NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BISMARCK, NORTH DAKOTA
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IM 5372

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

FROM: Michele Gee, Director, Economic Assistance

SUBJECT: Healthy Steps Changes

PROGRAMS: ACA Medicaid

EFFECTIVE: January 1, 2020

SECTIONS AFFECTED:
510-03-05 Definitions
510-03-12 Third Party Liability
510-03-10-15 Confidentiality
510-03-25-05 Application and Review
510-03-25-10 Eligibility – Current and Retroactive
510-03-25-25 Decision and Notice
510-03-30-05 Groups Covered Under ACA Medicaid
510-03-30-15 Assigning Category of Eligibility
510-03-35-15 Caretaker Relatives
510-03-50-05 Transitional and Extended Medicaid Benefits
510-03-50-10 Extended Medicaid Benefits
510-03-85-25 Income Compatibility
510-03-95-10 Healthy Steps
510-03-95-20 Refugee Medicaid Assistance Program
510-03-105 Reference Hard Cards

Definitions 510-03-05

Advance Payments of the Premium Tax Credit (APTC)

Individuals who are not eligible for Medicaid ~~or Healthy Steps~~ under the Affordable Care Act, may be eligible for tax credits for the health care insurance premiums they pay out of pocket.

Federally Facilitated marketplace (FFM)

The web portal through which Americans may choose a qualified health plan, and be assessed for possible eligibility for Medicaid~~, Healthy Steps~~ or Advance Premium Tax Credits (APTC).

~~Healthy Steps~~

~~An insurance program, for children up to age 19, administered under North Dakota Century Code Chapter 50-29 and Title XXI (CHIP).~~

MAGI-based Methodology

The method of determining eligibility for Medicaid ~~and Healthy Steps~~ that generally follows Modified Adjusted Gross Income rules. It is not a line on a tax return, rather a combination of household and income rules.

Minimum Essential Coverage

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act (ACA). This includes individual market policies, job-based coverage, Medicare, Medicaid, ~~CHIP (Healthy Steps),~~ TRICARE and certain other coverage.

Optional Children's Group

Coverage for children up to age 19 who do not have other health insurance coverage.

Title XXI

For eligibility months prior to January 1, 2020, Title XXI of the Social Security Act (Healthy Steps).

For eligibility months on or after January 1, 2020, Title XXI of the Social Security Act (Optional Children's Group).

Third Party Liability 510-03-12

Individuals applying for coverage under ACA Medicaid may have other insurance coverage except for individuals eligible under ~~Healthy Steps~~the Optional Children's Group (COE 078). ~~and Maintenance of Effort (COE 095).~~

There is no penalty for individuals who drop their Health Insurance coverage when they apply for ACA Medicaid, with the exception of those determined eligible under ACA Healthy Steps through December 31, 2019.

Effective January 1, 2020, the penalty for dropping Health Insurance Coverage will no longer be effective.

Confidentiality 510-03-10-15

All applications, information and records concerning any applicant or recipient of Medicaid shall be confidential and shall not be disclosed or used for any purpose not directly connected with the administration of the Medicaid ~~or Healthy Steps~~ program~~s~~. Application, information and records may not be released to elected officials or to any other person not directly connected with the administration of the Medicaid ~~or Healthy Steps~~ program~~s~~. Refer to Service Chapter 448-01-25 for additional guidelines.

1. Federal law and regulations:

   Federal law and regulations require that the State Plan have protections in place to ensure that the use or disclosure of information concerning applicants and recipients be limited to purposes directly connected with the administration of the plan. Those purposes include establishing eligibility, determining the amount of medical assistance, providing services, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. (42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300-306).

   > **NOTE:** Information from certain sources may not be released, even with a signed release form. For details see 448-01-25-10-05 "Confidential Information that Must Not be Released".

   Since there are many federal requirements when releasing client information, it is recommended that the SFN 1059, Authorization to Disclose Information, be used, as this form was developed to meet all of those requirements. If any other form is used, contact State Medicaid Policy to confirm that it meets federal requirements.

2. Sharing income, household composition, etc. information with social work staff:

   Information cannot be released unless the applicant or recipient has authorized the release of information (form or verbally).

3. Sharing information with Social Workers for investigations of abuse, neglect, or protective services:

    a. Information requests by social workers are not made for the purpose of administration of Medicaid, but are with regard to abuse investigations. The family may not be receptive, but that is not a valid reason to release the information. A signed release is necessary to share specific information about the child/family.

    b. 'Protective Service Alerts' from the North Dakota Department of Human Services, Children and Family Services (CFS) Division and other States are often sent to all county staff. These alerts request information regarding the family's whereabouts. These alerts, do not fall under 'administration of the Medicaid program' so specific information cannot be released. However, it is allowable to disclose the county and state in which the individual is residing and the county social service office that may be contacted for child protective service information, to the requestor as well as to their own county child protective service unit.

    Any additional information, including 'How eligibility staff knows this information' or 'The family has applied or is receiving services' may not be disclosed.

4. Sharing information with Child Support and other specific assistance programs:

    a. Can share information with Child Support as federal regulations specifically require.

    ~~b. Can share information between Healthy Steps and Medicaid per federal requirements to coordinate benefits between the two programs.~~

    ~~c.~~ b. Can share information between Medicaid and SSA for Title II and Title XVI benefits as federal regulations specifically require.

d. Can share information between TANF, SNAP, and the Aid to the Blind Remedial program per federal regulations to coordinate benefits between the programs.

5. Sharing information with Foster Care social workers when an application is received and the child is already on Medicaid:

   a. The county has care, custody, and control, so is acting on behalf of the child. Also, the child is going from one Medicaid case to another for the purpose of establishing eligibility.

   b. Copies of identifying information such as a birth certificate may be made for the Foster Care file so that both files contain the proper documentation.

   c. Only pertinent information needed to determine the child's eligibility should be provided. A social worker needs the parent's income information to determine if the child is IV-E eligible. If that has been established, the social worker should NOT be requesting the information, nor should the eligibility worker be releasing it without a signed release of information.

6. Sharing information with Law Enforcement:
   Medicaid cannot provide information about a specific applicant or recipient to law enforcement unless it has to do with administration of Medicaid.

7. Release of information on application:

   These statements allow county and state staff to obtain information from other sources, but do not give permission to release information to others.

Application and Review 510-03-25-05

1. Application.

   k. A new application is not required when a child loses eligibility under ~~Healthy Steps~~ the Optional Children's Group, becomes Medicaid eligible, and there is not a break in assistance. However, an Ex Parte (desk) review must be completed.

2. Review

c. When a review is due for an ACA individual, 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, 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 on the 90th day but is incomplete or does not include all of the requested verifications, the review must be denied and the individual informed that they must reapply.

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: For eligibility months prior to January 1, 2020, ~~R~~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.

For eligibility months on or after January 1, 2020, eligibility may be established for any month in the 90-day period from date of closure.

d. Ex Parte Reviews: In circumstances where a desk review is appropriate, such as when adding a child, moving to Transitional Medicaid Benefits, processing a change in the level of care, aligning review dates with ~~Healthy Steps,~~ SNAP, or TANF, or adding Medicare Savings Programs coverage; and in which the county agency has all information needed to complete a review, eligibility may be established without a review form. When the county agency has all information needed to complete a review, continued eligibility must be established without a completed form or requiring additional information from an ACA Medicaid Household. In circumstances in which information needed to complete a review is available through ~~Healthy Steps,~~ SNAP or TANF, that information must be used without again requiring that information from the individual or family. If all needed information is available, a review can be completed without requiring a review form. Care must be used to ensure all needed information is on hand. An online narrative must document the completion of the Ex Parte review.

j. It is 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:

i. If the child is found to be eligible for Medicaid (other than Medically Needy), eligibility must be authorized for Medicaid and the child will be given a new 12-month continuous eligibility period.

~~ii. If the child is found to be NOT eligible for Medicaid (other than Medically Needy), but is determined eligible for Healthy Steps, eligibility must be authorized for Healthy Steps and the child will be given a new 12-month continuous eligibility period.~~

~~iii.~~ii If the child is found to be NOT eligible for Medicaid (other than Medically Needy) ~~or Healthy Steps,~~ the child may not be terminated at the time of the early review unless the child meets one of the state's exceptions to terminate continuous eligibility. The child would remain eligible for the remainder of the original continuous eligibility period and a review would be required at that time.

Eligibility - Current and Retroactive 510-03-25-10

1. Current eligibility may be established from the first day of the month in which the signed application was received.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the signed application was received. Eligibility can be established if all factors of eligibility are met during each month of retroactive benefits. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application.

   Note: This provision does not apply to individuals eligible only under the Adult Expansion Group for the months of October, November, or December 2013.

   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.

3. An individual determined eligible for part of a month is eligible for the entire calendar month unless a specific factor prevents eligibility during part of that month. Examples of specific factors include:

   a. An individual is born in the month, in which case the date of birth is the first date of eligibility;

b. An individual enters the state, in which case the earliest date of eligibility is the date the individual entered the state unless still receiving Medicaid benefits from another state. Information regarding the date Medicaid benefits from the other state are no longer available should be established in order to determine the beginning date of eligibility in North Dakota; or

c. An individual is discharged from a public institution, in which case the earliest date of eligibility is the date of discharge.

4. A child cannot be eligible for Medicaid for the same period of time the child is covered under ~~the~~ ~~Healthy Steps~~ Optional Children's Group. ~~Program.~~

5. For an ongoing Medicaid case, coverage may be added retroactively up to 12 months for a non-covered household member, provided the individual lived in the household during the months requested.

   Note: Coverage under the Adult Expansion Group cannot begin prior to January 1, 2014.

Decision and Notice 510-03-25-25

Applicants and recipients may choose the method by which they are notified of their eligibility status. They may choose paper, electronic, or through their ND Client portal account.

1. A decision as to eligibility will be made promptly on applications, within forty-five days, except in unusual circumstances. When these time periods are exceeded, the case must contain documentation to substantiate the delay.

2. Following a determination of eligibility or ineligibility, an applicant must be notified of either approval or denial of Medicaid. The notice must address eligibility or ineligibility for each individual month requested including all prior months and through the processing month.

   Section 1902 of the Social Security Act requires that Medicaid ID Cards and Health Care Coverage notices be made available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. To meet these federal regulations, when an individual applies for Health Care Coverage and does not have a residential or mailing

address, or is unable to utilize a friend or relative's address to receive their mailing, the County Social Service Office address must be used for the individual.

Example: Applicant's Name
c/o XXXXX County Social Service Office
123 Main Street
Any town, ND 58111

When an individual applies for Health Care Coverage, and does not have an address to receive his/her mail, the individual must be informed of the following:

- The individual will be required to pick up their mail at the county office on a weekly basis; and

- Failure to pick up their mail for three (3) consecutive weeks may result in their Health Care Coverage being closed.

Since individuals who apply for Health Care Coverage are not required to complete a face to face interview:

- If the individual has a telephone contact number, the requirement to inform the individual will need to be done through a telephone call and this must be documented in the casefile.

- If the individual does not have a telephone contact number, all methods of informing the individual have been exhausted, and the individual does not stop by the county office for three (3) consecutive weeks, the case must be closed.

When an individual fails to pick up their mail for three (3) consecutive weeks and the individual has not contacted the county social service office, the case must be closed for the reason of 'Loss of Contact/ Whereabouts Unknown'. Remember to document this in the casefile narrative.

Note: A ten-day Advance Notice is not required however, a notice containing the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested, must be **mailed** no later than the effective date of the action.

If an applicant is denied, or is ineligible for any of the prior months or the processing month, the notice must include the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested.

3. Once a decision to deny eligibility is made on an application, a new application is needed to re-apply for assistance.

4. As specified below, a notice must be sent in all ongoing cases in which a proposed action adversely affects Medicaid eligibility.

    a. A notice must be mailed (as described in subsection 5) at least ten days in advance of any action to terminate or reduce benefits. The date of action is the date the change becomes effective.

This "Ten-Day Advance Notice" must include the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested. This gives the recipient an opportunity to discuss the situation with the county agency, obtain further explanation or clarification of the proposed action, or present facts to show that the planned action is incorrect. The recipient may appear on his own behalf or be represented by legal counsel, a relative, a friend, or any other spokesperson of their choice.

- When an individual is added to an eligible household and requests eligibility for a retroactive period, the addition of the member will NOT affect the eligibility for anyone already eligible for any prior month(s) or the current month. However, eligibility may change for future months provided the appropriate notice requirements can be met.

    Note: Eligibility for individuals within a Continuous Eligibility Period would not be changed.

- Any change to a lower coverage based on the hierarchy of Category of Eligibility will require a ten-day advance notice unless:

- The change occurs at the time a review is being completed or

- The reason for the change meets one of the circumstances when a ten day advance notice is not required.

Example: A child eligible as ACA Medicaid cannot have eligibility changed to ~~Healthy Steps (CHIP)~~ Optional Children's coverage without a 10-day advance notice, unless it meets one of the exceptions to the 10-day advance notice, as ~~Healthy Steps~~ Optional Children's coverage is lower on the hierarchy chart. However, a child eligible as an ACA Transitional child can have eligibility changed to an ACA child without a 10-day advance notice as ACA child coverage is higher on hierarchy chart.

Groups Covered Under ACA Medicaid 510-03-30-05

The following are the groups of individuals who can be covered under ACA Medicaid:

1. Categorically Needy Group

    a. Parents and Caretaker/relatives of deprived children under age 18 (through the month they attain age 18) and their spouses up to 54% FPL (COE of M063);

    b. Parents and Caretaker Relatives (and their spouses) of deprived children under age 18 (through the month they attain age 18) who were eligible under the Parents and Caretaker Relatives and their spouses Category in at least three of the six months immediately preceding the month in which the Parents or Caretakers lose coverage under the Parents and Caretaker Relatives and their spouses Category due to increased earned income or hours of employment, and their dependent children for up to 12 months (Transitional) (COE of M086 for Parents and Caretaker Relatives of deprived children and their spouses and M087 for children);

Exception: Children only become eligible under Transitional coverage when their Medicaid household income fails the respective children's group income level.

c. Parents and Caretaker Relatives (and their spouses) of deprived children under age 18 (through the month they attain age 18) who were eligible under the Parents and Caretaker Relative and their spouses Category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lose coverage under the Parents and Caretaker Relatives and their spouses Category due to increased alimony or spousal support and their dependent children for up to 4 months (Extended)(no budget test) (COE of M088 for Parents and Caretaker Relatives (and their spouses) of deprived children and M061 for Children);

   Exception: Children only become eligible under Extended coverage when their Medicaid household income fails the respective children's group income level.

d. Pregnant Women up to 147% FPL (COE of M066);

e. Eligible pregnant women who applied for and were eligible for Medicaid during pregnancy continue to be eligible for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls (COE of M066);

f. Children born to pregnant women who applied for and were found eligible for Medicaid on or before the day of the child's birth, for one year, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls (COE of M067);

g. Children ages 0 through 5 up to 147% FPL (COE of M067);

h. Children ages 6 through 18 up to 133% FPL (COE of M067);

i. Children ages 6 through 18 who become Medicaid eligible due to the increase in the Medicaid income levels. The income of these individuals falls between 111% and 133% of the Federal Poverty Level (FPL). (COE of M095)

j. Adults age 19 and 20 who are not pregnant, who pass the Adult Expansion Group but have income less than 90% FPL (M062);

k. Individuals ages 19 through 64 not eligible as children, parents, caretakers or pregnant women whose income does not exceed 133% FPL. This may include SSI recipients and other disabled individuals who fail the Medicaid asset limits, and individuals who are determined 'medically frail' or disabled with a large client share (Adult Expansion Group) (COE of M076)

Note: State Medicaid Policy may also assign COE's M058, M059, M060 M065, M077 or M089, but must be determined 'medically frail'.

l. Individuals under age 19 who meet the non-financial requirements of the Children's Category and who are residing in foster homes or private child care institutions licensed or approved by the Department, irrespective of financial arrangements, including children in a "free" foster home placement (non-IV-E Foster Care) (COE of M098);

m. Individuals who are not eligible as an ACA Medicaid Individual defined in a. thru h. above, who were in North Dakota foster care (Title IV-E, state-funded (non-IV-E) or tribal) in the month they turned age 18 must be covered through the month in which they turn age 26 with no budget test (COE of M091) .

2. Medically Needy Group

a. Pregnant Women who qualify and require medical services on the basis of insufficient income, but who do not meet pregnant women income requirements under ACA Medicaid (COE of M079).

b. Children under age 21 who qualify and require medical services on the basis of insufficient income, but who do not meet income requirements under ACA Medicaid (COE of M080).

c. Parents and caretaker relatives of deprived children and their spouses who qualify and require medical services on the basis of insufficient income, but who do not meet the parents and caretaker relatives of deprived children and their spouses or the Medicaid Expansion income requirements under ACA Medicaid. (COE of M068)

3. Optional Children's Group
   a. Children age 0 through 18 (through the last day of the month in which child turns age 19) and has income between 152% and 175% of the FPL (COE of M078).

Assigning Category of Eligibility 510-03-30-15

There are six (6) major Categories of Eligibility (COE), each of which have related categories that fall under them. The six major categories are:

1. Children Under age 19;
2. ~~Healthy Steps (CHIP);~~ Optional Children's Group;
3. Parents, caretaker relatives and their spouses;
4. Pregnant Women;
5. Adults.
6. Former Foster Care Children

The following rules determine how to assign the COE for eligible individuals:

1. Children Under Age 21

COE	COE Description	Rule to Assign COE
61	Extended ACA Children	The Child: • Is under age 18 (through the month the child attains age 18) • Is deprived due to the absence, disability, incapacity, age or

		unemployment/ underemployment of a parent; • Resides with one or both natural or adoptive parents, or one non-parent caretaker relative; • Not eligible under the ACA Medicaid Children Poverty Levels; AND The child's parent(s) or caretaker relative: • Lost eligibility under the Parents and Caretaker Relative and their spouses Category due to increased alimony or spousal support; and • Was eligible under the Parent, Caretaker Relative and their Spouses Category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lost coverage under the Parents, Caretaker Relatives and their Spouses Category.
67	Children ages 0 thru 18 (including month turn age 19) -- other than MOE, Foster Care, Transitional, Extended, Med Needy or Healthy Steps	The Child: • Is age 0 to 6 (including the month the child attains age 6); • Was found eligible for ACA Medicaid with income **at or below** 152% of the Federal Poverty Level (FPL). **OR** • Is age 6 (month following month attains age 6) thru age 18 (including the month the child attains age 19); • Was found eligible for ACA Medicaid with income at or below 138% of the Federal Poverty Level (FPL). **OR** • The child's mother applied for Medicaid before the child's birth; • The child is deprived due to the absence, disability, incapacity or age of a parent;

		• The child is age 0 to 1 (including the month the child attains age 1);
87	ACA Transitional Children	The Child: • Is under age 18 (through the month the child attains age 18) • Resides with one or both natural or adoptive parents, or one non-parent caretaker relative; • Not eligible under the ACA Medicaid Children Poverty Levels; **AND** The child's parent(s) or caretaker relative: • Lost eligibility under the Parents and Caretaker Relative and their spouses category due to increased earned income or hours of employment; • Was eligible under the Parent, Caretaker Relative and their Spouses Category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lost coverage under the Parents, Caretaker Relatives and their Spouses Category.
95	Maintenance of Effort Child Absence Deprived (Age 6 to 19) ~~Healthy Steps (CHIP) to Medicaid~~	The Child: • Is age 6 to 19 (month following month attains age 6 through the end of the month the child attains age 19); • Was found eligible for ACA Medicaid with income **between** 111% and 133% of the FPL. • ~~Cannot have other creditable health insurance coverage.~~
98	State or Tribal Foster Care (Non-IV-E)	The Child: • Meets the definition of a Foster Care Child; • Is eligible under regular Foster Care (non-Title IV-E, tribal or state-funded).

80	Child Age 0 to 21 (Medically Needy)	The Child: • Is age 0 to 21 (including the month the child attains age 21); • Has income **above** 152% of the FPL; • Has a medical need that exceeds the calculated Client Share (Recipient Liability);

2. ~~Healthy Steps (CHIP Children)~~Optional Children's Group

COE	COE Description	Rule to Assign COE
78	~~Healthy~~ ~~Steps~~ Optional Children's Group	The Child is: • Age 0 through age 18 (through the last day of the month in which child turns age 19); • Is not eligible for full Medicaid Coverage; • Does not have current creditable health insurance coverage; ~~• Coverage is not available through the child's parents' or legal guardians' employer at no additional cost;~~ ~~• The child did not have creditable health insurance coverage within the past 90 days;~~ • Has income between 152% and 175% of the FPL

ACA Eligible Individuals Health Care Coverage 510-03-30-20

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 provided through Sanford Health Plan (SHP).

Individuals who have their coverage under Traditional Medicaid are:

a. Eligible children under age 19.

b. 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.

c. 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.

d. Eligible pregnant women with income below 147% of the Federal Poverty Level (FPL) and for the duration of the 60 free day period.

e. Eligible foster care children.

f. Eligible Former Foster Care children.

g. 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.

h. 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.

2. Individuals who have their coverage under the Alternative Benefit Plan (ABP), which is currently provided through Sanford Health Plan (SHP) are:

    a. 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).

3. 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:

    a. Eligible adults who meet the Medically Frail criteria;

    b. Eligible individuals who have been approved for the Medicaid Women's Way Treatment Program and whose income is less than 138% of the FPL.

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

4. Individuals who have coverage under the Optional Children's Group are:

   a. Eligible children under age 19 (thru the end of the month they turn 19) who do not have other creditable health insurance coverage.

Caretaker Relatives 510-03-35-15

1. Caretaker relatives may be eligible for Medicaid under the Parents and Caretakers of deprived children and their spouses category when:

   a. A child is residing with the caretaker/relative AND is eligible for Medicaid, ~~Healthy Steps~~ or enrolled in a health insurance policy which includes the minimal essential coverage's; and

   b. The caretaker relative assumes primary responsibility for the child's care (does not mean the caretaker relative must claim the child for tax purposes); and

   c. The caretaker relative is related within the 5th degree of relationship to the child; and

   d. The caretaker relative's household has income at or below the parent/caretaker and their spouses' category income level.

When the child is NOT eligible for Medicaid (with no 'client share'), ~~Healthy Steps~~ or enrolled in a health insurance policy that meets the minimal essential coverage criteria, the caretaker relative is not eligible for any coverage. This policy applies to coverage under Medicaid Expansion in the same way. However, this policy DOES NOT apply to the following:

- A caretaker relative who is a pregnant woman;
- A caretaker relative who is eligible under Medically Needy coverage with a 'client share';
- A caretaker relative who is eligible for coverage under Emergency Services only;
- A caretaker relative who is eligible under the Breast ~~and~~ or Cervical

Cancer Early Detection (Women's Way) Program as defined at 510-05-67;

- A caretaker relative who has a child residing in the household and the child fails immigration/citizenship requirements;
- Caretaker relative who is eligible under ACA Transitional Parent Caretaker coverage.

Transitional Medicaid Benefits 510-03-50-05

A parent or caretaker relative who ceases to be eligible under the Parent/caretaker relative and their spouses category and who meets the requirements of this section may continue to be eligible for Medicaid benefits without making further application for Medicaid.

> **Note:** Children eligible under one of the child categories, ~~other than Healthy Steps~~, will remain eligible under that category when a parent or caretaker relative becomes Transitional Medicaid Eligible.

Extended Medicaid Benefits 510-03-50-10

A Parent(s) or caretaker relative who ceases to be eligible under the Parent/caretaker for Family Coverage category and who meets the requirements of this section, may continue to be eligible for Medicaid benefits without making further application for Medicaid.

> **Note:** Children eligible under one of the child categories, ~~other than Healthy Steps~~, will remain eligible under that category when a parent or caretaker relative becomes Extended Medicaid Eligible.

Income Compatibility 510-03-85-25

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. Employers are not required to provide their payroll information to TALX and therefore, verification of wages may not always be available through TALX.

> **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.

Related Programs 510-03-95

Healthy Steps 510-03-95-10

For eligibility months prior to January 1, 2020, Healthy Steps is the name given to the Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act.

For eligibility months on or after January 1, 2020, Healthy Steps is changing from a Managed Care Program to a Fee for Service (FFS) program and are under the Optional Children's Group category.

Children from birth through age 18 who are ineligible for Medicaid because of income may qualify for coverage under the ~~Healthy Steps~~Optional Children's Group. Information and eligibility criteria can be found in Service Chapter 510-07.

Refugee Medical Assistance Program 510-03-95-20

The Refugee Medical Assistance Program is a program designed to cover Medical expenses for unaccompanied minors and other legally admitted refugees who are not eligible for Medicaid ~~or Healthy Steps~~. Medicaid receives 100% federal funding for Refugee Medical Assistance (RMA).

For Refugee Medical Assistance Program policy, please refer to Non-ACA Manual Section 510-05-95-20.

Coverage Hierarchy Order 510-03-105-05

This Reference Hard Card explains the order in which eligibility is tested under ACA Health Care Coverage.

Coverage Hierarchy Order (Highest to Lowest) COEs DESCRIPTION	COEs	DESCRIPTION
1	M098	Non IV-E State or Tribal Foster Care Children
2	M067, M095	ACA Children
3	M066	ACA Pregnant Woman

4	M063	ACA Parent/Specified Caretaker Relative
5	M086	ACA Transitional Parent/Specified Caretaker Relative
6	M088	ACA Extended Parent/Specified Caretaker Relative
7	M087	ACA Transitional Children
8	M061	ACA Extended Children
9	M078	~~Healthy Steps (CHIP) Children~~ Optional Children's Group
10	M091	ACA Former Foster Care Child
11	M075, M069, M064	Women's Way
12	M062	ACA Adult 19 or 20
13	M058, M059, M077, M089, M060, M065	Adults Medically Frail
14	M076	ACA Adult Expansion
15	M081	Emergency Services