Par.1**. Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 510-03 Eligibility Factors for ACA (Affordable Care Act) Medicaid which are indicated in **red**. This manual letter also incorporates changes made with the following IM's, if the information in the IM continues to be valid:

- IM 5254 Definition of Spouse/Marriage
- IM 5255 Estate Recovery – Changes Required per Senate Bill 2050
- IM 5259 No or Invalid Recipient Address
  - Amended IM 5259 No or Invalid Recipient Address
- IM 5260 Coverage for Inmates who are Inpatients in a Hospital Setting
  - Attachment - IM 5260 – Vision Processing
- IM 5261 Clarification in Policy for Determining State Residency for Children
- Amended IM 5261 Clarification in Policy for Determining State Residency for Children
- IM 5262 Medicaid Cover for Children in Foster Care and those aging out of Foster Care
- IM 5264 ACA Policy Clarifications and Changes due to Implementation of SPACES
- IM 5272 2016 Health Care Coverage Poverty Levels
  - Attachment IM 5272 - ACA and Non ACA Medicaid Income Level Chart
  - Amended IM 5272 2016 Health Care Coverage Poverty Levels
  - Amended IM 5272 Attachment ACA and Non ACA Medicaid Income Level Chart
- IM 5275 Policy Updates for ACA and Non-ACA Medicaid and Healthy Steps
- IM 5288 Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
  - Amended IM 5288 Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
  - Second Amended IM 5288 Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
- IM 5292 2017 Health Care Coverage Poverty Levels
  - Attachment IM 5292– ACE & Non-ACA Income Level Chart

Par. 2. **Effective Date** – Policy changes included in this manual letter are effective May 1, 2017. Policy that was incorporated with the IM's is effective based on the date listed in the IM.

Definitions 510-03-05

1. 510-03-05 Definitions. Incorporating the change for the definition of Spouse implemented with IM 5254. All other definitions remain unchanged and therefore, are not included in this Manual Letter.

Definitions 510-03-05

For the purpose of this chapter:

Spouse
~~A person of the opposite sex who is a husband or a wife. One man and one woman can become husband and wife through marriage (a legal union). North Dakota Medicaid does not consider members of a civil union or same-sex marriage as spouses.~~

A spouse is a person who is legally married to another person.

For a marriage performed in North Dakota to be considered valid in North Dakota, couples are required to obtain a marriage license through the County Recorder's Office.

Marriages that occur outside of North Dakota are considered valid in North Dakota if:

1. ~~A Common law marriage from another state is valid in North Dakota only if it can be verified that the marriage is recognized by the other state.~~ The Marriage was legally performed in another state;

2. ~~A non-traditional marriage from another country is valid in North Dakota only if it can be verified that the union is declared valid by the other country.~~ The marriage is a common law marriage that occurred in another state and was considered a valid marriage in that state (the

couple would be required to provide documentation verifying that the common-law marriage was considered valid by the state in which it took place);

3. ~~In polygamy situations, the first marriage is the valid marriage in North Dakota. Any additional spouses are considered non-relatives.~~ The marriage occurred in another country and the marriage was considered valid according to the law of the country were the marriage was contracted, unless the marriage violates the strong public policy of North Dakota.

4. Polygamous marriages violate the strong public policy of North Dakota. In situations where polygamy has occurred, the first marriage is considered valid in North Dakota if the marriage meets the criteria in #1, 2 or 3 above. Any additional spouse (s) claimed after the first marriage are considered non-relatives.

General Provisions 510-03-10

2. 510-03-10-25 Improper Payments and Suspected Fraud. **A 'Note:' has been added to the bullet under 2.c.ii.a., confirming that an overpayment will not be established and a referral should not be made to the Surveillance Utilization Review (SURS) Unit if the individual fails to report a change and the change would have resulted in the individual to be eligible under another coverage.** The sections titled **Determining Amounts of Overpayments** and **Repayment of Overpayments** are unchanged and therefore not included in this manual letter.

Improper Payments and Suspected Fraud 510-03-10-25

Improper payments can result from agency errors, recipient errors, and provider errors. All reasonable and practical steps must be taken on all errors to prevent further overpayments, waste, or abuse.

1. Agency caused errors do not result in an overpayment that the recipient is responsible to repay. However, the error must be corrected to prevent further overpayments from occurring.

   Suspected provider related errors must be reported to the Surveillance Utilization Review (SURS) Unit in the Medical Services Division using SFN 20, "SURS Referral Form" with a copy to the Medicaid eligibility unit. SFN 20 may be sent to SURS as described in the 'Determining Amount of Overpayments' section below. The SURS unit will be responsible for recoupment from any provider.

2. Recipient errors may occur as a result of:
   a. Health Care Coverage granted pending a fair hearing decision subsequently made in favor of the county agency;
      i. Decrease or end eligibility effective the end of the month the decision is received.
         - Any amount paid during the period the individual was granted Health Care Coverage pending the fair hearing is considered an overpayment.
   b. Payment that was provided as a result of a medical expense or increased medical need for a given time period (i.e. medical care payments);
      i. The months in which the payments are intended for must be reworked in the system utilizing the monthly payment amount.
         Note: Eligibility Staff must contact State Medicaid Policy to approve authorization to increase the 'client share'. Send all requests to the State Medicaid Policy Group Mailbox at - Info-DHS Medicaid Policy hccpolicy@nd.gov.
   c. Failure to report a change in circumstance:
      i. If the change does not result in a change in eligibility for any individual in the household, document the findings and nothing further needs to be done.
      ii. When a household fails to report a change that results in an increase or decrease in coverage:
         a. If the change results in an INCREASE in coverage, the change will be made for the future benefit month based on the date the verification/information is received. An increase in coverage results when:

- An individual was eligible for Medicaid Expansion Coverage and should have been eligible for Traditional Medicaid Coverage with or without a client share.

  Note: If an individual fails to report a change and the change would have resulted in eligibility for the individual under another coverage:

  - An overpayment will not be established for the coverage and
  - A referral should not be made to the Surveillance Utilization Review (SURS) Unit and
  - Document the reason the overpayment was NOT completed and a referral to SURS was NOT made.

b. If the change results in a DECREASE in coverage, the change will be made prospectively following the 10-10-10 rules, based on the date the change is reported. Document the findings in the narrative.

- If the individual was eligible for Traditional Medicaid coverage with no client share and should have been Medicaid eligible with a 'client share', the amount of the overpayment is the difference between the correct amount of 'client share' (using actual income) and the amount of the client share met by the ACA Medicaid Household.
- If the individual was eligible for Traditional Medicaid coverage with or without a client share, and should have been eligible for Medicaid Expansion, no overpayment will result. However, the individual must be changed to Medicaid Expansion Coverage based on 10-10-10 rules.

iii. If the individual was eligible for Traditional Medicaid coverage or Medicaid Expansion and based on the change, the individual is no longer eligible for any coverage, the change will be made prospectively following the 10-10-10 rule, based on the date the change was reported.

a. If the individual was eligible under Traditional Medicaid coverage, the amount of the overpayment is the amount paid in error for all months the individual should not have been eligible under Traditional Medicaid Coverage.

b. If the individual was eligible under Medicaid Expansion, the amount of the overpayment is equal to the total amount of all premiums paid in error for all months the individual should not have been eligible under Medicaid Expansion.

d. An individual attains age 65, or if under age 65, becomes Medicare eligible:

i. When an individual attains age 65 and eligibility continued under Medicaid Expansion, Medicaid Expansion coverage must be ended at the end of the month prior to the month the individual attains age 65. Any premiums paid for the month the individual attained age 65 or after must be recouped from the insurance vendor.

- Eligibility for the individual MUST be pursued under Non-ACA Medicaid policy:
  - If the individual is determined eligible for Non-ACA Medicaid coverage, the individual must be determined eligible beginning with the month the individual attains age 65.
  - If the individual is determined not eligible for Non-ACA Medicaid coverage, contact the State Medicaid Policy Unit for assistance to process Non-ACA Medicaid Coverage for the months the premiums were recouped. Send all requests to the State Medicaid Policy Group Mailbox at -Info-DHS Medicaid Policy <hccpolicy@nd.gov>.

ii. When an individual under age 65 became Medicare eligible but continued eligible under Medicaid Expansion, Medicaid Expansion coverage must be ended at the end of the month prior to the month the individual became Medicare eligible. Any premiums paid for the month(s) the individual received coverage under Medicaid Expansion while Medicare eligible, must be recouped.

- Eligibility for the individual MUST be pursued under Non-ACA Medicaid policy:
  - If the individual is determined eligible for Non-ACA Medicaid coverage, the individual must be determined eligible beginning with the month the individual becomes Medicare eligible.

- If the individual is determined not eligible for Non-ACA Medicaid coverage, contact the State Medicaid Policy Unit for assistance to process Non-ACA Medicaid Coverage for the months the premiums were recouped. Send all requests to the State Medicaid Policy Group Mailbox at -Info-DHS Medicaid Policy <hccpolicy@nd.gov>

e. An individual moves out of State/loses State Residency:
   i. Close the individual's coverage the end of month it becomes known the individual has moved out of State (10 day notice not required).
      - If the individual moved out of state prior to the month it became known they moved, an overpayment equal to the amount of Medicaid benefits/premiums paid beginning the month following the month the individual actually moved out of state and the date the case closed would result. Also, refer the case to SURS if Medicaid benefits/premiums were paid out.
      - If the individual moved out of state in the month equal to the month the case was closed, no overpayment results. No referral needs to be made to SURS.

f. Individuals request coverage be terminated and premiums recouped for the entire period of time they were eligible.
   i. If the individual contacts the county within 30 days from the date the notice was sent, all premiums must be recouped. (Refer to the ACA Processing Guide for the Mini-App Recoupment Process).
   ii. If the individual contacts the county after 30 days from the date the notice was sent, close the individual's coverage at the end of the month of the request and no recoupments are made. Since the client requests their case closed, adequate notice is sufficient.

g. Error made when FFM determined an individual was eligible and the individual was not eligible:
   i. Since the determination was made by the FFM, the change will be made prospectively following the 10-10-10 rules, based on the date the change is reported.

- Document the findings, no overpayment will result and nothing further needs to be done.

h. For any month(s) an individual received coverage under Medicaid Expansion through the insurance vendor, and meets all three of the following criteria:
   i. Is determined eligible for Social Security Disability or SSI; **AND**
   ii. Meets the asset requirements for Non-ACA Medicaid coverage; **AND**
   iii. Has medical bills for the month(s) which are not being covered by Medicaid Expansion through the insurance vendor but could be paid under Traditional Medicaid coverage.
      - Premiums for those months the individual meets **all** three of the above criteria must be recouped from the insurance vendor.
      - Due to notice requirements, Non-ACA Medicaid coverage must be approved for those months the premiums were recouped.

        Note: If the individual has been residing in a LTC facility and the Level of Care does not equal the date of entry, contact the State Medicaid Policy Unit. Send all requests to the State Medicaid Policy Group Mailbox at -Info-DHS Medicaid Policy <hccpolicy@nd.gov>.

i. Medically Frail individuals who chose to be covered under Traditional Medicaid coverage, who are in receipt of nursing care services and fail to report a Disqualifying Transfer(s):
   i. Any amount paid for nursing care services during the Disqualifying Transfer penalty period is the amount of the overpayment.

j. Sharing Medicaid ID's:
   i. When an individual shared their Medicaid ID card with another individual who utilized it to receive services, and it becomes known, a referral to the SURS Unit must be made immediately.

3. 510-03-10-30 Liens and Recoveries. Incorporates the policy relating to the Department no longer filing claims against the estate to recover

premium paid by Medicaid, for insurance received through a private carrier, from IM 5255.

Liens and Recoveries 510-03-10-30

1. No lien or encumbrance of any kind shall be required from or be imposed against the individual's property prior to his death, because of Medicaid paid or to be paid in his behalf (except pursuant to the judgment of a court incorrectly paid in behalf of such individual). (42 CFR 433.36)

2. A recovery of Medicaid correctly paid will be made from the estate of an individual who was 55 years of age or older when the recipient received such assistance or who had been permanently institutionalized regardless of age, with the exception of payments made for coverage through a private carrier. Recovery is pursued only after the death of the recipient's spouse, if any, and only at a time when the recipient has no surviving child who is under age 21, or who is age 21 or older and who is blind or permanently and totally disabled defined by the Social Security Administration.

   Note: Individuals eligible under Medicaid Expansion currently receive their coverage through the Sanford Health Plan, which is considered receiving coverage through a private carrier. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover premiums paid by Medicaid, for insurance received through a private carrier, which Sanford Health Plan meets this definition. All other Estate Recovery provisions remain unchanged.

   The recovery of Medicaid paid for individuals under age 65 is only for assistance paid on or after October 1, 1993. Medicaid benefits incorrectly paid because of a recipient error can be recovered regardless of the individual's age at the time the assistance was received. Overpayments due to recipient errors that are still outstanding are subject to recovery upon the individual's death without regard to whether or not there is a surviving spouse.

   'Permanently institutionalized individuals' are persons who, before reaching age 55, began residing in a nursing facility, the state hospital, the Anne Carlsen facility, the Prairie at St. John's center,

the Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing bed care in hospitals, resided there continuously for at least six months and did not subsequently reside in any other living arrangement for at least 30 consecutive days, and have received written notice that they are consider to be permanently institutionalized. Permanently institutionalized individuals have a right to appeal their permanently institutionalized status.

~~If an individual is enrolled in the Adult Expansion coverage, all payments made on behalf of that individual after the individual turns 55 years of age are subject to Medicaid Estate recovery. This means that payments made on your behalf (including premium payments to Sanford Health Plan) are subject to estate recovery upon your death.~~

Application and Decision 510-03-25

4. 510-03-25-05 Application and Review. Incorporates the policy relating to Applications and Reviews from IM 5264 and IM 5275.

Application and Review 510-03-25-05

1. Application.
    a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.
    b. A relative or other interested party may file an application on behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.
    c. An application is a request for assistance on a prescribed form designed and approved by the North Dakota Department of Human Services.

    For ACA Medicaid Households, individuals can apply using one of the following prescribed applications:

i. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application;
ii. The single streamlined application as submitted through the North Dakota client portal;
iii. The SFN 1909, "Application for Health Coverage and Help Paying Costs";
iv. Telephonic applications utilizing any one of the prescribed applications;
v. SFN 405, "Application for Assistance"; or
vi. SFN 641, "Title IV-E/Title XIX Application-Foster Care";
vii. The Department's online "Application for Assistance", located at http://www.nd.gov/dhs/.
viii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or
ix. ICAMA (Interstate Compact on Adoption and Medical Assistance) form 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specified child.
x. SFN 958, "Health Care Application for the Elderly and Disabled". However, notification must be sent to the individual requesting information needed to make the ACA eligibility determination.
xi. An Application submitted through the Self-Service Portal.

d. There is no wrong door when applying for Medicaid or any of the Healthcare coverage's. The experience needs to be as seamless and with as few barriers as possible.
e. North Dakota Medicaid applications may be received, filed and maintained at any county office within the state, based on what is most convenient for the applicant or recipient.

Example: Mom and one child reside in one county, and another child is attending school in another. If it is more convenient for the household to apply and maintain the case in the county where the mom resides than the county in which the child, who is a student, is residing, the county where mom resides should process and maintain that case.

f. A prescribed application form must be signed by the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
g. The date of application is the date an application, signed by an appropriate person, is received at a county agency, the Medical Services Division, a disproportionate share hospital, or a federally qualified health center. An application is considered signed if the signature is found anywhere on the application, other than to answer a question. The date received must be documented.

   Applications must be registered in the eligibility system as soon as possible upon receipt, but no later than the fifth day following receipt. Applications will be considered received on the day submitted. If an application is submitted after business hours, on a weekend or holiday, the application will be considered received on the next business day.
h. An application is required to initially apply for Medicaid, to re-apply after a Medicaid application was denied, to re-apply after a Medicaid case has closed, or to open a new Medicaid case for a child who has been adopted through the state subsidized adoption program.
i. A recipient may choose to have a face-to-face or telephone interview when applying for Medicaid. However, an interview is not required in order to apply for assistance.
j. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.
k. 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, an Ex Parte (desk) review must be completed.

2. 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.

Review forms are 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.

- 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.
- If the returned document includes a forwarding address in North Dakota:
    - Update the case address in the system;
    - Re-mail the form to the new address;
    - Send a notice requesting verification of the change in address.
    - Narrate the action taken.
- If the returned document includes a forwarding address outside of North Dakota:
    - Update the household address and state residency in SPACES;
    - Close the case; and
    - Send notice of adverse action to the new out-of-state address.
    - Narrate the action taken.
- If the returned document does not include a forwarding address:
    - Close the case for loss of contact
    - Send an adequate notice of adverse action to the last known address.

- Narrate the action taken.

a. A recipient has the same responsibility to furnish information during a review as an applicant has during an application.

b. A review must be completed at least annually using the Department's:
   i. System generated "Monthly Report;"
   ii. System generated "Review of Eligibility;"
   iii. SFN 407, "Review for Healthcare Coverage";
   iv. SFN 642, "Title IV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility;
   v. One of the previously identified applications;
   vi. The on-line ~~application or~~ review through OASYS located at http://www.nd.gov/dhs/; or
   vii. The streamlined ~~application or~~ review received through the ND Client portal for ACA Medicaid reviews.
   viii. When completing a review for children eligible for subsidized adoption assistance, receipt of one of the above reviews forms is not required. However, the following two criteria must be verified:
      - The child remains a resident of North Dakota; and
      - The child continues to be eligible for the subsidized adoption program.

      In addition contact should be made with the household to determine whether the child has obtained or lost other insurance coverage.

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 are 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: 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 months 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.

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.
e. 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. In these

cases, the individual/household must be notified of the eligibility determination and basis and that the individual/household must inform the agency if any of the information contained in the notice is inaccurate. The individual is not required to sign and return such notice if all information in the notice is accurate.

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, 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.

f. A review must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category (e.g. SSI to non-SSI), or when adding an individual to an existing Medicaid case. This

includes when adding an individual as eligible who was previously in the household as ineligible.

When the county agency has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be completed. When additional information is needed one of the forms identified in b. must be used.

g. A review, using one of the forms identified in b, is required to open a new Medicaid case for recipients who move from an existing case to their own case (e.g. an 18 year old attains age 19, moves out of the parental home, on other than a temporary basis.)
h. A recipient may choose to have a face-to-face or telephone interview for their review. However, an interview is not required in order to complete a review.
i. Reviews must be completed and processed no later than the last working day of the month in which they are due.
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 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.

5. 510-03-25-25, Decision and Notice. Incorporates the policy relating to No or Invalid Recipient Addresses from IM 5259 and notice requirements when adding individuals to a household from IM 5275.

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) without a 10-day advance notice, unless it meets one of the exceptions to the 10-day advance notice, as Healthy Steps 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.

b. A "Ten-Day Advance Notice" is not required when information exists confirming the death of a recipient.
c. Under the following circumstances 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 (as described in subsection 5) no later than the effective date of action:

i. The recipient provides a signed, clearly written statement providing information that requires a termination or reduction in benefits, and the recipient indicates that he or she understands that benefits will be reduced or terminated (changes reported on the change report form, the TANF monthly report, the review form, or via an applicant's or recipient's known email address meet this requirement);

ii. The recipient provides a signed statement requesting termination of assistance (an oral request will also suffice if recorded in the casefile narrative and reflected on the adequate notice to terminate assistance. Termination may be effective as of the current date or a date in the future). An email from an applicant's or recipient's known email address is considered a signed statement for Medicaid;

iii. The recipient has been admitted to an institution where he or she is ineligible for further services;

iv. The recipient's whereabouts are unknown and mail directed to the client is returned by the post office indicating no known forwarding address;

v. There is factual information that responsibility for providing assistance has been accepted by another state or jurisdiction; or

vi. The recipient has a change in the level of medical care prescribed by the individual's physician, such as the recipient begins or ceases to receive care in a specialized facility, an institution for mental diseases (IMD), a Psychiatric Residential Treatment Facility (PRTF), or nursing care services in a facility (LTC) or in the community (HCBS), or in an ICF-IID.

d. A "Ten-Day Advance Notice" is not required when probable fraud exists.

When the county agency obtains facts through objective collateral sources indicating the likely existence of fraud, an advance notice of proposed termination or reduction of benefits must be mailed only five days in advance of the date the action

is to be taken. This shorter period allows for more prompt corrective action when probable fraud situations are uncovered.

5. System generated notices are dated and mailed on the next working day after they are approved in the eligibility system. Consideration must be given to weekends and holidays (i.e. a notice approved on a Friday is dated and mailed the following Monday, however, if Monday is a holiday, the notice is dated and mailed on Tuesday. This may mean approving the notice 1 to 5 days prior to the effective date of action).
6. Assistance may terminate at any time during the month. If, however, eligibility exists for at least one day of the month, eligibility generally exists for the entire month. Some exceptions to this rule are:
    a. The date of death is the ending day of eligibility;
    b. The last day of eligibility is the date of entry into a public institution.

        Reminder: When eligibility is terminated due to death, the eligibility of other individuals in the case cannot be reduced or terminated without appropriate notice. Likewise, when a caretaker relative is no longer eligible because the last child entered foster care, or parental rights were terminated, the caretaker relative's eligibility cannot be ended without a review of their eligibility.
7. Assistance cannot be terminated as of a past date except in case of death or if another state has assumed responsibility for providing assistance and then only if no assistance has been paid by North Dakota for the period in question.
8. Errors made by public officials and delays caused by the actions of public officials do not create eligibility or additional benefits for an applicant or recipient who is adversely affected.

Coverage Groups 510-03-30

6. 510-03-30-10 Applicants choice of category. Incorporating policy relating to the hierarchy of the Category of Eligibility from IM 5275. **New Policy is also being added to define when an individual who is in receipt of Medicare can be eligible under ACA**

Medicaid.

Applicants Choice of Category 510-03-30-10

An individual, who could establish eligibility under more than one category, such as between ACA Medicaid categories and Non-ACA Medicaid categories or within the ACA Medicaid categories may have eligibility determined under the category the individual selects. A hierarchy of these Categories of Eligibility has been established and can be found in the Reference Hard Card section of this manual at 510-03-105-05.

Individuals eligible as QMBs and SLMBs are eligible as aged, blind or disabled for that coverage but may also establish eligibility under the ACA Medicaid categories as a caretaker/relative or pregnant woman. An individual who is not a caretaker relative who has Medicare coverage cannot chose to be covered under ACA Medicaid Expansion.

SSI recipients must first be tested for eligibility under Non-ACA Medicaid and only if they fail Non-ACA Medicaid (such as excess assets) may they be tested under ACA Medicaid. This also applies to SSI recipients who are pregnant women.

7. 510-03-30-20, ACA Eligible Individuals Health Care Coverage. A new section is being added to incorporate the policy for ACA Eligible Individuals Health Care Coverage from IM 5264.

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).

1. 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).

Basic Factors of Eligibility 510-03-35

8. 510-03-35-15, Caretaker Relatives. Incorporating the policy regarding the ineligibility for Medicaid of Caretakers when a 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, from IM 5275. **New policy is being included to add a list of individuals this provision does NOT apply.**

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

2. The following individuals may be considered a caretaker relative:
    a. A natural, adoptive, or stepparent;

b. A grandparent (including a great, great-great, or great-great-great grandparent);
c. A sibling, half-sibling, or stepsibling (if age sixteen or older);
d. An aunt or uncle (including a great or great-great aunt or great or great-great uncle);
e. A niece or nephew (including a great or great-great niece or great or great-great nephew);
f. A first cousin (an aunt or uncle's child) or first cousin once removed (an aunt or uncle's grandchild);
g. A second cousin (a great aunt or great uncle's child);
h. A spouse of any of the above individuals even after the marriage is terminated by death or divorce.

3. A child is considered to be 'living with' a caretaker relative when away at school or when otherwise temporarily absent from the home.
4. A child is **NOT** considered to be living with a caretaker relative when either the child or the caretaker is residing in a nursing care facility, an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a specialized facility on other than a temporary basis.
5. A child may not be considered to be living with more than one caretaker relative in more than one Medicaid household for the same time period.
6. When the only child in common is an unborn and there is deprivation of unemployment/underemployment, incapacity, or disability, the prospective parents must be married in order for the father to be eligible as a caretaker relative under the Parents and Caretakers of deprived children and their spouses' category.
7. Termination of parental rights removes all relationships and responsibilities between the parent and the child(ren). The parent becomes a "legal stranger" to the child(ren). However, for Medicaid purposes, the blood relatives of a parent whose parental rights have been terminated continue to be treated as relatives of the child(ren).

9. 510-03-35-40, Age and Identity. Incorporates the Policy relating to the Reasonable Opportunity Period, from IM 5264.
Note: The charts included in the manual under d. e. f. and g. in this section are unchanged and therefore not listed in this Manual Letter.

Age and Identity 510-03-35-40

1. Caretaker relatives are not subject to any age requirements for purposes of Medicaid eligibility.
2. In instances where only the year and not the exact date of birth can be established, use July 1 to designate the date of birth; or if the year and month can be established, use the year and first day of the month for purposes of Medicaid eligibility.
3. Identity must be established and documented as provided in this section.
   a. The following individuals are exempt from the identity verification requirements:
      i. SSI recipients who claim that they are US Citizens and that claim is not questionable (can prove using the SDX, NDVerify Other Benefits match);
      ii. Medicare beneficiaries who claim that they are US Citizens and that claim is not questionable (can prove using the NDVerify Other Benefits match);
      iii. Individuals receiving SSA disability insurance benefits based on their own disability;
      iv. Individuals receiving Foster Care maintenance payments;
      v. Individuals receiving Subsidized Guardianship payments.
   b. Newborn children: A child, born to a woman who has applied for and been determined Medicaid eligible and is in receipt of Medicaid when the child is born, may be eligible without verifying identity. This provision also applies in instances where labor and delivery services were furnished prior to the date of the Medicaid application and covered based on retroactive eligibility.

      This provision applies to all children whose Mother is eligible for Medicaid at the time of their birth, including those under the emergency services only provisions.

      Children who are born to a woman who is here on a temporary basis and who is not eligible for Medicaid or emergency medical services must comply with the verification requirements if Medicaid is requested.
   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.

d. Primary and preferred verification of identity. Verification documents must be presented in their official and original form as received from the issuing agencies. Photocopies or notarized copies are not acceptable. Once an original document is presented, a photocopy must be made and maintained in the casefile.
e. Secondary verifications of identity may be accepted if primary verifications are not provided. Verification documents must be presented in their official and original form as received from the issuing agencies. Photocopies or notarized copies are not acceptable. Once an original document is presented, a photocopy must be made and maintained in the case file.

f. Third level verification of identity. These documents should only be used when documentation from levels one and two are unavailable.
g. Identity verifications for minor children. Exceptions identified in this section are allowed when a child does not have or cannot get any of the identity documents from the first three levels.
h. Identity verifications for disabled individuals in institutional care facilities. Exceptions identified in this section are allowed when a disabled individual in an institutional care facility does not have or cannot get any of the identity documents from the first three levels.

10. 510-03-35-45, Citizenship and Alienage. Incorporates the Policy relating to the Reasonable Opportunity Period from IM 5264.
Note: The charts included in the manual under d. e. f. and g. in this section are unchanged and therefore not listed in this Manual Letter.

Citizenship and Alienage 510-03-35-45

1. As a condition of eligibility, applicants or recipients must be a United States citizen or an alien lawfully admitted for permanent residence. Verification of citizenship, naturalization, or lawful alien status must be documented. This section addresses:
    a. Exceptions to verification of citizenship;
    b. Newborn children;
    c. Verification requirements;
    d. Acceptable documentation for US citizens and naturalized citizens; and
    e. Individuals born in Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and Nationals from American Samoa.

    For aliens, apply the appropriate policy identified in sections 510-03-35-50 through 510-03-35-70.
2. Exceptions to verification of citizenship. The following individuals are exempt from the citizenship verification requirements:
    a. SSI recipients who claim that they are US Citizens and that claim is not questionable (can prove using SDX or NDVerify SSI match);
    b. Medicare beneficiaries who claim that they are US Citizens and that claim is not questionable (can prove using NDVerify SSA match);

c. Individuals receiving SSA disability insurance benefits based on their own disability;
d. Individuals receiving Foster Care maintenance payments;
e. Individuals receiving Subsidized Guardianship payments.

3. Newborn children. A child, born to a woman who has applied for and been determined Medicaid eligible and is in receipt of Medicaid when the child is born, may be eligible without verifying citizenship. This provision also applies in instances where labor and delivery services were furnished prior to the date of the Medicaid application and covered based on retroactive eligibility.
   This provision applies to all children whose Mother is eligible for Medicaid at the time of their birth, including those under the emergency services only provisions.

   Children who are born to a woman who is not eligible for regular Medicaid must comply with the verification requirements if Medicaid is requested.
4. Verification Requirements: Applicants must provide satisfactory documentary evidence of citizenship or naturalization.
   a. The only acceptable verifications from individuals must be either originals or copies certified by the issuing agency. Photocopies or notarized copies may not be accepted; however, a photocopy of the original document must be maintained in the casefile.
   b. Verifications may be accepted from another state agency that may have already verified citizenship, but a photocopy must be obtained for the casefile.
   c. Once an individual's citizenship is documented and recorded, subsequent changes in eligibility do not require repeating the documentation unless questionable, or there is no verification in the casefile.
      Example: John Doe applies for Medicaid and supplies his citizenship verifications and his case closes. If his casefile is purged after the three year retention period and he reapplies, he will need to again provide his verifications so that his casefile is complete.
   d. If an individual has made a good faith effort to obtain verifications, but cannot obtain them within the processing timeframes , or because the documents are not available, assistance must be

provided to the individual in securing evidence of citizenship. Matches with other agencies may be used to assist the individual.

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.

5. Acceptable documentation for US citizens and naturalized citizens.
   a. The following documents may be accepted as proof of both citizenship and identity because either the US, a state, or Tribal government has established the citizenship and identity of the

individual. These documents are considered to be the primary (Level 1) and preferred verification documents.

b. If an individual does not have one of the primary verifications, the individual must supply one document from one of the Citizenship lists (Levels 2, 3, or 4) and one document from the Identity lists (Levels 2, 3, or 4).

The verifications are listed in levels and the levels indicate the degree of reliability of the verifications. Level 1 has the highest reliability and is the preferred verification. Level 4 has the lowest reliability and those verifications should be used only when documents from levels 1-3 are not available. The verifications in level 1 must be requested prior to requesting those in level 2, those in level 2 must be requested prior to requesting those in level 3, and so on.

Verification documents must be presented in their official and original form as received from the issuing agencies. Photocopies or notarized copies are not acceptable. Once an original document is presented, a photocopy must be made and maintained in the casefile.

11. 510-03-35-80 Social Security Numbers. Incorporates the Policy relating to the SSN requirement for Newborns from IM 5264.

Social Security Numbers 510-03-35-80

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 benefits are sought except the following individuals do not have to provide a SSN, or verification of application for SSN:
   a. 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;
   b. An individual who is currently eligible for Transitional or Extended Medicaid Benefits;

c. An illegal alien seeking emergency services. (see 510-03-35-70 for a description of emergency services.), and
d. An individual who is determined eligible under Hospital Presumptive Eligibility (HPE).

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 coverage.

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

2. Applicants who do not have a number must be referred to the Social Security Administration to apply for one. The county agency may assist the applicant as needed.
3. A copy of the enumeration at birth form (SSA 2853) that is completed at the hospital, or any other receipt from the Social Security Administration, is adequate verification of application for SSN.
4. The Medicaid household must be informed, at the time of application that the agency will use the SSN in the administration of the Medicaid Program. The SSN will be used to verify income and asset information from the Social Security Administration, Internal Revenue Service, Job Service, Unemployment Compensation, SNAP, TANF Program, Child Support Enforcement, State Motor Vehicle, Department of Vital Statistics and other states.

   The informing requirement is met by the appropriate language found on the Application for Assistance.
5. Social Security numbers are electronically verified through NUMIDENT and the NDVerify system for all recipients. When a number is reported as not valid, the recipient must provide their valid SSN in order to continue to be eligible for Medicaid.

   NUMIDENT - This interface is used to verify an individual's social security number, age and sex. Administrative Manual Section 448-01-50-15-60, "NUMIDENT" provides additional information regarding the NUMIDENT

interface, and defines the alerts that are created when the NUMIDENT match is determined 'Invalid'.

When the return NUMIDENT file is processed, the following indicators display in the NUMIDENT field on Client Profile in both the TECS and Vision systems with the results of the match:

- Blank – means the information has not been sent to Social Security Administration
- I – Invalid match for social security number
- S – Sent to Social Security Administration for verification
- V – Valid match for social security number

If the indicator is 'I' (invalid) the SSN, name, date of birth or sex of the individual was an invalid match with the SSA information.
When the worker receives one of the following alerts, a valid or active SSN has not been provided:

- SSN Invalid
- SSA has different SSN for client, a valid SSN has not been provided
- More than 1 SSN at SSA

When the worker receives one of the following alerts, information entered into the system may be incorrect or the individual's NUMIDENT record at SSA has incorrect information.

- SSN Invalid – sex does not match
- SSN Invalid – DOB does not match
- Sex & DOB do not match SSA
- Name does not match SSN

The eligibility system may be incorrect or the individual's NUMIDENT record at SSA has incorrect information. The worker should check the information entered into the system for accuracy. If the worker is unable to determine if the information in the system is accurate, the worker must contact the household (via phone or notice) to determine the correct date of birth or sex and then correct the information in the system.

If the worker contacts the household by phone, the contact must be thoroughly documented in the narrative. The worker must document the request and give the household 10 days to provide the number.

- If the household refuses to provide the SSN, or fails to respond to the request, that individual's coverage must be ended or denied.
- If the household requests additional time, another 10 days may be allowed.
- Household members who are not requesting coverage are not required to provide a SSN.

If the individual can only show a request date and not a number, they have until the next review to provide a SSN, or eligibility will end for that individual. Newborns may be eligible until the month of their first birthday with a request date, after that, a SSN must be provided.

6. Except for recipients excused in Subsection 1, recipients who provide verification of application for a SSN must provide a SSN by the next review. If a child is within a continuous eligibility (CE) period when the case review is being completed, and the SSN is not provided, the child is eligible through the end of the current CE period; however, the child's SSN must be provided for eligibility to continue past the end of that CE period.

12. 510-03-35-85 State Residence. Incorporates the Policy relating to the determining State Residency for Children from IM 5261

State Residence 510-03-35-85

An individual must be a resident of North Dakota to be eligible for Medicaid through this state. A resident of the state is an individual who is living in the state voluntarily with the intention to remain there permanently or for an indefinite period (not a temporary purpose), or is entering the state with a job commitment or seeking employment. Temporary absences from the state with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished, do not interrupt continuity of residence. Residence is retained until abandoned or established in another state.

1. For individuals entering the state, the earliest date of residency is the date of entry. Residence may not be established for individuals who claim residence in another state.
   An individual's Medicaid case may remain open in the other state for a period of time after the individual moves, however, most states will not cover out-of-state care so eligibility may be determined as of the date the individual entered the state. If the other state will pay for the care in North Dakota, wait to open the case until the other state stops the coverage.
   > **Note:** If the only reason the other state will not pay for the medical care is due to a North Dakota provider failing to register as a provider in that state, we must wait to open the case in North Dakota until the other state ends the individual's coverage.

   Likewise, when an individual leaves the state, eligibility is ended as soon as, and in accordance with, proper notice. North Dakota Medicaid will no longer extend coverage through the month in which an individual moves out of the state. This information must be documented in the casefile.
2. For students entering the state to attend school full time and are between the ages of 18 and ~~Students up to age~~ 22 (including the month the child attains age 22), who apply for ACA Medicaid on their own behalf, are considered North Dakota residents if~~:~~ the individual intends to remain in North Dakota when their education has been completed. Individuals who do not intend to remain in North Dakota when their education has been completed are considered to be residing in the state temporary and are not considered a resident of North Dakota.
   > **Note:** For students under age 18 policy outlined in #3 and #4 below applies.

   ~~a. Either parent resides in North Dakota; or~~
   ~~b. Claimed as a tax dependent by someone who resides in North Dakota.~~
3. Individuals under age 21:
   a. For any individual under age twenty-one who is married and capable of indicating intent, the state of residence is the state where the individual is living, with the intention to remain.

b. Children receiving non-IV-E adoption assistance payments from another state are considered residents of North Dakota for Medicaid purposes if there is an Interstate Compact on Adoption and Medical Assistance (ICAMA) agreement with a member state that indicates that the receiving state will cover the Medicaid. Likewise, children from North Dakota receiving non-IV-E adoption assistance payments who move to another member state may no longer be considered North Dakota residents if the ICAMA agreement indicates that the receiving state will cover the Medicaid. The Children and Family Services division provides county agencies with information on whether a sending or receiving state is a member state and which state is responsible for the medical coverage per the agreement.

4. For any other non-institutionalized individual under age 21, the state of residence is the state in which the child is living with the child's parent or another caretaker relative on other than a temporary basis. A child is normally considered to be living in the state temporarily for reasons that include, but are not limited to the following ~~if~~:
    a. The child comes to North Dakota to receive services in the Anne Carlson School, maternity homes, etc. if the intent is to return to the child's home state upon completion of the ~~education or~~ service;
    b. The non IV-E foster child is placed by an out-of-state court into the home of relatives or foster parents in North Dakota on other than a permanent basis or on other than an indefinite period; or
    c. The child entered the state to participate in specialized services if the intent is to return to the child's home state upon completion of the activity or service. (Specialized services include a temporary stay in a PRTF, TBI facility, etc.)
5. Individuals age 21 and over:
    a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period or is entering the state with a job commitment or seeking employment.

       The state of residence, for Medicaid purposes, of migrants and seasonal farm workers is the state in which they are living due to employment or seeking employment.

b. For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.
c. For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

6. An "individual incapable of indicating intent" means one who:
   a. Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the Division of Mental Health of the Department of Human Services;
   b. Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01;
   c. Has been found by a court of competent jurisdiction to be legally incompetent; or
   d. Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation.
7. Individuals placed in out-of-state institutions by a state agency retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. State residence ends, however, when the competent individual leaves the facility in which the individual was placed by the state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

   State agencies include human service centers, the Division of Juvenile Services, special education, county social service offices, the Department of Human Services, and the Health Department. Tribal entities and hospital social workers or other staff are not state agencies.

8. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.
9. For any individual on whose behalf payments for regular foster care are made, the state of residence is the state making the payment.
10. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of an affected individual is the state determined under that agreement.

    North Dakota has a specific agreement with the State of Minnesota. The agreement states that individuals who enter a nursing facility in the other state remain a resident of the state they were a resident of prior to admission into the nursing facility for 24 months following admission, and if the individual has a community spouse, they continue to be a resident of the state the community spouse lives in beyond the 24 month time limit. This agreement terminates at the point the individual is discharged from a nursing facility unless the individual is being transferred to a different nursing facility.
11. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.
12. North Dakota residents will be provided Medicaid outside the state when:
    a. It is a general practice for residents of a particular locality to use medical resources outside the state;
    b. The availability of medical resources requires an individual to use medical facilities outside the state for short or long periods. Prior approval from the Medical Services Division must be obtained when an individual is being referred for out-of-state medical services.

       Transportation for approved out-of-state medical services will be arranged jointly by the individual and the county agency.
    c. Individuals are absent from the state for a limited period of time to receive special services or training;
    d. It is an emergency situation; and
    e. Services are received during an eligible period but prior to application.

13. 510-03-35-95, Public Institutions. **This section is being renamed to remove information regarding IMDs, as IMDs are being added to a new section.**

Public Institutions 510-03-35-95

1. An "inmate" of a public institution is not eligible for Medicaid unless the eligible individual is a child under the age of 21, who is determined to be continuously eligible. Such child remains eligible for Medicaid; however, no medical services will be covered during the stay in the public institution.
    a. A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, but does not include a medical institution.
        Examples include (but are not limited to): School for the Blind, School for the Deaf, North Dakota Youth Correctional Center, Women's Correctional Center in New England, North Dakota State Penitentiary, Bismarck Transition Center, and city, county, or tribal jails.

        The Bismarck Transition Center (BTC) is a community-based correctional program designed to help eligible, non-violent offenders transition back into the community, and is a public institution. Individuals entering this facility as "inmates" who are sent to the facility for assessment purposes are committed under the penal system and will be arrested if they leave. Because such individuals are "inmates," they are not eligible for Medicaid. (Individuals entering this facility on a voluntary basis while on probation are not "inmates.")

        While some institutions are owned or controlled by governmental entities, they do not meet the definition of public institutions because they are medical institutions.
            Examples include (but are not limited to): State Hospital, State Developmental Center at Grafton, Veterans Administration Hospitals, and the North Dakota Veteran's Home.

b. An "inmate" of a public institution is a person who has been involuntarily sentenced, placed, committed, admitted, or otherwise required to live in the institution, and who has not been unconditionally released from the institution.

   "Unconditionally released" means released, discharged, or otherwise allowed or required to leave the institution under circumstances where a return to the institution cannot be required by the operator of the institution.

   Residence in a penal institution is terminated by parole, discharge, release on bond, or whenever the individual is allowed to return and reside in their home. A transfer from a penal facility to the state hospital or another medical institution, for evaluation or treatment does not terminate inmate status.

   Example: A release from a penal institution to a hospital for the birth of the inmate's child will not terminate inmate status if the inmate is required to return to the penal institution following discharge from the hospital.

c. An individual who is voluntarily residing in a public institution or who has not yet been placed in the facility is not an "inmate." An individual is not considered an "inmate" (so can remain or become eligible for Medicaid) if:
   i. The individual is attending school at the North Dakota School for the Blind in Grand Forks, or the North Dakota School for the Deaf in Devils Lake;
   ii. The individual is in a public institution for a temporary period pending other arrangements appropriate to the individual's needs (i.e., Juvenile Detention Center, Fargo);
   iii. The individual has not yet been placed in a public institution. For instance, an individual who is arrested and transported directly to a medical facility is not an inmate until actually placed in the jail. The individual may remain Medicaid eligible until actually placed in jail; or
   iv. The individual enters the Bismarck Transitional Center (BTC) on a voluntary basis while on probation.

The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from a public institution or IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the public institution or IMD. See Paragraph (4)(c)(iii) of 510-03-25-25, "Decision and Notice," for further information.

Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions 510-03-35-95-05

14. 510-03-35-95-05, Coverage for Inmates Receiving Inpatient Care in Certain medical Institutions. This new section was created to incorporate the policy for Coverage of Inmates Receiving Inpatient Care in Certain medical Institutions from IM 5260 and IM 5275.

General Statement (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-03-35-95-05-05

As a general rule, an individual becomes ineligible for Medicaid coverage when he or she is incarcerated and is an inmate with the Department of Corrections and Rehabilitation (DOCR) or a county jail. The 2011 Legislature passed Senate Bill 2024 which required the Department to expand Medicaid coverage to include Medicaid-covered services provided to an inmate who is admitted as an inpatient in certain Medical Institutions. This provision became effective with the benefit month of October 1, 2015, with the implementation of the new MMIS Health Enterprise System.

Definitions for Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions 510-03-35-95-05-10

For purposes of the Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions section:

1. Inpatient: A patient who has been admitted to a medical institution as an 'inpatient' on recommendation of a physician or dentist and:
    a. Receives room, board and professional services in the institution for a 24 hour period or longer, or
    b. Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer

even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

NOTE: An individual may be placed in a hospital under an 'observation' status, which is an 'outpatient' category. These individuals are not considered receiving inpatient medical care and not eligible for Medicaid under this provision.

2. Medical Institution means an institution that:
   a. Is organized to provide medical care, including nursing and convalescent care;
   b. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
   c. Is authorized under State law to provide medical care; and
   d. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.
3. Department of Corrections and Rehabilitation includes the ND State Penitentiary and Missouri River Correctional Center in Bismarck, Dakota Women's Correctional and Rehabilitation Center in New England, James River Correctional Center in Jamestown, and the North Dakota Youth Correctional Center in Mandan.
4. County Jail means a place of confinement for persons held in lawful custody under the jurisdiction of a local government. A listing of county jails in North Dakota can be found at: http://www.nd.gov/docr/county/jails.html

   Note: This does not include Tribal run jails.

Individuals Covered (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-03-35-95-05-15

Individuals who are not eligible for Medicaid because they are incarcerated and are inmates with the Department of Corrections and Rehabilitation (DOCR) or with a county jail are eligible for payment of their Medicaid-

covered services received while an inpatient in one of the following Medical Institutions:

- A hospital,
- A nursing facility (nursing home),
- A Psychiatric Residential Treatment Facility (PRTF),
- An Intermediate Care Facility for the Intellectually Disabled (ICF-ID),

The inmate must apply for and meet all other Medicaid factors of eligibility. Individuals who are not aged or disabled will have their eligibility determined under this Chapter.

Individuals who are aged or disabled will have their eligibility determined based on Non-ACA Medicaid Policy defined in Manual Chapter 510-05.

Note#1: Individuals who become incarcerated will have their Social Security and SSI benefits terminated by the Social Security Administration. However, these individuals continue to be considered disabled for Medicaid purposes.

Note #2: Individuals who are under age 65, disabled, and do not have Medicare coverage, who fail the asset limits, can have their eligibility determined under ACA Medicaid.

Eligibility begins on the date the inmate is admitted as an inpatient in a medical institution and ends the day they are discharged from the medical institution. Any services received before the inmate is admitted or after the inmate is discharged from the medical institution will not be covered by Medicaid.

Individuals who are:

- Greater than age 21 but less than age 65 will be assigned a COE of M072.
- Pregnant, under age 21, or aged or disabled will be assigned a COE of M073.

  Note: For individuals who are aged, blind or disabled, please refer to policy at 510-05-35-95-05-10.

Regardless of the COE assigned individuals eligible under this provision:

- Will have their inpatient care paid through the Traditional Medicaid Fee for Service benefit plan.

- Will receive notification of their Medicaid ID Number from ND Health Enterprise MMIS;
- Will not be issued a Medicaid ID Card;
- Will not be subject to the inpatient hospital co-payment.

Asset Considerations (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-03-35-95-05-20

There is no asset test for applicants and recipients whose eligibility is determined under ACA Medicaid. Asset provisions do not apply to these individuals.

The medically needy asset provisions defined in Service Chapter 510-05-70 apply to all aged, blind, and disabled applicants and recipients under this provision.

Income Considerations (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-03-35-95-05-25

Income calculations for those eligible under ACA Medicaid are defined at 510-03-85.

Income Levels (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-03-35-95-05-30

Income levels for those eligible under ACA Medicaid are defined at 510-03-85-40.

Budgeting (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-03-35-95-05-35

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

Refer to Section 510-03-110, Policy Processing Appendix for information on how to process eligibility for these individuals.

15. 510-03-35-95-10, Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities. This new section was created to incorporate the policy for Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities from IM 5288

Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-03-35-95-10

Inmates of public institutions, who are held **involuntarily,** are not eligible for Medicaid coverage with the exception of Medicaid coverage for inmates who receive care as an inpatient in a hospital, nursing facility (nursing home), Psychiatric Residential Treatment Facility (PRTF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Recently, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states on facilitating access to all covered Medicaid services for inmates, in certain circumstances, **after** a stay in a public institution, who are residing in corrections-related supervised community residential facilities.

Note: Different than coverage for Inmates Receiving Inpatient Services, this coverage is available for inmates who were inmates in a Tribal jail and residing in one of the corrections-related supervised community residential facilities, provided all criteria below are met.

Inmates residing in state or local corrections-related supervised community residential facilities (whether operated by a governmental entity or a private entity) are eligible for Medicaid unless the inmate does not have the freedom of movement and association while residing at the facility. To meet this requirement, the facility must operate in such a way as to ensure that individuals living there have freedom of movement and association, and the resident:

1. MUST be able to work outside the facility in employment available to individuals who are not under justice system supervision;
2. MUST be able to use community resources (libraries, grocery stores, recreation, education, etc.) "at will"; and
3. MUST be able to seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state.

   For this purpose, "at will" includes and is consistent with requirements related to operational "house rules" where, for example the residence may be closed or locked during certain hours or where residents are required to

report during certain times and sign in and out. Similarly, an individual's supervisory requirements may restrict traveling to or frequenting certain locations that may be associated with high criminal activity.

Currently, we have the following corrections-related supervised community residential facilities that house inmates.

- Bismarck Transition Center
- Centre Inc. in Mandan
- Centre Inc. in Fargo
- Centre Inc. in Grand Forks
- Teen Challenge in Mandan
- Lake Region Residential Reentry Center

Note: These facilities also house individuals who are on parole and probation. Individuals on probation or parole are not considered inmates.

Based on this guidance, and in discussion with staff at the Department of Corrections and Rehabilitation, inmates residing in these facilities meet the criteria listed in #1 through #3 above and may be eligible for Medicaid **if all other factors of eligibility are met.**

Federal inmates residing in "Residential Reentry Centers" are not eligible for Medicaid coverage under this provision as the Department of Justice (DOJ) and/or Bureau of Prisons (BOP) retains responsibility for payment of health care services rendered to individuals in Residential Re-entry Centers (RRCs).

If an inmate was incarcerated by another state and was sent to North Dakota for any reason, including the other state not having capacity to house the individual, the other state remains the state of residence. The inmate would retain residency for purposes of Medicaid eligibility in the other state and eligibility in North Dakota would be denied for 'Not a Resident'.

Likewise, if an inmate was incarcerated by North Dakota and was sent to another State for any reason, including North Dakota not having capacity to house the individual, North Dakota remains the state of residence. The inmate would retain residency for purposes of Medicaid eligibility in North Dakota. When determining the Medicaid Unit for this individual under ACA, the household of the individual is determined based on their tax filing status. While the individual is considered NOT residing in the home, this may result in a spouse or child(ren) needing to be included in the ACA case.

Many of these individuals are allowed to work in the community. This income must be considered when determining eligibility.

Processing for these individuals can be found in the Processing Appendix at 510-03

Institutions for Mental Disease (IMD) 510-03-35-97

16. 510-03-35-97, Institutions for Mental Disease (IMD). This is a new section being added to incorporate policies from Section 510-045-95 relating to IMD's only.

Institutions for Mental Disease (IMD) 510-03-35-97

An individual under age 65 who is a "patient" in an IMD is not eligible for Medicaid, except as identified in subdivision d, unless the individual is under age 21 and is receiving inpatient psychiatric services and meets the certificate of need for admission. An individual who attains age 21 while receiving treatment, and who continues to receive treatment as an inpatient, may continue to be eligible through the month the individual attains the age of 22.

a. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. A facility with 16 beds or less is not an IMD. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of mental diseases. An intermediate care facility for individuals with intellectual disabilities (ICF-IID) is not an IMD.

   IMDs include the North Dakota State Hospital, facilities determined to be a Psychiatric Residential Treatment Facility (PRTF) by the Medical Services Division, Prairie at St. John's, and the Stadter Psychiatric Center. For any other facility, contact the Medical Services Division for a determination of whether the facility is an IMD.

b. An individual on conditional release or convalescent leave from an IMD is not considered to be a "patient" in that institution. However, such an

individual who is under age 21 and has been receiving inpatient psychiatric services is considered to be a "patient" in the institution until unconditionally released or, if earlier, the last day of the month in which the individual reaches age 22.

c. An individual on conditional release is an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.
d. A child under the age of 19 who is determined to be continuously eligible for Medicaid, but who does not meet the certificate of need, remains eligible for Medicaid, however, no medical services will be covered during the stay in the IMD.

The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from a public institution or IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the public institution or IMD. See Paragraph (4)(c)(iii) of 510-03-25-25, "Decision and Notice," for further information.

Child Support Enforcement 510-03-40

17. 510-03-40-15, Cooperation – Child Support. Incorporating policy regarding child support requirements from IM 5264 and IM 5275.

Cooperation – Child Support 510-03-40-15

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

1. Pregnant women are not required to cooperate with Child Support and may remain eligible for Medicaid 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. Recipients of Extended Medicaid Benefits and Transitional Medicaid Benefits are not required to cooperate with Child Support and remain eligible for Medicaid.
3. Caretaker relatives under age 19 who are within a continuous eligibility period are not required to cooperate with Child Support and remain eligible for Medicaid
4. Parent/Caretaker relatives of subsidized adoption children are exempt from cooperation.
5. Parent/Caretaker relatives of deprived children are exempt from cooperation if they are not requesting Medicaid for themselves.
6. ~~Cooperation with Child Support is required for all other legally responsible caretaker relatives for the purpose of establishing paternity and securing medical support. This requirement may be waived for "good cause" as described in 510-03-40-20.~~ 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.

The requirement may be waived for good cause as described in 510-03-40-20.

The determination of whether a legally responsible caretaker relative is cooperating is made by the Child Support Agency. 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.

  Note: The form must be filed in the casefile and MUST NOT be mailed to the Regional Child Support Office.

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.

Continuous Eligibility for Children 510-03-53

18. 510-03-53-15, Continuous Eligibility Periods. Incorporated policy regarding continuous eligibility periods will no longer be established during the three months prior (THMP) from IM 5275.

Continuous Eligibility Periods 510-03-53-15

1. Continuous eligibility may be established from the first day of:
   a. The application month; or
   b. ~~The earliest month of eligibility during the three month prior (THMP) period, or~~
   c. The month after the application month in which the individual becomes eligible for Medicaid under a coverage group other than medically needy~~, if not eligible during the three months prior to the application month~~.

When eligibility is being determined for one of the three prior months or when any other retroactive eligibility is approved, the continuous eligibility period DOES NOT begin during any of the retroactive months. An individual may be Medicaid eligible during the retroactive months; however, their eligibility is based on their actual circumstances during those months.

Example: A family applies for Medicaid on May 8 and requests coverage for the THMP period of February, March and April. When processing the application month and THMP months, the child is determined eligible as an ACA Child in February and March, Medically Needy with a 'spend down' in April and as an ACA child in May. The child becomes continuously eligible effective May 1.

~~When assigning the 12 month continuous eligibility period do not include THMP months when determining the 12 month period.~~

~~**Example 1:** Mom and child apply for Medicaid on June 8 and eligibility for the three prior months is not requested. The child is determined to be categorically needy eligible as an ACA child. The child becomes continuously eligible effective June 1. The continuous eligibility period would run thru May 31st.~~

~~**Example 2:** Mom and child apply for Medicaid on July 1 and request Medicaid for May and June. When determining eligibility for May and June, the child is categorically eligible as an ACA Child. The child becomes continuously eligible effective July 1, 2014. The continuous eligibility period would end June 30th, 2015.~~

~~**Example 3:** Mom and child apply for Medicaid on June 1 and request Medicaid for April and May. When determining eligibility for April, the child is categorically eligible. When determining eligibility for May, the child would be medically needy eligible.~~

~~Since the child became continuously eligible effective April 1, 2014 the changes in income for May forward would not be acted on for the child's eligibility. However, the changes would be acted on for mom's eligibility. The continuous eligibility period would end May 31st, 2015.~~

~~**Example 4:** An application was taken for the month of September and the child was determined medically needy for September and October. When determining eligibility for November, the family's income decreased so the child becomes categorically needy eligible for November. The child becomes continuously eligible effective November~~

~~1 and their continuous eligibility period end date would be equal to the review due date of August 31.~~

~~In November the parents provide verification of decreased income for October and when re-working the month of October the child is now categorically needy eligible. The child's continuous eligibility period would begin October 1, but their continuous eligibility period end date would remain as is; equal to the review due date of August 31.~~

~~**Example 5:** An application was taken in October. The household consists of a woman who gave birth in August and is requesting coverage of her labor and delivery costs. The woman was categorically needy eligible in August. The newborn became continuously eligible for Medicaid beginning in August and the continuous eligibility period runs through July 31, the end of the month prior to the month of its first birthday. The woman is not entitled to 60 days of extended coverage because she applied after the birth.~~

2. Except as identified in subsection 4, once an individual becomes continuously eligible, they remain eligible for Medicaid without regard to changes in circumstances, until they have been on Medicaid for 12 consecutive months. They do not have to have been continuously eligible for the entire 12 months.
3. When a review of eligibility is completed an eligible individual may be determined to be eligible for a new continuous eligibility period.

   Reviews must be completed at least annually, but may be scheduled earlier in order to align continuous eligibility periods within a case between children, or to align review dates with other programs.
   a. If the individual's previous continuous eligibility period ended, the individual must meet all eligibility criteria to continue eligible for Medicaid.
   b. If a review is being completed before the individual's continuous eligibility period has ended, and the individual meets all Medicaid eligibility criteria, the individual begins a new continuous eligibility period.
   c. If a review is being completed before the individual's continuous eligibility period has ended, and the individual fails to meet all Medicaid eligibility criteria, the individual remains eligible only until the end of their current continuous eligibility period. A new review

of eligibility is required at that time to establish any further eligibility.

4. A continuous eligibility period must be ended earlier than when the review is due for any of the following reasons:
   a. The recipient turns age 19;
   b. The recipient loses state residency;
   c. The recipient requests that their coverage end;
   d. The recipient dies;
   e. The agency has lost contact with the family and the child's whereabouts are unknown; or
   f. The recipient has failed to provide verification of citizenship or identity within their reasonable opportunity period.

   A continuous eligibility period must also be ended if it is determined that the recipient should not have become continuously eligible because the individual was approved in error; approval was based on fraudulent information; an appealed ending is upheld in favor of the agency.

Foster Care and Related Groups 510-03-55

19. 510-03-55-05 Foster Care. Incorporates the policy that a child no longer is required to reside in an approved licensed foster care home or facility in order to be considered 'in foster care', from IM 5262.

Foster Care 510-03-55-05

For Medicaid purposes, a child is not considered to be in foster care unless all the following requirements are met:

1. There is a current foster care court order;
2. A public agency has care, custody, and control of the child;
3. ~~The child is residing in an approved licensed foster care home or facility (a Psychiatric Residential Treatment Facility (PRTF) is not a licensed foster care facility); and~~

3. ~~4.~~ The child is a foster care child in the state foster care system through the state's Children and Family Services unit, or a Tribal 638 Foster Care child.

Example: A child is placed with a relative who is not a licensed Foster Care home. Since the child is NOT residing in an approved licensed foster care home or facility, the child's eligibility is determined using non-Foster Care ACA Medicaid policies.

Children who are placed on Trial Home Visits, including those who are placed on a Trial Home Visit during the month they attain age 18, will be considered 'in Foster Care'. Therefore, these children will now meet the requirements to be eligible under the Former Foster Care Child group through the month they attain age 26, without requiring a budget test, if all other factors of eligibility are met.

Note: If a foster care child was on a trial home visit when the child attained age 18 prior to November 1, 2015, the child should now be considered to have been in ND foster care at that point in time for the purpose of determining current and future Medicaid eligibility for the former foster care eligibility group effective November 1, 2015.

A child who was previously found ineligible for coverage under the Former Foster Care group due to being placed on a Trial Home Visit may meet the requirement for eligibility beginning November 1, 2015. The child's eligibility cannot be changed prior to November 1, 2015, including any THMP months prior to November 1, 2015.

Children who were determined eligible based on the Foster Care eligibility criteria and who no longer meet one of the criteria listed above are no longer considered Foster Care children. Eligibility must be determined based on non-Foster Care criteria.

Children who are removed from the parental home and placed directly into a facility that is not an approved licensed foster care home or facility (PRTF) do not meet the four (4) criteria listed above. Therefore, they cannot have their eligibility determined using the Foster Care eligibility criteria.

Hospital Presumptive Eligibility (HPE) 510-03-60

20. 510-03-60 - Hospital Presumptive Eligibility (HPE). Creating this new section to incorporate the policy for Hospital Presumptive Eligibility (HPE)

implemented with IM 5256.

General Statement (Hospital Presumptive Eligibility (HPE) 510-03-60-05

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) 510-03-60-10

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) 510-03-60-15

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 in the individual attains age 65);

Eligibility Requirements for Hospital Presumptive Eligibility (HPE) 510-03-60-20

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) 510-03-60-25

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

Hospital Presumptive Eligibility (HPE) Periods 510-03-60-30

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) 510-03-60-35

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) 510-03-60-40

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 510-03-60-45

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

Hospital Responsibility under Hospital Presumptive Eligibility (HPE) 510-03-60-50

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.

Income 510-03-85

21. 510-03-85-13 ACA Income Methodologies. Incorporates the policy for treatment of lump sum income from IM 5275.

ACA Income Methodologies 510-03-85-13

The following income methodologies will be used in determining income eligibility for individuals eligible under ACA Medicaid:

1. Income is based on household composition, tax filer rules, and who resides with the individual.
2. Monthly income is used prospectively.
3. Current, point in time income is used—prospecting reasonable expected changes.

Married couples, who file their taxes jointly, must be included in each other's households, even if they are not residing together. This includes situations where one of spouses is incarcerated.

Note: The incarcerated spouse is not eligible for Medicaid.

Income of most children NOT expected to be required to file a federal income tax return is considered as follows:

1. A tax dependent CHILD's income does not count in a tax filer's parents or caretaker's household if the child is not required to file a tax return.
2. A tax dependent CHILD's income does not count in the child's household, IF the tax filer parent or tax filer caretaker is in the child's ACA Medicaid household.
3. If the tax filer parent or tax filer caretaker is NOT in the child's ACA Medicaid household, the child's income DOES count in the child's household. (E.g. the child is in (non-IV-E) foster care).
4. If the child is not required to file a tax return, however, files a return in order to get a refund of taxes withheld, that child's income is NOT counted in either the tax-filer's or the child's household.

If the child IS required to file a tax return, the child's income is counted in all the households in which the child is included.
Filing requirements change every year and this information may be found in the instructions for Form 1040 at http://www.irs.gov/.

In determining whether a child has to file income tax:

1. If a child has income other than SSA benefits, the child must file if their unearned income (excluding child support) exceeds $1000 annually.
2. The TAXABLE portion of the child's Social Security (SSA) benefits must be considered. Normally, only 50% of the SSA benefit is subject to taxation.

SSA benefits are only taxable to the extent that 50% of the SSA benefit PLUS the individual's other income exceeds $25,000. The child's TOTAL yearly income minus half of the SSA income would have to be more than $25,000 to be taxable; and then only the excess over $25,000 would be taxable.

If the child's only income were SSA income, the monthly benefit would have to be over $4,166.67 per month to be countable, and over $4,333.33 to require filing a tax return.

Example: A child, age 17, receives $480 per month in Social Security survivor benefits. In addition, the 17 year old is employed and earns

approximately $1000 per month. The child is claimed as a dependent on his parent's tax return.

Based on the child's earned income, he is required to file a tax return. However, his SSA benefits are not taxable as his earnings of $12,000 for the year plus 50% of the SSA benefits ($2,880) do not exceed $25,000.

Non-recurring and recurring lump sum payments of income not identified as Disregarded Income in section 510-03-85-30, count only in the month received.

- ~~When a payment is received and prorated in an ongoing case, or after a period of Medicaid eligibility, and the case is closed and then reopened during the prorated period, or within the following proration period, the lump sum payment proration must continue.~~

- ~~All other recurring unearned lump sum payments received before application for Medicaid are considered income in the month received and are not prorated.~~

Calculating "self-employment" Income

The most recent income tax forms must be requested from individuals who are self-employed. If the individual provides their most recent income tax forms, the information will be used to determine their countable self-employment income IF it is indicative of what the income will be for the current year.

When a self-employed individual has not filed their taxes or the business is newly established, there are no federal income tax forms to use. In this situation, the household needs to submit copies of their ledgers, receipt books, etc. The county agency and self-employed individual will use the best information available to determine the countable income as defined in #1 through #8 below, minus allowable expenses identified in section 510-03-85-35, Income Deductions.

Net earnings or losses from self-employment as considered for income tax purposes are counted for ACA Medicaid Households.

NOTE: Losses from self-employment can be used to offset other countable income.

1. Using the amount from the line on the income tax forms titled 'Adjusted Gross Income (AGI)';
2. Subtract any amount in the line titled 'Wages, salaries, tips, etc.', as current, point in time income is used.
3. Subtract the amount in the Capital Gain line, if Capital Gains are not expected to recur. (If they are expected to recur, do not subtract them).
4. Subtract the amount in the 'Taxable refunds, credits, or offsets of state and local income taxes' line as these are ONLY countable in the month received.
5. Subtract any scholarships, awards, or fellowship grants used for education purposes and not for living expenses, IF they are included in the 'Adjusted Gross Income'.
6. Add tax-exempt interest;
7. Add tax-exempt Social Security income (determined by subtracting the taxable amount of Social Security Benefits from the total amount.)

22. 510-03-85-20, Income Conversion. Incorporating the policy to no longer convert income in a THMP month, implemented with IM 5264.

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.

Example#1: 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.

Example #2: 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 application received on or after February 1, 2016, ~~W~~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.~~

23. 510-03-85-25, Income Compatibility. A new section is being added to include the policy for Income Compatibility from IM 5264.

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.

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.

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

24. 510-03-85-40, Income Levels. Incorporated the income level changes that became effective April 1, 2017, from IM 5272.

Income Levels 510-03-85-40

Following are the Income Levels for the various categories under ACA Medicaid Categorically Needy:

1. Parents and Caretakers of Deprived Children and their Spouses who are NOT eligible for Medicare, SSI or over age 65 – (ACA Equivalent to 1931 Fixed Levels).

The family size is increased for each unborn when determining the appropriate family size.

~~Number of Persons~~ Household Size	Monthly Income Level	Yearly Income Level
1	$517	$6,204
2	694	8,328
3	871	10,452
4	1,048	12,576
5	1,226	14,712
6	1,403	16,836
7	1,580	18,960
8	1,757	21,084
9	1,934	23,208
10	2,111	25,332
Plus - 1	178	2,136
Effective January 1, 2014		

2. Parents and Caretaker Relatives who ARE Medicare beneficiaries, SSI recipients or over age 65. (Parent and Caretaker Relative fixed dollar level listed in #1 above PLUS the 5% Federal Poverty Level disregard.)
   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Annual Income Level
1	$566	$6,792
2	760	9,120
3	955	11,460
4	1,149	13,788
5	1,344	16,128
6	1,539	18,468
7	1,733	20,796
8	1,927	23,124
9	2,122	25,464
10	2,316	27,792

Plus - 1	195	2,339
Effective April 1, 2015		

3. Children ages 6 through 18 and Individuals eligible for the Adult Expansion Group - 133% + the 5% disregard or 138%.

   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Annual Income Level
1	~~$1,353~~ 1,386	~~$16,243~~ 16,643
2	~~1,831~~ 1,867	~~21,983~~ 22,411
3	~~2,310~~ 2,348	~~27,724~~ 28,180
4	~~2,788~~ 2,829	~~33,465~~ 33,948
5	~~3,267~~ 3,309	~~39,206~~ 39,716
6	~~3,745~~ 3,790	~~44,947~~ 45,485
7	~~4223~~ 4,271	~~50,687~~ 51,253
8	~~4702~~ 4,751	~~56,428~~ 57,022
9	~~5180~~ 5,232	~~62,169~~ 62,790
10	~~5659~~ 5,713	~~67,910~~ 68,558
Plus - 1	~~478~~ 480	~~5,741~~ 5,768
Effective April 1, ~~2015~~ 2017		

4. Children ages 0 through ~~5~~ 6 and Pregnant Women - 147% + the 5% disregard or 152%.

   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Annual Income Level
1	~~$1,490~~ 1,527	~~$17,890~~ 18,331
2	~~2,017~~ 2,057	~~24,214~~ 24,685
3	~~2,544~~ 2,586	~~30,537~~ 31,038
4	~~3,071~~ 3,116	~~36,860~~ 37,392

5	~~3,598~~ 3,645	~~43,183~~ 43,746
6	~~4,125~~ 4,174	~~49,506~~ 50,099
7	~~4,652~~ 4,704	~~55,830~~ 56,453
8	~~5,179~~ 5,233	~~62,153~~ 62,806
9	~~5,706~~ 5,763	~~68,476~~ 69,160
10	~~6,233~~ 6,292	~~74,799~~ 75,514
+1	~~526~~ 529	~~6,323~~ 6,354
Effective April 1, ~~2015~~ 2017		

5. ACA Medically Needy (Pregnant Women) – 90% of Poverty Level.

   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Yearly Income Level
1	$~~882~~ 904	$~~10,593~~ 10,854
2	~~1,194~~ 1,218	~~14,337~~ 14,616
3	~~1,506~~ 1,531	~~18,081~~ 18,378
4	~~1,818~~ 1,845	~~21,825~~ 22,140
5	~~2,130~~ 2,158	~~25,569~~ 25,902
6	~~2,442~~ 2,472	~~29,313~~ 29,664
7	~~2,754~~ 2,785	~~33,057~~ 33,426
8	~~3,066~~ 3,099	~~36,801~~ 37,188
9	~~3,378~~ 3,412	~~40,545~~ 40,950
10	~~3,690~~ 3,726	~~44,289~~ 44,712
+1	~~312~~ 313	~~3,744~~ 3,762
Effective April 1, ~~2015~~ 2017		

6. ACA Medically Needy (Child 0 to 21) - 92% of Poverty Level.

   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Yearly Income Level
1	$~~902~~ 924	$~~10,828~~ 11,095

2	~~$1,221~~ 1,245	~~$14,656~~ 14,941
3	~~$1,540~~ 1,565	~~$18,483~~ 18,786
4	~~$1,859~~ 1,886	~~$22,310~~ 22,632
5	~~$2,178~~ 2,206	~~$26,137~~ 26,478
6	~~$2,497~~ 2,526	~~$29,964~~ 30,323
7	~~$2,815~~ 2,847	~~$33,792~~ 34,169
8	~~$3,134~~ 3,167	~~$37,619~~ 38,014
9	~~$3,453~~ 3,488	~~$41,446~~ 41,860
10	~~$3,772~~ 3,808	~~$45,273~~ 45,706
+1	~~$318~~ 320	~~$3,827~~ 3,846
Effective April 1, ~~2015~~ 2017		

7. ACA Medically Needy (Parents/Caretaker relative and their spouses) - 93% of Poverty Level.

   The family size is increased for each unborn when determining the appropriate family size.

Household Size	Monthly Income Level	Yearly Income Level
1	~~$912~~ 934	~~$10,946~~ 11,216
2	~~$1,234~~ 1,258	~~$14,815~~ 15,103
3	~~$1,556~~ 1,582	~~$18,684~~ 18,991
4	~~$1,879~~ 1,906	~~$22,553~~ 22,878
5	~~$2,201~~ 2,230	~~$26,421~~ 26,765
6	~~$2,524~~ 2,554	~~$30,290~~ 30,653
7	~~$2,846~~ 2,878	~~$34,159~~ 34,540
8	~~$3,168~~ 3,202	~~$38,028~~ 38,428
9	~~$3,491~~ 3,526	~~$41,897~~ 42,315
10	~~$3,813~~ 3,850	~~$45,765~~ 46,202
+1	~~$322~~ 323	~~$3,869~~ 3,887
Effective April 1, ~~2015~~ 2017		

8. ACA Maintenance of Effort – Medicaid – Children ages 6 through 18.

The family size is increased for each unborn when determining the appropriate family size.

Household Size	111% FPL Monthly	111% FPL Annual	133% FPL Monthly	133% FPL Annual
1	~~$1,088~~1,115	~~$13,065~~ 13,387	~~$1,304~~ 1,336	~~$15,654~~ 16,040
2	~~$1,473~~ 1,502	~~$17,682~~ 18,026	~~$1,765~~ 1,799	~~$21,187~~ 21,599
3	~~$1,858~~ 1,888	~~$22,300~~ 22,666	~~$2,226~~ 2,263	~~$26,720~~ 27,159
4	~~$2,243~~ 2,275	~~$26,918~~ 27,306	~~$2,687~~ 2,726	~~$32,253~~ 32,718
5	~~$2,627~~ 2,662	~~$31,535~~ 31,946	~~$3,148~~ 3,189	~~$37,785~~ 38,277
6	~~$3,012~~ 3,048	~~$36,153~~ 36,586	~~$3,609~~ 3,653	~~$43,318~~ 43,837
7	~~$3,397~~ 3,435	~~$40,770~~ 41,225	~~$4,070~~ 4,116	~~$48,851~~ 49,396
8	~~$3,782~~ 3,822	~~$45,388~~ 45,865	~~$4,531~~ 4,579	~~$54,384~~ 54,956
9	~~$4,167~~ 4,208	~~$50,006~~ 50,505	~~$4,993~~ 5,042	~~$59,917~~ 60,515
10	~~$4,551~~ 4,595	~~$54,623~~ 55,145	~~$5,454~~ 5,506	~~$65,449~~ 66,074
+1	~~$384~~ 386	~~$4,618~~ 4,640	~~$461~~ 463	~~$5,533~~ 5,559
Effective April 1, ~~2015~~ 2017				

Budgeting 510-03-90

25. 510-03-90-30 Budgeting Procedures When Adding and Deleting Individuals. Incorporates the policy regarding the effects on eligibility for household members when adding individuals to a case from IM 5264 and IM 5275

Budgeting Procedures When Adding and Deleting Individuals 510-03-90-30

When an individual is added to an ACA Medicaid Household, a review must be completed to process eligibility for the individual. ~~This may affect the established household.~~

1. Individuals may be added to an eligible unit up to one year prior to the current month, provided
   a. The individual meets all eligibility criteria for Medicaid;

b. The eligible unit was eligible in all of the months in which eligibility for the individual is established; and
c. The individual was in the unit in the months with respect to which eligibility for that individual is sought.

Note: Individuals eligible under the Adult Expansion Group only, cannot be added as eligible prior to January 1, 2014.

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.

Client share (recipient liability) will be based on the unit's actual income and circumstances when adding each individual for retroactive periods. Client share must be based on the unit's income and circumstances from the base month, plus the best estimate of each individual's income and circumstances when adding each individual to the current or next month. Client share for other individuals in the ACA Medicaid Household who were medically needy eligible may increase or decrease with the addition of the new member. Any client share, or lack of, applied to previously paid claims will be adjusted.

Other individuals in the ACA Medicaid Household who were previously determined to be poverty level eligible remain poverty level eligible, regardless of any income change, when adding an individual to the unit.

2. Budgeting procedures when deleting individuals from a case.

When a member of an existing unit is expected to leave the unit during the benefit month, that person may remain as a member of the unit until the end of the benefit month.

Refer to Manual Section 510-03-53-20 for policy regarding deleting individuals who are Continuously Eligible and move out of the ACA Medicaid Household

26. 510-03-90-60 Budgeting Procedures for Three Prior Months (THMP). Incorporating the change to longer convert income in a THMP month, implemented with IM 5256.

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.

Related Programs 510-03-95

27. 510-03-95-50, North Dakota Health Tracks. Adding a new section to incorporate the information from IM 5275.

North Dakota Health Tracks 510-03-95-50

North Dakota Health Tracks (formerly EPSDT) is a preventive health program that is free for children age 0 to 21, who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help

prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling and other important health services. Health tracks will help schedule appointments for services and will also help with finding transportation to the services. Some services require prior authorization so be sure to check with your screener about these requirements.

Federal legislation requires states to make available to all Medicaid-eligible children under age 21 comprehensive, periodic health assessment, dental, vision and hearing services, and "medically necessary" follow-up diagnostic and treatment service. Due to the federal requirement, when approving a case that includes children under age 21 who are eligible for Medicaid, Eligibility Workers must manually create the ND Health Tracks Referral, print it locally and provide it to staff responsible for completing the screening in your county. In addition, the 'Health Tracks Initial History Questionnaire' form is automatically created and mailed at the time Medicaid Eligibility is initially authorized.

Reference Hard Cards 510-03-105

28. 510-03-105 Reference Hard Cards. This new section is being added to incorporate the Reference Hard Cards that can be utilized when determining eligibility for ACA Medicaid.

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
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
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

Intentionally Left Blank

29. 510-03-105-10 - Reference Hard Cards. This new section is being added to incorporate the Reference Hard Cards that can be utilized when determining eligibility for ACA Medicaid.

Medicaid Living Arrangement Reference Hard Card 510-03-105-10
This Reference Hard Card from IM 5295 lists all of the living arrangements used when determining eligibility for ACA Health Care Coverage.

MARCH 2017

MEDICAID LIVING ARRANGEMENTS IN SPACES

CD	Description	Examples	Comments	MA Level
IH	IN HOME	House Apartment Assisted Living Mobile Home Hospitalized		Full Income level
IS	AWAY AT SCHOOL	Boarding School Dormitory Living in Another Community to attend any school		Full Income level
AH	AWAY FROM HOME (Not in School)	Living in Another Community for Work Living in Another Community for Medical Care		Full Income level
SF	SPECIALIZED FACILITY	Basic Care Facility School for the Blind School for the Deaf Licensed Foster Care Home or Foster Care Facility Residential Treatment Center Transitional Living Center	Provides "remedial services" meaning services in specialized facilities which produce the maximum reduction of physical or mental disability and restoration of a resident to his best possible level of functioning. (Receiving services under the Voluntary Placement Program are considered residing in a Specialized Facility	Full Income level
LT	LONG TERM CARE FACILITY	Nursing Homes Swing Bed Psychiatric Residential Treatment Centers (PRTF's) • 3 Dakota Boys & Girls Ranch Facilities (DBGR) o Western Plains - Bismarck o DBGR – Minot o DBGR - Fargo • Luther Hall in Fargo • Pride Manchester in Bismarck • Ruth Meiers Adolescent Center – Grand Forks	**All of these Types require a Level of Care (LOC).** For PRTF: • **The LOC will designate PRTF.** • **If in a Foster Care Bed, there will either be no LOC or the LOC will indicate RCCF.** Prisoners placed in a Long Term Care Facility or PRTF will be given this Living Arrangement and must need care in LTC or PRTF for a 24 hour period or longer.	$85 - Full Calendar Month
IM	INTERMEDIATE CARE FACILITY FOR THE INTELECTUALLY DISABLED (ICF/IID'S)	Anne Carlsen Life Skills Transition Center **(See additional Listing on Additional Page)**	Prisoners placed in an ICF/IID will be given this Living Arrangement and must need care in the ICF/IID for a 24 hour period or longer.	ICF/IID - $100 – Full Calendar Month
JC	INSTITUTION FOR MENTAL DISEASES (IMD)	Out of State IMD Facility Stadter Psychiatric Center Prairie Psychiatric Center Robinson Recovery Center	**Must have Certification of Need (CON)** - If there is no CON, Individual is not eligible and Eligibility will be Suspended.	If Spousal case, $85 for all months including partial months
SH	STATE HOSPITAL	North Dakota State Hospital in Jamestown	No screening or certification of need required for individuals over age 65. Used for anyone over age 21. If age 21 and was in the State Hospital month attained age 21, continue to use State Hospital < age 21 through the month attaining age 22.	
JH	STATE HOSPITAL< AGE 21	North Dakota State Hospital in Jamestown	Used for anyone under age 21. If age 21 and was in the State Hospital month attained age 21, continue to use State Hospital < age 21 through the month attaining age 22.	
HH	HOME AND COMMUNITY BASED SERVICES/IN OWN HOME	. **(See Examples above for In Own Home)**	Screened for LTC but choose to receive services in their own home (outside of a Nursing Care Facility). Receive traditional Medicaid services plus services to enable them to remain in their home.	Full Calendar month – Medically Needy Level.
HS	HOME AND COMMUNITY BASED SERVICES/SPECIALIZED FACILITY	**(See Examples for "Specialized Facility")** **(See additional Listing on Additional Page)**	Screened for LTC but choose to receive services in a Specialized Facility (outside of a Nursing Facility). Receive traditional Medicaid services plus services to enable them to remain in their home.	If Spousal case, Medically Needy Level for all months including partial months
AI	PUBLIC INSTITUTION	ND State Penitentiary Youth Correctional Center James River Correction Center County Jails Dakota Women's Correctional Center Tribal Jails Missouri River Correctional Center	Individual is not eligible and Eligibility will be Suspended.	N/A
IP	INPATIENT PRISONER CARE	Use if in a Hospital setting ONLY: Only be available in SPACES with the Implementation for Phase 2.	Prisoners must need care in the hospital, nursing facility (nursing home), Psychiatric Residential Treatment Facility (PRTF) or an Intermediate Care Facility for the Intellectually Disabled (ICF-ID) for a 24 hour period or longer.	$85 - Full Calendar Month

March 2017

ICF/IID Facilities In North Dakota

Individuals residing Facilities at the listed address would be given the Living Arrangement of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Provider	Residential Address	City	Provider	Residential Address	City
4th Corporation	1110 Central Avenue	New Rockford	HIT, Inc.	1004 27th Street N. W.	Mandan
4th Corporation	927 3rd Street NE	Fessenden	HIT, Inc.	1417 S. Washington St.	Bismarck
4th Corporation	1510 1st Street South	Carrington	HIT, Inc.	1201 7th Ave. SE	Mandan
ABLE, Inc.	632 23rd Street West	Dickinson	HIT, Inc.	1203 7th Ave. SE	Mandan
ABLE, Inc.	1304 2nd Avenue S.	Hettinger	HIT, Inc.	1301 7th Ave SE	Mandan
ABLE, Inc.	1387 24th Street West	Dickinson	HIT, Inc.	1302 7th Ave SE	Mandan
ABLE, Inc.	1297 23rd Street West	Dickinson	Lake Region Corporation	923 6th Avenue	Devils Lake
ABLE, Inc.	1750 4th Ave E	Dickinson	Minot Voc. Adj. Workshop	1007 11th Avenue SE	Minot
Alpha Opportunities, Inc.	112 6th Avenue SE	Jamestown	Minot Voc. Adj. Workshop	1005 11th Avenue SE	Minot
Alpha Opportunities, Inc.	1510 8th Avenue NE	Jamestown	Minot Voc Adj. Workshop	11 Park Drive	Rolla
Anne Carlsen Center	701 3rd Ave. N.W.	Jamestown	Open Door Center	220 5th Avenue SW	Valley City
Anne Carlsen Center	603 -3rd St N.W.	Jamestown	Open Door Center	491 2nd Avenue NE	Valley City
Anne Carlsen Center	605 -3rd St N.W.	Jamestown	Open Door Center	664 10th Avenue SE	Valley City
Anne Carlsen Center	601-3rd St N.W.	Jamestown	Open Door Center	240 4th Avenue SE	Valley City
Development Homes Inc.	2585 South 19th Street	Grand Forks	Opportunity Foundation,	821 5th Avenue West	Williston
Development Homes Inc.	1551 24th Avenue South	Grand Forks	Opportunity Foundation,	1808 17th Court West	Williston
Development Homes Inc.	2720 17th Street South	Grand Forks	Red River Human Services Found.	348 14th Street North	Wahpeton
Enable, Inc.	3656 East Princeton	Bismarck	Red River Human Services Found.	821 Western Road	Wahpeton
Enable, Inc.	3665 West Princeton	Bismarck	Red River Human Services Found.	1348 15th Avenue North	Wahpeton
Enable, Inc.	1549 South Washington	Bismarck	Red River Human Services Found.	903 Mulberry Lane	West Fargo
Enable, Inc.	2100 12th Avenue SE	Mandan	REM-North Dakota, Inc.	415 North 51st Street	Grand Forks
Enable, Inc.	2004 8th Avenue SE	Mandan	REM-North Dakota, Inc.	5017 7th Avenue North	Grand Forks
Fraser, LTD.	2574 Arrowhead Road	Fargo	REM-North Dakota, Inc.	301 39th Avenue South	Grand Forks
Fraser, LTD.	2726 18th Street South	Fargo	REM-North Dakota, Inc.	1575 Manvel Avenue	Grafton
Fraser, LTD.	631 22nd Street East	West Fargo	REM-North Dakota, Inc.	730 Summit Avenue	Grafton
Fraser, LTD.	651 12 1/2 Avenue East	West Fargo	REM-North Dakota, Inc.	1824 1st Street Southwest	Minot
Friendship, Inc.	1635 34th Avenue South	Fargo	REM-North Dakota, Inc.	1405 32nd Avenue Southwest	Minot
Friendship, Inc.	2502 33rd Avenue South	Fargo	REM-North Dakota, Inc.	1404 18th Avenue Southwest	Minot
Friendship, Inc.	2302 18th Street South	Fargo	REM-North Dakota, Inc.	506 13th Street West	Devils Lake
Friendship, Inc.	2424 18th Street South	Fargo	REM-North Dakota, Inc.	1104 15th Street South	Devils Lake
Friendship, Inc.	412 East 10th Street	Grafton	Tri-City Cares, Inc.	709 Eagle Drive	New Town
Friendship, Inc.	503 Hilltop Drive	Park River	Tri-City Cares, Inc.	723 2nd Street SW	Stanley
Friendship, Inc.	605 Hilltop Drive	Park River	Tri-City Cares, Inc.	220 North Gilbertson St.	Tioga
HIT, Inc.	324 West Apollo Ave.	Bismarck			
HIT, Inc.	1901 2nd Street N. E.	Mandan			

March 2017

Development Disabilities (DD's) Waiver HCBS Group Homes

Individuals residing Facilities at the listed address would be given the Living Arrangement of Home and Community Based Services/Specialized Facility (HS)

Provider	Residential Address	City	Provider	Residential Address	City
4th Corporation	1006 2nd Avenue North	New Rockford	Minot Voc. Adj. Workshop	330 14th Avenue SE	Minot
ABLE, Inc.	653 19th Street West	Dickinson	Minot Voc. Adj. Workshop	1320 6th Ave SE	Minot
ABLE, Inc.	14 3rd Ave SE	Bowman	Minot Voc. Adj. Workshop	1508 17 1/2 Ave SW	Minot
Alpha Opportunities, Inc.	906 9th Avenue NE	Jamestown	Minot Voc. Adj. Workshop	1101 11th Avenue SE	Minot
Alpha Opportunities, Inc.	705 14th Street NE	Jamestown	Minot Voc. Adj. Workshop	1109 11th Avenue SE	Minot
Development Homes, Inc.	1211 10th Avenue S.	Grand Forks	Open Door Center	931 4th Street SW	Valley City
Development Homes, Inc.	101 Chestnut Street	Grand Forks	Opportunity Foundation, Inc.	701 8th Street East	Williston
Development Homes, Inc.	210 Chestnut Street	Grand Forks	Opportunity Foundation, Inc.	526 Reclamation Drive	Williston
Development Homes, Inc.	802 North 4th Street	Grand Forks	Opportunity Foundation, Inc.	1814 21st Ave. W.	Williston
Fraser, LTD.	4311 9th Ave. Circle S.	Fargo	Pride, Inc.	708 Boundary Rd	Mandan
Fraser, LTD.	1621 34th St. South	Fargo	Pride, Inc.	1005 NW 18th Street	Mandan
Fraser, LTD.	717 South University Dr.	Fargo	Pride, Inc.	2611 Gateway Avenue	Bismarck
Fraser, LTD.	514 South University Dr.	Fargo	Pride, Inc.	3011 E Rosser Avenue	Bismarck
Fraser, LTD.	3419 & 3421 58 Court S.	Fargo	Pride, Inc.	1913 E Capitol Avenue	Bismarck
Fraser, LTD.	3585 & 3587 58 Court S.	Fargo	Pride, Inc.	1102 S. 3rd St.	Bismarck
Friendship, Inc.	532 Stephen Ave.	Grafton	Pride, Inc.	3318 E Rosser Avenue	Bismarck
HAV-IT ADULT SERVICES	301 Jackson Avenue	Harvey	Red River Human Services Found.	608 South 4th Street	Wahpeton
HAV-IT ADULT SERVICES	300 W North Street	Harvey	Red River Human Services Found.	109 4th Avenue South	Wahpeton
HAV-IT ADULT SERVICES	409 West Brewster St.	Harvey	Red River Human Services Found.	808 South 6th Street	Wahpeton
HIT, Inc.	304 11th Street N.E.	Mandan	Red River Human Services Found.	1685 6th St W.	West Fargo
HIT, Inc.	1007 18th St. NW	Mandan	Red River Human Services Found.	1689 6th St W.	West Fargo
HIT, Inc.	1509-11 S. Washington	Bismarck	Red River Human Services Found.	1693 6th St W.	West Fargo
HIT, Inc.	1517-19 S. Washington	Bismarck	Red River Human Services Found.	1697 6th St W.	West Fargo
Knife River Group Homes	508 3rd Avenue NW	Hazen	Red River Human Services Found.	812 6th St. S.	Wahpeton
Lake Region Corporation	116 20th Street	Devils Lake	Red River Human Services Found.	207 4th Ave S	Wahpeton
Lake Region Corporation	1201 4th Avenue	Devils Lake	REM-North Dakota, Inc.	1422 10th St S	Grand Forks
Minot Voc. Adj. Workshop	1105 11th Avenue SE	Minot	REM-North Dakota, Inc.	224 Summit Ave	Grafton
Minot Voc. Adj. Workshop	330 14th Avenue SE	Minot	REM-North Dakota, Inc.	824 7th Ave NW	Minot
Minot Voc. Adj. Workshop	10 Park Drive	Rolla			
Minot Voc. Adj. Workshop	505 Turtle Creek Dr. NE	Belcourt			

Policy Processing Appendix 510-03-110

This is a new section to include Processing Guides to support Medicaid Policy

30. 510-03-110, Process for No or Invalid Recipient Address. This process is being added from IM 5259.

Process for No or Invalid Recipient Address 510-03-110-05

Should a household consist of some individuals eligible for Medicaid in SPACES also have a member eligible for Medicaid in TECS or Vision, the address also needs to be updated in those systems.

Note: If the only open Medicaid case resides in the Mini-App, the address does not need to be changed in TECS or Vision.

- If the Medicaid program is NOT open in TECS, the address in TECS does NOT need to be updated.

- If the only open program is Medicaid, enter the County SSB address in the Residence Address.

```
ADDR                                   ADDRESS                          032417 22:20
 CASE: 00006632          CASE NAME: ADDRESS , MARY                       BRENDA P
 TELEPHONE:          CELL PHONE:          WORK PHONE:
 EMAIL:                                EMAIL NOTIFY: N TEXT NOTIFY: N
 CELL PHONE PROV:    CELL PHONE PROV OTHER:
                  STREET OR R.R.              CITY         STATE ZIP
 RESIDENCE :      C/O MORTON COUNTY SSB       MANDAN         ND 58554
                  200 2nd Ave NW
 DIRECTIONS:
   TO HOME:
 MAILING   :
   ADDRESS:

 NAME TYPE:   SURNAME:             GIVEN:          MI:  SUFX:
  ADDR TYPE:
 ADDRESS   :


 NAME TYPE:   SURNAME:             GIVEN:          MI:  SUFX:
 ADDR TYPE:
 ADDRESS   :

                                  MORE ADDRESSES:  N      NEXT-->
```

- If both Medicaid and SNAP are open in TECS, enter an 'RP' Name and Address Type of the County Social Service Office.

```
ADDR                                ADDRESS                                  032417 22:14
CASE: 00006632        CASE NAME: ADDRESS, MARY                               BRENDA P
TELEPHONE:             CELL PHONE:          WORK          EMAIL NOTIFY: N TEXT NOTIFY: N
CELL PHONE PROV:      CELL PHONE PROV OTHER:
          STREET OR R.R.                CITY          STATE ZIP
RESIDENCE :  123 MAIN STREET        MANDAN          ND 58554

DIRECTIONS:
  TO HOME:
MAILING   :
  ADDRESS:

NAME TYPE: RP          SURNAME: ADDRESS       GIVEN: MARY      MI:   SUFX:
ADDR TYPE: RP
ADDRESS   : C/O MORTON COUNTY SSB    MANDAN          ND 58554
            200 2ND AVE NW

NAME TYPE:   SURNAME:            GIVEN:          MI:   SUFX:
ADDR TYPE:
ADDRESS   :

                                                  MORE ADDRESSES:   N      NEXT-->
```

31. 510-03-110-10, Revert to Open for Medicaid. This process defines when a case can be reverted to open for Medicaid.

Revert to Open for Medicaid 510-03-110-10

1. Eligibility Workers can revert Medicaid cases to open in the following situations:
   - During the first 3 working days of the month following the month of closure.
   - When the revert to open is prior to the closure effective date.
     - Eligibility Workers can complete this revert to open action.
     - This pertains to an 'effective closure date' in **Vision** and a 'Frozen' status in **TECS**.

2. System Support and Development can revert HCC/Medicaid cases to open without policy approval in the following situations:

- When case closes without allowing an effective closure date in **SPACES**. EX. Fail to provide information, loss of contact, excess income, close future month for no review.
    - SSD can revert these to open due to system processing of closing the case effective the date the action is taken.
    - SSD will use the reason of 'Complied with program requirements before negative action deadline'.
- Due to a Social Security appeal.
    - The Eligibility Worker can contact SSD directly, provided the client informed them within 6 months of the appeal decision and the application was denied for the correct reason of 'not disabled'.
- When an application was denied.
    - The Eligibility Worker can revert the denial to open if it is the same day the denial was processed.

For all other requests to revert to open, the Eligibility Worker must contact their Regional Representative for approval.

32. 510-03-110-15, Processing for Inmates Receiving Inpatient Care in Certain Medical Institutions. This process explains where eligibility should be processed for Inmates Receiving Inpatient Care in Certain Medical Institutions.

Processing for Inmates Receiving Inpatient Care in Certain Medical Institutions 510-03-110-15

Currently, the Vision system must be utilized to process eligibility for these inmates for both ACA and Non-ACA Medicaid. Refer to the Vision Maintenance Rollout for September 18, 2015 for Vision System Processing Instructions.

A short Computer-based Training (CBT) module titled '*Medicaid Coverage for Inmates Who are Inpatients in a Hospital Setting'* has been developed to assist with the training of Eligibility Workers on this provision.

- To access the course, login to PeopleSoft at: https://www.cnd.nd.gov/psp/strp/?cmd=login&languageCd=ENG&
    - Click on **"my Training".**

- Click on **"Search Catalog"**.
- Search the Catalog for the title of the course in which you'd like to enroll. For example: 'ACA' course. Once you find the course you want, click .
- This places the course onto your 'My Learning' list.

33. 510-03-110-20, Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities. This process explains where eligibility should be processed for Inmates Residing in Corrections-related Supervised Community Residential Facilities.

Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-03-110-20

If an individual is determined eligible under Non ACA policies, their eligibility will be processed in TECS or Vision.

- Enter the address of the facility where the individual is residing for the individual's address.
- Enter the Living Arrangement of 'In Own Home' with a date equal to the date they began residing in one of the facilities listed above.

  Note: If the individual is applying in the month they began residing in one of the facilities listed above, the living arrangement of 'AI' (TECS or 'Public Institution" (Vision) will need to be entered with a date prior to the month eligibility is being requested.

If an individual is determined eligible under ACA policies their eligibility will be processed in SPACES.

- Enter the information in SPACES just like any other case with the following exceptions:
  - Enter the address of the facility where the individual is residing for the individual's address.
  - Enter the Living Arrangement of 'In Own Home' with a date equal to the first day of the first month they began residing in one of the facilities listed above.

    Note: SPACES is being enhanced to process eligibility for partial months when an individual leaves a Public Institution. This enhancement is planned to be implemented in February. Please watch for the SPACES Rollout document confirming the

implementation of this change and at that time, being entering the Living Arrangement of 'Transitional Living Specialized Facility' with a date equal to the date they began residing in one of the facilities listed above.