Eligibility Factors for ACA (Affordable Care Act) Medicaid

Service Chapter 510-03

North Dakota Department of Human Services
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(Revised 5/1/2017 ML #3498)

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N.D.A.C. Section 75-02-02.1-01)

For the purpose of this chapter:

ACA

Affordable Care Act, also known as the Patient Protection and Affordable Care Act of 2010, which was signed into law by President Obama on March 23, 2010.

ACA (Affordable Care Act) Medicaid

The Medicaid policies and procedures used to determine eligibility for individuals covered under the Affordable Care Act of 2010, which became effective January 1, 2014.

ACA Individual

An individual required to be budgeted using MAGI methodologies as defined in Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid. Individuals include:

1. Parents and Caretaker/relatives of deprived children up to age 18 (through the month the child attains age 18) and their spouses;

2. Parents and Caretaker Relatives of deprived children and their spouses who were eligible under the Parents and Caretaker Relatives and their spouses category in at least three of the six months immediately preceding the month in which the Parents or Caretakers lose coverage under the Parents and Caretaker Relatives and their spouses category

due to increased earned income or hours of employment, and their dependent children for up to 12 months (Transitional);

3. Parents and Caretaker Relatives of deprived children and their spouses who were eligible under the Parents and Caretaker Relative and their spouses category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lose coverage under the Parents and Caretaker Relatives and their spouses category due to increased alimony or spousal support and their dependent children for up to 4 months (Extended)(no budget test);

4. Pregnant Women;

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

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

7. Children Ages 0 through 18 (through the month the child turns 19);

8. Adults ages 19 through 64 (Adult Expansion Group)

   Note: This may include SSI recipients and other disabled individuals who fail the Medicaid asset limits and individuals who are disabled with a large client share;

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

10. Individuals who are not eligible as an ACA Individual defined in #'s 1 thru 7 above, who were in North Dakota foster care (Title IV-E, state-funded (non-IV-E) or tribal) in the month they turned age 18 must be covered through the month in which they turn age 26 with no budget test.

(Exception: Those eligible under Children, Pregnant Women, or Parent Caretaker Group must be covered under those categories.)

ACA Medicaid Household

ACA Medicaid Household

One or more individuals, whose countable income and allowable expense are used to determine eligibility under ACA Medicaid.

- Each eligible individual must have their ACA Medicaid Household determined based on whether the individual is a tax filer, a tax dependent, or an adult or child non-filer as well as the individual's relationship to those with whom the individual resides.

Adjusted Gross Income

The amount that displays on the bottom line of the front page of IRS Form 1040. This is also a line on the 1040A.

Adult Expansion Group

Individuals age 19 through 64 and who are not eligible for Medicare or Medicaid under other categories. As of January 1, 2014, North Dakota Medicaid is expanded to cover these individuals. Some individuals, including individuals found to be medically frail, will be covered under an Alternative Benefit Plan (ABP).

Advance Payments of the Premium Tax Credit (APTC)

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

Alternative Benefit Plan (ABP)

Formerly known as Medicaid Benchmark or Benchmark Equivalent Plans, Alternative Benefit Plans must cover the 10 Essential Health Benefits (EHB) described in section 1302(b) of the Affordable Care Act. Individuals in the new adult eligibility (Expansion) group will receive benefits through an Alternative Benefit Plan unless they are determined to be medically frail.

County Agency

The county social service board.

Department

The North Dakota Department of Human Services.

Essential health Benefits

Starting in 2014, a set of health care service categories that must be covered by insurance policies in order to be certified and offered in the Health Insurance Marketplace by States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid. Essential health benefits must include items and services within at least 10 specified categories. The 10 categories are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Federally Facilitated marketplace (FFM)

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

Fee for Service

The most common method of Medicaid payments under which Medicaid pays providers directly for their services. Medicaid pays a specific dollar limit for a specific service.

Full Calendar Month

The period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

Healthy Steps

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

Institutionalized Individual

An individual who is an inpatient in a nursing facility, an ICF/IID, the State Hospital, Prairie at St. John's, the Stadter Psychiatric Center, an out-of-state institution for mental disease (IMD), the Anne Carlsen facility, a Psychiatric Residential Treatment Facility (PRTF), or who receives swing bed care in a hospital.

Living with:

'Living with' means those individuals who reside together as one household. Individuals who are out of the household temporarily for health, educational, training or employment purposes are considered to be 'living with' the household.

- Other than the above, individuals who have moved away with the intent not to return to live in the household are not considered to be 'living with' the household. This includes a child, who moved away with the intent not to return, who remains on their parents' health insurance coverage or whose parents are paying court ordered child support.

Long Term Care, (LTC)

Refers to services received in a nursing facility, the State Hospital, the Anne Carlson facility, Prairie at St. John's, the Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a swing bed when the individual in the facility is screened or certified as requiring the services provided in the facility.

MAGI-based Methodology

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

Medicaid

A program implemented pursuant to North Dakota Century Code chapter 50-24.1 and Title XIX of the Act.

Medically Frail

Under the Affordable Care Act, recipients covered under the Adult Expansion Group, who request to be considered for coverage as 'medically frail' and have the choice to be provided coverage similar to that in the Medicaid state plan.

Minimum Essential Coverage

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

Modified Adjusted Gross Income (MAGI)

Income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in Section 36B(d)(2)(B) of the Internal Revenue Code, with exceptions. Adjusted Gross Income from Form 1040 plus tax-exempt interest, tax-exempt Social Security Benefits, and any foreign earned income excluded from taxes.

No Wrong Door

The federal mandate that allows individuals to apply for Medicaid through any means, may be through the Federal Facilitated Marketplace, the State eligibility portal, by telephone, through the OASYS application, by FAX or in-person.

Non-ACA Individual

Individuals who are required to be budgeted using Non-ACA methodologies as defined in Service Chapter 510-05, Eligibility Factors for Non-ACA Medicaid. These include:

1. Aged, blind and disabled individuals who choose to be treated as aged or disabled, including individuals eligible for Workers with Disabilities and Children with Disabilities;

2. Individuals qualifying as disabled under original Medicaid requirements
   a. Individuals receiving HCBS or Waivered Services
   b. Workers with Disabilities
   c. Children with Disabilities;

3. MEDICARE recipients who choose to be treated as aged, blind or disabled;

4. Individuals who request or are eligible for coverage under the Medicare Savings Programs;

5. Individuals who request eligibility under Spousal Impoverishment;

6. SSI individuals who pass the Medicaid asset test;

7. Individuals who are eligible under the Women's Way Program;

   Note: If eligible for Medicaid Expansion, the individual may choose coverage under Traditional Medicaid or through North Dakota's insurance policy vendor. This would include women who are not eligible as Pregnant Women, Parent Caretaker, or as a disabled person.

8. Individuals who are eligible under Refugee Medical Assistance;

9. Individuals who are eligible under Title IV-E and Non IV-E Subsidized Adoption Program;

10. Individuals who are eligible under Title IV-E foster care;

11. Individuals who are eligible under Title IV-E Kinship Guardianship Program.

Non-ACA Medicaid

The Medicaid policies and procedures used to determine eligibility for individuals whose eligibility cannot be determined based on methodologies of the Affordable Care Act. These Medicaid policies can be found in Service Chapter 510-05.

Non-Filer

An individual who neither files an income tax return nor is claimed as a dependent by another tax filer unless:

- They are claimed as a tax dependent by someone other than a spouse, or natural, adoptive or stepparent;
- They are a child under age 19 living with both parents but the parents do not file a joint return; or
- A child under age 19 who expects to be claimed by a non-custodial parent.

Nursing Care Services

Care provided in a medical institution, a nursing facility, a swing bed, the state hospital, the Anne Carlson facility, Prairie at St. John's, the Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a home and community based services setting.

Public Institution

An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. (e.g. 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.)

Qualified Health Plan

An insurance plan that is certified by the Health Insurance Marketplace which provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments and out-of-pocket maximums) and

meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Specialized Facility

A residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the Department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility. Examples of a specialized facility include a foster care bed at the Dakota Boys Ranch, Home on the Range, and Manchester House.

Spouse

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. The Marriage was legally performed in another state;

2. 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. 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.

State Agency

The North Dakota Department of Human Services.

Supplemental Nutrition Assistance Program (SNAP)

Previously known as the Food Stamp Program, SNAP is a uniform nationwide program intended to promote the general welfare and safeguard the health and well-being of the nation's population by raising the levels of nutrition among low-income households.

Tax Dependent

An individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

Tax Filer

An individual who is required to file, or who is not required to file but chooses to file a Federal Income Taxes based on IRS Regulations.

Temporary Assistance for Needy Families (TANF)

A program administered under North Dakota Century Code Chapter 50-09 and Title IV-A of the Social Security Act. References to TANF include TANF Kinship Care Assistance, Diversion Assistance, and Transition Assistance.

Title II

Title II of the Social Security Act (Social Security benefits).

Title IV-D

Title IV-D of the Social Security Act (Child Support).

Title IV-E

Title IV-E of the Social Security Act (Foster Care and Adoption Assistance).

Title XVI

Title XVI of the Social Security Act (Supplemental Security Income (SSI)).

Title XIX

Title XIX of the Social Security Act (Medicaid).

Title XXI

Title XXI of the Social Security Act (Healthy Steps).

General Statement, Purpose, and Objectives 510-03-07

General Statement 510-03-07-05

(New 7/1/2014 ML #3404)

View Archives

The Medicaid Program was authorized in 1965 during a special session of the North Dakota Legislature for the purpose of strengthening and extending the provision of medical care and services to certain groups of people whose resources are insufficient to meet such costs. Medicaid began in North Dakota effective January 1, 1966. Corrective, preventive and rehabilitative medical services are provided to help individuals and families retain or attain capability for independence, self-care, and self-support.

In 2010, the Patient Protection and Affordable Care Act of 2010 commonly called the Affordable Care Act (ACA), was signed into law by President Obama on March 23, 2010. This law represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965, with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government.

In 2013, the North Dakota Legislature approved the expansion of the Medicaid Program as a result of the passage of the Affordable Care Act. The expanded Medicaid program is available to individuals between the ages of 21 and 65 with household incomes up to 138% of the federal poverty level (FPL).

Purpose and Objective 510-03-07-10

(New 7/1/14 ML #3404)

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It is known that in addition to imposing financial difficulties, illness and health problems have their effects on personality functioning and interpersonal relationships. Illness can be used as an escape from unpleasant responsibilities and can distort family relationships. Unmet health needs can, therefore, be detrimental to the overall growth and adjustment of individuals and families.

The immediate purpose of the Medicaid Program is to provide an effective base upon which to provide comprehensive and uniform medical services that will enable persons previously limited by their circumstances to receive needed medical care. It is within this broad concept that the Medicaid Program in North Dakota participates with the medical community, to the greatest extent possible, in attempting to strengthen existing medical services in the state.

General Provisions 510-03-10

General Information 510-03-10-05

(New 7/1/2014 ML #3404)

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Following are instructions relating to applications for ACA Medicaid. Additional information concerning administrative procedures, application processing, case maintenance, and appeals are contained in Service Chapter 448-01 through 448-01-60.

Nondiscrimination in Federally Assisted Programs 510-03-10-10

(New 7/1/14 ML #3404)

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Public Law 88-352, Section 601 (Title VI) of the Civil Rights Act of 1964 states:

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." (Section 504 of the Rehabilitation Act of 1973 as amended, prohibits discrimination solely on the basis of handicap for those otherwise qualified.)

The Department of Human Services makes available all services and assistance without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage or public assistance, in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the North Dakota Human Rights Act of 1983. Persons who contract with or receive funds to provide services for the North Dakota Department of Human Services are obligated to abide by the provisions of these laws. The Department of Human Services makes its programs accessible to persons with disabilities. Persons needing accommodation or who have questions or complaints regarding the provisions of services according to these Acts may contact the Civil Rights Officer, North Dakota Department of Human Services, Judicial Wing, State Capitol, 600 E. Boulevard, Bismarck, ND 58505 or the US Department of Health and Human Services, Office for Civil Rights, Region VIII, 999 18th Street, Suite 417, Denver, Colorado 80202 or call 1-800-368-1019 or 1-800-537-7697 (TTY) or 303-844-2025 (FAX).

Refer to Service Chapter 300-01, Non-discrimination to Clients, for additional guidelines.

Confidentiality 510-03-10-15

(Revised 6/1/2015 ML #3441)

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

1. Federal law and regulations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Sharing information with Law Enforcement:

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

7. Release of information on application:

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

Assignment of Rights to Recover Medical Costs 510-03-10-20

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. The assignment of rights to benefits is automatic under North Dakota Century Code sections 50-24.1-02 and 50-24.1-02.1. The assignment is effective to the extent of actual costs of care paid under the North Dakota Medicaid Program. As a condition of eligibility, the applicant or recipient may be required to execute a written assignment whenever appropriate to facilitate establishment of liability of a third party or private insurer. Form SFN 560, "Assignment of Benefits," may be used for this purpose. If it becomes necessary to secure signatures on additional documents, specific instructions will be provided on a case-by-case basis.

2. The Department and county agency must take reasonable measures to obtain from the applicant or recipient health coverage information to determine the liability of third parties and private insurers.

3. For purposes of this section:
   a. "Private insurer" includes any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-related insurance contract and indemnity contracts; any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services covered by the Medicaid program; and any organization administering health or casualty insurance plans for professional associations, employer-employee benefit plans, or any similar organization offering these payments or services, including self-insured and self-funded plans.

   b. "Third party" means any individual, entity, or program that is or may be liable to pay all or a part of the expenditures for services

furnished under Medicaid, including a parent or other person who owes a duty to provide medical support to or on behalf of a child for whom Medicaid benefits are sought.

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

(Revised 5/1/2017 ML #3498)

View Archives

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. There is no overpayment applied to the Medicaid recipient.

Determining Amount of Overpayments

Any overpayment resulting from a recipient error is subject to recovery. Overpayments are established on recipient errors in which Medicaid funds were misspent regardless of the reason the error occurred.

To determine the amount of the overpayment for Traditional Medicaid Coverage and Medicaid Expansion through the insurance vendor:

1. For Traditional Medicaid overpayments not related to incorrect client share (recipient liability), the amount of the overpayment is the amount of Medicaid payments paid in error on behalf of the ACA Medicaid eligible individual.

2. For Traditional Medicaid overpayments related to incorrect client share (recipient liability), the amount of the overpayment is the lesser of:
    i. The amount of Medicaid payments paid in error on behalf of the ACA Medicaid Unit; or
    ii. The difference between the correct amount of client share (using actual income) and the amount of the client share met by the ACA Medicaid Unit.

3. For Medicaid Expansion overpayments, the amount of the overpayment is equal to the total amount of all premiums paid in error.

All recipient errors in which there is an overpayment or suspected fraud (regardless of overpayment) must be referred 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 by:

- Mail: SURS, 600 East Boulevard Avenue, Department 325, Bismarck, ND 58505;
- Fax: 701-328-1544; or
- Email: medicaidfraud@nd.gov.

Copies may be sent to the Medicaid Eligibility Unit as follows:

- Mail: Medicaid Eligibility Unit, 600 East Boulevard Avenue, Department 325, Bismarck, ND 58505;
- Fax: 701-328-5406; or
- Email: -Info-DHS Medicaid Policy.

Repayment of Overpayments

Any repayment of an overpayment received at the county agency must be submitted to the Fiscal Administration unit using SFN 828, "Credit Form".

Liens and Recoveries 510-03-10-30

(Revised 5/1/17 ML#3498)

View Archives

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.

Certificate of Creditable Coverage 510-03-10-33

(New 7/1/2014 ML #3404)

View Archives

1. The Health Insurance Portability and Accountability Act of 1996 included provisions designed to improve the availability and portability of health coverage. This act limits exclusions for preexisting medical conditions by allowing credit for prior health coverage. Exclusions for preexisting conditions can be up to 12 months (18 months for late enrollees) but are reduced by days an individual has creditable coverage for that condition under another health plan. Coverage under Medicaid is considered creditable coverage.

2. Effective June 1, 1997, Medicaid began providing certificates of creditable coverage for individuals who lose Medicaid eligibility. These certificates are sent as automatic notices on all Medicaid case or client closings except for Medicare recipients. The certificate provides information regarding each individual's Medicaid coverage for the past 18 months.

3. In order to avoid sending certificates on recipients whose eligibility ends and then reopens the next month, the automatic certificates are not sent until 32 days after the case or client is closed. The certificate is then only sent if the case or recipients have not been reopened.

Third Party Liability 510-03-12

Individuals applying for coverage under ACA Medicaid may have other insurance coverage.

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

Cooperation - Third Party Liability 510-03-12-05

(New 7/1/2014 ML #3404)

View Archives

1. States are required to pursue known third parties that may be liable to pay for care or services. The Department and county agency are required to make reasonable efforts to obtain the necessary information needed to pursue third parties. This includes following up on any leads that indicate there may be a third party payer, and assisting applicants and recipients in obtaining necessary information.

2. As a condition of eligibility, legally able applicants or recipients and their spouses must cooperate with the Department and county agency in identifying and providing information to assist Medicaid in pursuing third parties who may be liable to pay for care or services, unless there is good cause not to cooperate.

   This policy is not intended to place an unreasonable burden on applicants or recipients, or to shift the state's responsibility to pursue third parties. If Department and county staff have the ability to obtain the information, it cannot be shown that an applicant or recipient is not cooperating. If the necessary information cannot be obtained without the applicant or recipient's cooperation, and the applicant or recipient has the ability to assist, this provision applies. As part of cooperation, the Department or agency may require an individual to:

   a. Appear at a state or local office designated by the Department or county agency to provide verbal or written information or evidence relevant to the case;
   b. Appear as a witness at a court or other proceeding;
   c. Provide information, or attest to lack of information, under penalty of perjury;
   d. Complete SFN 566, "Medicaid Questionnaire and Assignment," (which is available on eforms).
   e. Pay to the agency any medical payments received that are covered by the assignment of benefits; and
   f. Take any other reasonable steps to assist the state in securing third party payments and in identifying

information to assist the state in pursuing any liable third party.

3. An exception to cooperation exists when the recipient is receiving Extended or Transitional Medicaid Benefits.

4. It is never a condition of a child's eligibility that a parent or caretaker cooperates. A parent or caretaker who does not cooperate will not be eligible for Medicaid, but the children in the ACA Medicaid Household remain eligible. When a parent or legally responsible caretaker relative is not eligible because they are not cooperating, the earned and unearned income of that individual must still be considered in determining eligibility for the ACA Medicaid Household.

5. The determination of whether an applicant or recipient is cooperating is made by the county agency in conjunction with their Economic Assistance regional representative. The determination may be based on information received from the Third Party Liability unit. The applicant or recipient has the right to appeal the decision.

6. When an applicant initially applies for Medicaid, it can usually be assumed that there will be cooperation. If the recipient then fails to cooperate, without "good cause," eligibility for that recipient is terminated. For applications in which a recipient clearly states that he or she will not cooperate, and there is no "good cause," that recipient is ineligible for Medicaid. Once the individual begins cooperating, eligibility can be restored or established. Eligibility can begin retroactively if the individual cooperates for the period to be covered. If an individual who failed to cooperate, and eligibility was terminated, later reapplies for assistance, the individual will remain ineligible until the individual begins to cooperate.

"Good Cause" - Third Party Liability 510-03-12-10

(New 7/1/2014 ML #3404)

View Archives

The requirement to cooperate may be waived when an applicant or recipient has "good cause" not to cooperate.

1. There is no particular form used to claim "good cause"; however, the applicant or recipient will need to provide information and evidence to substantiate the claim. If "good cause" is claimed the applicant or recipient can be eligible for Medicaid while the decision is pending.

2. The determination of whether there is good cause is made by the county agency. The county agency may waive the requirement to cooperate if it determines that cooperation is against the best interests of a child in the unit. Cooperation is against the best interests of a child only if the applicant or recipient's cooperation is reasonably anticipated to result in:

    a. Physical or emotional harm to a child in the ACA Medicaid Household; or
    b. Physical or emotional harm to the parent or caretaker with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately.

3. There must be evidence to substantiate a claim of "good cause." Exemptions on the basis of physical or emotional harm, either to the child, parent, or caretaker must be of a genuine and serious nature. Mere belief that cooperation might result in harm is not a sufficient basis for finding "good cause." Evidence upon which the county agency bases its finding must be supported by written statements and contained in the case record.

    It is the applicant or recipient's responsibility to provide the county agency with the evidence needed to establish "good cause." The applicant or recipient is normally given 20 days from the date of claim to collect the evidence. In exceptional cases, the county agency may grant reasonable additional time to allow for difficulty in obtaining

proof. Records of law enforcement, social service, or adoption agencies may be readily available to document instances of physical harm, perhaps without requiring further investigation. Documentation of anticipated emotional harm to the child, parent, or caretaker, however, may be somewhat more elusive. Whenever the claim is based in whole or in part on anticipated emotional harm, the county agency must consider the following:

a. The present emotional state, and the emotional health history, of the individual subject to emotional harm;
b. The intensity and probable duration of the emotional impairment;
c. The degree of cooperation to be required; and
d. The extent of involvement of the child in pursuing third parties who may be liable to pay for care or services.

4. Upon request, the county agency is required to assist the applicant or recipient in obtaining evidence necessary to support a "good cause" claim. This, however, is not intended to place an unreasonable burden on staff, shift the applicant or recipient's basic responsibility to produce evidence to support the claim, or to delay a final determination.

5. The county agency is directly responsible for investigating a "good cause" claim when it believes that the applicant or recipient's claim is authentic, even though confirming evidence may not be available. When the claim is based on a fear of serious physical harm and county agency staff believes the claim, investigation may be conducted without requiring corroborative evidence by the applicant or recipient. It may involve a careful review of the case record, evaluation of the credibility of the applicant or recipient's statements, or a confidential interview with an observer who has good reasons for not giving a written statement. Based on such an investigation, and on professional judgment, the county agency may find that "good cause" exists without the availability of absolute corroborative evidence.

6. Except for extenuating circumstances, the "good cause" issue must be determined with the same degree of promptness as for the determination of other factors of eligibility (45 days). The county agency may not deny, delay, or discontinue assistance pending the resolution of the "good cause" claim.

7. The applicant or recipient and the Third Party Liability unit must be informed of the "good cause" decision. The applicant or recipient must be informed, in writing, of the county agency's final decision that "good cause' does or does not exist and the basis for the findings. A copy of this communication must be maintained in the case record. If "good cause" was determined not to exist, the communication must remind the applicant or recipient of the obligation to cooperate if he or she wishes to be eligible for Medicaid, of the right to appeal the decision, and of the right to withdraw the application or have their eligibility terminated.

8. The county agency must review the "good cause" decision at least every twelve months. If "good cause" continues to exist, the applicant or recipient must again be informed in writing. If circumstances have changed so "good cause" no longer exists, the applicant or recipient must be informed, in writing, and given the opportunity to cooperate, terminate assistance, withdraw the application, or appeal the decision. The Third Party Liability unit must also be informed of whether or not "good cause" continues to exist.

Cost-Effective Health Insurance Coverage 510-03-20

General Information 510-03-20-05

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

Any recipient of Medicaid benefits, who is enrolled in a cost-effective health plan, may have the health plans premium paid by Medicaid. (This provision began in North Dakota in June 1993.)

Definitions (Cost Effective Health Insurance) 510-03-20-10

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

For purposes of the cost-effective health insurance sections:

1. Cost-effective" means that Medicaid payments for a set of Medicaid-covered services are likely to exceed the cost of paying the health plan premium, coinsurance charges, and deductibles for those services.
2. "Health plan" means any plan under which a third party is obligated by contract to pay for health care provided to an applicant for or recipient of Medicaid.

Applicant's and Recipient's Responsibility 510-03-20-15

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

1. Applicants for and recipients of Medicaid benefits must provide the information necessary to determine if a health plan is cost-effective.

2. Recipients with a health plan the Department has determined is cost-effective must cooperate with all of the conditions or requirements of the health plan. Applicants and recipients must take any optional coverage provided through the plan when it is cost-effective to do so. Failure to cooperate with plan requirements, or to select cost-effective options of the plan, will:
    a. Result in termination of payments for the health plan premiums; and
    b. Result in nonpayment for services, by Medicaid, which the health plan would pay, or would have paid, had the recipient conformed to the requirements of the health plan.

Cost-effectiveness Determination 510-03-20-20

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

1. Health plans requiring a formal cost-effective determination should be submitted to the Medicaid Eligibility Division on SFN 817, "Health Insurance Cost-Effectiveness Review," along with any other information the worker feels is pertinent (i.e. a copy of the health plan, available payment reports, information regarding pre-existing conditions . . .). The form asks for information about the policy coverage, the individuals covered, and the premium. The Medicaid Eligibility Division will obtain or request any additional information needed and will make a timely determination (within 15 days) of cost-effectiveness. The county agency will be notified of that determination. An application for assistance should not be held up beyond the standard of promptness pending a cost-effective determination.

2. When an individual has more than one health plan, both plans may be considered cost-effective if they do not provide duplicate coverage.

3. If an individual is eligible for Medicare Part B, but is not enrolled in Part B, enrollment in any other health plan is not considered cost-effective.

4. Premium payments normally are only allowed for eligible Medicaid recipients. A family policy, however, may cover ineligible members. Payment of the full premium amount is allowed when it is determined that the health plan is cost-effective. The needs of the ineligible family members are not taken into consideration when determining cost-effectiveness.

5. The following health plans are usually not considered to be cost-effective.

    a. Medicare supplement policies for individuals with routine medical needs (the exceptions are recipients with higher

medical needs and the recipient's covered costs exceed the premium);

b. Hospital indemnity policies if the recipient is not currently collecting benefits;
c. Policies where the absent parent is the policy holder;
d. Specific illness policies (i.e. cancer ins.) if the individual covered does not have the illness;
e. Accident insurance policies, if the recipient is not currently collecting benefits; or
f. Policies where all of the members of the ACA Medicaid Household, who are covered by the health plan, have a client share (recipient liability).

If the cost-effectiveness of any of these policies is questionable, the policy should be submitted to the Medicaid Eligibility Division for a formal determination.

6. All cost-effective health plans must be reviewed at least annually.

   Changes in a plan’s, premium, coverage or individuals included in the plan must be reported to the Medicaid Eligibility Division.

7. Cost-effective health plan premiums will be paid effective with the month in which the information is sent to the Medicaid Eligibility Division for approval or is required to maintain the health plan.

Application and Decision 510-03-25

Application and Review 510-03-25-05

(Revised 5/1/17 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-02)

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 review through OASYS located at http://www.nd.gov/dhs/; or
   vii. The streamlined 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 is submitted within 90 days after the termination, eligibility must be reconsidered back to the termination date.**

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

When the review form is received on the 90th day but is incomplete or does not include all of the requested verifications, the review must be denied and the individual informed that they must reapply.

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

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

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

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:

i. If the child is found to be eligible for Medicaid (other than Medically Needy), eligibility must be authorized for Medicaid and the child will be given a new 12-month continuous eligibility period.
ii. If the child is found to be NOT eligible for Medicaid (other than Medically Needy), but is determined eligible for Healthy Steps, eligibility must be authorized for Healthy Steps and the child will be given a new 12-month continuous eligibility period.
iii. If the child is found to be NOT eligible for Medicaid (other than Medically Needy) or Healthy Steps, the child may not be terminated at the time of the early review unless the child meets one of the state's exceptions to terminate continuous eligibility. The child would remain eligible for the remainder of the original continuous eligibility period and a review would be required at that time.

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

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-10)

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

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

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

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

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

   a. An individual is born in the month, in which case the date of birth is the first date of eligibility;
   b. An individual enters the state, in which case the earliest date of eligibility is the date the individual entered the state unless still receiving Medicaid benefits from another state. Information regarding the date Medicaid benefits from the other state are no longer available should be established in

order to determine the beginning date of eligibility in North Dakota; or

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

4. A child cannot be eligible for Medicaid for the same period of time the child is covered under the Healthy Steps Program.

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

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

Duty to Establish Eligibility 510-03-25-15

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-02.1)

It is the responsibility of the applicant or recipient to provide information sufficient to establish the eligibility of each individual for whom assistance is requested, including, but not limited to, the furnishing of a social security number, and establishing age, identity, residence, citizenship, and financial eligibility in each of the months in which Medicaid benefits are requested.

Requesting information from an individual or household that is already available to the worker through other sources is prohibited.

No age, residence, citizenship, or other requirement that is prohibited by Title XIX of the Social Security Act will be imposed as a condition of eligibility.

Medicaid Brochures 510-03-25-20

(New 7/1/2014 ML #3404)

View Archives

All applicants for ACA Medicaid must be provided the "Application for Assistance Guidebook" or, in place of the guide book:

1. A brochure entitled "Medicaid" (376kb pdf) outlining the services available under the Medicaid Program;

2. A brochure entitled "Your Civil Rights" (152kb pdf);

3. A notice entitled "Notice of Privacy Practices" (18 kb pdf) (DN 900 which is available in E-Forms);

4. All households with individuals of childbearing age must be made aware of the opportunity they have to receive family planning services and must be given a brochure entitled "Family Planning-Choosing Your Family Size," or "Family Planning Program";

5. All households with individuals under the age of twenty-one must be made aware of the availability of "North Dakota Health Tracks" (early and periodic screening, diagnosis and treatment services) and be given the brochure entitled "ND Health Tracks"; and

6. All households with pregnant, breast feeding or postpartum women, or children under age five, must be made aware of the availability of the WIC (Women, Infants, and Children) Program, and must be provided a "WIC" outreach brochure.

Decision and Notice 510-03-25-25

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-03)

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.

Electronic Narratives 510-03-25-27

(New 7/1/2014 ML #3404)

View Archives

All Medicaid cases must include electronic narratives (in Lotus Notes) to support eligibility, ineligibility, and other actions related to the case. The narrative must be detailed to permit a reviewer to determine the reasonableness and accuracy of the determination. Complete and accurate narratives include documenting the action taken; what the action was based on; sources of the information used; or if no action was taken, the reason for no action.

Narratives are also required to document contacts with the applicant, recipient, or other individuals regarding the case, regardless of whether the contact had an impact on the case.

Appeals 510-03-25-30

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Chapter 75-01-03)

1. Applicants or recipients of Medicaid who are dissatisfied with a decision made by the county agency or the North Dakota Department of Human Services, or who have not had their application acted on with reasonable promptness, may appeal to the North Dakota Department of Human Services.

2. A request to appeal must be in writing and not later than 30 days from the date the notice of action is mailed. When an applicant or recipient requests a hearing without completing the SFN 162, Request for Hearing, the county must complete an SFN 162, Request for Hearing, based on the information available. When the county is completing the SFN 162, the form is not signed by the county.

3. When a recipient requests an appeal prior to the effective date of an adverse decision, the recipient's Medicaid eligibility may not be reduced or terminated until a decision is rendered after the appeal hearing unless it is determined that the sole issue is one of Federal or state law or policy. In these cases, the recipient must be informed in writing that eligibility will be reduced or terminated pending the final appeal decision. This applies even when a review of eligibility is due before the final appeal decision is made.

4. When assistance has continued pending an appeal decision and the county agency's decision to close the case or reduce benefits is upheld, the case must be closed, or the benefits reduced, immediately upon receipt of the notice of decision. Pursue collection of any Medicaid benefits paid during the period assistance was continued pending the appeal decision.

5. Refer to Service Chapter 448-01-30 for more information with regard to Hearings and Appeals.

Coverage Groups 510-03-30

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

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-05)

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

1. Categorically Needy

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

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

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

    c. Parents and Caretaker Relatives (and their spouses) of deprived children under age 18 (through the month they

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

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

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

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

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

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

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

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

j. Adults age 19 and 20 who are not pregnant, have no children, who pass the Adult Expansion Group but have income less than 90% FPL (M062);

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

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

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

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

2. Medically Needy

a. Pregnant Women who qualify and require medical services on the basis of insufficient income, but who do not meet pregnant women income requirements under ACA Medicaid (COE of M079).
b. Children under age 21 who qualify and require medical services on the basis of insufficient income, but who do not meet income requirements under ACA Medicaid (COE of M080).

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

Applicant's Choice of Category 510-03-30-10

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-06)

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.

Assigning Category of Eligibility 510-03-30-15

(Revised 6/1/2015 ML #3441)

View Archives

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

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

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

1. Children Under Age 21

COE	COE Description	Rule to Assign COE
61	Extended ACA Children	The Child: • Is under age 18 (through the month the child attains age 18) • Is deprived due to the absence, disability, incapacity, age or unemployment/ underemployment of a parent; • Resides with one or both natural or adoptive parents, or one non-parent caretaker relative;

		• Not eligible under the ACA Medicaid Children Poverty Levels; AND The child's parent(s) or caretaker relative: • Lost eligibility under the Parents and Caretaker Relative and their spouses Category due to increased alimony or spousal support; and • Was eligible under the Parent, Caretaker Relative and their Spouses Category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lost coverage under the Parents, Caretaker Relatives and their Spouses Category.
67	Children ages 0 thru 18 (including month turn age 19) -- other than MOE, Foster Care, Transitional, Extended, Med Needy or Healthy Steps	The Child: • Is age 0 to 6 (including the month the child attains age 6); • Was found eligible for ACA Medicaid with income **at or below** 152% of the Federal Poverty Level (FPL). **OR** • Is age 6 (month following month attains age 6) thru age 18 (including the month the child attains age 19); • Was found eligible for ACA Medicaid with income at or below 138% of the Federal Poverty Level (FPL). **OR** • The child's mother applied for Medicaid before the child's birth; • The child is deprived due to the absence, disability, incapacity or age of a parent; • The child is age 0 to 1 (including the month the child attains age 1);
87	ACA	The Child:

	Transitional Children	• Is under age 18 (through the month the child attains age 18) • Resides with one or both natural or adoptive parents, or one non-parent caretaker relative; • Not eligible under the ACA Medicaid Children Poverty Levels; **AND** The child's parent(s) or caretaker relative: • Lost eligibility under the Parents and Caretaker Relative and their spouses category due to increased earned income or hours of employment; • Was eligible under the Parent, Caretaker Relative and their Spouses Category in at least three of the six months immediately proceeding the month in which the Parents or Caretaker Relatives lost coverage under the Parents, Caretaker Relatives and their Spouses Category.
95	Maintenance of Effort Child Absence Deprived (Age 6 to 19) Healthy Steps (CHIP) to Medicaid	The Child: • Is age 6 to 19 (month following month attains age 6 through the end of the month the child attains age 19); • Was found eligible for ACA Medicaid with income **between** 111% and 133% of the FPL.
98	State or Tribal Foster Care (Non-IV-E)	The Child: • Meets the definition of a Foster Care Child; • Is eligible under regular Foster Care (non-Title IV-E, tribal or state-funded).
80	Child Age 0 to 21	The Child:

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

2. Healthy Steps (CHIP Children)

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

3. Parents, Caretakers and their Spouses

COE	COE Description	Rule to Assign COE
63	Parents, Caretaker Relatives (& their Spouses) of Deprived Children	The Parent(s) or Caretaker: • Is the natural or adoptive parent, or a caretaker/relative within the 5th degree of relationship to a child under age 18 (through the

		month the child attains age 18); • Has a child residing with them who is deprived due to the absence, disability, incapacity, age or unemployment/ underemployment of a parent; • Has income below 54% of the FPL.
86	ACA Transitional Parents and Caretakers	The Parent(s) or Caretaker relative: • Has at least one child residing with them who is deprived due to the absence, disability, incapacity, age or unemployment/ underemployment of a child under age 18 (through the month the child attains age 18); • Lost eligibility under the Parents and Caretaker Relative and their Spouses category due to increased earned income or hours of employment; and • Was eligible under the Parent, Caretaker Relative and their Spouses category in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lost coverage under the Parents, Caretaker Relatives and their Spouses Category.

4. Pregnant Women

COE	COE Description	Rule to Assign COE
66	Pregnant Woman (Categorically Needy)	A woman who is: • Pregnant and through the end of the month in which the 60th post-partum day fails; • Has income at or below 152% of the FPL.
79	Pregnant Woman (Medically	A woman who is: • Pregnant and through the end of the month in which the 60th post-partum day fails;

	Needy)	• Has income above 152% of the FPL; • Has a medical need that exceeds the calculated Client Share (Recipient Liability).

5. Adults

a. Adult Expansion

COE	COE Description	Rule to Assign COE
76	Adult Expansion Category	Individual is: • Age 19 through age 64 (month following the month attained age 19 and month prior to attaining age 65); • Not eligible under the Parent/Caretaker or Pregnant Woman Category; • Not eligible under the Adults age 19 and 20 Category; • Not eligible as Medically Frail; • Has income at or below 138% of the FPL.

b. Adults age 19 and 20

COE	COE Description	Rule to Assign COE
62	Adult Age 19 and 20	The Adult: • Must be age 19 or 20 (month following month attains age 19 through the month attains age 21); • Is **NOT** pregnant; • Has no children • Pass the Adult Expansion Group BUT have income **less than** 90% of FPL

c. Medically Frail

COE	COE Description	Rule to Assign COE
58	Adults Medically Frail- Non-institutionalized	The Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65); • Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Not residing in an Institution; • Income **at or below** 85% of FPL.
59	Adults Medically Frail- Non-Institutionalized	Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65); • Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Not residing in an Institution; • Income **above** 85% of FPL.
60	Adults Medically Frail-Institutionalized	Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65); • Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Residing in an Institution; • Income **at or below** 85% of FPL.
65	Adults Medically Frail-Institutionalized	Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65);

		• Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Residing in an Institution; • Income **above** 85% of FPL.
77	Adults Medically Frail- Non-Institutionalized Managed Care	Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65); • Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Not residing in an Institution; • Income **at or below** 85% of FPL.
89	Adults Medically Frail- Non-Institutionalized Managed Care	Individual is: • Age 19 through 64 (month following month attains age 19 through the month prior to the month attains age 65); • Passes the Adult Expansion Group criteria; • Determined Medically Frail; • Not residing in an Institution; • Income **above** 85% of FPL.

6. Former Foster Care Children

COE	COE Description	Rule to Assign COE
91	Former Foster Care Child	The Child: • Was in North Dakota Foster Care (including Tribal 638 children) and on ND Medicaid (Title IV-E, state-funded(non-IV-E) or tribal) in the month he/she turned age 18; • Is under age 26 (through the month attaining age 26);

		• Is not eligible for Medicaid under: ○ The Parent, Caretaker Relative and the Spouse coverage, ○ Pregnant Woman coverage, or ○ Children (up to age 19) coverage. **NOTE:** An individual age 18 through 21 whom voluntarily sign him/herself back into Foster Care would also be assigned the COE of M091.

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

(New 5/1/2017 ML #3498)

View Archives

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

ACA Medicaid Household 510-03-35-05

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-08)

Each eligible individual must have their ACA Medicaid Household determined separately based on whether the individual is a tax filer, a tax dependent, or an adult or child non-filer as well as the individual's relationship to those with whom the individual resides.

NOTE: Under ACA-based Methodologies, individuals may no longer be opted out of a household. However, they can choose to not receive coverage.

1. Tax Filer Unit

If the person is a **tax filer**, that person's Medicaid household includes:

a. The individual,
b. The spouse who lives with them, (regardless if they file jointly or separately),
c. Everyone the tax filer claims as a tax dependent, and
d. If any of these individuals are pregnant, include the number of unborn children.

Note: If the tax filer is also claimed as a tax dependent, follow the tax dependent rules.

2. Tax Dependent Unit

If a person is a **tax dependent**, that person's Medicaid household includes:

a. The individual,

b. The spouse who lives with them, (regardless if they file jointly or separately)
c. Everyone in the tax filers household, UNLESS the tax dependent meets one of the following **exceptions**:

    i. The individual is claimed as a dependent by someone other than a parent, adoptive parent, or step-parent, (example by a grandparent or older adult sibling) or
    ii. The individual is under age 19 and claimed as a dependent by an absent parent (example, child lives with Mom but absent Dad is claiming as a tax dependent), or
    iii. The individual is under age 19 and lives with both parents but the parents do not expect to file jointly (example—parents live together but are not married).

d. If any of these individuals are pregnant, include the number of unborn children. If more than one unborn child is expected, verification is required.

If the tax dependent meets any of the above exceptions in 2.c., we must follow the **non-filer rules** in determining household size.

3. Non-Filer Unit

If a person is a **non-filer**, that person's Medicaid household is determined based on whether or not the non-filer is an Adult (Age 19 and older) or a Child (Under age 19).

- Non-filer Adult Household (age 19 or older) includes:

    a. The non-filer adult, and
    b. Their spouse who lives with them, and
    c. Their natural, adopted or step-children under age 19
    d. If any of these individuals are pregnant, include the number of unborn children. If more than one unborn child is expected, verification is required.

- Non-filer Child Household (under age 19) includes:

  a. The non-filer child,
  b. The child's natural, adopted or stepparents who lives with them,
  c. The child's natural, adopted or step siblings under age 19 who lives with them,
  d. The child's spouse, who lives with them,
  e. The child's natural, adopted or step children under age 19 who lives with them.
  f. If any of these individuals are pregnant, include the number of unborn children. If more than one unborn child is expected, verification is required.

Married couples, who file jointly, must be included in each other's Medicaid households for budgeting purposes, even if not residing together.

Married couples, where one spouse is incarcerated, the incarcerated spouse must be included in other's Medicaid households for budgeting purposes, IF-the spouses file their taxes jointly.

Note: The spouse who is incarcerated is not eligible for ACA Medicaid.

When both parents live in the household AND they are not married, only 1 parent may be eligible under the Parent, Caretaker Relatives and their Spouses group. The parent that claims to have primary responsibility over the child is the one that can be eligible under the parent/ caretaker group, provided they meet the parent/caretaker relative income limit. The other parent would have to be covered under the Adult Group, if eligible under that group.

- If there is more than one child in the home, each parent could be eligible if each claimed primary responsibility over at least one child.
- The parent that claims primary responsibility does not have to be the parent that claims the child on their taxes. The parent just has to indicate having primary responsibility for that child.

  Example 1:

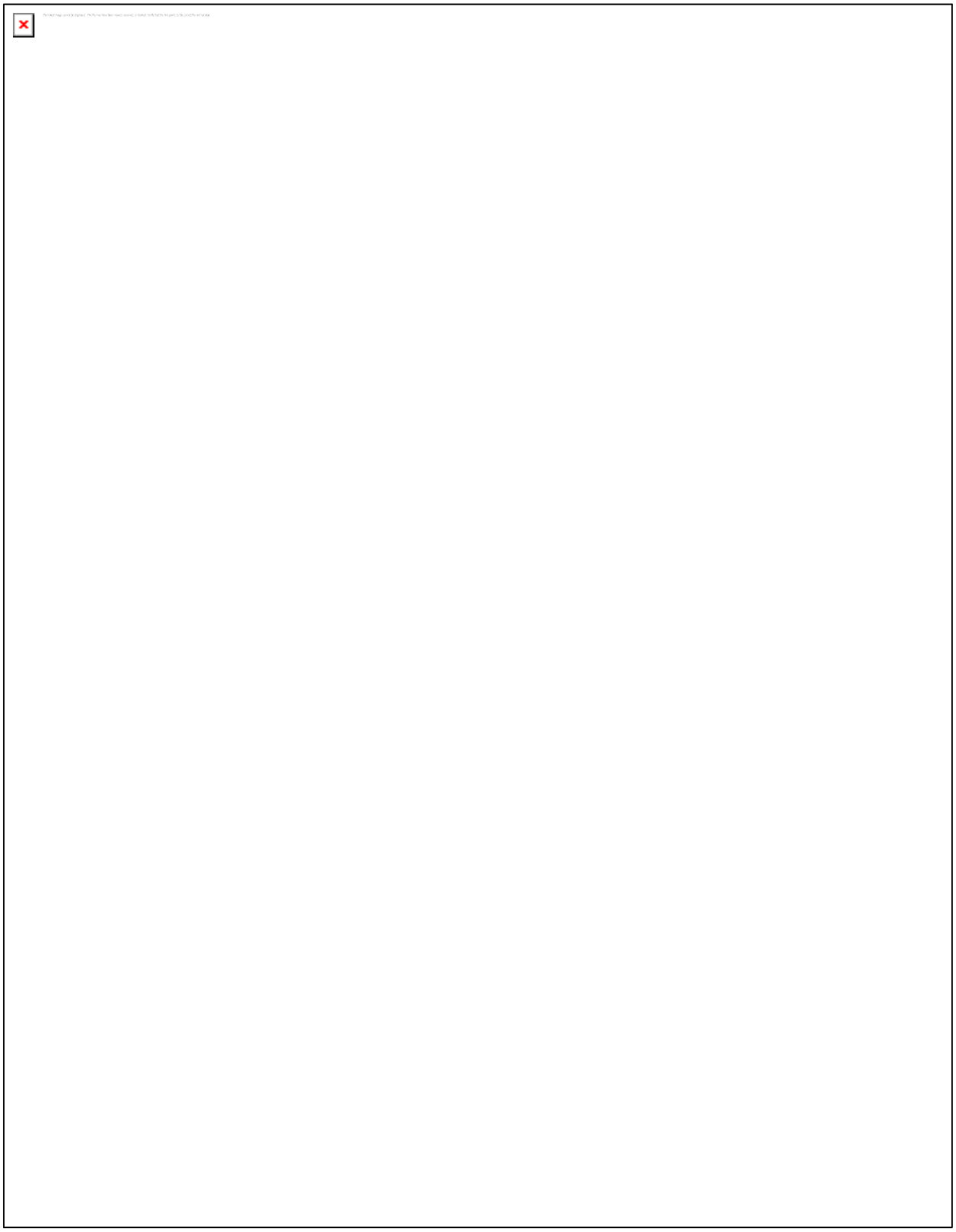
  Joe and Jill are the unmarried parents of Jessie, age 5. Jill claims to have primary responsibility for Jessie. No one has income at this time, so no one is filing taxes. Jill's household will be Jill and Jessie. Jessie's household will be Joe, Jill and Jessie. Joe's household is Joe and Jessie.

Jill is eligible under the parent/caretaker and their spouses group. Jessie is eligible under the children's group. Joe is eligible under the Adult Group.

Example 2:

Mark and Mary are the unmarried parents of Mindy, age 15. Neither has claimed primary responsibility for Mindy. Mark is working and earns $2,000 per month. He also claims Mindy on his taxes. Mark's household is Mark and Mindy. Mindy's household is Mark, Mary and Mindy. Mary's household is Mary and Mindy. Mark is not eligible because his income exceeds the Adult Group Income Level for 2. Mary is eligible under the adult group only since she is not claiming primary responsibility for Mindy. Mindy is Medicaid eligible as a child. (Note that if household comes back in and says that Mary has primary responsibility for Mindy, it would be a change in circumstance and would have to be acted upon. We accept client attestation for this.)

The following flowchart and examples will assist in determining the ACA Medicaid Household for each individual:



Examples:

Note: (In all of the following examples in this section, step, half, adoptive and natural parents, siblings and children are all treated the same.)

1. John is a single individual who is applying on his own. He does not plan to file income taxes.
   - John is a non-filer and his household size is 1.

2. Joe is a single individual who is applying on his own. He plans to file income taxes. He is not claiming any dependents.
   - Joe is a tax-filer and his household size is 1.

3. a. Tony is a single individual who is applying on his own. He plans to file income taxes and is claiming his 12 year old son, Jacob who resides with his mother, Claudia.
   - Tony is a tax-filer and since he is claiming his son, his household size is 2.

   b. Since Jacob resides with his mother, Claudia applies for herself and her son, Jacob. Claudia files taxes, but does not claim Jacob as his father does.

   - Jacob is considered a non-filer as he meets one of the exceptions in #2.c., Tax Dependent Unit rules, above. Therefore, his household size is 2. Since Jacob lives with his mother, she must be a part of Medicaid household.
   - Claudia is considered a tax-filer and since Tony claims Jacob, her household size is 1.

4. Paul and Pam are married, live together, have no children and Pam is not pregnant. Paul plans to file taxes jointly with Pam.
   - Paul and Pam are tax filers and each has a household size of 2.

5. Paul and Pam are married and live together with their son Peter. Paul and Pam are filing jointly and claiming Peter as a tax dependent.
   - Paul and Pam are tax filers and each has a household size of 3.
   - Peter is a tax dependent and his household size of 3.

6. Paul and Pam are married and live together with their minor son, Peter. Paul and Pam plan to file taxes separately. Paul expects to claim their son, Peter, as his tax dependent.
    - Paul is a tax filer and his household size of 3 as he is claiming his son.
    - Pam is a tax filer and her household size of 2, as she is not claiming her son.
    - Peter is a tax dependent but his parents are filing their taxes separately. Therefore, his household size is 3.

7. Paul and Pam are married and live together with their son Peter and Pam's mother. They plan to file taxes together and claim their son and Pam's mother as tax dependents.
    - Paul and Pam are tax filers and each has a household size of 4.
    - Peter is a tax dependent and his household size is 4.
    - Pam's mother is a non-filer and her household size is 1.

8. John and Julie are married. They have 2 children in common, Derik age 2 and Shawn age 10. Julie has a child from a previous relationship, Brynn, age 16. Mom and Step Dad file jointly and claim all the children on their taxes.
    - John and Julie are tax filers and each has a household size of 5.
    - Brynn, Shawn and Derik are tax dependents and each has a household size of 5.

9. Marty lives with his grandmother, who is widowed, and she expects to claim him as a tax dependent (even though Marty is a dependent someone other than a parent is claiming him so he is treated as a non-filer).
    - Marty is a non-filer and his household size is 1.
    - Grandmother is a tax filer and is claiming Marty. Grandmother's household size is 2.

10. Marcy lives with both of her biological parents, Mary and Mark, who are married but expect to file separately. Marcy expects to be claimed as a tax dependent by Mary.
    - Marcy is considered a non-filer as she meets one of the exceptions in #2.c., Tax Dependent Unit rules, above. Her household size is 3.
    - Mary is a tax filer and is claiming her daughter and her household size is 3.

- Mark is a tax filer and is not claiming his child. His household size is 2.

11. Matt lives with his mother, Mary. Matt expects to be claimed as a tax dependent by his father, Mark who lives separately.
    - Matt is considered a non-filer as he meets one of the exceptions in #2.c., Tax Dependent Unit rules, above. Therefore, his household size is 2.
    - Mary is a tax filer and not claiming her son. Her household size is 1.

12. Carol and Bill reside together with their 2 children, Kyle and Sarah, and Carol's nephew, Travis. Carol and Bill file their taxes jointly and claim their two children and Carol's nephew. Kyle, Sarah and Travis are under age 18 and not required to file income taxes.
    - Carol is considered a tax-filer and claims her two children and nephew. Her household size is 5.
    - Bill is considered a tax-filer and claims his two children and Carol's nephew. His household size is 5.
    - Kyle is considered a tax dependent and his household is that of the tax filer (his parents). Therefore, his household size is 5.
    - Sarah is considered a tax dependent and her household is that of the tax filer (her parents). Therefore, her household size is 5.
    - Travis is considered a non-filer child. His household size is 1.

13. John lives with his girlfriend, Susan and Susan's daughter, Mariah, age 3, who is not John's biological, adopted, or step-daughter. He does not plan to file taxes. Susan will file taxes and claim her daughter only.
    - John is a non-filer and his household size is 1.
    - Susan is a tax-filer and her household size is 2.
    - Mariah is a tax dependent and her household is 2.

14. Katie and Alex are married and file taxes separately. They have two children, Allan and Hannah, both under age 16. Alex claims them both on his taxes.
    - Katie is a tax filer and her household size is 2.
    - Alex is a tax filer and his household size is 4.
    - Allan is a non-filer and his household size is 4.
    - Hannah is a non-filer and her household size is 4.

15. Jack and Diane are married and file taxes together. They have two children in common, Quinn age 7 and Lucy age 9. They also have a Foster Child, Stephanie, age 14. They claim their children as well as the Foster Child on their taxes.
    - Jack and Diane are tax filers and each has a household size of 5.
    - Quinn and Lucy are tax dependents and each has a household size of 5.
    - Stephanie is a non-filer and her household size is 1.
16. Tom and Francine are married and have 2 children, Garrett age 15 and Sonya age 19, who is living in a dorm attending college in another city. They file taxes jointly and claim both of the children on their taxes.
    - Tom and Francine are tax filers and each has a household size of 4.
    - Garret and Sonya are tax dependents and have a household size of 4.

    a. Tom and Francine are married and have 2 children, Garrett age 15 and Sonya age 19, who is living in a dorm attending college in another city. Sonya also works and will be required to file taxes on her own. However, her parents will be filing jointly and claiming both of the children on their taxes.
        - Tom and Francine are tax filers and each has a household size of 4.
        - Garret is a tax dependent and has a household size of 4.
        - Sonya is a tax dependent and has a household size of 4.

        Note: Since Sonya is required to file taxes, her income is counted in all the households in which she is included.

17. Sharon is disabled and in receipt of SSI. She has 1 child, Ben, who is age 18. Sharon does not file taxes. Her son Ben is employed and earns sufficient income to require him to file taxes.
    - Sharon is a non-filer and her household size is 2; herself and her son.
    - Ben is a tax filer. His household size is 1.

    Note: If Ben claimed his mother, his household size would be 2.

18. Case consists of Sandy, her boyfriend Carl, and Sandy's daughter Meghan, age 6 (who is not Carl's daughter). Carl is employed and files taxes. He is claiming Sandy and her daughter.
    - Carl is a tax filer and his household size is 3.

- Sandy is a non-filer and her household size is 2.
- Meghan is a non-filer and her household size is 2.

Deprivation 510-03-35-10

(New 7/1/2014 ML #3404)

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Deprivation must be established in order for an individual to be found eligible under the Parent, Caretaker Relative and their Spouses categories or the 'Absence' and 'Unemployment, or Underemployment of a Parent (UP)' deprived children's categories.

A child, under age 19 (including the month the child attains age 19) is considered deprived of a natural or adoptive parent's support or care due to continued absence of a parent or inability of a parent to meet the child's needs.

A child will be considered deprived under the following reasons:

1. Absence of a Parent
   a. Death of a parent;
   b. Divorce or legal annulment;
   c. Separation, legal or mutual, as long as there was no collusion between the parents to render the family eligible, or

      Note: A child will still be considered deprived when the absent parent was included in the household for budgeting purposes, due to spouses filing their taxes jointly.

   d. Imprisonment of one or both parents

      Note: A child will still be considered deprived when the imprisoned parent was included in the household for budgeting purposes due to spouses filing their taxes jointly.

      To establish continued absence, the parent must be sentenced to a minimum of a thirty-day jail term. Any portion of a sentence actually suspended and not served does not count toward the thirty-day minimum. A parent who is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the work day is not considered absent from the home;

e. Unmarried parenthood (when not residing together);
f. Abandonment;

2. Disability, Incapacity or Age of a parent
   a. Disability of a parent (as defined in Service Chapter 510-05, Section 510-05-35-100, Blindness and Disability);
   b. Incapacity of a parent;
   c. A parent is age sixty-five or older;

3. Unemployment, or underemployment, of a parent, if either parent is:
   a. Employed less than one hundred hours per month (based on pay stub hours, including holiday and sick pay hours; or if self-employed, in the absence of other credible information, by dividing the gross monthly income by minimum wage); or
   b. Employed more than one hundred hours in the current month, but employed less than one hundred hours in the previous month and is expected to be employed less than one hundred hours in the following month.

   When the only means of income to a household is self-employment and both parents are actively involved in the business, consider both parents working more than 100 hours.

A parent's contact with his or her child(ren) does not have to stop in order for continued absence to exist. A continuing relationship between an absent parent and child(ren), by itself, cannot be a basis for finding that continued absence does not exist. The continued absence of either parent from the home is established when a parent maintains and resides in a separate verified residence apart from the ACA Medicaid Household for reasons other than employment, education, training, medical care, or uniformed service. The parent is considered absent from the home and the absent parent's functioning as a provider of maintenance, physical care, or guidance to the child(ren) is considered interrupted. ('Uniformed service' is defined to mean duty in the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, Public Health Service, and reserve duty.).

A parent temporarily living apart from the child(ren) due to employment, education, training, medical care, uniformed service, or any other temporary reason is not considered "Absent from the home" as long as the parent continues to function as a parent, even if the level of support or

care is somewhat deficient. An exception is made when there is evidence that continued absence would have existed irrespective of the above reasons.

Divorce courts often award custody of children to both parents, however, legal custody orders have no bearing on whether or not a child is considered "deprived." It is the parent’s absence from the home and the child’s physical presence rather than legal custody that is relevant.

Deprivation of unemployment, underemployment, incapacity, or disability may be established on an unborn child only when the prospective parents are married and in the same ACA Medicaid household.

Caretaker Relatives 510-03-35-15

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-08.1)

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).

Relative Responsibility 510-03-35-20

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Sections 75-02-02.1-25 and 75-02-02.1-34)

Each ACA Medicaid individual's financial responsibility is determined in the same manner as their ACA Medicaid household defined in Section 510-03-35-05, ACA Medicaid Household.

Income of all individuals included in the individual's ACA Medicaid household must be counted unless disregarded as defined in Section 510-03-85-30, Disregarded Income.

Need 510-03-35-35

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-11)

Need is a factor of eligibility. Need in this sense is not to be confused with the necessity for a particular medical service.

1. Need is automatically established for individuals who are determined to be categorically needy eligible under ACA Medicaid

2. For an ACA Medicaid medically needy applicant or recipient, need is established when there is no client share (recipient liability) or when the applicant or recipient has incurred medical expenses for which the applicant or recipient is responsible (after any third party payments) that equal or exceed the client share. If there is no need, there is no eligibility, and the application must be denied or the case must be closed.

   To determine need under ACA Medicaid Medically Needy,

   a. Determine the Monthly ACA Income; deduct any ACA allowable deductions to arrive at the Countable ACA Medicaid Income.
   b. Subtract the Medically Needy Income Level for the household size from the Countable ACA Medicaid Income.

3. When financially eligible individuals (individuals listed above in #1 or those in #2 with no client share) are not utilizing the program, assistance may be terminated if a written request is obtained from the recipient. An oral request will also suffice if recorded in the case file narrative and reflected on the closing notice, which must be mailed to the recipient.

Age and Identity 510-03-35-40

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-12)

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 90 days from the date the application is submitted and for the remaining days of the month in which the 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.

These Documents Verify Both Citizenship and Identity:	Explanatory Information
US Passport or US Passport Card Issued since 2007	• Issued by the Department of State • Does not have to be currently valid, as long as it was issued without limitation; (any passport issued with a limitation cannot be used to verify citizenship, but CAN be used to verify identity). • Through 1980, spouses and children were often included on one passport; after that each person is issued his own passport. • The passport card is for frequent travelers by land or sea between the US and Canada, Mexico, the Caribbean and Bermuda.
Certificate of Naturalization (DHS/INS Forms N-550 or N-570)	• Department of Homeland Security or Immigration and Naturalization Service (INS) issues for naturalization.
Certificate of US Citizenship (DHS/INS Forms N-560 or N-561)	• Department of Homeland Security or INS issues certificates of citizenship to individuals who derive citizenship through a parent.
Tribal Enrollment Card Certificate of Degree of Indian Blood **OR** other documents issued by a federally recognized Indian tribe that evidences membership or enrollment with such tribe	• A Document issued by a federally recognized Indian tribe evidencing membership or enrollment or affiliation with, such tribe. See following table for acceptable verification from ND tribes.

Citizenship verification received from using the "Other Benefits" inquiry in the NDVerify system or from the citizenship verification system available through the Federally Facilitated Marketplace (FFM) – as automated through the Streamlined application process.	• Acceptable codes are: ○ "Citizenship Verified" or ○ "Verified with positive citizenship; Deceased."

Documents Issued by Recognized ND Tribes

Sisseton-Wahpeton (Wahpeton—SE corner of ND)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood; ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, degree of Indian blood, SSN, photo and individual's signature; ○ Issued to enrolled members age 16 and older who request it; ○ Issued by tribal enrollment office;
Spirit Lake (Devils Lake)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office;

	• Tribal Photo ID: ○ Photo ID including name, DOB, tribal enrollment #, and degree of Indian blood (may have more information); ○ Issued by tribal motor vehicle office; ○ Issued to enrolled members;
Standing Rock Sioux Tribe (Fort Yates)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, last 4 digits of SSN (may have more information); ○ Issued to enrolled members age 14 and older who request it; ○ Issued by tribal enrollment office;
Three Affiliated Tribes (T. A. T.) (New Town)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing

	address, physical address, photo (plastic card with hologram on back) (will enter SSN (non-verified) at individual's request); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office (Cost = $10; free to seniors); ○ Expire every 4 years;
Turtle Mountain Chippewa (Belcourt, Trenton)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Enrollment cards: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to enrolled members age 18 and older who request it; ○ Issued by tribal enrollment office.

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.

Secondary Verifications of Identity
(Level 2)

Acceptable Verifications:	Explanatory Information
Driver's license issued by a state or territory (DO NOT accept Canadian driver's license)	• Must include a photograph of the applicant or recipient: or • Have other personal identifying information for the individual such as name, age, sex, race, height, weight, or eye color.
Identification card issued by a US Federal, State or local government with the same information as a driver's license.	• DO NOT accept a voter's registration card.
School ID card	• Must include a photograph of the applicant or recipient.
U. S. military ID card or draft record	
Military dependent's identification card	
U. S. Coast Guard Merchant Mariner card	

f. Third level verification of identity. These documents should only be used when documentation from levels one and two are unavailable.

Third Level Verifications of Identity

(Level 3)

Acceptable Verifications:	Explanatory Information
3 or more documents that together reasonably corroborate the identity of an individual, provided such documents have not been used to establish the individual's citizenship AND the individual has submitted at least second or third level citizenship verification	• Only to be used if no other evidence of identity is available. • Must contain the individual's name plus additional identifying information (employer ID cards, high school and college diplomas from accredited institutions, marriage certificates, death certificates, divorce decrees and property deeds/titles.).

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.

Identity Verifications for Children
(Level 4)

Acceptable Verifications:	Explanatory Information
School record	• Must show child's date and place of birth and parents' name.
Clinic, doctor, or hospital record	• Must show child's date and place of birth and parent's name.
Daycare or nursery school record showing date and place of birth	• Eligibility worker must call and verify with the school that issued the record.
An affidavit, signed under penalty of perjury, by the parent, guardian, or caretaker relative which states the date and place of birth of the child	• Only one affidavit may be used to establish either citizenship or identity. If an affidavit is used to establish citizenship, then identity must be established using a different document from the identity list. • The affidavit is not required to be notarized. • May be used for a child aged 16 to 18 only when school identity cards and driver's licenses are not available to the individual in that area until that age. • SFN 691, "Affidavit of Identity for Children," has been created for convenience.

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.

Citizenship and Alienage 510-03-35-45

(Revised 5/1/17 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

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 90 days from the date the application is submitted and for the remaining days of the month in which the 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.

Primary Verifications

(Level 1)

These Documents Verify both Citizenship and Identity:	**Explanatory Information:**
US Passport or US Passport Card issued since 2007	• Issued by the Department of State.

	• Does not have to be currently valid, as long as it was issued without limitation; (any passport issued with a limitation cannot be used to verify citizenship, but CAN be used to verify identity). • Through 1980, spouses and children were often included on one passport; after that each person is issued his own passport. • The passport card is for frequent travelers by land or sea between the US and Canada, Mexico, the Caribbean and Bermuda.
Certificate of Naturalization (DHS/INS Forms N-550 or N-570)	• Department of Homeland Security or Immigration and Naturalization Service (INS) issues for naturalization.
Certificate of US Citizenship (DHS/INS Forms N-560 or N-561)	• Department of Homeland Security or INS issues certificates of citizenship to individuals who derive citizenship through a parent.
Tribal Enrollment Card Certificate of Degree of Indian Blood; or Other documents issued by a federally recognized Indian tribe that evidences membership or enrollment with such tribe.	• A document issued by a federally recognized Indian tribe evidencing membership or enrollment or affiliation with, such tribe. See following table for acceptable verifications from ND tribes.
Citizenship verification received from	• Acceptable codes are:

using the "Other Benefits" inquiry in the NDVerify system or from the citizenship verification system available through the Federally Facilitated Marketplace (FFM) – as automated through the Streamlined application process.	○ "Citizenship Verified" or ○ "Verified with positive citizen; Deceased."

Documents Issued by Recognized ND Tribes

Tribe:	Documents
Sisseton-Wahpeton (Wahpeton—SE corner of ND)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood; ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, degree of Indian blood, SSN, photo and individual's signature; ○ Issued to enrolled members age 16 and older who request it; ○ Issued by tribal enrollment office;
Spirit Lake (Devils Lake)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Photo ID: ○ Photo ID including name, DOB, tribal enrollment #, and degree of Indian blood (may have more information); ○ Issued by tribal motor vehicle office; ○ Issued to enrolled members;

Standing Rock Sioux Tribe (Fort Yates)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, last 4 digits of SSN (may have more information); ○ Issued to enrolled members age 14 and older who request it; ○ Issued by tribal enrollment office;
Three Affiliated Tribes (T. A. T.) (New Town)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo (plastic card with hologram on back) (will enter SSN (non-verified) at individual's request); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office (Cost = $10; free to seniors); ○ Expire every 4 years;
Turtle Mountain Chippewa (Belcourt, Trenton)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Enrollment cards: ○ Name, DOB, enrollment #, and degree of Indian

	blood (may have more information); ○ Issued to enrolled members age 18 and older who request it; ○ Issued by tribal enrollment office.

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.

Secondary Verification of Citizenship

(Level 2)

Acceptable Verifications:	Explanatory Information:
Certificate of Birth in the United States	• Must have the embossed seal of the issuing agency. • North Dakota only issues certified copies. If it does not have the raised seal, it is not a certified copy - i.e. the old black and white prints. • The original must have been recorded before the person was 5 years of age. (For issuance date, use

	the "Date received by Local Registrar".) If recorded at or after 5 years of age, it is a 4th level verification. • Must show birth in one of the 50 states, or the District of Columbia. • Persons born to foreign diplomats are not citizens of the United States. • An electronic match with the ND vital statistics agency showing the individual's place of birth will suffice.
Report of Birth Abroad of a Citizen of the United States (FS-240) aka Consular Report of a Birth Abroad of a Citizen of the United States	• Prepared by the Department of State Consular office. • Can only be prepared at an American Consular office overseas while the child is under age 18. • Children born outside the US to US military personnel usually have one of these.
Certificate of Birth Abroad (FS-545 or Form DS-1350) aka Certificate of Report of Birth or Certification of Birth Abroad	• For those who were born outside the US and acquired US Citizenship at birth and is based on FS-240. • FS-545 issued prior to November 1, 1990. • DS-1350 issued on and after November 1, 1990. • Is issued only within the US.
United States Citizen Identification Card (I-197 or I-179)	• Issued by the Immigration and Naturalization Service from 1960-1973 as I-179; Issued to naturalized US Citizens living near the Canadian or Mexican border who needed it for frequent border crossings. • Issued as I-197 from 1973-1983. • No longer currently used, but still

	valid.
American Indian Card (I-872) with the classification code "KIC" and a statement on the back	• Issued by the Department of Homeland Security to identify US citizen members of the Texas Band of Kickapoos living near the US / Mexican border.
Evidence of Civil Service Employment	• Must show employment by the US Government prior to June 1, 1976.
Official Military record of service	• Including a DD-214. • Must show a US place of birth.
A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizen	• Determines if someone is a naturalized citizen. • May need to provide the individual's alien registration number.
Adopted or biological children born outside the US may establish their automatic citizenship if verification is provided	• Showing at least one parent is a US citizen by either birth or naturalization. • Child is under age 18. • Child is residing in the US in the legal and physical custody of the US citizen parent. • Child was admitted to the US for lawful permanent residence. • If adopted, the child must be a lawful permanent resident as an IR-3 (child adopted outside the US) or as IR-4 (child coming to the US to be adopted); with the final adoption having subsequently occurred.

Third Level Verification of Citizenship

(Level 3)

Acceptable Verifications:	Explanatory Information:

Extract of hospital record on hospital letterhead established at the time of birth and created at least 5 years prior to the Medicaid application	• It must indicate a US place of birth. • A souvenir 'birth certificate' issued by the hospital cannot be accepted. • For children under 16 the document must have been created near the time of birth or 5 years prior to the Medicaid application.
Life or health or other insurance record	• Showing a US place of birth for the individual. • Created at least 5 years before the initial application date.
Official religious record (recorded with the religious organization) recorded in the US within 3 months of birth	• Must show a US place of birth. • Must show the individual's date of birth or age at the time the record was made. • In questionable cases, such as where the child's religious record was recorded near a US international border and the child may have been born outside the US, the worker must verify the religious record with the religious organization and verify that the mother was in the US at the time of birth.
Early school record showing a US place of birth	• Must show the name, date of birth, and US place of birth of the child. • Must show the date of school admission. • Must show the name(s) and place(s) of birth of the applicant's parents.

Fourth Level Verification of Citizenship
(Level 4)

Acceptable Verifications:	Explanatory Information:
Federal or state census record showing	• Must also show the applicant's age.

US citizenship or a US place of birth - *(generally for persons born 1900-1950)*	• Census records from 1900 through 1950 contain citizenship information. • To obtain this information the applicant or recipient should complete a Form BC-600, "Application for Search of Census Records for Proof of Age", adding in the remarks portion, "US Citizenship data requested for Medicaid eligibility." This form can be obtained online at: http://www.census.gov/genealogy/www/bc-600.pdf. • A fee will be charged.
Seneca Indian tribal census record	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Bureau of Indian Affairs tribal census records of the Navajo Indians	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
US State Vital Statistic official notification of birth registration	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Delayed US public birth record that is amended more than 5 years after the person's birth	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Statement signed by the physician or midwife who was in attendance at the time of birth	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Institutional admission papers from a nursing home, skilled care facility or other institution	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Medical (clinic, doctor or hospital) record (An	• Must be created at least 5 years prior to initial Medicaid application (or near the time

immunization record is NOT considered a medical record for establishing citizenship)	of birth, if a child under age 16 only); and • Must show
Written affidavit, made under penalty of perjury, by at least two individuals--one of which is not a relative--showing they have personal knowledge of the event(s) establishing the applicant's claim of citizenship (date and place). These individuals must provide proof of their own citizenship and identity	• It must also state a reasonable basis of personal knowledge that an applicant or recipient who cannot produce documentary evidence of citizenship is a citizen. SFN 707, "Affidavit of Citizenship," has been created for convenience. • A second affidavit from the applicant/recipient or other knowledgeable individual explaining why the information cannot be obtained must also be supplied. SFN 706, "Affidavit of Explanation why Citizenship Cannot be Supplied," has been created for convenience. • Use only in rare circumstances.

6. Individuals born in Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and Nationals from American Samoa. For purposes of qualifying as a United States citizen, individuals born in Puerto Rico, Guam, the Virgin Island, the Northern Mariana Islands and Nationals from American Samoa may qualify as follows:
   a. Puerto Rico:
      - Certificate of birth in Puerto Rico on or after January 13, 1941 (For applicants whose eligibility is determined for the first time on or after November 1, 2010, the birth certificate must have an issue date of on or after July 1, 2010, to be considered valid.)
      - Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the US, a US possession, or Puerto Rico on January 13, 1941 (For applicants whose eligibility is determined for the first time on or after November 1, 2010, the birth certificate must have an issue date of on or after July 1, 2010, to be considered valid.)

- Evidence that the individual was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917, and that he or she did not take an oath of allegiance to Spain

b. Guam:

- Evidence of birth in Guam on or after April 10, 1899

c. The US Virgin Islands:

- Certificate of birth in the US Virgin Islands on or after January 17, 1917
- Evidence of birth in the US Virgin Islands and the applicant's statement of residence in the US, a US possession, or the US Virgin Islands on February 25, 1927
- The applicant's statement indicating residence in the US Virgin Islands as a Danish citizen on January 17, 1917 and residence in the US, a US possession, or the US Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship
- Evidence of birth in the US Virgin Islands and the applicant's statement indicating residence in the US, a US possession, or the Canal Zone on June 28, 1932

d. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- Certificate of birth in the Northern Mariana Islands after November 4, 1986.
- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the US or a US territory or possession on November 3, 1986 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986. These individuals carry the Northern Mariana Identification Card (I-873). This form is no longer issued, but is still valid.
- Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981, voter registration prior to January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986.

- Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986.
- If the person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a US Citizen.

e. U.S. Nationals refers to individuals who were born in or having ties with "an outlying possession of the United States which, as of 2005, were American Samoa or Swain's Islands:

- Certificate of birth in American Samoa or Swain's Islands after November 4, 1986
- Persons born in American Samoa or Swain's Islands are treated as citizens for Medicaid purposes

f. Persons born to foreign diplomats while residing in one of the preceding jurisdictions of the US are not citizens of the United States.

- The child's citizenship or alien status follows that of the parent.

American Indians Born in Canada 510-03-35-50

(New 7/1/2014 ML #3404)

View Archives

1. American Indians born in Canada who may freely enter and reside in the United States are considered to be lawfully admitted for permanent residence if at least one-half American Indian blood. This does not include a spouse or child of such an Indian nor a noncitizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. These American Indians are qualified aliens and are considered to be lawful permanent residents.

   Article III of the 'Jay Treaty' declared the right of "Indians" ("Native Americans") to trade and travel between the United States and Canada, which was then a territory of Great Britain. As a result of the "Jay Treaty", Native Indians born in Canada are entitled to enter the Unites States for the purpose of employment, study, retirement, investing, and/or immigration.

2. Verification of percentage of American Indian blood may be obtained from INS Form I-551 with the code 513, S1-3, or S-13, or an unexpired temporary I-551 stamp (with the code 513, S1-3, or S-13) in a Canadian passport or on Form I-94. If the individual does not have an INS document, satisfactory evidence of birth in Canada and a document indicating the percentage of American Indian blood must be provided. Documents, indicating the percentage of American Indian blood include a birth certificate issued by the Canadian reservation, or a Blood Quantum Letter, card, or other record issued by the tribe (each tribe provides some type of evidence). The Blood Quantum Letter may use the following verbiage: at least 50% Aboriginal blood, at least 50% Indigenous blood, at least 50% North American Indian blood, or at least 50% American Indian blood. Do not accept a Certificate of Indian Status card ("Band" card) issued by the Canadian Department of Indian Affairs, information from any internet sites, or any other document not directly issued by the individual's tribe.

   Note: The Blood Quantum Letter can be used to show that an individual possesses at least 50% blood of the American Indian

Race, but cannot be used to show that an individual does not possess at least 50% blood of the American Indian Race. If the letter does not show an individual possesses at least 50% blood of the American Indian Race, additional verification may be warranted.

Non-Qualified Aliens 510-03-35-55

(New 7/1/2014 ML #3404)
View Archives

(N.D.A.C. Section 75-02-02.1-18)

1. Ineligible Aliens. Some aliens may be lawfully admitted for a temporary or specified period of time and are not eligible for Medicaid. They have the following types of documentation: Form I-94, Arrival-Departure Record; Form I-185, Canadian Border Crossing Card; Form I-186, Mexican Border Crossing Card; Form SW-434, Mexican Border Visitor's Permit; Form I-95A, Crewman's Landing Permit. These aliens are not eligible for Medicaid because of the temporary nature of their admission status. Ineligible aliens are eligible for coverage of emergency services. The following categories of individuals are ineligible aliens:
   a. Foreign government representatives on official business and their families and servants;
   b. Visitors for business or pleasure, including exchange visitors;
   c. Aliens in travel status while traveling directly through the U.S.;
   d. Crewman on shore leave;
   e. Treaty traders and investors and their families;
   f. Foreign students;
   g. International organization representation and personnel and their families and servants;
   h. Temporary workers including agricultural contract workers; and
   i. Members of foreign press, radio, film, or other information media and their families.

2. Illegal Aliens. Aliens who are not lawfully admitted for permanent residence in the United States are not eligible for Medicaid, except for emergency services. Ongoing eligibility does not exist.

3. Individuals from the Federated States of Micronesia, the Marshall Islands, or Palau, are permanent non-immigrants. While considered non-qualified aliens, they are here permanently and therefore can be eligible for emergency services.

Qualified Aliens 510-03-35-58

(New 7/1/2014 ML #3404)

View Archives

Qualified aliens are aliens that have been legally admitted and may be eligible for Medicaid if they meet all other Medicaid eligibility criteria. Some qualified aliens may be eligible under the Refugee Medical Assistance Program if they do not meet all other Medicaid eligibility criteria. The following categories of individuals are qualified aliens: (Forms indicated below are USCIS or INS forms and the sections refer to the Immigration and Nationality Act (INA).

Individuals with the documents described in subsections 2 through 13 below may be eligible for Medicaid from their date of arrival in North Dakota, without being subject to the five-year ban or required to meet the forty qualifying quarters of social security coverage, as long as they meet other Medicaid criteria:

1. Aliens who are lawfully admitted for permanent residence (LPR) may be eligible as described in sections 510-03-35-60 and 510-03-35-65.

2. Honorably discharged veterans, aliens on active duty in the United States' armed forces, and the spouse or unmarried dependent child(ren) of such individuals:
   a. Verification of honorable US military discharge (such as a DD214);
   b. Verification of relationship of family members.

3. Refugees:
   a. Form I-94 (Arrival Departure Record) showing "207" or "REFUG" or codes RE1, RE2, RE3, RE4; or RE5;
   b. Form I-688B (Temporary Resident Card) annotated 274a.12(a)(3);
   c. Form I-766 (Employment Authorization Document) with code A3;
   d. Form I-571 (Refugee Travel Document);
   e. Form I-551 or I-151 (Permanent Resident Card) with codes R8-6; RE6, RE7, RE8, RE9.

4. Asylees who have been granted asylum (not applicants for asylum):

a. Form I-94 showing "208" or "asylee" and/or codes of AS1, AS2, or AS3);
b. Form I-688B annotated 274.a12(a)(5);
c. Form I-766 annotated A5;
d. Grant letter from Asylum office of USCIS;
e. Order from immigration judge granting asylum;
f. Form I-571;
g. Form I-551 or I-151 with codes AS6, AS7, AS8, AS9, GA-6 to GA-8.

5. Cuban and Haitian Entrants:
   a. Form I-94 showing "Cuban/Haitian Entrant" or "parole" under Section 212(d)(5) or codes CU6, or CU7 or "OOE" or "outstanding orders of exclusion";
   b. Form I-151 or I-551 with National of Cuba or Haiti and codes CH6, CNP, CU0, CU-6, CU-7, CU-8, CU-9, CUP, HA-6 to HA-9; HB-6 to HB-9; HD-6 to HD-9; HE-6 to HE-9, or NC-6 to NC-9.

6. Victims of a severe form of trafficking and their families (aliens granted nonimmigrant status under 101(a)(15)(T) of the Immigration and Nationality Act who have a pending application that sets forth a prima facie case for eligibility for that nonimmigrant status):
   a. I-94 showing codes T-1 or T-2;
   b. I-94 or passport showing non-immigrant status under 101(a)(15)(T);
   c. I-688B or I-766 showing 247a.12(a)(16), A16, 274a.12(c)(25) or C25;
   d. Other INS document showing nonimmigrant status under 101(a)(15)(T);
   e. Any verification from the INS or other authoritative documents showing non-immigrant status under 101(a)(15)(T).

7. Aliens whose deportation was withheld under Section 243(h) of the Immigration and Naturalization Act (INA):
   a. I-94 or foreign passport showing "243(h)" or "241(b)(3)";
   b. I-688B or I-766 with code of "274a.12(a)(10) or A10;
   c. I-571.

8. Aliens admitted as an Amerasian immigrant:
   a. I-94 showing National of Vietnam and AM1, AM2, or AM3;

b. I-151 or I-551 showing National of Vietnam and AM-1, AM-2, AM-3, AM-6, AM-7; or AM-8.

9. American Indians born in Canada as described in 510-03-35-50.

10. Aliens paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year:
    a. I-94 showing "212(d)(5)" or "parolee" or "PIP";
    b. Form I-688B or I-766 with code such as 274a.12(a)(4), or A4, or 274a.12(c)(11);
    c. Cuban-Haitian entrants with parole status are considered Cuban-Haitian entrants.

11. Certain battered aliens; battered alien children; and the parents of such children with an I-551 card showing B2-1, B2-3, B2-6, or B2-8.

12. Iraqi and Afghan Special Immigrants and their families:
    a. I-94 with a stamp of "IV" and category SQ1, SQ2, SQ3, SI1, SI2 or SI3 and date of entry;
    b. Afghan or Iraqi passport with a stamp of "IV" and category SQ1, SQ2, SQ3, SI1, SI2 or SI3 and DHS stamp or notation on passport showing date of entry;
    c. I-551 showing national of Afghanistan or Iraq with "IV" code of SQ6, SQ7, SQ9, SI6, SI7, SI9.

13. Aliens granted conditional entry under section 203(a)(7) of the Immigration and Nationality Act in effect prior to April 1, 1980:
    a. I-94 or other document showing "conditional entrant", "refugee conditional entry", "seventh preference"; "section 203(a)(7)"; "P7" ;
    b. I-688B annotated "274a.12(a)(3);
    c. I-766 annotated "A3"; or
    d. Any verification from the INS or other authoritative document.

Aliens Lawfully Admitted for Permanent Residence before August 22, 1996 510-03-35-60

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

Aliens who lawfully entered the United States for permanent residence before August 22, 1996, and who meet all other Medicaid criteria may be eligible for Medicaid. These individuals have Forms I-551 or I-151 (Resident Alien Cards) or a Foreign Passport stamped LPR or I-551.

Aliens Lawfully Admitted for Permanent Residence on or After August 22, 1996 510-03-35-65

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

1. Aliens admitted for Lawful Permanent Residence (LPR) on or after August 22, 1996 are banned from Medicaid, for five years from the date they obtained LPR status. After the five-year ban, aliens who are lawful permanent residents who can be credited with forty qualifying quarters of social security coverage may be eligible for Medicaid.

   Verifications of this status are:

   a. Form I-551 or I-151 (Resident Alien Card) (these are also known as 'green cards' but are not green);
   b. Foreign passport stamped LPR or I-551.

      Note: If a qualified alien's status has changed to LPR, the codes at 510-03-35-58 apply. If the code on the Permanent Resident Card is not in 510-03-35-58, the individual is subject to the 5–year ban and forty qualifying quarter requirements.

      Example: An asylee entered as an AS1 (which shows on his I-94 card). He has now become a LPR and his code on his I-551 is AS8. He is still an Asylee and a qualified alien. If his LPR code had been issued as an SD6, which is not a qualified alien code instead of the AS8, he is subject to the 5-year ban or the forty-quarter requirements.

2. Qualifying quarters of social security coverage determined by Social Security can be obtained using the NDVerify system. Earnings of some federal civilian employees hired before 1984, earnings of employees of some state and local governments, and certain agricultural and domestic earnings are not calculated by Social Security. These earnings count in establishing qualifying quarters of social security coverage and must be determined using the same process used by Social Security. If

an alien claims to have work history that may qualify, but that the NDVerify system does not support, gather the information regarding the amount of earnings by quarter and contact the Medicaid Eligibility unit for further assistance.

a. When determining the number of qualifying quarters an individual has, count:
    i. All qualifying quarters the alien has due to work;
    ii. All qualifying quarters worked by the alien's spouse during their marriage, if the alien remains married to such spouse or the spouse is deceased; and
    iii. All qualifying quarters worked by a natural, adoptive, or stepparent of such alien while the alien was under age 18. Qualifying quarters of an adoptive parent count from the quarter of the adoption. Qualifying quarters of a stepparent count from the quarter of marriage to the alien's parent.
b. Do not count or deem any qualifying quarters for any quarter in which an individual received TANF, SNAP, Medicaid, or SSI benefits (including benefits received in another state), for at least one month in the quarter, or from any parent whose parental rights have been terminated.

3. Adopted or biological children born outside the US may establish their automatic citizenship if verification is provided as described in the Secondary Verification of Citizenship table at 510-03-35-45.

Emergency Services for Non-Citizens 510-03-35-70

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

Non-qualified aliens -- Ineligible aliens, illegal aliens, permanent non-immigrants (identified in subsection 3 of 510-03-35-55), and qualified aliens, who are not eligible for Medicaid because of the time limitations or forty qualifying quarters of social security coverage requirement, may be eligible to receive emergency services that are not related to an organ transplant procedure, if all of the following conditions are met:

1. The alien has a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
   a. Placing health in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part.

2. The alien meets all other eligibility requirements for Medicaid except illegal aliens do not have to meet the requirements concerning furnishing social security numbers and verification of alien status; and

3. The alien's need for the emergency service continues. Eligibility for Medicaid ends when the emergency service has been provided, and does not include coverage of follow-up care if the follow-up care is not an emergency service. A pregnant woman may be covered from the date she entered the hospital for labor and delivery through the date she was discharged. A pregnant woman who delivers a child and is covered under this provision is not eligible for the sixty-day period of eligibility after pregnancy. Her child, however, is a citizen and may be eligible for twelve months of continuous coverage.

When a non-qualified alien is requesting coverage for 'Emergency Services' for reasons other than childbirth, a completed SFN 451, Eligibility Report on Disability/Incapacity and medical reports must be submitted to the State Review Team for a determination of whether the medical condition meets ALL the criteria listed in #1 above.

Note: Remember to check the box in the upper right hand corner titled 'Emergency Services'.

Social Security Numbers 510-03-35-80

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-13)

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.

State Residence 510-03-35-85

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-16)

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 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.

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:
   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 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.

Application for Other Benefits 510-03-35-90

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-17)

1. As a condition of eligibility, applicants and recipients (including spouses and financially responsible absent parents) must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits, to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions; old age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation.
2. Good cause under this section exists if:
   a. The recipient is a pregnant woman or a newborn who is within the 60 days of free Medicaid;
   b. The recipient is eligible for Transitional or Extended Medicaid Benefits;
   c. Receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage; or
   d. The individuals is NOT permanently disabled and receipt of the annuity, pension, retirement, disability benefit, etc. would result in a penalty being imposed due to the age requirements of the benefit plan. If the individual is permanently disabled, they will be required to access the funds.

      Example: Individual is age 58, NOT permanently disabled and has an IRA. The IRA requirements state the individual can obtain a stream of income at age 59 ½ without a penalty. The individual would not be required to annuitize the IRA until he/she attains age 59 1/2 unless the individual becomes permanently disabled.

   e. An employed or self-employed individual who has not met their full retirement age chooses not to apply for Social Security early retirement or widows benefits.

Good cause must be documented in the case file.

3. Application for needs based payments (e.g. SSI, TANF, etc.) cannot be imposed as a condition of eligibility.

Public Institutions 510-03-35-95

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-19)

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.

2. 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.

3. 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.

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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.

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)
View Archives

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.

b. 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.

c. 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.

d. 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.

e. 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.

Disability and Medically Frail 510-03-35-100

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-14)

Under final rules for the Affordable Care Act published on July 15, 2013, individuals determined eligible under the Adult Expansion Group MUST be given the option to be covered under a broader coverage plan.

> **Note:** All determinations for this coverage are done by DHS Medically Frail Determination Team.

Once eligibility under the Adult Expansion Group is determined, the approval notice includes information informing the recipient to provide verification of their disability and assets if they would like to receive broader coverage under the 'medically frail' provisions. It is Medicaid's obligation to screen for the disability.

Recipients, who request to be considered for coverage as 'medically frail', MUST complete a self-assessment, using SFN 1598, and return the completed form to:

DHS Medical Services
600 E Boulevard Ave, Dept. 325
Bismarck ND 58505-0250
EMAIL: medicallyfrail@nd.gov

EXCEPTION #1: If the individual is a Medicare beneficiary and not eligible under the Parents, Caretaker Relative's and their Spouses Category, that individual must be tested under Non-ACA Medicaid.

EXCEPTION#2: If the individual is determined disabled by the Social Security Administration and is eligible under Non-ACA Medicaid or ACA Medicaid, other than the Adult Expansion Group, the 'medically frail' provisions do not need to be pursued for these individuals.

EXCEPTION #3: 'Medically Frail' provisions do not apply to individuals over age 65.

Individuals requesting coverage as Medically Frail, who complete the self-assessment:

- If the self-assessment meets a threshold score set by the department, the individual shall schedule an appointment with a primary care provider to review and validate the information on the self-assessment. After the individual attends a face-to-face appointment with the primary care provider, the individual shall ensure that the primary care provider provides documentation to the department that validates the diagnosis or medical condition and that includes a medication list.

  Upon review of the information provided by the primary care provider, the department shall determine whether the individual meets 'medically frail' eligibility requirements.

If the individual eligible under the Adult Expansion Group:

- Is approved for eligibility as 'medically frail', the individual may choose coverage through a Managed Care Organization (currently, the coverage under the Sanford Health Plan) or through the Medicaid State Plan fee-for-service.

  Individuals determined 'medically frail' and who are requesting assistance for nursing care services are subject to the Disqualifying Transfer Provisions described in Service Chapter 510-05, Medicaid Eligibility Factors for Non-ACA Medicaid , Section 510-05-80, Disqualifying Transfers.

- Is denied for eligibility as 'medically frail', the individual will remain eligible under the Adult Expansion Group.

Coverage of an individual approved as 'medically frail' will begin the first of the month following the month in which the determination is made.

If the individual who requested a 'medically frail' determination also applied for SSA Disability:

1. If the individual is found not disabled by State Review Team and/or SSA, we will continue coverage under the Adult Expansion group.

2. If the individual is determined disabled by the Social Security Administration or the State Review Team and is not eligible for Non-ACA Medicaid or ACA Medicaid other than the Adult Expansion Group, the individual will continue eligible under the Adult Expansion Group.

3. If the individual does not cooperate, does not provide verification of disability or assets, or refuses to do so, but is otherwise eligible for the Adult Expansion Group, coverage will continue under the Adult Expansion Group.

4. Refer to 'Processing for Individual's Claiming to be Disabled (Medically Frail)' section of the ACA Medicaid Processing Guide.

Incapacity of a Parent 510-03-35-105

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-15)

Incapacity should be pursued for parents who would meet the criteria defined under this section as these parents would receive coverage under Traditional Medicaid fee-for-service.

1. A child, if otherwise eligible for Medicaid benefits, is "deprived of parental support or care" when the child's parent, whether married or unmarried, has a physical or mental defect which is of such a debilitating nature as to reduce substantially or eliminate the parent's capacity either to earn a livelihood (breadwinner) or to discharge the parent's responsibilities as a homemaker and provider of child care (homemaker) for a period of thirty days or more. A parent may establish incapacity by demonstrating that the parent has reached age sixty-five. When the only child is an unborn, the prospective parents must be married, and in the same ACA Medicaid Household to claim incapacity.

2. If the incapacitated parent is a breadwinner, the incapacity must be such that it reduces substantially or eliminates employment in the parent's usual occupation or another occupation to which the parent may be able to adapt. The fact that a breadwinner may have to change occupation or work location does not establish incapacity. It does not matter whether a parent was employed or fulfilled the role of homemaker prior to the onset of the asserted incapacity. Incapacity is established either when a parent is unable to earn a livelihood or to act as a homemaker. The county agency must, therefore, be alert in identifying persons with potential for vocational training so that referrals can be made promptly to Vocational Rehabilitation Services for rehabilitation services, or to Job Service of North Dakota for possible training, or other appropriate programs.

3. A determination that a parent is disabled or blind, made by the Social Security Administration, constitutes adequate substantiation of incapacity for purposes of this section. If the medical approval date is prior to the eligibility date for SSI, medical and social information must be submitted to the State Review Team for an incapacity or disability determination for the period prior to the SSI approval date. Likewise, incapacity is established upon attaining age sixty-five years without submitting medical or social information to the State Review Team. Such person, however, must be informed of the potential eligibility for SSI and that choosing SSI will likely yield a larger amount of total income for the family.

4. The county agency is responsible for determining all eligibility factors except for incapacity which is determined by the State Review Team. Since the State Review Team does not see the person, it must depend on the examining physician's medical report to document the individual's physical or mental condition. In addition, the State Review Team must rely on the county agency's report which is based on both observation and the applicant's or recipient's judgment of how the incapacity affects the family in terms of employment or ability to discharge homemaking and child care responsibilities. Pertinent information about the person's past employment or homemaking adjustments, type of housing, method of heating the home, the availability or lack of modern conveniences in the home, ability to manage personal needs and affairs, attitudes and behavior, motivation, etc., is invaluable to the State Review Team. This information, which is reported on SFN 451, "Eligibility Report on Disability/Incapacity", is forwarded along with any other medical reports to the State Review Team for evaluation and decision.

   Incapacity is periodically reviewed by the State Review Team. When an incapacity review is due within three months of the previous decision, a new SFN 451 does not need to be completed by the county agency. The county is only required to inform the State Review Team whether the individual continues to be eligible for Medicaid.

5. A parent continues to be incapacitated, for purposes of this section, if the incapacity is not reasonably subject to remediation, or if the parent makes reasonable progress towards remediation of the incapacity. For purposes of this section, "reasonable progress towards remediation of the incapacity" means cooperation with medical practitioners who

prescribe a course of treatment intended to remediate or limit the effect of the incapacity, including, but not limited to, physical therapy, counseling, use of prosthesis, drug therapy and weight loss, cooperation with vocational practitioners, cooperation with vocational and functional capacity evaluations, and reasonable progress in a course of training or education intended to qualify the parent to perform an occupation which, with that training or education, the parent would have the capacity to perform.

6. A parent who engages in activities inconsistent with the claimed incapacity, may be determined to not be incapacitated.

7. The Department may require a parent to demonstrate reasonable progress towards remediation of the incapacity, and may set reasonable deadlines for the demonstrations.

Child Support Enforcement 510-03-40

Paternity 510-03-40-05

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. As a condition of eligibility for a parent or caretaker, the parent or caretaker must cooperate with the Department and county agency in establishing paternity of any child under age eighteen in the ACA Medicaid Household. An exception to this provision exists when the child is a subsidized adoption child or the parent or caretaker is pregnant, within a continuous eligibility period for Medicaid, receiving Extended Medicaid Benefits, or receiving Transitional Medicaid Benefits. It is never a condition of a child's eligibility that the parent or caretaker cooperates.

2. A child for whom "paternity has not been established" means a child who was born out of wedlock and for whom paternity has not been legally established. A child is not considered to be born out-of-wedlock if the child is born within three hundred (300) days after the marriage is terminated by death, annulment, declaration of invalidity, or divorce, or after a decree of separation is entered by a court. Paternity is not considered to be legally established unless adjudicated by a court of law, or the parents completed the process using the "North Dakota Acknowledgment of Paternity" form, SFN 8195, with a revision date of 4/98 or later.

3. An automated referral will be made to Child Support when paternity has not been legally established and a caretaker who is not excluded in subsection 1 is seeking eligibility, or when a child is eligible for foster care.

Medical Support 510-03-40-10

(New 7/1/2014 ML #3404)
View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. An assignment of rights to medical support from any absent parent of a child who is under age eighteen and who is deprived of parental support or care is automatic under North Dakota state law. (Refer to Section 510-03-35-10 for the description of deprivation.)

2. The assignment of rights to medical support from absent parents continues through the month in which the child reaches the age of eighteen or until the child's eligibility for assistance ends, whichever occurs first.

3. An automated referral will be made to Child Support to pursue Medical Support for all children whose deprivation is based on the absence of a parent, except that no referral is made:
   a. For any Subsidized Adoption child;
   b. In any case in which the only eligible individuals are children;
   c. In any case in which the only eligible caretaker is pregnant; or
   d. In any case in which the only eligible caretakers are continuously eligible, receiving Extended Medicaid Benefits, or receiving Transitional Medicaid Benefits.

Cooperation - Child Support 510-03-40-15

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

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. 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.

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.

"Good Cause" - Child Support 510-03-40-20

(New 7/1/2014 ML #3404)

View Archives

IM 5275

IM 5264

(N.D.A.C. 75-02-02.1-09)

The requirement to cooperate may be waived when a legally responsible caretaker relative has "good cause" not to cooperate.

1. All legally responsible caretaker relatives must be given the opportunity to claim "good cause". Applicants are notified of their rights to claim good cause in the SFN 405, Application for Assistance, DN 405, the Application for Assistance Guidebook, and the SFN 1909, Application for Health Coverage and Help Paying Costs. Applicants can indicate their request to claim good cause in either application. Recipients who become subject to the cooperation requirements may be notified by providing each legally responsible caretaker with SFN 443, "Notice of Right to Claim 'Good Cause'". The notice briefly summarizes the legislative intent of child support enforcement, defines the caretaker's responsibility to cooperate in the support enforcement effort, and advises them of their right to claim "good cause". The notice also describes circumstances under which cooperation may be "against the best interests" of the child or caretaker and cites the kinds of evidence needed to substantiate a claim.

   A legally responsible caretaker wishing to claim "good cause" may do so by completing SFN 446, "Request to Claim 'Good Cause'".

   If "good cause" is claimed, the caretaker relative can be eligible for Medicaid while the decision is pending.

2. The determination of whether there is "good cause" is made by the county agency. The county agency may waive the requirement to cooperate if it determines that cooperation is against the best interests of the child. A county agency may determine that cooperation is against the best interests of the child only if:

a. The applicant's or recipient's cooperation in establishing paternity or securing medical support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought;

(2) Emotional harm to the child for whom support is to be sought;

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces such person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately; or

b. At least one of the following circumstances exists, and the county agency believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure medical support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape;

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep or relinquish the child for adoption, and the discussions have not gone on for more than three months.

3. There must be evidence to substantiate a claim of "good cause." Exemptions on the basis of physical or emotional harm, either to the child or to the caretaker relative must be of a genuine and serious nature. Mere belief that cooperation might result in harm is not a sufficient basis for finding "good cause." Evidence upon which the county agency bases its finding must be supported by written statements and contained in the case record.

It is the caretaker relative's responsibility to provide the county agency with the evidence needed to establish "good cause." The caretaker is normally given twenty days from the date of claim to collect the evidence. In exceptional cases, the county agency may grant reasonable additional time to allow for difficulty in obtaining proof. Records of law enforcement, social service, or adoption agencies may

be readily available to document instances of rape, physical harm, or pending adoption, perhaps without requiring further investigation. Documentation of anticipated emotional harm to the child or caretaker, however, may be somewhat more elusive. Whenever the claim is based in whole or in part on anticipated emotional harm, the county agency must consider the following:

a. The present emotional state of the individual subject to emotional harm;
b. The emotional health history of the individual subject to emotional harm;
c. The intensity and probable duration of the emotional impairment;
d. The degree of cooperation to be required; and
e. The extent of involvement of the child in establishing paternity or health insurance coverage.

4. Upon request, the county agency is required to assist the caretaker in obtaining evidence necessary to support a "good cause" claim. This, however, is not intended to place an unreasonable burden on staff, shift the caretaker's basic responsibility to produce evidence to support the claim, or to delay a final determination. The county agency must promptly notify the caretaker if additional evidence is necessary and actively assist in obtaining evidence when the individual is not reasonably able to obtain it.

5. The county agency is directly responsible for investigating a "good cause" claim when it believes that the caretaker's claim is authentic, even though confirming evidence may not be available. When the claim is based on a fear of serious physical harm and the claim is believed by county agency staff, investigation may be conducted without requiring corroborative evidence by the caretaker. It may involve a careful review of the case record, evaluation of the credibility of the caretaker's statements, or a confidential interview with an observer who has good reasons for not giving a written statement. Based on such an investigation, and on professional judgment, the county agency may find that "good cause" exists without the availability of absolute corroborative evidence.

   While conducting an investigation of a "good cause" claim, care must be taken to ensure that the location of the child is not revealed.

Except for extenuating circumstances, the "good cause" issue must be determined with the same degree of promptness as for the determination of other factors of eligibility (45 days). The county agency may not deny, delay, or discontinue assistance pending the resolution of the "good cause" claim. In the process of making a final determination, the county agency is required to give Child Support Enforcement staff the opportunity to review and comment on the findings and basis for the proposed decision. It is emphasized, however, that responsibility for the final determination rests with the county agency.

6. The claimant and the child support agency must be informed of the "good cause" decision.
   a. Claimants – The caretaker must be informed, in writing, of the county agency's final decision that "good cause' does or does not exist and the basis for the findings. A copy of this communication must be maintained in the case record. If "good cause" was determined not to exist, the communication must remind the caretaker of the obligation to cooperate with child support if he or she wishes to be eligible for Medicaid, of the right to appeal the decision, and of the right to withdraw the application or have the case closed. In the event the caretaker relative does appeal, Child Support must be advised to delay its activity until the results of the appeal are known.
   b. Child Support Enforcement – The automated referral process notifies Child Support of the status of all "good cause" claims by:

      (1) Informing them of all caretaker relatives who claim "good cause" exemptions which suspend child support activity pending a determination;

      (2) Informing them of all cases in which it has been determined that there is "good cause" for refusal to cooperate. Once the exemption is established, no child support activity may be pursued unless at a future time it is determined that "good cause" no longer exists; and

      (3) Informing them of all cases in which it has been determined that "good cause" for refusing to cooperate does not exists and that child support enforcement activity can begin or resume.
7. The county agency must review the "good cause" decision at least every twelve months. If "good cause" continues to exist, the caretaker must again be informed in writing. If circumstances have changed so

"good cause" no longer exists, the caretaker must be informed, in writing, and given the opportunity to cooperate, terminate the caretaker's assistance, close the case, or appeal the decision. When "good cause" no longer exists Child Support will commence its child support activity.

Extended Medicaid for Pregnant Women and Newborns 510-03-45

Extended Medicaid for Pregnant Women 510-03-45-05

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-05)

Pregnant women who applied for Medicaid during pregnancy, and are determined to be eligible as of the last day of pregnancy, continue eligible for Medicaid for 60 days, beginning on the last day of pregnancy, and for the remaining days of the month in which the 60th day falls.

A pregnant woman is considered to be eligible for Medicaid as of the last day of pregnancy when she is eligible with no client share (recipient liability), or if there is a client share (recipient liability), when the full client share is incurred as of the last day of pregnancy.

This provision applies regardless of the reason the pregnancy was terminated, and without regard to changes in income or whether a review of eligibility is due during the free eligibility period.

If the Medicaid case closes for loss of residency during the extended period and the family returns to the state and reapplies while still in the extended period, eligibility may be reestablished for the remainder of the period.

For Budgeting Procedures for Pregnant Women, refer to section 510-03-90-25.

Extended Medicaid for Children born to Pregnant Women 510-03-45-10

(New 7/1/2014 ML #3404)

View Archives

Children born to pregnant women, who were determined to be eligible as of the last day of pregnancy, are eligible for Medicaid for one year, beginning on the date of birth, and for the remaining days of the month in which the twelfth month falls.

Children who are eligible for the extended eligibility period become continuously eligible for the 12 months.

If the Medicaid case closes for loss of residency during the extended period and the family returns to the state and reapplies while still in the extended period, eligibility may be reestablished for the remainder of the period.

Transitional and Extended Medicaid Benefits 510-03-50

Transitional Medicaid Benefits 510-03-50-05

Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-20)

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

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

1. When at least one parent or caretaker relative, who was eligible under the Parent/caretaker (COE M063 in Mini App) category in at least three of the six months immediately preceding the month in which the individual became ineligible because of the caretaker relative's hours or earnings from employment, may continue eligible for Medicaid benefits for up to twelve months if:
   a. The household has a child living in the home that meets the children's coverage age requirements; and
   b. The caretaker relative remains a resident of the state; and
   c. The caretaker relative remains employed or shows good cause for not being employed (In families with two caretaker relatives, as long as one of the caretaker relatives remains employed; the provision is met. If both caretaker relatives stop working, the good cause provision applies to the last one that was employed); and

2. A family becomes ineligible under the Parent/caretaker (COE M063 in Mini App) category because of the caretaker relative's earned income when it is determined that the household would continue to be eligible under the Parent/caretaker (COE M063 in Mini App) category, if the caretaker relative's earned income is not counted, but they fail when the earned income is counted.

3. An individual that seeks to demonstrate eligibility in at least three of the six months immediately preceding the month in which the household became ineligible must have been eligible in this state in the month immediately preceding the month in which the household became ineligible. Eligibility from another state may be substituted for the other two months. Verification of eligibility in another state is required.

4. Only recipients become eligible for Transitional Medicaid Benefits. Applicants who fail the Parent/caretaker (COE M063 in Mini App) category due to earned income must be eligible under the Parent/caretaker (COE M063 in Mini App) category for at least one month, including any of the three prior months, before considering whether they were eligible under the Parent/caretaker category in three of the past six months.

5. If a child loses eligibility under one of the child categories during the parent/caretakers 12 month Transitional Medicaid Period, and the reason for the child's loss of eligibility is due to the parent/caretakers earned income, the child will be added to Transitional Medicaid for the remaining 12 month period of the parent/caretaker.

   Example 1: Household consists of mom and one child. Mom is eligible under the Parent/caretaker category in January and February.

   - The entire case closes at the end of February per the family's request.
   - In June, the family reapplies for Medicaid and requests assistance for the three prior months.
   - When the application is processed, mom is NOT eligible under the Parent/caretaker category for March, but is in April.
   - Mom fails under the Parent/caretaker category for May due to income.

   Because mom received three months,(January, February and April), of coverage under the Parent/caretaker category in the past six months, mom became INELIGIBLE under the Parent/caretaker category due to earned income in May, and the mom was a recipient, Mom is eligible for Transitional Medicaid Benefits effective May 1.

   - If mom's child is eligible under one of the child categories, the child remains eligible under that category and ONLY Mom becomes Transitional Medicaid Eligible.

- If mom's child is no longer eligible under one of the child categories, the child will also become Transitional Medicaid eligible at the same time as Mom does.
- If mom's child loses eligible under one of the child categories during mom's 12 month Transitional Medicaid Period, and the reason for the child's loss of eligibility is due to mom's earned income, the child will be added to Transitional Medicaid for the remaining 12 month period.

Example 2: Household consists of mom and 2 children. Mom is eligible under the Parent/caretaker category in January, February, and March.

- The case closes at the end of March per the family's request.
- In June, the household reapplies for Medicaid and does NOT request, or is not eligible for, assistance for April and May.
- When the application is processed, mom is NOT eligible under the Parent/caretaker category for June due to earned income.

Even though mom received three months, (January, February and March) of coverage under the Parent/caretaker category in the past six months, she is an applicant and not a recipient (no approved months based on this application). This household is NOT eligible for Transitional Medicaid Benefits.

6. If an individual was included as eligible under the Parent/caretaker category the month eligibility ended under the Parent/caretaker category, the individual is included in the Transitional Medicaid Benefits.

   The following individuals are also eligible for Transitional Medicaid Benefits:

   a. Children, deprived or non-deprived

      i. Who meet the age requirements under the Children category, and
      ii. Who are born, adopted, or who enter the home of a caretaker relative during the twelve month period, and
      iii. Who are not eligible under one of the children categories.

b. Parents who were absent from the household when the family became ineligible under the Parent/caretaker relative and their spouses category but who return during either period.

Example: Mom and her child are eligible under the Parent/caretaker relative and their spouses category from January through April. Dad moves in during the month of April, and is not eligible under the Parent/caretaker relative and their spouses category. His earnings make mom and Dad ineligible under the Parent/caretaker relative and their spouses category for May, so mom is eligible for Transitional Medicaid Benefits beginning May.

Note: Dad is NOT eligible for Transitional Medicaid Benefits because he was not covered under the Parent Caretaker relative and their spouses category in the month coverage under the Parent Caretaker relative and their spouses category ended.

7. Children who no longer meet the age requirements are not eligible for Transitional Medicaid Benefits.

8. If a Transitional Medicaid Benefits case closes for loss of state residency and the household returns to the state and reapplies while still in the twelve-month period, eligibility may be re-established for the remainder of the Transitional period.

   Refer to Section 510-03-85-40 for the Transitional Medicaid Benefits income level.

Extended Medicaid Benefits 510-03-50-10

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-20)

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

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

1. When at least one parent or caretaker relative, who was eligible under the Parent/caretaker or Family Coverage (in Vision) categories in at least three of the six months immediately preceding the month in which the parent/ caretaker relative became ineligible as a result (wholly or partly) of the collection or increased collection of spousal support (alimony) continue eligible for Medicaid for four calendar months if:
   a. The household has a child living in the home that meets the children's coverage age requirements; and
   b. The caretaker relative remains a resident of the state.

2. If an extended Medicaid Benefits case closes for loss of state residency and the household returns to the state and reapplies while still in the four-month period, eligibility may be re-established for the remainder of the period.

3. A household that seeks to demonstrate eligibility in the Parent/caretaker or Family Coverage (in Vision) categories in at least three of the six months immediately preceding the month in which the household became ineligible must have been eligible in this state in the month immediately preceding the month in which the household became ineligible. Eligibility from another state may be substituted for the other two months. Verification of eligibility in another state is required.

4. If a parent or caretaker relative was included as eligible in the Parent/caretaker or Family Coverage (in Vision) categories the month eligibility under the Parent/caretaker or Family Coverage (in Vision) categories ended, that individual is included in the Extended Medicaid Benefits. No individuals may be added in to Extended Medicaid Benefits.

Continuous Eligibility for Children 510-03-53

General Statement 510-03-53-05

(New 7/1/2014 ML #3404)

View Archives

Continuous eligibility for children allows recipients under age 19 who have been determined eligible for Medicaid, other than Medically Needy, to be deemed eligible for a total of up to 12 months regardless of changes in circumstances other than attainment of age 19. This has an effective date of June 1, 2008.

Individuals Covered 510-03-53-10

(New 7/1/2014 ML #3404)

View Archives

1. An individual may be continuously eligible for Medicaid if he or she:
   a. Is under age 19 (including the month the individual turns age 19); and
   b. Is not eligible as medically needy.

2. Individuals under age 19 include children, caretaker relatives, and pregnant women.

3. Individuals eligible for Refugee Medical Assistance (RMA) or Emergency Services are NOT entitled to continuous eligibility.

Continuous Eligibility Periods 510-03-53-15

(Revised 5/1/2017 ML #3498)

View Archives

1. Continuous eligibility may be established from the first day of:
   a. The application month; or
   b. The month after the application month in which the individual becomes eligible for Medicaid under a coverage group other than medically needy.

   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.

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.

Continuously Eligible Individuals Moving Out of the ACA Medicaid Household 510-03-53-20

(New 7/1/2014 ML #3404)

View Archives

When an individual who is continuously eligible for Medicaid moves out of the ACA Medicaid Household, that individual's eligibility continues.

1. When a continuously eligible child leaves the ACA Medicaid Household and enters foster care, a new application is processed to determine the child's ongoing eligibility. If the child meets all eligibility criteria, the child begins a new continuous eligibility period. If the child does not meet the eligibility criteria, or would be eligible as medically needy, the child must be approved and remains continuously 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.

2. When a continuously eligible individual enters a long term care facility, the individual is still considered part of the ACA Medicaid Household; however, the post eligibility treatment of income (510-05-85-25) applies. Even though the individual is continuously eligible and remains eligible as other than medically needy, the individual's income must be considered toward the cost of care, and he or she may have a client share (recipient liability). Once the individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

3. When a continuously eligible individual enters a specialized facility other than foster care, the individual is still considered part of the ACA Medicaid Household. The individual remains eligible as other than medically needy. Once the individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

4. When a continuously eligible individual elects to receive HCBS, the individual is still considered part of the ACA Medicaid Household. The individual remains eligible as other than medically needy. Once the

individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

5. A continuously eligible individual is still considered part of the ACA Medicaid Household when the individual is considered 'Living With' the ACA Medicaid Household.

6. A continuously eligible individual may move from one case to another case. If the individual, through an application or review, meets all eligibility criteria to be continuously eligible in the new case, the individual begins a new continuous eligibility period. If the individual does not meet the eligibility criteria, or would be eligible as medically needy, the individual must be approved and 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 in the new case.

7. When a continuously eligible individual moves out of a household on other than a temporary basis, and is not being added to another case, the individual remains eligible in the case, but is no longer considered part of the ACA Medicaid Household. Accordingly, the individual's income will no longer affect other members of the ACA Medicaid Household. Likewise, any caretaker relative remaining in the ACA Medicaid Household can no longer remain eligible if their eligibility is based on being a caretaker relative for the child that left the household. If the caretaker relative remains eligible because of other children still in the case, or because the caretaker relative is eligible in their own right, the caretaker relative is no longer required to cooperate with Child Support for the child that left the household. Once the child's continuous eligibility period ends, the child's eligibility ends in the case.

8. When a continuously eligible individual leaves the household to enter a public institution or IMD, the child remains continuously eligible through the end of their continuous eligibility period. Refer to 510-03-35-95 "Public Institutions and IMD's" for information regarding whether a medical service will be covered by Medicaid.

Foster Care and Related Groups 510-03-55

Foster Care 510-03-55-05

(Revised 5/1/2017 ML #3498)

View Archives

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 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.

Foster Care Financial Eligibility Requirements 510-03-55-10

(New 7/1/2014 ML #3404)

View Archives

1. Children who are receiving a Title IV-E Foster Care Maintenance Payment (including Tribal IV-E payments) are categorically needy eligible for Medicaid and no further financial determination is needed. (Title IV-E foster care eligibility is determined using the Aid to Families with Dependent Children rules in effect on July 16, 1996.) These individuals must have their eligibility determined based on Non-ACA Medicaid Policy.

2. Medicaid eligibility for all regular foster care (non-Title IV-E, tribal or state-funded) children is determined under ACA Medicaid Policy.

Volunteer Placement Program 510-03-55-15

(New 7/1/2014 ML #3404)

View Archives

Children in the Volunteer Placement Program are **not** considered to be in foster care. The parents retain care, custody, and control of the child; and the income of the child and parents is considered. Eligibility for these individuals is determined under ACA Medicaid Policy.

The child could be placed in a facility that is not in-patient care including PATH and county foster families or facilities, i.e. Manchester House, Dakota Boys Ranch, Prairie learning Center, etc. For a child to qualify under this program, there must not be a delinquency, abuse and/or neglect issue.

The child must be Medicaid eligible to cover medical expenses and the cost of treatment. The Volunteer Placement Program pays the room and board for the child to the county foster home or to the facility. The Administrators of the Volunteer Placement Program, and Mental Health and Substance Abuse must approve any placement in the Volunteer Placement Program.

Subsidized Guardianship Project 510-03-55-20

(New 7/1/2014 ML #3404)

View Archives

The Subsidized Guardianship Project is designed to serve North Dakota children who are in foster care, but who need a permanency alternative. The program was created in response to the Adoption and Safe Families Act of 1997.

Children in the Subsidized Guardianship Project are no longer foster care children, and the subsidy is not a foster care payment. The guardianship subsidy is paid to help meet the maintenance needs of the child and is considered the child's income.

When determining Medicaid eligibility, the child's income is considered, and parental income is not used unless the guardianship court order specifies that the parents are responsible for the child's needs. Eligibility for these individuals is determined under ACA Medicaid Policy unless the child is eligible under Non-ACA Medicaid. In this instance, the assets of the child and parents are also considered.

The guardian is not included as part of the case and the guardian's income and assets are not considered in determining the child's Medicaid eligibility. An exception is in cases in which the guardian is a relative, and the relative becomes eligible for Medicaid because of the child. In such cases, the relative chooses to be an eligible caretaker.

> **Note:** The Subsidized Guardianship Project is a North Dakota program. Occasionally, children come to North Dakota from states that have opted to cover children under a Title IV-E program called Kinship Guardianship program. This is not to be confused with either the ND Subsidized Guardianship Project or TANF's Kinship Program. Children who come from those states under the Title IV-E Kinship Guardianship program are categorically eligible.

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

(New 5/1/2017 ML #3498)

View Archives

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

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

(New 5/1/2017 ML #3498)

View Archives

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.

Assets 510-03-70

General Information 510-03-70-05

(Revised 6/1/2015 ML #3441)

View Archives

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

> **Note:** Although assets are not a consideration for this coverage, individuals requesting long term care services under ACA Medicaid are subject to the disqualifying transfer provision as described in section 510-05-80 of the Non ACA Medicaid manual.

Income and Asset Considerations in Certain Circumstances 510-03-75

Ownership in a Partnership or Corporation 510-03-75-05

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Sections 75-02-02.1-28(1) and 75-02-02.1-34(8))

Income from ownership in a Partnership or Corporation is countable income for ACA Medicaid.

1. Partnerships

   A partnership is a self-employment business set up as a partnership with two or more partners. A partner's share of income, gain, loss, deductions or credits is determined by a partnership agreement.

   An individual, who is an owner or part owner in a partnership, will be issued a Schedule K-1 (Form 1065) from the partnership, which lists the income they received. The information from the appropriate K-1 is carried over to the Form 1040.

2. Corporation

   A company or group of people authorized to act as a single entity (legally a person) and recognized as such in law. Shareholders have the right to participate in the profits, through dividends and/or the appreciation of stock, but are not held personally liable for the company's debts.

   The information from the Form 1099-DIV is used when the individual files their personal income taxes.

3. S –Corporation

An S-Corporation is a separate business entity with 1 to 100 shareholder(s) that passes through the net profit or loss to their shareholder(s). The business profits are taxed at individual tax rates on each individual shareholder's income tax.

The information from the appropriate K-1 is entered on the Schedule E of the individuals' personal income tax forms.

If the individual provides a copy of their income tax forms, the countable income from the K-1, 1099-DIV, or Schedule E would be carried over to the Form 1040. Therefore, the Schedule E amount from the Form 1040 would be used.

If the individual does not file taxes, the net income from the individual's schedule 1099-DIV or K-1 from the corporation or partnership, will be used, plus any wages paid to the individual in addition to the net income.

If the 1099-DIV or K-1 is not prepared, ledgers must be provided.

Treatment of Conservation Reserve Program (CRP) Property and Payments 510-03-75-10

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Sections 75-02-02.1-28(1) and 75-02-02.1-37(3))

1. Conservation Reserve Program (CRP) payments are considered income. They will be included in the net income from Schedule C, E, or F.

    a. The income will be treated as follows if tax forms are provided:

        - The countable income would be carried over to the Form 1040 from the respective schedules.
        - The allowable expenses would have been subtracted from the income prior to the income being carried over to the Form 1040. Therefore, do not allow additional expenses.

    b. The income will be treated as follows if tax forms are NOT provided:

        - Use the gross amount from the form 1099. CRP payments no longer need to be segregated from farm/rental income for ACA Medicaid Households.
        - The individual will need to provide ledgers of the expenses including property taxes, insurance and other expenses for the land.

Communal Colonies 510-03-75-15

(New 7/1/2014 ML #3404)

View Archives

Individuals who live communally (i.e. Hutterites, Mennonites, Amish, etc.) may or may not have a collective ownership of property and income. In determining eligibility, it will first be necessary to determine whether collective ownership of assets and income exists.

If the commune has collective ownership, also determine whether the commune is self-employed. Most communal colonies are self-employed in agricultural or manufacturing and are incorporated, or set up as a large partnership. Occasionally, some colonies are not self-employed, but may be working under contract for wages.

1. Income. Most colonies have collective ownership of income, which is often generated from their self-employment venture. When colonies have a collective ownership in income, a share attributable to each individual or family must be determined. Countable income is established as follows:
   a. If the colony is self-employed, calculate self-employment income based on the previous year of self-employment. From the colony's corporate or partnership tax return:
      i. Divide the total amount of adjusted gross income by the number of members in the colony to establish each individual's share of income. Multiply this amount by the number of individuals in the ACA Medicaid Household to determine the unit's yearly share.

         Example: There are 124 members in a colony that is engaged in farming. A family of six in the colony applies for Medicaid. The corporate tax return indicates $4,922,603 in adjusted gross earnings. Divide $4,922,603 by 124 members to arrive at each individual's share of $39,698.41. Multiply $39,698.41 by six to arrive at the unit's yearly income of $238,190.46.

ii. Identify the income as belonging only to the adults in the ACA Medicaid Household, or older children who are actively engaged in the operation and are not students. If no individuals in the ACA Medicaid Household are actively engaged in the business, such as an aged or disabled individual, the income is considered to be unearned income; or

Example: An aged individual from a colony engaged in farming applies for Medicaid. The corporate tax return indicates $4,922,603 in adjusted gross earnings, which is divided by the 124 members in the colony to arrive at each individual's share of $39,698.41. The income is shown as unearned income because the aged person is no longer actively engaged in the business.

b. If the colony is not self-employed, but is working under contract for wages:

i. Divide the total contract income by the number of members in the colony to establish each individual's share of income. Multiply this amount by the number in the ACA Medicaid Household to determine the unit's share; and
ii. Identify the income as belonging only to the adults in the ACA Medicaid Household, or older children who are actively engaged in the operation and are not students. If no individuals in the ACA Medicaid Household are actually engaged in the business, such as an aged or disabled individual, the income is considered to be unearned income.

c. For members who have other earned or unearned income, the income counts as income of the individual who receives it. Income is counted for the individual, even if the income has been given to the colony.

2. Adding or deleting individuals:
   a. Changes in the unit's share of income must be changed when adding or deleting members to the unit and is based on the number of individuals in the unit. The share is not changed when adding an unborn child until the child is born.

Example: The individual share of income established for a colony, based on the colony's self-employment, is $350 per individual per month. A family within the colony consists of 5 individuals so the ACA Medicaid Household's total monthly income is $1,750 (5 x $350) or $21,000 per year. A child is born and added to the unit, so now the unit consists of 6 individuals, and monthly income is $2,100 (6 x $350), or $25,200 per year. If the unit had instead lost a member and reduced in size to 4, the income would have decreased to $1,400 (4 x $350), or $16,800 per year.

b. The individual's share of income, which is based on the number of members in the colony, is normally determined when calculating annual income from self-employment for self-employed colonies, or for a new contract period for colonies working under a contract for wages. The number of members in the colony does not need to be changed in between these calculations, or when adding or deleting a member from the household. However, if the colony reports a change in the number of members, the individual share must be recalculated based on the new information.

Example 1: The individual share of income has been established for a colony at $350 per individual per month. This amount was originally calculated based on the number of members in the colony and the colony's self-employment income. A child is born to a family. A new calculation does not have to be made because there may now be more members in the colony, but the $350 per person per month continues to be used as the individual share of income.

Example 2: The individual share of income has been established for a colony at $350 per individual per month, and was based on 124 members. A child is born to a family and reported. At the same time, new information is provided that the colony now has 118 members because a different family left the colony, and one member died. A new calculation must be made because a change in the actual membership number has been confirmed by the colony. The new individual share has now increased to $367.80 per person per month.

Income 510-03-85

Income Considerations 510-03-85-05

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-34)

Income is defined as any cash payment, which is considered available to an ACA Medicaid Household for current use. Income may be earned or unearned. It must be reasonably evaluated.

"Earned Income" is income that is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. Income is "earned" only if the individual or family contributes an appreciable amount of personal involvement and effort. "Earned income" shall be applied in the month in which it is normally received.

> **Note:** If earnings from more than one month are received in a single payment, the payment must be prorated over the months for which it is intended.

1. MAGI income methodologies must be applied to all ACA Medicaid Households.

2. Current, point-in-time income must be used.

3. All income which is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible individual; when the applicant, recipient, or responsible individual has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible individual has the lawful power to make the income available or to cause the income to be made available.

An individual may have rights, authority, or powers that he or she does not wish to exercise. An example includes an individual who allows a relative to use excluded assets free or at a reduced rental. In such cases, a fair rental amount will be counted as available income whether the applicant or recipient actually receives the income.

Income that is withheld because of garnishment or to pay a debt or other legal obligation is still considered available.

Title II and SSI overpayments being deducted from Title II benefits, are normally considered to be available because the applicant or recipient can pursue a waiver of the overpayment. Only if the waiver has been denied after a good faith effort, can the Title II or SSI overpayment deductions be considered unavailable.

Occasionally other delinquent debts owed to the federal government may be collected from an individual's federal payment benefit (i.e. Title II, Civil Service, and Railroad Retirement). These other reductions of federal benefits are not allowed to reduce the countable benefit amount. The award amount of the federal benefit payment is counted as available except to the extent an undue hardship is approved for the individual.

Requests for undue hardship exceptions must be submitted to the Medicaid Eligibility Unit where a determination will be made whether an undue hardship exists. An undue hardship may be determined to exist for all or a portion of the debt owed, or all or a portion of the reduction from the monthly income.

An undue hardship will be determined to exist only if the individual shows all of the following conditions are met:

a. The debt is a debt owed to the Federal government;
b. The deduction from the individual's federal payment benefit was non-voluntary;
c. The amount of the deduction exceeds the Medicaid income level(s) to which the individual and the individual's spouse is subject;
d. The individual has exhausted all lawful avenues to get the reduction waived, forgiven, or deferred; and
e. The individual or their spouse does not own assets that can be used to pay for the debt.

4. Financial responsibility of any individual for any applicant or recipient is subject to their tax filing status as well as the individual's relationship

to those with whom the individual resides, as defined at 510-03-35-05, "ACA Medicaid Household".

5. Monthly income is considered available when determining eligibility for ACA Medicaid, however, an individual may die before their income is actually received for the month. An income payment received after death is no longer considered income, but an asset to the individual's estate. In circumstances where the Department will pursue estate recovery, Medicaid eligibility can be re-determined counting only that income which was received prior to the individual's death; resulting in the elimination or reduction of the client share (recipient liability).

   When a Medicaid provider reports that a recipient's current month client share (recipient liability) was not paid as of the date of death, determine whether the following conditions are met:

   a. There is no surviving spouse;
   b. There is no surviving minor or disabled child; and
   c. Countable monthly income was not received prior to death.

   If all conditions are met, refer the case to the Medicaid Eligibility Unit. Information regarding the date of death and the dates of the month in which each source of income is received must also be provided. The Medicaid Eligibility Unit will determine whether Medicaid estate recovery is being pursued and an adjustment to the client share (recipient liability) can be approved. If approved, the Medicaid Eligibility unit will process the adjustment.

6. Income may be received weekly, biweekly, monthly, intermittently, or annually. However income is received, a monthly income amount must be computed.

7. Many benefit programs deposit an individual's monthly benefit onto a debit card. Examples of these benefit programs are TANF benefits, Unemployment Insurance Benefits (UIB), Child Support benefits, Workforce Safety and Insurance benefits (WSI), Social Security Administration benefits (SSA), and Supplemental Security Income benefits (SSI).

   Individuals may also receive as gifts or bonuses such things as gift cards, debit cards, prepaid credit cards or 'in-store credits'. Examples

include bonus or commission payments, compensation for work performed, or Tribal Gaming Per Capita Distributions from gaming revenues etc.

> **Note:** These benefits must be determined whether countable or disregarded based on ACA Medicaid policy.

8. Earnings paid under a contract must be prorated over the period the contract covers.

   > **Example:** A teacher receives paychecks in August through May, however the contract covers 12 months and the contracted salary is $30,000. The annual salary is prorated over 12 months. Countable ACA Income is $2500 per month.

   Occasionally, migrants or seasonal farm workers may receive an advance lump sum payment to reimburse or cover travel expenses. Such reimbursement is normally received prior to their arrival and is not considered earned income. An advance for wages, however, is counted as earned income and is prorated over the months it is intended to cover.

   > **Example:** Don is a migrant worker who received a reimbursement from his grower for traveling to North Dakota to work. This reimbursement is disregarded from income as a reimbursement. Don's grower also gave him a wage advance of $900 in May for the months of June, July and August. The wage advance would be prorated over the months of June, July, and August as earned income.

   In addition, migrants or seasonal farm workers may not receive an advance lump sum, but will be paid in a lump sum at the end of their employment or contract period. Such income is prorated over the period the payment is intended to cover.

9. Bonuses, profit sharing, and other similar payments are not considered lump sum earnings or wages received other than monthly, but an extra payment of earned income based on a productive period. These are considered income in the month received.

10. Individuals who lost a source of income (earned or unearned) in the month of application will not have income from that source annualized. The terminated source of income actually received in the application month will only be counted in the month terminated.

Determining Ownership of Income 510-03-85-10

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-34(7)

1. In determining ownership of income from a document (e.g. a tax return for a self-employment business, or a rental agreement for rental property . . .), income must be considered available to each individual as provided in the document, or, in the absence of a specific provision in the document:
   a. If payment of income is made solely to one individual, the income shall be considered available only to that individual; and
   b. If payment of income is made to more than one individual, the income shall be considered available to each individual in proportion to their interest.

2. In the case of income available to a couple in which there is no document establishing ownership, one-half of the income shall be considered to be available to each spouse.

3. Except in the case of income from a trust, the rules for determining ownership of income are superseded to the extent that the applicant or recipient can establish that ownership interests are otherwise than as provided in those rules.

ACA Income Methodologies 510-03-85-13

(Revised 5/1/17 ML #3498)

View Archives

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.

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.)

Countable Income 510-03-85-15

(New 7/1/2014 ML #3404)
View Archives

(N.D.A.C. Section 75-02-02.1-37)

The following types of income are countable when determining eligibility for ACA Medicaid:

1. Gross taxable wages, salaries, tips (must deduct pre-tax deductions)
2. Interest income, including tax exempt
3. Dividend income, including tax exempt
4. Taxable refunds of state income taxes
5. Gross Alimony received
6. Adjusted net income or loss from self-employment
7. Net Capital Gains (capital gains minus capital losses), if expected to recur in the current year
8. Taxable amounts of IRA distributions
9. Taxable Amount of Pensions and annuities
10. Net rents, royalties, lease, partnerships, S corporation or trust income
11. Gross unemployment compensation
12. Gross Social Security income
13. Veteran's Administration (VA) Retirement Pensions
14. Gross foreign earned income

15. Child's income (See section 510-03-85-13, ACA Income Methodologies regarding when to count a child's income.)

16. Short Term Disability payments to replace income

17. The portion of educational scholarships, awards, and fellowship grants that is used for living expenses or other non-educational related expenses

18. Per capita payments paid from tribal casino gambling proceeds

19. Value of prizes or awards

20. Gambling winnings

21. Alaska Permanent Funds dividends

22. Payments for work performed at sheltered workshops, (e.g. Minot Vocational Adjustment Workshop, etc.)

23. Work-Study Income reported as wages on the individuals tax return

24. Payments from a trust fund, or from other countable sources deposited into a trust account for the client's benefit count as income of the client

25. Jury duty pay not given to employer as reimbursement of wages

26. Income from a life estate

27. Value of cancelled debts

28. Other taxable income

Income Conversion 510-03-85-20

(Revised 5/1/2017 ML #3498)

View Archives

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, 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.

Income Compatibility 510-03-85-25

(New 5/1/2017 ML #3498)

View Archives

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.

Disregarded Income 510-03-85-30

(Revised 6/1/2015 ML #3441)

View Archives

The following income types are not reported on Form 1040 and are not countable income under ACA Medicaid:

1. Non-taxable income other than
   a. Non-taxable foreign earned income,
   b. Non-taxable interest or dividend income;
   c. The non-taxable portion of Social Security Benefits
2. Supplemental Security Benefits (SSI)
3. Child support income
4. Veteran's Administration
   a. Disability Benefits
   b. Aid and attendance payments,
   c. Homebound benefits
   d. Reimbursements for unusual medical expenses
5. Temporary Assistance for Needy Families (TANF) benefit and support services payments made by the Department or another state
6. Workforce Safety and Insurance (WSI) Benefits
7. Child's income (See section 510-03-85-13, ACA Income Methodologies regarding when to count a child's income.)
8. Proceeds from life, accident or health insurance
9. Federal tax credits,(i.e. Child Tax credit)
10. Federal Income tax refunds and earned income tax credits
11. Gifts and Loans
12. Proceeds from inheritances

13. Tribal General Assistance Payments

14. Subsidized Guardianship Project payments

15. Educational scholarships, awards, and fellowship grants used for educational expenses do not count as income. Count only the portion of educational income that is used for living expenses or other non-educational related expenses

16. Certain distributions, payments and student financial assistance for American Indians/Alaska Natives can **only** be disregarded if they were initially counted as taxable income

17. Non-recurring and recurring lump sum payments of disregarded earned or unearned income
    a. Veteran's Administration Aid and attendance payments,
    b. Veteran's Administration Homebound benefits
    c. Veteran's Administration Reimbursements for unusual medical expenses
    d. Veteran's Administration Dependents Indemnity Compensation;
    e. Insurance settlements for destroyed exempt property;
    f. Death benefits
    g. Health or long-term care insurance payments;
    h. Life Insurance proceeds
    i. Accident Insurance proceeds

18. Voluntary cash contributions from others

19. Proceeds from a loan agreement, including reverse mortgages. However, if the person lending the money receives interest, the interest received is income

20. Hostile Fire Pay when an individual is on active military duty serving in a combat zone, the full amount of the person's military pay can be excluded from taxable income

21. Deposits to a joint checking account made by a non-household member

22. Money payments made by the Department, another state, or tribal entities in connection with the State LTC Subsidy program, foster care, subsidized guardianship, or the subsidized adoption program

23. Benefits received through the Low Income Home Energy Assistance Program

24. Refugee cash assistance or grant payments

25. County general assistance that may be issued on an intermittent basis to cover emergency type situations

26. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home

27. Payments from the family subsidy program

28. Income received as a housing allowance by programs sponsored by the United States Department of Housing and Urban Development and rent supplements or utility payments provided through the Housing Assistance Program

29. Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property, is considered an asset conversion and is therefore not considered as income (even if the money is taken out of the IIM account in the same month it was deposited into the account). This includes distributions of per capita judgment funds or property earnings held in trust for a tribe. This does not include local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of Interior (e.g., tribally managed gaming revenues - which is countable income)

30. Income derived from sub marginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114

31. Compensation received by volunteers participating in the ACTION program as stipulated in the Domestic Volunteer Service Act of 1973, including the National Senior Volunteer Corps, including Retired Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companion Program; National Volunteer Programs to Assist Small Businesses and Promote Volunteer Services by Persons with Business Experience; Volunteers in Service to America (VISTA) (now

AmeriCorps*VISTA, not to be confused with AmeriCorps, a separate program), VISTA Literary Corps and University Year for VISTA

32. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970

33. All income, allowances, and bonuses received as a result of participation in the Job Corps Program

34. Payments received for the repair or replacement of lost, damaged or stolen assets

35. Homestead tax credits

36. Training funds received from Vocational Rehabilitation

37. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program

38. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act (WIA), and through the Job Opportunities and Basic Skills program

39. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs

40. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act

41. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act

42. Agent Orange payments

43. Crime Victims Reparation payments

44. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act

45. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a presidentially declared major disaster (including disaster assistance unemployment compensation), and interest earned on that assistance. Comparable assistance received from a state or local government, or from a disaster assistance organization is also excluded

46. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects

47. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286

48. Radiation Exposure Compensation, Public Law 101-426

49. The Medicare part B premium refunded by the Social Security Administration

50. Medicare Part D premiums, copayments, and deductibles refunded by prescription drug plans

51. For periods after October 1, 2008, all wages paid by the Census Bureau for temporary employment related to census activities will be disregarded as income

52. Reimbursements from an employer, training agency, or other organization for past or future training, or volunteer related expenses are disregarded from income. Reimbursements must be specified for an identified expense, other than normal living expenses, and used for the purpose intended. Reimbursements for normal household living expenses or maintenance such as rent or mortgage, clothing or food, are a gain or benefit and are not disregarded

    Examples of disregarded reimbursements include:

a. Reimbursements for job or training-related expenses such as travel, per diem, uniforms, and transportation to and from the job or training site
b. Reimbursements for out-of-pocket expenses of volunteers incurred in the course of their work

53. The first $2,000 received by an individual age 19 and over as compensation for participation in a clinical trial for rare diseases or conditions meeting the requirements of Section 1612(b)(26) of the Act. This disregard is only allowed if approved by the Medicaid Eligibility Unit and will expire on October 5, 2015

54. Monthly food coupons distributed to individuals age 55 and over from the Sisseton-Wahpeton Oyate Lake Traverse Reservation Food Distribution program

55. Payments of flat rate insurance like a hospital plan that pays a daily rate to the client for each day in the hospital. These are usually referred to as an indemnity policy

56. Any withdrawal made from a 529 plan is excluded as income if the funds are used for the intended purposes. If the funds are withdrawn and not used for their intended purpose, they become taxable income and must be counted.

Income Deductions 510-03-85-35

(New 7/1/2014 ML #3404)

View Archives

Instead of itemized disregards and deductions, a standard deduction equal to 5% of the Federal Poverty Level (FPL) is allowed under ACA Medicaid.

> **Note:** This disregard is not deducted from income as the ACA Income Levels have been increased by 5% to allow for this disregard.

In addition, the following deductions can be allowed from income under ACA Medicaid:

1. Pre-tax deductions (from the gross pay listed on paystubs)

2. Adjusted Gross Income deductions from gross income that are used in determining the countable Adjusted Gross Income for tax purposes (Listed on the Form 1040 in the 'Adjusted Gross Income' section)
   a. Educator expenses
   b. Business expenses of reservist, performing artists and fee-basis government officials
   c. Health savings account deduction
   d. Moving expenses
   e. Deductible portion of self-employment tax
   f. Contributions to self-employed SEP, SIMPLE and qualified plans
   g. Self-employed health insurance deduction
   h. Penalty on early withdrawal of savings
   i. Alimony paid
   j. Contributions to IRA
   k. Student loan interest deduction
   l. Tuition and fee
   m. Domestic production activities deduction

When determining income using the Federal Income Tax forms, amounts for the above deductions can only be allowed IF they have not been allowed when determining the Adjusted Gross Income.

Income Levels 510-03-85-40

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. Sections 75-02-02.1-40, 75-02-02.1-22(7), 75-02-02.1-24.2(8), and 75-02-02.1-24(5))

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 Levels).

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

Household Size	Monthly Income Level	Yearly Income Level
1	$517	$6,204
2	694	8,328
3	871	10,452
4	1048	12,576
5	1226	14,712
6	1403	16,836
7	1580	18,960
8	1757	21,084
9	1934	23,208
10	2111	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
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	$1,386	$16,643
2	1,867	22,411
3	2,348	28,180
4	2,829	33,948
5	3,309	39,716
6	3,790	45,485
7	4,271	51,253
8	4,751	57,022
9	5,232	62,790
10	5,713	68,558

Plus - 1	480	5,768
Effective April 1, 2017		

4. Children ages 0 through 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	$1,527	$18,331
2	2,057	24,685
3	2,586	31,038
4	3,116	37,392
5	3,645	43,746
6	4,174	50,099
7	4,704	56,453
8	5,233	62,806
9	5,763	69,160
10	6,292	75,514
+1	529	6,354
Effective April 1, 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	$904	$10,854
2	1,218	14,616
3	1,531	18,378
4	1,845	22,140
5	2,158	25,902
6	2,472	29,664
7	2,785	33,426
8	3,099	37,188
9	3,412	40,950

10	3,726	44,712
+1	313	3,762
Effective April 1, 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	$924	$11,095
2	1,245	14,941
3	1,565	18,786
4	1,886	22,632
5	2,206	26,478
6	2,526	30,323
7	2,847	34,169
8	3,167	38,014
9	3,488	41,860
10	3,808	45,706
+1	320	3,846
Effective April 1, 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	$934	$11,216
2	1,258	15,103
3	1,582	18,991
4	1,906	22,878
5	2,230	26,765
6	2,554	30,653

7	2,878	34,540
8	3,202	38,428
9	3,526	42,315
10	3,850	46,202
+1	323	3,887
Effective April 1, 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	$1,115	$13,387	$1,336	$16,040
2	1,502	18,026	1,799	21,599
3	1,888	22,666	2,263	27,159
4	2,275	27,306	2,726	32,718
5	2,662	31,946	3,189	38,277
6	3,048	36,586	3,653	43,837
7	3,435	41,225	4,116	49,396
8	3,822	45,865	4,579	54,956
9	4,208	50,505	5,042	60,515
10	4,595	55,145	5,506	66,074
+1	386	4,640	463	5,559
Effective April 1, 2017				

Budgeting 510-03-90

Definitions 510-03-90-05

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. Section 75-02-02.1-41.2(1))

1. For purposes of this section:
   a. "Base month" means the calendar month prior to the processing month.
   b. "Benefit month" means the calendar month for which eligibility and client share (recipient liability) is being computed.
   c. "Best estimate" means an income, deductions, or circumstance prediction based on past amounts of income and deductions and known factual information concerning future circumstances which affect eligibility, deductions to be incurred; or income to be received in the benefit month. Factual information concerning future circumstances must be based on information by which the applicant or recipient demonstrates known changes or highly probable changes to the income, deductions, or circumstances which offset eligibility, from the base month to the benefit month.
   d. "Processing month" means the month between the base month and the benefit month.
   e. "Prospective budgeting" means computation of a household's eligibility and client share based on the best estimate of income, deductions, and circumstances for a benefit month.

10-10-10 Rule 510-03-90-10

(New 7/1/2014 ML #3404)

View Archives

1. The "10-10-10 Rule" means:
   a. The recipient has ten days from the date they become aware of a change to report that change to the county agency.
   b. The county agency has ten days in which to act on a reported change.
   c. The county agency must allow ten days for an advance notice before any adverse action can be taken on a case (unless the change is one of the exceptions to the Ten-Day Advance Notice as defined in section 510-03-25-25, Decision and Notice).

2. The purpose of the 10-10-10 rule is to describe the ACA Medicaid Household's responsibility to report changes and to determine when the county agency can or cannot act on changes. It can, and should be, used as a caseload management tool.

Guidelines for Anticipating Income 510-03-90-15

(New 7/1/2014 ML #3404)

View Archives

Use prospective budgeting to determine eligibility based on the countable income which is anticipated to be received and the allowable deductions that are anticipated to be incurred. Anticipated income and deductions are an estimate based on reasonable expectations and knowledge of past, current, and future events.

The following guidelines are offered to assist in this determination.

An employed individual who does not expect a significant change should have the previous month's earnings and employment deductions verified by pay stub or employer's statement. The previous month's earnings serve as the basis for estimating the income likely to be received during the initial prospective month.

> **Example:** A person applies for assistance on November 15 and reports there should be no significant change in income and deductions from the month of October. The October income should be verified and converted if paid weekly or bi-weekly, to anticipate the income and deductions likely to be available in November.

If the applicant or recipient indicates that he or she expects to begin working or that a material change in income is likely, the statement shall be documented as the basis for the "best estimate" of income to be received. The employer may be contacted, with the applicant's or recipient's permission, to verify the statement that income will be reduced or increased during the prospective month, or the applicant or recipient may provide other documentation supporting the expected change.

If new income is expected during the prospective month, the worker needs to arrive at a "best estimate" of the income likely to be available. If the income is from employment in which "tips" are likely, these also need to be estimated.

When anticipating income, also anticipate bonuses, profit sharing, and other such additional income whenever possible. This type of income can be anticipated based on prior receipt of such income. The amount anticipated can be estimated based on amounts previously received, unless factual information suggests otherwise.

To summarize, the method(s) used to anticipate income will vary according to the circumstances in each case. It is the responsibility of the county agency to decide on the best approach. Whatever the method used, it is imperative that the rationale for arriving at estimated income be clearly and thoroughly documented in the case file.

Client Share (Recipient Liability) 510-03-90-17

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. 75-02-02.1-41.1)

Client Share (Recipient Liability) is the amount of monthly net income remaining after the 5% income disregard from their total countable ACA income and the appropriate ACA Medically Needy income level have been allowed. All such income must be considered to be available for payment of medical services provided to the eligible individual or family.

Computing Client Share (Recipient Liability) 510-03-90-20

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. Section 75-02-02.1-41.1)

1. Computing client share (recipient liability) for previous months. Compute the amount of client share by using actual verified information, rather than best estimate, in each of the previous months for which eligibility is sought.

2. Computing client share for the current month and next month at time of approval of the application. Compute the amount of the client share prospectively for the current month and the next month. The income received or best estimate of income to be received during the current month must be used to compute the client share for the current month. The best estimates of income to be received during the next month must be used to compute the client share for the next month.

Offset of Client Share (Recipient Liability) 510-03-90-23

(New 7/1/2014 ML #3404)

View Archives

(N.D.A.C. 75-02-02.1-41.1)

1. Up to fifteen dollars per month of expenses for necessary medical or remedial care, incurred by a member of the ACA Medicaid Household, or a spouse or child they were legally responsible for, in a month prior to the month for which eligibility is being determined, may be subtracted from client share (recipient liability), other than client share created as a result of medical care payments, to determine remaining client share, provided that:
   a. The expense was incurred in a month during which the individual who received the medical or remedial care was not a Medicaid recipient or the expense was incurred in a month the individual was a Medicaid recipient, but was for a service not covered by Medicaid;
   b. The expense was not previously applied in determining eligibility for, or the amount of, Medicaid benefits for any Medicaid recipient;
   c. The medical or remedial care was provided by a medical practitioner licensed to furnish the care;
   d. The expense is not subject to payment by any third party, including Medicaid and Medicare;
   e. The expense was not incurred for swing bed services provided in a hospital, nursing facility services, or HCBS during a period of ineligibility because of a disqualifying transfer;
   f. Each expense claimed for subtraction is documented by the applicant or recipient in a manner which describes the service, the date of the service, the amount of the cost incurred, the amount of the cost remaining unpaid, the amount of the cost previously applied in determining Medicaid benefits for any Medicaid recipient, and the name of the service provider; and
   g. The ACA Medicaid Household is still obligated to pay the expense.

2. The ACA Medicaid Household must apply the remaining client share to expenses of necessary medical care incurred by a member of the ACA Medicaid Household in the month for which eligibility is being determined. The ACA Medicaid Household is eligible for Medicaid benefits to the extent the expenses of necessary medical care incurred in the month for which eligibility is being determined exceed remaining client share in that month.

Budgeting Procedures for Pregnant Women 510-03-90-25

(Revised 6/1/2015 ML #3441)

View Archives

(N.D.A.C. 75-02-02.1-21)

The Omnibus Budget Reconciliation Act of 1990 provided for extended eligibility for pregnant women effective July 1, 1991.

When a pregnant woman becomes eligible for Medicaid, including during the three month prior period (THMP), she continues to be eligible, without regard to any increase in income of the ACA Medicaid Household, for sixty days after the day her pregnancy ends, and for the remaining days of the month in which the sixtieth day falls. Decreases in income, however, will be considered to further reduce any client share (recipient liability). All other Medicaid eligibility factors continue to apply.

- Self-attestation of a single-birth pregnancy is accepted unless it is questionable. Multiple births must be medically verified in order to increase the household size by more than one unborn child. Medical verification is a pregnancy determination made by medical personnel or a public health agency.
- For determinations made after the birth of the baby, the child's birth verification may be used as verification of pregnancy.

When a woman applies for coverage and is pregnant, if eligible, she must be enrolled in Medicaid coverage as a pregnant woman, rather than in the new Adult Expansion Group.

When a woman is already enrolled in the Adult Expansion Group, and becomes pregnant after her enrollment, she must be informed of the benefits of moving to Medicaid coverage for pregnant women and given a choice to move to that coverage group.

- If the woman chooses Medicaid coverage as a pregnant woman, during the final month of the 60 free day period of eligibility, a review must be completed to evaluate whether she will remain eligible for Medicaid under another coverage group, including the Adult Expansion Group, or be referred to the Marketplace to choose an insurance policy. This will ensure there is no loss of coverage.
- If the woman chooses to remain covered under the Adult Expansion Group, the 60 free day period of eligibility does not apply. Thus a review will not need to be completed at that time.

When a Pregnant Woman becomes eligible and during her pregnancy a review is due, the Pregnant Woman must complete the review or her eligibility will end the last day of the month in which the review was due.

> **Exception:** If a review is due within the 60 free days and is not completed, the pregnant woman remains eligible through the end of the month that the 60th day falls.

The individual must submit her review or reapply within 90 days to avoid a loss in coverage.

For policy relating to Extended Eligibility for Pregnant Women, refer to 510-03-45-05.

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

(Revised 5/1/2017 ML #3498)

View Archives

(N.D.A.C. 75-02-02.1-41.2(5) & (6))

When an individual is added to an ACA Medicaid Household, a review must be completed to process eligibility for the individual.

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.

Budgeting Procedures for SSI Recipients 510-03-90-45

(New 7/1/2014 ML #3404)

View Archives

1. SSI individuals must first be tested under the Non-ACA Medicaid methodologies and, if eligible, budgeted under the Non-ACA Medicaid rules Service Chapter 510-05, Eligibility Factors for Non-ACA Medicaid

2. If the SSI recipient is not eligible under the Non-ACA Medicaid methodologies (excess assets), the individual may be eligible under one of the ACA Medicaid coverage's. In those cases, ACA Medicaid budgeting methodologies applies.

Budgeting Procedures for Medically Needy under ACA Medicaid 510-03-90-50

(Revised 6/1/2015 ML #3441)

View Archives

Parents and caretaker relatives of deprived children and their spouses, Pregnant Women and children under age 21, who fail under the ACA Medicaid Categorically Needy Coverage Group, may be eligible under the ACA Medicaid Medically Needy Coverage Group, provided they have a Medical Need as defined in 510-03-35-35, Need.

To determine ACA Medicaid Medically Needy eligibility:

1. Determine if the individual has a Medical Need.
    a. Determine the ACA countable monthly income for the individual's household.
    b. Calculate and subtract 5% of the ACA countable monthly income to arrive at the net ACA countable monthly income.
    c. Subtract the appropriate ACA Medically Needy Income Level for the individuals' household size from the net ACA countable monthly income.

If the individual's household has a Medical need, eligibility can be determined for ACA Medicaid Medically Needy coverage.

> **Note:** Processing for ACA Medicaid Medically Needy coverage is completed in the Vision System.

2. Once 'need' has been established, enter the case into Vision. Refer to the ACA Processing Guide, 'Determining ACA Medically Needy' section for instructions on processing ACA Medically Needy in Vision.

For new applications, **PRIOR TO** processing eligibility for Medically Needy under ACA Medicaid, please contact your Regional Representative.

For ongoing cases, each time a month is authorized, Medicaid Policy MUST be notified to ensure the correct COE is reported.

Budgeting Procedures for Continuous Eligibility for Children Under Age 19 510-03-90-55

(New 7/1/2014 ML #3404)

View Archives

When a child becomes continuously eligible for Medicaid, including during the three month prior period (THMP), that child continues to be eligible without regard to any changes in income and/or deductions of the ACA Medicaid Household until the next review.

For policy relating to Continuous Eligibility for Children, refer to 510-03-53.

Budgeting Procedures for Three Prior Months (THMP) 510-03-90-60

(Revised 5/1/2017 ML #3498)

View Archives

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.

> **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.

Action on Reported Changes 510-03-90-65

(New 6/1/2015 ML #3441)

View Archives

Recipients are required to report changes in income, household size, employment, residence, new tax filing status, etc., within 10 days of their knowledge of the change. Because every household's circumstances are unique, all changes must be reported and reviewed, and it will depend on those circumstances whether it affects the recipient's coverage.

Under ACA Medicaid, clients will no longer be required to monthly report, but are required to report changes that may affect their eligibility, such as those itemized above. A revised change report has been created, which is currently being generated electronically. This is for the client's reporting convenience and does not require the individual to submit a form monthly.

We must not impose a threshold on what the household reports, or how often. In some cases, a $20 increase in income can make someone ineligible, in others; it may be a few thousand dollars. It all depends on the situation. Therefore, there is no dollar amount or percentage threshold, all changes must be reported.

Upon receipt of a reported change, the Eligibility Workers will determine whether a change in eligibility results and process the change based on the policy defined in section 510-03-10-25, Improper Payments and Suspected Fraud.

> **Note**: The 10-10-10 requirements defined in section 510-03-90-10 and the Notification requirements defined in section 510-03-25-25 must be adhered to when acting on reported changes.

Related Programs 510-03-95

General Information 510-03-95-05

(New 7/1/2014 ML #3404)

View Archives

There are other non-Medicaid programs that help meet the health needs of individuals and families. Some of these programs closely interact with Medicaid. Applicants who are ineligible for Medicaid may qualify for these other programs and should be referred accordingly.

Healthy Steps 510-03-95-10

(New 7/1/2014 ML #3404)

View Archives

Healthy Steps is the name given to the Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act.

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

Refugee Medical Assistance Program 510-03-95-20

(New 7/1/2014 ML #3404)

View Archives

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

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

Aid to the Blind - Remedial Care 510-03-95-25

(New 7/1/2014 ML #3404)

View Archives

The Aid to the Blind - Remedial Care program is a program for individuals age 21 to 65 who cannot qualify for Medicaid, and who have certain sight related health problems in which their best eye has less than 20.50 visual acuity with corrective lenses. The program is intended for short duration and not as a maintenance program. Information and eligibility criteria can be found in Service Chapter 400-32.

Primary Care Provider Program 510-03-95-30

(New 7/1/2014 ML #3404)

View Archives

The Department has elected mandatory enrollment of eligible caretaker relatives, poverty level pregnant women, and children 19 (effective 01-01-14) years of age and under, into managed care. The purpose of this mandatory enrollment is to assure adequate access to primary care, improve the quality of care, promote coordination and continuity of health care, reduce costs, and to assist recipients to use the health care system appropriately. The Primary Care Provider Program also establishes co-payments for certain services. Information about the program can be found in Service Chapter 510-06.

Children's Special Health Services 510-03-95-40

(New 7/1/2014 ML #3404)

View Archives

Children's Special Health Services provides services for children with special health care needs and their families. Services include coverage for diagnosis and treatment for children who have disabilities or chronic conditions. The program supports family-centered, community-based, coordinated services and systems of health care that meet the diverse needs of families. For information, contact the Children’s Special Health Services Program, North Dakota Department of Health, Division of Maternal and Child Health, 600 East Boulevard Ave, Dept 301, Bismarck ND 58505-0200, or call 701-328-2436, 1-800-755-2714, or FAX: 701-328-1645.

Coordinated Services Program 510-03-95-45

(New 6/1/2015 ML #3441)

View Archives

North Dakota Medicaid's Coordinated Services Program (CSP) (formerly Lock-In program) helps individuals find healthcare services that match their medical needs. Individuals have one coordinated services medical provider and one pharmacy provider who will work regularly with them to understand their health care needs and coordinate your care. The coordinated services medical provider can also refer them to specialists who can help maintain and improve their health.

This program was developed to assist individuals eligible for Traditional Medicaid coverage who may be unintentionally misusing program benefits and to ensure the continuity and quality of care for recipients. When deciding if someone meets the criteria to be placed on the CSP, the following areas are examples of what is taken into consideration;

- Use of multiple providers and clinics;
- Early prescription refills;
- Use of multiple pharmacies;
- Trips to the emergency room (ER) for services other than emergent care. Examples of non-emergent care include, refills of medication, chronic pain, headaches including migraines, constipation, or menstrual cramps;
- Use of multiple controlled drugs; and
- Prescriptions obtained from multiple providers

The State is to inform the insurance vendor of individuals who were participating in the CSP Program while eligible for Traditional Medicaid coverage, when their coverage changes to Medicaid Expansion coverage. The Insurance vendor is required to apply a similar policy under the insurance coverage provided.

North Dakota Health Tracks 510-03-95-50

(New 5/1/2017 ML #3498)

View Archives

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.

Forms Appendix 510-03-100

Family Planning Program 510-03-100-05

(New 7/1/2014 ML #3404)

View Archives

This information is available through the Department of Human Services.

Family Planning Program (pdf)

WIC Program 510-03-100-10

(New 7/1/2014 ML #3404)
View Archives

This information is available through the Department of Human Services.

WIC: Because You Care brochure (tif)

DN 143, "Your Civil Rights Brochure" 510-03-100-15

(New 7/1/2014 ML #3404)

View Archives

This brochure is available through the Department of Human Services.

DN 143, "Your Civil Rights Brochure" (33 kb pdf)

DN 555, "Medicaid Program Brochure" 510-03-100-20

(New 7/1/2014 ML #3404)

View Archives

Medicaid Program Brochure (4,043 kb pdf)

Brochures are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

DN 1442, "ND Health Tracks" 510-03-100-25

(New 7/1/2014 ML #3404)

View Archives

This brochure is available through the Department of Human Services.

DN 1442, "Health Tracks" brochure (248kb pdf)

SFN 20, "Surveillance & Utilization Review Section (SURS) Referral" 510-03-100-30

(New 7/1/2014 ML #3404)

View Archives

This form is used by workers to report suspected provider or recipient related errors to the Surveillance Utilization Review (SURS) Unit who wish to request a hearing.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 162, Request for Hearing 510-03-100-35

(New 7/1/2014 ML #3404)

View Archives

This form is used by recipients who wish to request a hearing.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 443, "Notice of Right to Claim 'Good Cause'" 510-03-100-40

(New 7/1/2014 ML #3404)

View Archives

The front of the form briefly summarizes the legislative intent of the IV-D Program and the applicant's or recipient's obligation to cooperate with Child Support. The back of the form describes in some detail the circumstances under which cooperation may be "against the best interests" of the child and provides examples of the kinds of evidence necessary to substantiate a claim.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (34 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 446, "Request to Claim 'Good Cause"
510-03-100-45

(New 7/1/2014 ML #3404)

View Archives

The form provides the caretaker with the opportunity to describe the circumstances which he/she believes will have a bearing on the claim.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (44 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 451, "Eligibility Report on Disability/Incapacity" 510-03-100-50

(New 7/1/2014 ML #3404)

View Archives

This form may be used by the county agency to submit social information to the State Review Team for the evaluation of disability or incapacity.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (180 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 560, "Assignment of Benefits" 510-03-100-55

(New 7/1/2014 ML #3404)

View Archives

This form is used to obtain the signature of someone legally able to assign benefits when the individuals who sign the application do not have the right to do so.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (42 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 566, "Medicaid Questionnaire and Assignment" 510-03-100-60

(New 7/1/2014 ML #3404)

View Archives

This form is used to obtain information from the recipient if other sources of payment are available for recovery of Medicaid funds.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (42 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 691, "Affidavit of Identity For Children" 510-03-100-65

(New 7/1/2014 ML #3404)

View Archives

This form is used by the parent, guardian, or caretaker relative to verify either citizenship or identity, but not both, for a child aged 16 to 18 only when school identity cards and driver's licenses are not available.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 706, "Affidavit of Explanation why Citizenship Cannot be Supplied" 510-03-100-70

(New 7/1/2014 ML #3404)

View Archives

This form is used by an applicant/recipient or other knowledgeable individual explaining why verification of citizenship cannot be obtained.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 707, "Citizen Affidavit' 510-03-100-75

(New 7/1/2014 ML #3404)

View Archives

This form is used when an applicant or recipient cannot produce documentary evidence of citizenship.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 817, "Health Insurance Cost-Effectiveness Review" 510-03-100-80

(New 7/1/2014 ML #3404)

View Archives

This form is used by the county agency to refer Medicaid eligible cases with health insurance to the state Medicaid Eligibility unit to determine if the health insurance is cost-effective and can be paid by Medicaid.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (96 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 828, "Credit Form" 510-03-100-85

(New 7/1/2014 ML #3404)

View Archives

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 1598, "Medically Frail Questionnaire" 510-03-100-90

(New 7/1/2014 ML #3404)

View Archives

This form is used by recipients who wish to request to be considered for coverage as 'medically frail'.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

Reference Hard Cards 510-03-105

Coverage Hierarchy Order 510-03-105-05

(New 5/1/2017 ML #3498)

View Archives

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

Coverage Hierarchy Order (Highest to Lowest) COEs DESCRIPTION	COEs	DESCRIPTION
1	M098	Non IV-E State or Tribal Foster Care Children
2	M067, M095	ACA Children
3	M066	ACA Pregnant Woman
4	M063	ACA Parent/Specified Caretaker Relative
5	M086	ACA Extended 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

Medicaid Living Arrangement Reference Hard Card 510-03-105-10

(New 5/1/2017 ML #3498)

View Archives

This Reference Hard Card from IM 5295 lists all of the living arrangements used when determining eligibility for ACA Health Care Coverage.

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 **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.	

LT	LONG TERM CARE FACILITY	Nursing Homes
		Swing Bed
		Psychiatric Residential Treatment Centers (PRTF's)
		• 3 Dakota Boys & Girls Ranch Facilities (DBGR)
		  • Western Plains - Bismarck
		  • DBGR - Minot
		  • DBGR - Fargo
		• Luther Hall in Fargo
		• Pride Manchester in Bismarck
		• Ruth Meiers Adolescent Center - Grand Forks
				$65 - Full Calendar Month
				ICF/IID - $100 - Full Calendar Month
				If Spousal case, $65 for all months including partial months

IM	INTERMEDIATE CARE FACILITY FOR THE INTELLECTUALLY 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.	$65 - Full Calendar Month ICF/IID - $100 - Full Calendar Month If Spousal case, $65 for all months including partial months
JC	INSTITUTION FOR MENTAL DISEASES (MD)	Out of State IMD Facility Prairie Psychiatric Center Stadter 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.**	
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)**		Full Calendar month-Medically Needy Level.

MEDICAID LIVING ARRANGEMENTS IN SPACES				
			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.	If Spousal case, Medically Needy Level for all months including partial months
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.	Full Calendar month-Medically Needy Level. If Spousal case, Medically Needy Level for all months including partial months
AI	PUBLIC INSTITUTION	ND State Penitentiary James River Correction Center Dakota Women's Correctional Center Missouri River Correctional Center Youth Correctional Center County Jails Tribal Jails	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.	$65 - Full Calendar Month

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			

Policy Processing Appendix 510-03-110

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

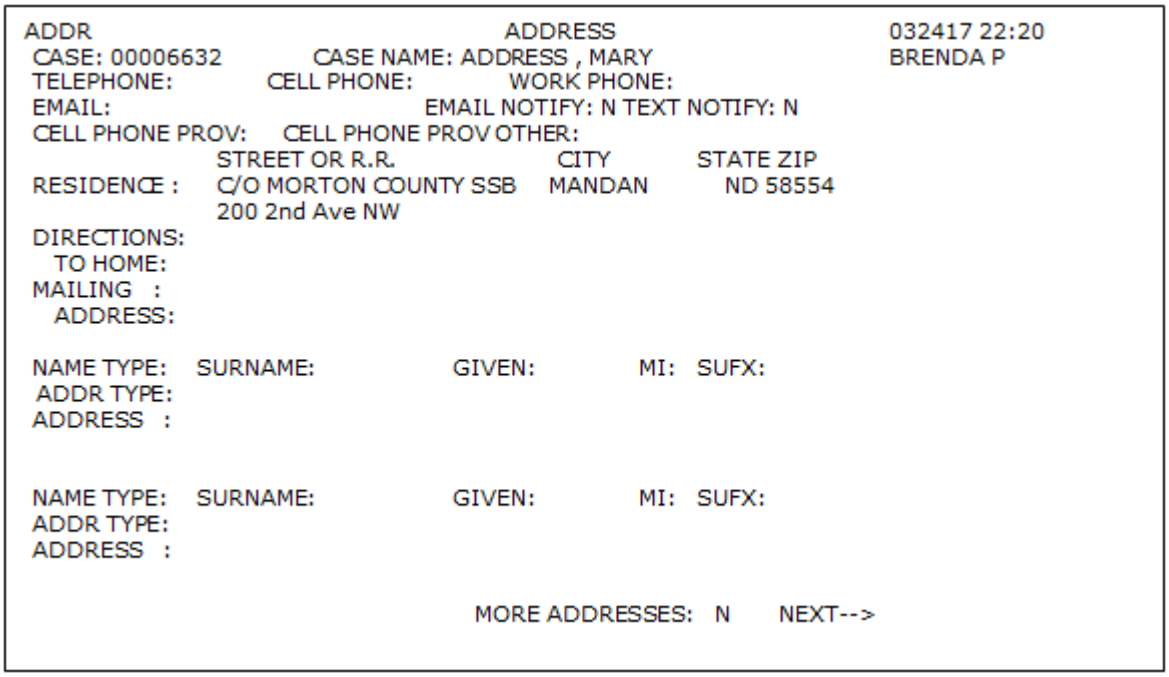
(New 5/1/2017 ML #3498)

View Archives

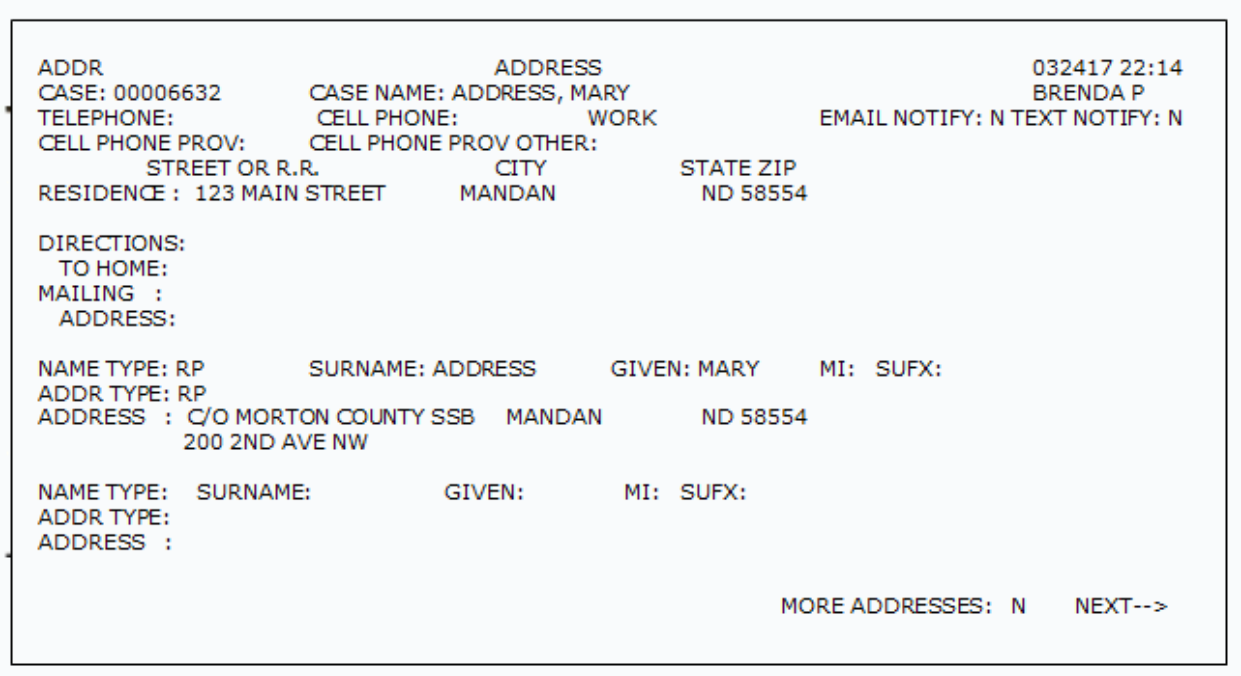
Should a household consist of some individuals eligible for Medicaid in SPACES also have a member eligible for Medicaid in TECS or Vision, the address also needs to be updated in those systems.

> **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.



- 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-->
```

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

(New 5/1/2017 ML #3498)

View Archives

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.

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

(New 5/1/2017 ML #3498)

View Archives

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.

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

(New 5/1/2017 ML #3498)

View Archives

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.