTED:** Sections affected for each topic are indicated at the
beginning of each section

This IM includes ACA Policy clarifications and changes due to the implementation of the ND SPACES System and were reviewed during the SPACES System Training held from November 9th through December 4th.

Application and Review

- **510-03-25-05 – ACA Medicaid**
- **510-05-25-05 – Non-ACA Medicaid**
- **510-07-15-05 – Healthy Steps**

Application

The new SPACES System has a Self-Service Portal where applicants and recipients can complete and submit their applications and reviews. An Application or Review submitted through the Self-Service Portal is considered a 'prescribed' application or review form for Medicaid and Healthy Steps. Previously, when a child was in receipt of Healthy Steps and at review or upon request the child became Medicaid eligible, a new application was required.

Effective February 1, 2016, a new application is not required when a child loses eligibility under Healthy Steps, becomes Medicaid eligible, and there is not a break in assistance. However, a Ex Parte (desk) review must be completed.

Review

A review requires the evaluation of all financial and non- financial requirements affecting eligibility, which may include income, household composition, health insurance coverage, cost-effective compliance, alien status, etc. listed in the casefile, reported and verified on the most recent application or review form, and verifications received from all electronic sources. Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if a recipient's Social Security Number has not been verified via interface by the next scheduled review, other action must be taken to verify the Social Security Number.

A review must be completed at least annually for Medicaid and Healthy Steps. It is also permissible to complete an early review of a child's eligibility for Medicaid and Healthy Steps. However, the household may not be required to provide any information that is needed specifically for determining only the eligibility of the Medicaid and Healthy Steps children who were determined to be continuously eligible. The family may voluntarily provide Medicaid and Healthy Steps specific information, but must not be required to do so.

If all factors of eligibility are reviewed and the child is determined eligible for Medicaid or Healthy Steps, a new 12-month period of eligibility would be approved. Since continuous eligibility applies to children eligible for Medicaid and Healthy Steps, should the child be determined no longer eligible for Medicaid and/or Healthy Steps, the child may not be terminated from either at the time of the early review unless the child meets one of the state's exceptions to continuous eligibility, or if the child is found to be eligible for Medicaid. A review would be required at the end of the original 12-month period.

When a review is due, when the individual does not provide the review form or requested information and loses eligibility, if the renewal form and all information to determine eligibility is submitted within 90 days after the termination, **the case must be reverted to open** and eligibility must be reconsidered back to the termination date.

Example: A case closed June 30 as the household did not submit their review, which was due in June. On September 5th, the household provided their Review Form and verification of income and expenses for July and August. Since the household provided the review form and all verifications within 90 days, eligibility must be determined back to the 1st day of the month following the month the case closed, July 1st.

When the review form is received during the 90 day period but does not include verification for one or more of the months during the 90 day period:

- If the verification is not received for any month other than the month the review is received or the month prior to the month the review was received, the review must be completed and eligibility determined for the months the information was received. The months in which the verifications were not received must be determined 'not eligible'. Should the individual provide the verifications during the 12 month period after the month that was determined ineligible, eligibility can be determined.

Note: Regardless of when the review is received during the 90 day period, if the child is determined eligible for Healthy Steps, eligibility can only be reinstated effective the 1st day of the month following the month of the determination.

- If the verification is not received for the month the review was received or the month prior to the month the review was received, but was for any month between the case closure and review receipt date, eligibility can be determined for the month(s) the information was received. However, the case must be closed at the end of the month for which the verifications were received.

Note: If any children were determined 'CE' eligible, they will remain eligible. However, the caretaker's eligibility would end.

If a household submits an incomplete review on or after the 85th day after case closure for 'Non-Receipt' or 'Incomplete' review, a notice is not required to be sent to the household. However, an attempt to contact the household (by telephone or email, if applicable) must be made. If the information is not received by the 90th day the case will remain closed and a new application must be mailed to the household along with information explaining the need to reapply. Documentation of the Eligibility Workers Actions must be included in the electronic narrative.

Note: If the Eligibility Worker sends a notice requesting the information, the household must be allowed 15 days to provide the requested information. The period of time to submit the information must be honored, even if it exceeds the 90th day.

When the review form is received after the 90th day, the case will remain closed and a new application must be sent to the household along with information explaining the need to reapply.

Passive Reviews: A Passive Review is a process in which the recipient is only required to report changes in their circumstances. If there are no changes, the recipient/household is not required to confirm, verify or respond to the review form/notification.

The county agency must make a review of eligibility without requiring information from the ACA individual or ACA Medicaid household if able to do so based on reliable information available in the individual's account or other more current information available such as through any available ~~data-bases~~ electronic verification sources.

Review forms will be mailed to the household 15 calendar days prior to the month the review is due (e.g. if the review is due in January, the form will be mailed December 15th). The form will be pre-populated with the information known to the Department as entered into the SPACES system. The household is instructed to update any information that has changed, enter any new information that is not reflected on the review form, and return the review form by the 1st day of the month in which the review is due.

The review form is not required to be returned to the county office. It is a tool used to communicate information between the county and the recipient/household. An adverse action **cannot** be taken simply because the review form was not returned, completed or signed.

1. If a review is returned as undeliverable, the reason for the return and the information provided by the post office must be treated as a change in circumstances.
 - a. If the returned document includes a forwarding address in North Dakota:
 - i. Update the case address in the system;
 - ii. Re-mail the form to the new address;
 - iii. Send a notice requesting verification of the change in address.
 - iv. Narrate the action taken.
 - b. If the returned document includes a forwarding address outside of North Dakota:
 - i. Update the household address and state residency in SPACES;
 - ii. Close the case; and
 - iii. Send notice of adverse action to the new out-of-state address.
 - iv. Narrate the action taken.
 - c. If the returned document does not include a forwarding address:
 - i. Close the case for loss of contact
 - ii. Send an adequate notice of adverse action to the last known address.
 - iii. Narrate the action taken.

2. If the review form is not received by the 1st day of month it is due, an alert will be given informing the Eligibility Worker to complete a Passive Review. To complete the Passive Review:
- a. The household's details and income must be verified through the available electronic verification source(s); and
 - b. A determination of reasonable compatibility of the existing information and the verified information must be completed. (See the Reasonable Compatibility Section below)
 - i. If the information is determined to be "reasonably compatible", continued eligibility must be determined.

Once the eligibility determination has been made, the household must be notified of the results, the basis of the determination, and the need for the household to inform the county social service office of any information contained in the notice that is inaccurate.
 - ii. If the information is determined NOT to be "reasonably compatible", a 'Request for Verification' notice must be sent to the household reminding them to submit their review form, verification of the inconsistent information and any other information necessary to complete the review.
 - iii. If the information is not received by Advance Notice Deadline, will an automatic closure notice will be sent to the household due to failure to provide the necessary information to complete the review.
 - iv. If the information is not received by the last day of the month the review is due, the case will close and the 90 day provision will apply.

Income Compatibility

- **510-03-85 (new Section will be added)**
- **510-07-40 (new Section will be added)**

Background

Provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA) require states to rely as much as possible on electronic data sources when verifying information provided by applicants or recipients. Federal regulations restrict states from requesting verification from applicants or recipients unless the verification cannot be obtained through an electronic data source, or information from the data source is not "reasonably compatible" with what the applicant or recipient has reported.

Available Electronic Verification Sources

The Centers for Medicare and Medicaid (CMS) have defined electronic verifications received from the following sources to be valid when determining reasonable compatibility for health care:

- ND Child Support (FACSES)
- ND State Directory of New Hires
- ND Job Service Unemployment Insurance Benefits
- ND Job Service Wage information, including the Quarterly Wage Verification
- Other Benefit Information (SSA and SSI Income)
- PARIS Interface

In addition, effective February 8, 2016 North Dakota will connect to the Federal Data Services Hub (FDSH) in order to obtain real-time verification of earnings based on data from Equifax (previously known as TALX or The Work Number). This verification service is available to states free of charge through the FDSH and can ONLY be used to determine eligibility for Health Care Coverage Programs.

Note: Information received through the Federal Data Services Hub (FDSH) can ONLY be used to determine eligibility for Medicaid or Healthy Steps.

Reasonable Compatibility

For purposes of this section, verification of income from all data sources is "reasonably compatible" if it results in the same eligibility outcome as member-reported information from those same sources. "Reasonable Compatibility" must be applied to each category of income; earned and unearned, as well as each source of income.

Note: When determining 'reasonable compatibility' of income, the most recent verification of income from electronic sources must be used.

Verification of income CANNOT be requested from an applicant or recipient unless the information cannot be obtained through an electronic data source, or information from the data source is not "reasonably compatible" with what the applicant or recipient has reported.

Exception: 'Reasonable compatibility' does not apply to THMP months. Refer to policy at 510-03-90-60.

If at the time an individual applies for or submits a review for Medicaid or Healthy Steps the individual also applies for or submits a review for another program:

- Any income verifications requested and received as a result of the application or review of the other program shall be used to determine eligibility for Medicaid and "reasonable compatibility" does not need to be determined.

- If the income verifications requested as a result of the other program are not received, "reasonable compatibility" must be determined based on information the individual reported and the verifications received through the electronic sources.

If an individual has multiple income types and sources, "reasonable compatibility" must be determined for each type and source, and the highest amount from each type and source must be used to determine eligibility.

At application, the quarterly earned income verification will NOT have been received from the electronic data source of ND Job Service. Therefore, this source cannot be used to determine 'reasonable compatibility' at application.

At review, the quarterly earned income verification returned from the electronic data source of ND Job Service, MUST be used and is NOT permitted to be disregarded when applying the "reasonable compatibility" policy because of concerns about the accuracy of the data even though the information is not timely.

- When applying "reasonable compatibility" for verification for the most recent calendar quarter for which ND Job Service has reported, to arrive at a monthly amount to use for the reasonable compatibility test, divide the quarterly amount from each source by 13 and multiply by 4.3.

Exception: Income received on a monthly basis will not be converted.

1. When determining 'reasonable compatibility' for earned income other than self-employment:
 - a. If both the electronic data sources and the member-reported information for the same source results in the individual's total countable income being below the individual's budget unit income level, the two data sources are considered to be "reasonably compatible" and further verification may not be requested or required. The higher of the two amounts will be utilized.

Note #1: Allowable expenses must be deducted from both the client statement of income and the electronic source of income before doing the reasonable compatibility test.

Note #2: The calculation used to determine 'reasonable compatibility' MUST be narrated in the casefile.

Example #1: Joe is age 25 and single with an income limit of \$1,353.00 per month. At review, he reports that he works at Menards. He states his earnings are \$500/month. Job Service quarterly wage verification reports that his quarterly earnings from

Menards are \$2,659.72. To determine his monthly amount from the Job Service wage verification, divide \$2659.73 by 13 and multiply by 4.3. This results in verification of his monthly income of \$879.75 . Since both his self-declared income and the Job Service ND verified income is below his budget unit income level, his reported income is considered to be "reasonably compatible" with the Job Service wage verification and must be used. The highest monthly income amount of \$879.75 would be used to determine his eligibility, without requesting additional verification.

Example #2: A new application is received for Barb, who is age 31 and single. Barb reports she is employed at Kohl's and earns \$1,250 per month. Since Barb is a new applicant, search of the electronic source Job Service will not provide any response. Therefore, 'reasonable compatibility' cannot be determined and verification of wages must be requested from Barb.

Note: If the electronic source of Equifax received through the Federal Data Services Hub (FDSH) provided verification of Barb's wages from Kohl's, 'reasonable compatibility' must be used to determine Barb's eligibility.

- b. If both the electronic data source and the member-reported information results in the individual's total countable income being above the individual's budget unit income level, the two data sources are considered to be "reasonably compatible" and further verification may not be requested or required.

Note #1: Allowable expenses must be deducted from both the client statement of income and the electronic source of income before doing the reasonable compatibility test.

Note #2: The calculation used to determine 'reasonable compatibility' MUST be narrated in the casefile.

Example #1: Melanie is age 27 and single with an income limit of \$1,353.00 per month. At review, she reports that her earnings from her job at Walmart increased to \$1,500 per month. The Job Service quarterly wage verification reports that her quarterly earnings for the most recent quarter from Walmart are \$4,500 resulting in a monthly amount of \$1488.46 (\$4,500/13 X 4.3). Since both amounts exceed her budget unit income level, the income she declares is considered 'reasonably compatible' with the Job Service quarterly wage verification and the agency must use the higher of the two amounts, \$1,500 per month, without requesting additional verification. Melanie is not eligible for Medicaid and her case would be closed without requesting any further verification.

Example #2: A new application is received for Brady, who is age 40 and single. Brady reports he is employed at Target and earns \$1,925 per month. Since Brady is a new applicant, search of the electronic source Job Service will not provide any response. Therefore, 'reasonable compatibility' cannot be determined and verification of wages must be requested from Brady.

Note: If the electronic source of Equifax received through the Federal Data Services Hub (FDSH) provided verification of Brady's wages from Target, 'reasonable compatibility' must be used to determine Brady's eligibility.

- c. If verification from the electronic data source puts the individual's total countable income above the individual's budget unit income level, but the member-reported information puts the individual's total countable income below that level (or vice versa), the two data sources are not "reasonably compatible" and further verification is required in order to determine eligibility.

Note #1: Allowable expenses must be deducted from both the client statement of income and the electronic source of income before doing the reasonable compatibility test.

Note #2: The calculation used to determine 'reasonable compatibility' MUST be narrated in the casefile.

Example 1: Lynn is age 34 and single with an income limit of \$1,353.00 per month. At review, he reports that his earnings are \$1,100/month from Lowes. Job Service quarterly wage verification reports that his quarterly earnings from Lowes are \$4,925.85. To determine his monthly amount from the Job Service wage verification, divide \$4,925.85 by 13 and multiply by 4.3, which results in monthly income of \$2,066.95. Since there is a difference in the eligibility outcome when applying the Job Service wage reported income, Lynn's reported information is not considered to be "reasonably compatible", and the agency must request additional verification from Lynn in order to determine eligibility.

Example 2: Michelle applies for herself and her two children. She reports that she started a job last month at the Walmart and is earning \$1,400/month. Since this is a new application, the quarterly Job Service wage verification is not available and the reasonable compatibility test cannot be performed. Michelle will be required to verify her earnings.

Note: If the electronic source of Equifax received through the Federal Data Services Hub (FDSH) provided verification of Michelle's

wages from Walmart, 'reasonable compatibility' must be used to determine Michelle's eligibility.

- d. If the electronic data source does not provide verification of income from the same source as what the member reported, the two data sources are not "reasonably compatible" and further verification is required in order to determine eligibility.

Note #1: Allowable expenses must be deducted from both the client statement of income and the electronic source of income before doing the reasonable compatibility test.

Note #2: The calculation used to determine 'reasonable compatibility' MUST be narrated in the casefile.

Example: Charlie is age 45 and reports at review he is employed by Scheel's and earns \$1,400/month. The Job Service quarterly wage verification shows Charlie had \$6000 for the most recent quarter from West River Feed. Since the source of the Job Service verification does not match the source of Charlie's reported earnings, 'reasonable compatibility' does not apply and Charlie will need to provide verification of his income in order to determine his eligibility.

Note: If the electronic source of Equifax received through the Federal Data Services Hub (FDSH) provided verification of Charlie's wages from Scheel's, 'reasonable compatibility' must be used to determine Charlie's eligibility.

2. When determining 'reasonable compatibility' for unearned income:
- If the source of the income reported matches the source verified through the available electronic sources and the amounts are considered "reasonably compatible", further verification cannot be requested from the applicant or recipient. If verification cannot be obtained through the electronic source, the individual must provide documentation of the unearned income.

Note: The calculation used to determine 'reasonable compatibility' MUST be narrated in the casefile.

When determining 'reasonable compatibility' for self-employment income, the income must be verified based on current policy.

ACA Eligible Individuals Health Care Coverage

• 510-03-30-20 (New Section)

Individuals determined eligible under ACA Medicaid are assigned their Health Care Coverage under either Traditional Medicaid or the Alternative Benefit Plan (ABP), which is currently provide through Sanford Health Plan (SHP).

- Individuals who have their coverage under Traditional Medicaid are:
 1. Eligible children under age 19.
 2. Eligible parents and caretaker/relatives of deprived children under age 18 (through the month the child attains age 18) and their spouses with income below 54% of the FPL.
 3. Eligible parents and caretaker/relatives of deprived children under age 18 (through the month the child attains age 18), their spouses and children who are eligible as Transitional or Extended Medicaid.
 4. Eligible pregnant women with income below 147% of the Federal Poverty Level (FPL) and for the duration of the 60 free day period.
 5. Eligible foster care children.
 6. Eligible Former Foster Care children.
 7. Eligible individuals who have been approved for the Medicaid Women's Way Treatment Program and whose income is greater than 138% and less than 200% of the FPL.
 8. Medically Needy eligible pregnant women, children under age 19 (through the month they attain age 19) and parents/caretaker relatives of deprived children under age 18 and their spouses.
- Individuals who have their coverage under the Alternative Benefit Plan (ABP), which is currently provided through Sanford Health Plan (SHP) are:
 1. Eligible individuals between the ages of 19 (month following the month of their 19th birthday) and 65 (month prior to the month of their 65th birthday).
- Individuals who have the option to receive either the Traditional Medicaid Coverage or receive their coverage through the Alternative Benefit Plan (ABP), which is currently provided through Sanford Health Plan (SHP) are:
 1. Eligible adults who meet the Medically Frail criteria;
 2. Eligible individuals who have been approved for the Medicaid Women's Way Treatment Program and whose income is less than 138% of the FPL.

3. Eligible women who become pregnant while they are covered through the Alternative Benefit Plan (ABP), which is currently provided through Sanford Health Plan (SHP).

Age and Identity

- **510-03-35-40**

- c. Reasonable Opportunity Period. Applicants who claim they are U.S. citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual's eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual's eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

A 'reasonable opportunity period' is defined as ~~150~~ 90 days from the date the application is submitted and for the remaining days of the month in which the ~~150~~ 90th day falls.

An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence they have been making a good faith effort to obtain the verifications, but still have not received them.

A reasonable opportunity can only be allowed once for any individual. If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated, a second reasonable opportunity period is not allowed at a later application.

Citizenship and Alienage

- **510-03-35-45**

- e. Reasonable Opportunity Period. Applicants who claim they are U.S. Citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility

while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual's eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual's eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

A 'reasonable opportunity period' is defined as ~~150-90~~ days from the date the application is submitted and for the remaining days of the month in which the ~~150~~ 90th day falls.

An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence they have been making a good faith effort to obtain the verifications, but still have not received them.

A reasonable opportunity can only be allowed once for any individual. If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated, a second reasonable opportunity period is not allowed at a later application.

Social Security Numbers

- **510-03-35-80**
- **510-07-25-50**

1. A valid social security number (SSN), or verification of application for SSN, must be furnished as a condition of eligibility, for each individual for whom Medicaid or Healthy Steps benefits are sought except the following individuals do not have to provide a SSN, or verification of application for SSN:
 - a. An individual who is currently eligible for Transitional or Extended Medicaid Benefits;
 - b. An illegal alien who is seeking emergency services. (See 510-03-35-70 for a description of emergency services.);
 - c. An individual who is determined eligible under Hospital Presumptive Eligibility (HPE); and
 - d. A newborn child who is eligible during the birth month, for the first sixty days, beginning on the date of birth and for the remaining days of the month in which the sixtieth day falls, or if the newborn is continuously eligible, for the remaining days of the newborn's first eligibility period;

Note: If a newborn is NOT eligible in the birth month, but is eligible for months following the birth month an SSN or Application for SSN is required.

When the exempt period ends, a social security number or verification of application for SSN must be provided to continue Medicaid or Healthy Steps coverage.

Members of the ACA Medicaid or Healthy Steps household who are not seeking coverage may voluntarily provide their SSN; however, they are not required to do so.

Cooperation - Child Support

• 510-03-40-15

Cooperation with Child Support is required for all legally responsible caretaker relatives for the purpose of establishing paternity and securing medical support, with the following exceptions:

1. Pregnant women while pregnant and through the month of the sixtieth post-partum day. A pregnant woman must be informed of this exception at the time of application or, in the case of a recipient, at the time the pregnancy becomes known. When Child Support is informed that an applicant or recipient is pregnant, Child Support services will continue to be provided; however, any non-cooperation by the pregnant woman will not affect her eligibility for Medicaid.
2. Caretaker relatives who are recipients of Extended Medicaid Benefits and Transitional Medicaid Benefits.
3. Caretaker relatives under age 19 who are within a continuous eligibility period.
4. Parent/Caretaker relatives of subsidized adoption children.
5. Parent/Caretaker relatives of deprived children who are not requesting Medicaid for themselves.
6. Caretaker relatives of deprived children where all the children in the household are eligible to receive services through Indian Health Services (IHS).
7. Caretaker relatives who have a pending or approved "good cause" claim.

Cooperation with Child Support may be waived for "good cause"

- **510-03-40-20**

The determination of whether a legally responsible caretaker relative is cooperating is made by the Child Support Agency and the caretaker has the right to appeal that decision. Legally responsible caretaker relatives who are required to but do not cooperate with Child Support will not be eligible for Medicaid. Children in the Medicaid household, however, remain eligible.

With the implementation of the Affordable Care Act, the request for information regarding an absent parent cannot be made prior to the Medicaid eligibility determination. Therefore, upon authorization of eligibility for a legally responsible caretaker relative who is required to cooperate with child support, a 'Request for Absent Parent Information' form will be sent to the caretaker. The caretaker will have 10 days to complete and return the form to the Eligibility Worker.

- If the caretaker does NOT return the completed form within 10 days, the Child Support Division automatically deems the caretaker to be non-cooperating and the caretaker's eligibility for Medicaid ended due to this non-cooperation. A 10-day Advance Notice is required.
- If the caretaker returns the completed form, the Eligibility Worker MUST enter the information provided by the caretaker immediately, but no later than 25 days from the date the form was mailed to the caretaker.

Twenty-five (25) days from the date the form was mailed to the recipient, information for the case will be sent to the Child Support Agency. Until the electronic interface with CSEA is implemented, the CSEA will offer services to Medicaid families who are interested in receiving services and who are likely to cooperate.

Note: At the time the electronic interface with CSEA is implemented, updated information will be provided.

When a legally responsible caretaker relative is not eligible because of non-cooperation, the earned and unearned income of that ineligible caretaker must be considered in determining eligibility for the child(ren).

Should the caretaker return the form at a later date, the CSEA automatically deems the caretaker to be cooperating and the caretaker's eligibility can be restored effective the first day of the month in which the form was returned.

~~If a previously non-cooperating legally responsible caretaker relative begins cooperating in an open Medicaid case, and the caretaker is otherwise eligible, that caretaker's eligibility may be reestablished. The caretaker must demonstrate that they are cooperating with Child Support before Medicaid~~

~~coverage can be reestablished. When the caretaker previously stopped cooperating, the automated referral to Child Support ended.~~

- ~~a. If the child Support Enforcement case also closed, the caretaker must apply for Child Support services and fulfill the cooperation requirements as determined by the Child Support program (parents or other legal custodians/guardians can apply online at www.childsupportnd.com or mail a completed application to a Child Support office. Applications can be printed from the web or requested directly from a Child Support office).~~
- ~~b. If the Child Support Enforcement case did not also close, the caretaker may begin to cooperate with Child Support without application and confirmation of such can be secured by contacting the Child Support worker.~~

~~When child Support has confirmed that the caretaker is cooperating, Medicaid coverage for that caretaker can be reestablished beginning with the first day of the month in which the caretaker began cooperating.~~

~~(Confirmation of cooperation must be secured by communicating with the Child Support worker; confirmation of cooperating may not be determined based on the Cooperation indicator on the Fully Automated Child Support Enforcement System (FACSES).) Child Support has 20 days to process an application for services. However, typically, applications are processed more quickly than 20 days, and Child Support can be contacted as soon as an open case can be viewed in FACSES.~~

~~If When a previously non-cooperating legally responsible caretaker relative reapplies for Medicaid after the Medicaid case closed, the caretaker relative is eligible for Medicaid until it is again determined that the caretaker relative is not cooperating.~~

Income Conversion

- **510-03-85-20**

For purposes of this section:

'Biweekly' is defined as receiving earnings every two weeks.

Example: Individual receives a paycheck every other Monday.

In cases where income, (both earned and unearned) is received either weekly or biweekly, income must be converted when determining the household's countable income.

1. To convert earnings received weekly, total the weekly checks and divide by the number of checks (4 or 5) to arrive at the weekly average. The weekly average is then multiplied by 4.3.

2. To convert biweekly earnings, total the biweekly checks and divide by the number of checks (2 or 3) to arrive at the biweekly average. The biweekly average is then multiplied by 2.15.

If tips, commissions, bonuses or incentives are paid or reported weekly or biweekly and are included in the gross income on the weekly or biweekly paycheck or pay stub, they are converted.

If tips, commissions, bonuses or incentives are paid or reported weekly or biweekly and are included on the paycheck or pay stub, but not in the gross income and the paychecks are received weekly or biweekly, they must be added to the gross income and converted.

If tips, commissions, bonuses or incentives are not paid weekly or biweekly, they are not converted. The tips, commissions, bonuses or incentives must be counted separately as earned income.

- Cash tips received daily and reported monthly are not converted.
- Tips paid in a separate check that is not paid weekly or biweekly are not converted.
- A household reports June 20 that a member started a new job and received the first paycheck on June 25th and is paid every Wednesday. Income for the month of application is not converted (June) because the individual did not receive income each Wednesday in June. Actual anticipated income is used for June. Income is converted for July.
- A household reports on May 10 that a household member lost their job on May 9 and will receive a final paycheck on May 16. When calculating eligibility for May, the income for this household member is not converted, as the individual will not receive income each week in May. No income can be anticipated from this job for June.

Effective with applications received on or after February 1, 2016, when determining eligibility for Three Prior (THMP) months, income must be verified for each of the three prior months, and actual, verified income must be used. Income is not converted in THMP months. ~~and then converted in accordance with the income conversion rules.~~

Budgeting Procedures for Three Prior Months (THMP)

- **510-03-90-60**

When establishing eligibility for the three calendar months prior to the month in which the signed application was received, all factors of eligibility must be met during each month of retroactive benefits.

Retroactive eligibility may be established even if there is no eligibility in the month of application.

Budgets must be calculated for each of the three prior months, based on actual, verified income. ~~and then converted in accordance with the income conversion rules.~~

Exception: If the only eligible household members are children who were determined continuously eligible in one of the THMP months, budgets do not need to be calculated for any of the THMP months following the month the child became continuously eligible.

All case records shall be documented to reflect eligibility or ineligibility for each individual month assistance is requested prior to and through the month in which the application is processed.

Hospital Presumptive Eligibility (HPE)

- **510-03-60 – (new Section will be added)**

General Statement for Hospital Presumptive Eligibility (HPE)

The Affordable Care Act of 2010 requires states to implement policy and procedures to allow qualifying hospitals to make presumptive Medicaid eligibility determinations, also referred to as HPE. HPE offers a streamlined, expedited path to coverage for individuals in all states and allows clients to receive temporary Medicaid coverage while their eligibility is being determined for ongoing Medicaid.

Individuals do not need to be hospitalized to apply for HPE coverage. However, they can only apply for HPE coverage through qualifying hospitals approved to make HPE determinations.

Application and Review for Hospital Presumptive Eligibility (HPE)

A qualifying hospital must assist an individual who requests to apply for HPE coverage through the ND Self-Service Portal. The applicant need not be hospitalized in order to apply for HPE coverage. However, the applicant, an authorized representative or, if the applicant is incompetent or incapacitated,

someone acting responsibly for the applicant must sign the application. The ND SPACES system will make the HPE eligibility determination.

The applicant must provide all information the hospital needs to determine HPE eligibility. The HPE determination is based on the applicant's declaration; no verifications are needed.

In order for coverage to continue beyond the month following the month the HPE coverage will end, the individual must complete and submit one of the prescribed applications defined in section 510-03-25-05. If a completed Medicaid application is not submitted by the last day of the final month of HPE eligibility, the HPE eligibility period ends on that date.

Individuals Covered Under Hospital Presumptive Eligibility (HPE)

HPE may be determined for Medicaid only, for the following individuals:

1. Children under age 19 (through the month they attain age 19);
2. Former Foster Care Individual;
3. Parents and Caretaker/relatives;
4. Pregnant Women;
5. Medicaid Expansion Group ages 19 (month following the month they attain age 19) through 64 (month prior to the month the individual attains age 65);

Eligibility Requirements for Hospital Presumptive Eligibility (HPE)

In order to be eligible for coverage under HPE, the following must be attested to for each household member who is requesting assistance:

- US Citizen, US National, or Eligible Immigrant status; and
- ND residency; and
- Gross income amount; and
- Whether or not each applicant is currently enrolled in Medicaid; and
- Applicant(s) do not have any other health insurance coverage that meets the Minimal Essential Coverage definition.

Budgeting for Individuals Applying for Hospital Presumptive Eligibility (HPE)

Budgeting provisions for those eligible under HPE are defined at 510-03-90.

Hospital Presumptive Eligibility (HPE) Periods

HPE begins on the day the HPE eligibility determination is made and does not begin retroactive to the first of the month of the HPE Application. If determined eligible, the individual will remain eligible through the month following the month the HPE eligibility determination was made.

Example: Jane applies for and is found eligible for HPE coverage on January 10th. Jane's HPE eligibility period will be authorized for January 10th through February 28th.

When an application for ongoing Medicaid coverage has not been submitted, HPE ends on the last day of the month following the month the HPE eligibility determination is made,.

Example: Tyler applies for and is found eligible for HPE coverage on January 25th. His HPE eligibility period is authorized for January 25th through February 28th.

When an application for ongoing Medicaid coverage has been submitted, HPE ends on the date a full determination is made. If the individual requested eligibility for any of the THMP months based on the full application, eligibility must be determined for each month requested. In addition, if more time is needed to make a full determination of eligibility, the Eligibility Worker must grant a month by month extension of HPE coverage until the full determination is made.

- If eligible, the individual's eligibility may change from HPE to Traditional or Expansion Medicaid coverage.
- If not eligible, the individual's eligibility will remain unchanged.

Example #1: Sophie applies for and is found eligible for HPE coverage on January 25th. Her HPE eligibility period is authorized for January 25th through February 28th.

On February 15th, an application is received at the county and a full determination is made. The determination results in Sophie being determined eligible for Medicaid for the application month and ongoing. In addition, Sophie requested and was found eligible for the THMP month of January.

- For February and ongoing, Sophie's eligibility will change from HPE to Traditional Medicaid.
- For January, Sophie's eligibility will change from HPE to Traditional Medicaid.

Example#2: Mary applied for and was approved for HPE coverage on January 19th. Her HPE eligibility period was authorized for January 19th through February 28th.

On February 25th, a full application is received. The eligibility for the full application cannot be made in February as additional information is needed. Therefore, the worker must authorize an additional month of HPE eligibility. Thus the HPE eligibility end date changes from February 28th to March 31st.

On March 18th, the worker receives all of the information needed to make a full determination.

- If eligible, Mary's eligibility for March will change from HPE to Traditional Medicaid.
- If not eligible, Mary's HPE eligibility must end on March 18th.

Individuals are only eligible for one (1) period of HPE period per calendar year with the exception of an individual who is pregnant. Pregnant Women can receive HPE coverage once per pregnancy.

Coverage under Hospital Presumptive Eligibility (HPE)

Individuals eligible under HPE will receive full coverage of medical expenses based on the North Dakota Medicaid State Plan with the exception of Pregnant Women. Pregnant Women are not eligible for inpatient hospital services.

Three Months Prior Coverage Under Hospital Presumptive Eligibility (HPE)

Individuals applying for eligibility under HPE cannot request coverage for the three months prior period. In order to request coverage for the three prior months, the individual must submit a full application and request the three prior months on the full application.

Appealing a Hospital Presumptive Eligibility (HPE) Determination

The standard notice and appeal rights do not apply to HPE decisions.

Hospital Responsibility under Hospital Presumptive Eligibility (HPE)

Qualifying hospitals must be willing to abide by state policies and procedures to immediately enroll individuals who are likely eligible under a state's Medicaid eligibility guidelines for a temporary period of time. Each qualifying hospital has the choice to make HPE determinations, and if they choose to, the qualifying hospital and their designee's must:

1. Offer HPE to individuals without Medicaid or other health care coverage; and
2. Assure timely access to care while the HPE application and eligibility determination is made; and

3. Ensure all individuals designated to assist and complete HPE applications follow the regulations set forth for HPE; and
4. Provide the individual with the HPE determination notices; and
5. Inform individuals at the time of the HPE determination that in order to obtain Medicaid coverage beyond the HPE period they must file a full Medicaid Application.
6. Inform, recommend and assist individuals with completing and submitting a full application for Medicaid/Children's Health Insurance Program (CHIP) or subsidized insurance through the Federally Facilitated Marketplace; and
7. Meet the Performance Standards as listed below; and
8. Ensure the individual responsible for managing the Hospital's HPE and their designee's (person's assisting and completing HPE applications) attend all HPE Policy training provided by the Medicaid Eligibility Policy Unit of the North Dakota Department of Human Services and keep current with changes affective HPE through various means of communication, including but not limited to the following:
 - a. Participate in all in-person, telephone conference, webinar or computer-based HPE training sessions;
 - b. Read all information provided regarding updates and changes to HPE.
9. Provide, upon request, verification that all members listed in #8 above have completed the training.

Effective September 1, 2016, all qualifying hospitals will be required to meet ongoing performance standards in order to remain a Qualified Hospital. These standards include:

- Ninety-five percent (95%) of individuals that have an HPE determination made were not enrolled in Medicaid at the time the HPE determination was made.
- Ninety percent (90%) of individuals determined presumptively eligible by the hospital submit a full application during the HPE period;
- Eighty-five percent (85%) of individuals approved for Hospital Presumptive Eligibility, who submitted a full application during the HPE period, are subsequently determined eligible for Medicaid based on the full application.

Qualifying hospitals who do not meet the standards listed above for three (3) consecutive months will be required to participate in additional training and/or other reasonable corrective action measures provided by the North Dakota Department of Human Services. If after participation in the additional training or other reasonable corrective action measures the hospital continues to fail to meet the standards for two additional (2) consecutive months, action will be taken to disqualify the hospital under this section.

If you have questions, please contact your Regional Representative.