Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 510-05 Non-ACA Medicaid Eligibility Factors. This manual letter incorporates changes made with the following IM's if the information in the IM continues to be valid.

- IM 5424 Certificate of Creditable Coverage
- IM 5420 Average Cost of Nursing Facility
- IM 5419 Medicare Premium Assistance-QMB
  - IM 5419 Attachment QMB Work Around
- IM 5416 Community Spouse Income and Asset Limits and Home Equity Limits for 2021
- IM 5410 Burial Asset Exclusion
- IM 5403 Disqualifying Transfer Penalty Period
- IM 5402 Pace Eligible Individuals Admitted to IMD
- IM 5401 Overpayment
- IM 5400 Income Level
- IM 5399 Appeals
- IM 5398 Medicare Premium Assistance Program
- IM 5397 Calculation of Remedial Expenses in Excess of Medically Needy Level
  - IM 5397 Attachment Remedial Rates
- IM 5396 Overpayment
- IM 5395 Prescription Website Change
- IM 5388 Asset Assessment Requirements
- IM5387 Calculation of Remedial Expenses on Excess of Medically Needy Level

Par.2. **Effective Date** – Policy that was incorporated with the IM's is effective based on the date listed in the IM. Items that include a change in policy are indicated in **red**.

1. Certificate of Creditable Coverage

The certificate of creditable coverage will no longer be created and mailed to Medicaid individuals as it has been superseded by the prohibition on preexisting condition exclusions through the Affordable Care Act. IM 5424.

~~Certificate of Creditable Coverage 510-05-10-33~~

~~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 of recipients have not been reopened.~~

2. Disqualifying Transfers-Definitions

The average cost of nursing facility care for 2021 is used to determine the penalty period for individuals who have applied for Medicaid on or after January 1, 2021 and made a disqualifying transfer on or after their look back Date OR the transfer was discovered or determined on or after January 1, 2021. IM 5420

Definitions 510-05-80-05

Year	Daily Rate	Monthly Rate
2021	313.08	9522.85

3. Medicare Premium Assistance

Based on clarification from CMS, the eligibility start date for QMB will be changing. The eligibility start date will no longer be based on when the QMB application is processed but on when the person is determined to be eligible for QMB coverage. This will be effective for any application received on or after January 1, 2021. IM 5419

Adding clarification of when an individual needs to apply for Medicare. Also adding clarification of the process for paying Medicare Part A premium for individuals with SSI and not eligible for free Medicare Part A. IM 5398

General Information (Medicare Premium Assistance Program) 541-05-60-05

Individuals need to apply for Medicare through Social Security if they have not already done so. If the individual has applied for Medicare and has either Medicare Part A or Medicare Part B, they do not need to go to Social Security to apply again.

There are two ways an individual can receive assistance with their Medicare premiums and Medicare costs.

Individuals Covered and Benefits 510-05-60-10

Individuals who are in receipt of SSI income and have Medicare Part B only will be determined eligible under the SSI Buy-In program. Individuals in receipt of SSI or SSI/SSA who have free Medicare Part A and Part B or have requested Medicaid to pay the Medicare Part A, will be processed under the Medicare Savings Program (MSP). An individual cannot be covered under SSI Buy-In and Medicare Savings Programs for the same time period. The Medicare Savings program is the primary coverage for individuals who could qualify under both programs.

If the individual loses SSI, they will need to be processed under the Medicare Savings Program. If eligible for QMB, the Medicare Part A will need to be added effective the month QMB eligibility starts.

Individuals over 65 who are eligible for SSI and are not eligible for free Medicare Part A can request North Dakota Medicaid pay the Medicare Part A premium for them. The individual will need to be eligible for MSP/QMB to cover their Medicare Part A premiums. If the individual has applied for Medicare and has Medicare Part B, enter the Medicare Part A start date on the MEPO screen. Medicare Part A start date will be the date the state can start paying the Medicare Part A. This is based on when the individual is eligible for QMB. The individual will not need to apply for Medicare Part A at Social Security. If the individual does not have Medicare, refer them to Social Security to apply for Medicare.

Individuals over 65 who have no eligibility for SSI and are not eligible for free Medicare Part A can apply for Medicare Savings Program-Qualified Medicare Beneficiaries (QMB) to cover their Medicare premiums. The individual will need to apply for Medicare at Social Security. They will need to request Medicare Part A "conditional enrollment". Conditional enrollment allows an individual to apply for premium-Medicare Part A at SSA on the condition he or she only wants the coverage if the state approves their QMB application. Medicare Part A start date will be the date the state can start paying the Medicare Part A.

Individuals must have Medicare Part A to be eligible under the following Medicare Savings Program coverages.

1. Qualified Medicare Beneficiaries (QMB) are entitled to payment of Medicare Part B. QMB can also pay Medicare Part A if the individual does not have free Part A. QMB eligible individuals are entitled only to Medicare cost sharing benefits beginning in the month following the month in which the individual is determined eligible. ~~eligibility determination is made (i.e., the application is received on March 29, eligibility is determined in April, the first month of QMB eligibility is May).~~

- Application received March 29th. Eligibility worker processes the application on May 1st. The eligibility worker determines the client is eligible for QMB starting with March, QMB will begin April 1st. (the month after the month the individual is determined eligible)

- Application received February 15th and individual is requesting three prior months. The eligibility worker processes the application on March 1st. The eligibility worker determines the client is eligible for QMB starting with February, QMB will begin March 1st. (the month after the month the individual is determined eligible) The individual falls within the income level for QMB in the three prior months, however eligibility for QMB **cannot** be established for the three prior months.

4. Community Spouse Asset Allowance and Home Equity Limit

New Community Spouse Asset Allowance and Home Equity Limit for 2021 IM 5416

Community Spouse Asset Allowance 510-05-65-20

From the spousal share, the community spouse asset allowance is established, and is an amount that is equal to the community spouse share, but not less than ~~$25,728~~ $26,076, and not more than ~~$128,640~~ $130,380, effective January ~~2020~~ 2021 (~~$25,284 and $126,420 effective January 2019~~ $25,728 and $128,640 effective January 2020).

Example:

If the Spousal share is:	The community spouse asset allowance is:
$12,500	~~$25,728~~ $26,076(at least the minimum)
$45,000	$45,000

~~$130,000~~ $140,000	~~$128,640~~ $130,380(one-half is more than the maximum allowed, so the community spouse gets the maximum)

Home Equity Limit 510-05-70-27

Applicants or recipients who apply for Medicaid coverage on or after January 1, 2020 2021 are not eligible for coverage of nursing care services (which include HCBS) if the individual's equity interest in the individual's home exceeds ~~$595,000~~ $603,000. The applicant or recipient may, however, be eligible for other Medicaid benefits.

5. Excluded Assets and Assets which are excluded for Spousal Impoverishment

Based on clarification received from CMS, North Dakota Medicaid policy cannot grandfather in burial policies set up prior to August 1, 2019. Individuals with assets excluded for burial prior to August 1, 2019 will need to change the funds to a ND burial provision including the Irrevocable Itemized Burial Contract or SSI burial (prepay for burial space items and allowed $1500 exclusion for burial). IM 5410

Excluded Assets 510-05-70-30

8. A burial plot for each family member (eligible or ineligible) is excluded. A burial plot is defined to include a grave site, crypt or mausoleum.

9. Along with the burial plot an individual is allowed either the SSI burial or ND burial provision.

   The SSI burial provision provides for:

a. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds held for the individual and the individual's spouse are excluded from the date of application. Burial funds may consist of revocable burial accounts, revocable burial trusts, other revocable burial arrangements including the value of installment sales contracts for burial spaces, cash, financial accounts such as savings or checking accounts, or other financial instruments with definite cash value, such as stocks, bonds, the cash surrender value of life insurance not excluded under subsection 3a below, or certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by the applicant or recipient's statement.

The value of any irrevocable burial must be designated toward the burial fund exclusion.

Life or burial insurance excluded under this subsection ~~3a below,~~ (total face value is $1,500 or less), must be considered at face value toward meeting the burial fund exclusion.

Example 1: Mr. Smith has two life insurance policies each having a face value of $500. Because the total combined face value is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion.

Example 2: Mrs. Jones has two life insurance policies each having a face value of $1000. Because the total combined face value is more than $1500, the face value is ignored, and the cash surrender value is considered as an asset which may be applied towards either the burial exclusion or the asset limit.

Example 3: Mrs. Smith has two life insurance policies each having a face value of $500. Mrs. Smith also has a $1500 burial fund. Because the total face value of the two policies is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion. Only $500 of the burial fund may be excluded, and the remaining $1000 would be counted towards the asset limit.

Example 4: Mr. Jones has a life insurance policy with a face value of $1000 and an irrevocable burial with a face value of $1000. The face value of the irrevocable burial must be considered toward the $1500 burial provision leaving $500 that could still be excluded for the burial fund. The life insurance passes the $1500 face value test and is excluded as an asset, but since there is still $500 that could be excluded for burial, the life insurance must be applied. No other assets can be excluded towards the burial fund.

b. A burial space or agreement which represents the purchase of a burial space paid for in full for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this paragraph:

i. "Burial space" means a burial plot, gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

ii. "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends when the marriage ends.

~~8. Before August 1, 2019 - Any pre-need funeral service contracts, prepayments or deposits, regardless of ownership, which total $6000 or less, which are designated by an applicant or recipient for the applicant's~~

~~or recipient's burial. An applicant or recipient designates a prepayment or deposit for his or her burial by providing funds that are used for that purpose. Only those prepayments paid by members of the Medicaid unit are considered as burial prepayments.Earnings accrued on the total amount of the designated burial fund are excluded.~~

~~A burial plot for each family member (eligible or ineligible) will also be excluded. A burial plot is defined to include a grave site, crypt, or mausoleum. (Effective July 1, 1996.)~~

~~Markers, monuments, and vaults that have been pre-purchased separately from a pre-need funeral service contract are not considered part of a burial plot and are not considered as prepayments or deposits for burial. These items are countable assets for Medicaid, based on their current market value. A marker or monument that has already been engraved with some of the individual's information will likely have a reduced value. It may still have a market value; however, the value will be reduced by the cost to resurface the marker or monument. When a double marker has been purchased and one spouse has already passed away, it can be determined that there is no resale value for the marker.~~

~~a. A purchaser of a pre-need funeral service may make a certain amount of the pre-need funds irrevocable. The irrevocable amount may not exceed the amount of the burial asset exclusion at the time the contract is entered, plus the portion of the $3,000 asset limitation the purchaser designates for funeral expenses. The value of an irrevocable burial arrangement must be considered towards the burial exclusion. Amounts that may be designated as irrevocable vary from state to state. When an individual moves to North Dakota from another state, North Dakota Medicaid will honor the other state's limits on these burials.~~

~~The value of an irrevocable burial arrangement must be considered applied towards the burial exclusion first. Amounts that may be designated as irrevocable vary from state to state and another State's law may allow more than North Dakota.~~
~~When an individual moves to North Dakota from another state, North Dakota Medicaid will honor the other state's limits on these~~

burials irrevocable burial following the irrevocable burial laws in that state.

Example: In 2013, the burial asset exclusion is $6,000 and, while it is not wise to do so, the individual may put the remaining $3,000 of their asset limit into burial funds. If the individual puts $9,000 into an irrevocable burial fund, the $9,000 is applied to the $6,000 burial exclusion and the $3000 that exceeds the burial exclusion is a countable asset. This individual may not have one cent in additional assets and be eligible for Medicaid.

Note #1: This individual may not have one cent in additional assets and be eligible for Medicaid

Note #2: If the individual in the above example put $15,000 in an irrevocable burial fund, and requires Medicaid coverage for nursing care services within the 5- years look back period, amounts exceeding the $9,000 maximum would be a disqualifying transfer because the individual is taking available assets and making them unavailable.

Example: John Smith purchased a prepaid burial in the amount of $7500 with his local funeral home. The funeral home is the owner of the burial fund, and it is irrevocable. John has also designated $2500 in a CD for his burial. Because irrevocable burial funds must first be applied to the $6000 burial exclusion, $6000 is not a countable asset, but the excess $1,500 is. The $2500 CD designated for burial is also a countable asset which makes John exceed the asset test by $1000 and be ineligible for Medicaid.

Example: Jim Smith has an irrevocable burial account in the amount of $4,000. He also wishes to designate his savings account of $5,500.

Because the irrevocable burial MUST be applied towards the $6000 burial exclusion, only $2,000 of the savings account may be excluded. The remaining $3,500 in the savings, can still be designated for burial, but is a countable asset. If this individual is single or has other assets, he will fail the asset test.

b. Any funds, insurance or other property given to another person or entity in contemplation that its value will be used to meet the burial needs of the applicant or recipient must be considered towards the burial exclusion. This includes any funds set aside in a separate account or used to purchase insurance or any other burial product. Any amount in excess of the $6000 burial exclusion is a countable asset if the fund, insurance, or other property has a cash value, fair market value, or surrender value.

Example: A Medicaid recipient with an insurance policy that is designated for burial previously transferred ownership of the policy to his daughter. The policy has a current cost basis of $6400 and cash surrender value (CSV) of $7500. The insurance policy is considered to be transferred in trust to meet the burial needs of the recipient. $6000 is excluded under the burial exclusion and the additional $400 in cost basis is a countable asset to the recipient ($6400 - $6000 = $400). The extra $1100 in cash surrender value is earnings and is excluded ($7500 CSV - $6400 cost basis = $1100 earnings).

c. Normally a life insurance policy is a countable asset valued at its cash surrender value, however, when a whole life insurance policy is the amount considered designated for burial is the lesser of the cost basis or the face value of the insurance policy. The prepayments on the life insurance policy are the total premiums that have been paid less amounts paid for any riders and less any withdrawals of premiums paid. They are identified as the "remaining cost basis." Only those prepayments (remaining cost basis) paid by members of the Medicaid unit are considered as burial prepayments. Premium payments made by insurance dividends or disability insurance plans do not increase the remaining cost basis. Loans on life insurance affect the net cash surrender value only and do not affect remaining cost basis.

If the life insurance policy or annuity has a cash surrender value that exceeds the remaining cost basis, the excess cash surrender value is considered accrued earnings and are excluded. The following are two examples showing how remaining cost basis and cash surrender value are applied to the burial provision: **Example 1**: An applicant has a life

insurance policy with a face value of $5000. The policy remaining cost basis is

$2400 and the cash surrender value is $2900. The $2400 remaining cost basis is considered to be the designated burial. The excess cash surrender value of $500 is considered accrued earnings and is excluded.

Example 2: An applicant has a life insurance policy with a face value of $6,000. The cost basis of the policy is
$7,000 and the cash surrender value is $7,500. Because the $6,000 face value is less than the cost basis, if designated for burial, the prepaid burial would be $6,000. The difference between the cash surrender value and the face value is considered accrued earnings and is excluded.

In these two examples, if the cash surrender value had been less than the remaining cost basis, there would be no earnings exclusion.

Withdrawals from life insurance policies that reduce the face value of the life insurance also reduce the remaining cost basis and cash surrender value of the policy. Some applicants may make withdrawals to reduce the value of the insurance policy in order to qualify for Medicaid. Such withdrawals do not affect the designation of the insurance for burial

Example: An applicant has a life insurance policy with a remaining cost basis of $7500 and a cash surrender value of $9000. The applicant intended the policy for his burial expenses. When the applicant applied for Medicaid, he withdrew (not borrowed) $3000 from the policy, and spent it down, so he could be asset eligible. By withdrawing $3000, the policy's face value was reduced, the remaining cost basis was reduced to $4500, and the cash surrender value was reduced to $6000. The applicant's current designated burial is $4500 with $1500 in earnings.

d. A fund is considered to be designated for burial if identified as such on the account or by the applicant's or recipient'sstatement. A designated account can have more than one owner as long as the account is designated for only one person's burial and, a burial account does not

have to be in the applicant's or recipient's name. Life insurance that is designated for burial, however, must cover the life of the person for whom it is designated.

e. The burial fund must be identifiable and cannot be commingled with other funds. Checking accounts are considered to be commingled.

f. An applicant or recipient may designate all or a portion of the $3000 asset limitation for funeral purposes. These additional assets designated for burials are not excluded for purposes of this provision, but any earnings accrued to these additional funds are excluded.

g. A burial fund, which is established at the time of application, can apply retroactively to the three month prior period and the period in which the application is pending, if the value of all assets is within the Medicaid limits for each of the prior months. Future earnings on the newly established burial fund will be excluded.

h. Prepayments or deposits Irrevocable burial funds cannot be designated burial funds cannot be established for an individual's burial after the individual's death.

i. At the time of application the value of a designated burial fund is determined by identifying the value of the prepayments which are subject to the burial exclusion and asset limit amounts.

Designated burial funds, other than life insurance, which have been decreased prior to application for Medicaid will be considered redesignated as of the date of last withdrawal. The balance at that point will be considered the prepayment amount and earnings from that date forward will be disregarded.

> **For example**: A savings account of $5000 designated for burial has grown to $8000. The owner withdraws $1000 before application for Medicaid. All $7000 is now considered to be the principal amount designated. $6000 would be excluded for burial and the remaining $1000 would be applied to the $3000 asset limit.

~~Reductions made in a designated burial fund, other than life insurance, after application for Medicaid will first reduce the amount of earnings.~~

~~**For example**: A savings account of $3000 designated for burial has grown to $5000. The owner withdraws $1000 after application for Medicaid. Of the remaining $4000, the designated burial remains at $3000, with $1000 considered as excluded interest.~~

~~j. Burial funds can be moved to different accounts or financial institutions without being considered redesignated if the applicant or recipient can demonstrate the amount that was principal from that which was earnings, and these amounts are consistent in the new account or financial institution.~~

~~k. Information regarding the burial fund of a deceased recipient must be released to funeral home personnel upon request.~~

~~9. After August 1,2019~~ North Dakota Burial Provision - Any pre-need funeral service contracts, prepayments or deposits to a fund which are placed in an irrevocable itemized funeral contract designated by an applicant or recipient for the applicant's or recipient's burial. An applicant or recipient designates a prepayment of deposit for his or her burial by providing funds that must be used for that purpose. Only those prepayments paid by members of the Medicaid unit are considered as burial prepayments.

a. Amounts that may be designated as irrevocable vary from State to State. When an individual moves to North Dakota from another state, North Dakota Medicaid will honor the burial plan set up in the other state based on the other state's burial provision.

b. Earnings accrued on the total amount of the irrevocable itemized burial contract are excluded.

c. A burial plot for each family member (eligible or ineligible) will also be excluded. A burial plot is defined to include a grave site, crypt, or mausoleum. (Effective July 1, 1996)

d. Markers, monuments, and vaults that have been pre-purchased separately from an irrevocable itemized funeral contract are not considered part of a burial plot and are not exempt. These items are countable assets for Medicaid, based on their current market value. A marker or monument that has already been engraved with some of the individual's information will likely have a reduced value. It may still have a market value; however, the value will be reduced by the cost to resurface the marker or monument. When a double marker has been purchased and one spouse has already passed away, it can be determined that there is no resale value for the marker.

e. Individuals with burial funds set up based on the ND Burial exclusion prior to August 1, 2019, will need to ~~can~~ change their ~~revocable~~ funds designated for burial to an iIrrevocable iItemized ~~b~~Burial or SSI burial provision. Once the burial is changed to an irrevocable itemized burial contract it will be excluded in its entirety. If the funds are not changed to an Irrevocable Itemized Funeral Contract, any amount over the $1500 SSI burial allowable amount will become a countable asset.

- Individual has a $4000 CD set aside for burial ~~and wants to increase the amount set aside for burial.~~ The individual will need to contact the funeral home of their choosing and establish an Irrevocable Itemized Funeral Contract. The CD will need to be transferred into an irrevocable trust designating the interest and payout upon maturity into the trust. Also, the trust must name the funeral home as the beneficiary.

- Individual has a $4000 savings account set aside for burial ~~and wants to increase the amount set aside for burial.~~ The individual will need to contact the funeral home of their choosing and establish an Irrevocable Itemized Funeral Contract. The savings account will need to be transferred into an irrevocable trust with the funeral home named as the beneficiary.

f. Normally a life insurance policy is countable asset valued at its cash surrender value, however, when a whole life insurance policy is used to pay for an irrevocable itemized burial contract, the whole life insurance policy is exempt. Life insurance that is designate for burial must cover the life of the person for whom it is designated. The following are the steps the individual will need to take for their life insurance to be considered excluded for burial:

- The individual will need to contact the funeral home of their choosing.
- Change the beneficiary of the life insurance to the funeral home.
- Execute a contract between the individual and the funeral home to indicate the beneficiary of the life insurance cannot be changed, except for the ability to transfer to another licensed funeral establishment or cemetery association.

g. Information regarding the burial fund of a deceased recipient must be released to the funeral home personnel upon request.

h. A burial fund, which is established at the time of application, can apply retroactively to the three month prior period and the period in which the application is pending, if the value of all assets are within the Medicaid limits for each of the prior months. Future earnings on the newly established burial fund will be excluded.

Assets Which are Excluded for Spousal Impoverishment 510-05-65-25

2. ~~Before August 1, 2019 –~~ The institutionalized or HCBS spouse may choose either the North Dakota Medicaid burial provision or the SSI burial provision. The community spouse is ~~only~~ allowed the SSI burial provision or the Irrevocable Itemized Burial Contract. ~~After August 1, 2019 - The institutionalized or HCBS spouse may choose either the North Dakota~~

~~Medicaid irrevocable itemized burial contract provision or the SSI burial provision.~~

3. The following additional assets are excluded:

a. Life or burial insurance that generates a cash surrender value is excluded if the face value of all such life or burial insurance policies of that individual total one thousand five hundred dollars or less. (This exclusion is not allowed for an individual ~~institutionalized or HCBS spouse~~ who has an Itemized Irrevocable Funeral Contract which includes $1500 for funeral expenses ~~selects the North Dakota Medicaid burial provision~~.)

6. Disqualifying Transfer Penalty Period

Previously in IM 5401 the overpayment piece was removed, and it was stated we will no longer create overpayments. However, overpayments will occur based on the following policy for disqualifying transfers only. Information was added to this section to indicate what to do when an overpayment is determined due to a disqualifying transfer. IM 5403

Penalty Periods 510-05-80-15

7. Overpayment caused by disqualifying transfer.

a. If the disqualifying transfer period has not yet expired, send a notice informing the Medicaid Unit, they are no longer eligible for nursing care services.
- The amount of the overpayment will be the lessor of:
  - The amount of the disqualifying transfer; or
  - The amount of Medicaid payments paid in error on behalf of the individual, for nursing services.

b. If the disqualifying transfer has expired.
- The amount of the overpayment will be the lessor of:
  - The amount of the disqualifying transfer; or
  - The amount of Medicaid payments paid in error on behalf of the individual, for nursing care services.

If there is a suspicion of fraud, follow the policy at 510-05-10-25. If it has been determined that there is not a suspicion of fraud, the Eligibility Worker must send the information on what months are considered overpayments to SURS at medicaidfraud@nd.gov to determine the amount of the overpayment. SURS will send the letter to the client informing the client of the amount of the overpayment. The SURS unit will need to send the notice of overpayment to the client.

7. Institution of Mental Diseases

Pace eligible individuals admitted to IMD. An additional exception criterion has been added for individuals under 65 who will remain eligible for Medicaid and are a patient in an IMD. IM 5402

Institutions for Mental Diseases (IMD) 510-05-35-97

An individual under age 65 who is a "patient" in an IMD is not eligible for Medicaid, except as identified in subdivision d and e, 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.

e. Individuals eligible under the PACE program will remain eligible for Medicaid regardless of their age.

8. ~~Improper Payments and~~ Suspected Fraud

The following is the policy change for the Improper Payment and Suspected Fraud section of the manual. The title of the section has been renamed to Suspected Fraud. Eligibility Workers will no longer create overpayments. Eligibility workers will continue to send the SFN20 to the SURS unit if fraud is suspected. IM 5401

~~Improper Payments and~~ Suspected Fraud 510-05-10-25

The SFN 20 "SURS Referral Form" must be completed in all instances where there is a suspicion of fraud.

To assist with determining what constitutes a suspicion of fraud the following items should be considered:

- Was information listed on the application(s) on file false? – meaning they were employed or had other assets or household members, ect., were not disclosed at the time of application?
- Were false statement(s) made by the household member? – meaning denying (specifically indicated no) assets or employment on a certain date when there really were assets or employment?
- Recipient admitted they knew they should have reported.
- Other proof or evidence there was false information given in order to receive benefits.

~~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.~~

~~2. 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". SFN 20 may be sent to SURS as described in 5 below. The SURS unit will be responsible for recoupment from any provider.~~

~~3. 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.~~

~~For overpayments resulting from recipient errors, the amount of the overpayment is the amount of Medicaid payments paid in error on behalf of the Medicaid unit.~~

~~4. Recipient errors may occur as a result of:~~

~~i. 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.~~

~~ii. Medical Care Payment received by a member of the Medicaid Unit that was provided as a result of a medical expense or increased medical need for a given time period~~

~~i. The months in which the payments are incurred 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. Indicate in the subject line "request for increase in RL because of rework"~~

~~c. Failure to report income or other changes that affect eligibility or benefits, such as a change in household member composition, etc;~~

~~i. If the change does not result in a change in eligibility for any individual in the household the Medicaid Unit , document the findings and nothing further needs to be done.~~

~~ii. If the change results in an INCREASE in coverage, the change will be made for the future benefit month following~~

the month in which the verification/information is received.

Note: If an individual fails to report a change and the change would have resulted in equal or better 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.

Exception: Reductions to 'Client Share' can be made retroactively, upon receipt of actual verified information for the month the 'Client Share' is being reduced.

iii. 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 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.
- If the individual should have been eligible with a larger client share the amount of the overpayment is the difference between the incorrect amount of 'client share' (using actual income) and the correct amount of the client share that was met.

iv. If the individual was eligible for Medicaid coverage 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.

- The amount of the overpayment is the amount paid in error for all months the individual should not have been eligible.

d. Failure to disclose assets

i. If the undisclosed assets results in ineligibility, the amount of the overpayment is the lesser of:
ii. The amount of Medicaid payments paid in error on behalf of the Medicaid unit; or
iii. The difference between the actual amount of excess assets and the Medicaid asset limit.
iv. If the undisclosed assets did not result in a change in eligibility for any individual in the Medicaid Unit, document the findings and nothing further needs to be done.

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/loses State residency (10 day notice is 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 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 incurred.

- 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. An individual fails to report a Disqualifying transfers;

i. If the disqualifying transfer period has not yet expired, send a notice informing the Medicaid Unit they are no longer eligible for nursing care services.

i. The amount of the overpayment will be the lessor of:

- The amount of the disqualifying transfer; or
- The amount of Medicaid payments paid in error on behalf of the individual, for nursing care services;

ii. If the disqualify transfer has expired

i. The amount of the overpayment will be the lessor of:

- The amount of the disqualifying transfer; or
- The amount of Medicaid payments paid in error on behalf of the individual, for nursing care services;

g. Sharing Medicaid ID card.

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. The Eligibility Worker is not required to establish an overpayment; however, the SURS investigation may result in an overpayment.

An SFN 20 "SURS Referral Form" must be completed for all recipient errors where there is a suspicion of fraud. If a suspicion of fraud does not exist, the SFN 20 "SURS Referral Form" is not to be completed.

To assist with determining what constitutes a suspicion of fraud, the following items should be considered:

- Was information listed on the application(s) false? – meaning they were employed or had other assets or household members, etc., that were not disclosed at the time of application.
- Were false statements made by the Medicaid Unit member – meaning denying (specifically indicated no) assets or income on a certain date when there really were assets or income.

- ~~Recipient admitted they knew they should have reported.~~
- ~~Other proof or evidence there was false information given in order to receive benefits.~~

~~For questions regarding determining a suspicion of fraud, contact the Fraud, Waste, and Abuse Administrator at 701-328-4024 or via email medicaidfraud@nd.gov.~~

1. ~~If it has been determined there is a suspicion of fraud, review the information with a lead worker/supervisor and complete the SFN 20 "SURS Referral Form"~~

   - ~~The lead worker/supervisor must sign the SFN 20 "SURS Referral Form" to acknowledge their review of the referral and agreement with the suspicion of fraud determination.~~

     ~~**Note:** The SFN 20 "SURS Referral Form" will be returned if a lead worker or supervisor's signature is missing.~~

   - ~~If an SFN 20 "SURS Referral Form" has been submitted to the SURS Unit, DO NOT send a Letter of Overpayment as defined in #2 below.~~

   - ~~When completing the SFN 20, "SURS Referral Form", if you include programs other than Medicaid in the referral, it must be clearly stated.~~

2. ~~If it has been determined that there is NOT a suspicion of fraud, the Eligibility Worker must send a Letter of Overpayment (510-03-110-15 Letter of Overpayment) to the Medicaid Unit , regardless of the amount of the overpayment.~~

   ~~**Note:** Any SFN 20 "SURS Referral Form" received at the state which lacks proof for of suspected fraud, it will be returned to the county to send the Letter of Overpayment.~~

~~Once a Letter of Overpayment has been sent to the Medicaid Unit , immediately email a copy of the Letter of Overpayment to SURS at medicaidfraud@nd.gov. This information is needed for tracking of the overpayment, repayment plans, and other collection efforts.~~

~~When the overpayment amount includes the Medicaid Expansion premium payment(s), Eligibility Workers will need to send a request for this information to the Medicaid Eligibility Policy Group Box(in the email subject line indicate "overpayment-Medicaid Expansion premium payment amounts needed" at hccpolicy@nd.gov, or you can call (701) 328-1015 or toll free 1-844-854-4825.~~

~~6. Any repayment of an overpayment received at the county agency must be submitted to the Fiscal Administration unit using SFN 828, "Credit Form" (05-100-55).~~

9. Income Levels

Updating the family member income level in a spousal impoverishment case. IM 5400

Income Levels 510-05-85-40

2. Medically needy income levels.

e. Family member income level. The income level for each ineligible family member in a spousal impoverishment case is ~~$703~~ $718 effective July ~~2019~~ 2020 (~~$685~~ $703 effective July ~~2018~~ 2019 ~~and $677 effective July 2017~~).

10. Appeals

Adding information to clarify the only time the county worker is required to complete the SFN 162 is if the recipient requests a hearing by telephone and has not completed the SFN 162. IM 5399

Appeals 510-05-25-30

2. A request to appeal may be in writing, over the telephone, internet, mail, in person or through other commonly available means. The appeal must be file no later than 30 days from the mail date on the notice of action. When an applicant or recipient requests a hearing by telephone 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.

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.

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

11. Income Deductions

The website that can be used to inquire whether ND Medicaid covers a specified drug has changed. IM 5395

Income Deductions 510-05-85-35

Examples of expenses that can be used to reduce countable income and affect client share:

ii. *Over-the-counter medications that Medicaid does cover, such as Antacids (for stomach acid), analgesics (for pain), iron supplements (for anemia), artificial tears (for severe dry eye diseases). Also, those payable because of rebates, such as Maalox and Advil. (Non-payable are Mylanta and CVS generics). Medicaid covers drugs with a NDC code on the bottom of the bottle label. (www.hidesigns.com/ndmedicaid is a website that workers may use to inquire whether ND Medicaid covers a specified drug.);

12. Asset Assessment Requirement

Clarification has been added on where to send asset assessments for review, where to keep them and to whom they need to be sent to once completed.

Also, per clarification from the Legal department, SFN 52 is not needed. Direction around SFN 52 has been removed and the SFN will be removed. IM 5388

Asset Assessment Requirement 510-05-65-45

2. ~~We are changing where complete~~ Completed Asset Assessments: ~~are to be sent~~

- Send to Policy & System Support (PaSS) dhseahelpdesk@nd.gov for review.