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 5199 Reported Changes for Medicaid and Healthy Steps
- IM 5200 Income Levels effective April 1, 2014
- IM5205 Calculation of Remedial Expenses in Excess of Medically Needy Level
    - IM 5205 Attachment Remedial Expenses in Excess of Medically Needy Level Updated 5/1/2014 – Effective April 1, 2014
- IM 5211 Home and Community Based Services – waiver updates
- IM 5222 2015 – Home Equity Limit
- IM 5223 2015 – Spousal Impoverishment Asset Levels
- IM 5225 Retirement Accounts and Disqualifying Transfers
- IM 5227 Annuity Income Changes
- IM 5230 2015-Medicare Savings Program Asset Limits
- IM 5231 Average Cost of Long Term Care
- IM 5235 Request for Trust Review
- IM 5237 Children with Disabilities Premiums
- IM 5238 2015 Health Care Coverage Poverty Levels
    - IM 5238 Attachment April 2015 ACA and Non ACA Medicaid Income Level Chart
- IM 5240 SFN 451 Eligibility Report on Disability/Incapacity Emergency Services for Non-Citizens
- Amended IM 5242 Policy Clarifications for Non-ACA Medicaid – IRA's, Asset Assessments and Community Spouse Asset Allowance
    - IM 5242 Attachment Annuity Policy
        - IM 5242 Policy Clarifications for Non-ACA Medicaid – IRA's, Asset Assessments and Community Spouse Asset Allowance
- IM 5243 Calculation of Remedial Expenses in Excess of Medically Needy Level
    - IM 5243 Attachment Calculation of Remedial Expenses in Excess of Medically needy Level
- IM 5254 Definition of Spouse/Marriage
- IM 5256 Spousal Impoverishment – Additional Members
- IM 5257 Retirement Accounts and Irrevocable Burial Accounts
- Amended IM 5259 No or Invalid Recipient Address

  - IM 5259 No or Invalid Recipient Address

- IM 5260 Coverage for Inmates who are Inpatients in a Hospital Setting
  - IM 5260 – Attachment – Vision Processing
- IM 5262 Medicaid Coverage for Children in Foster Care and those Aging out of Foster Care
- IM 5264 ACA Policy Clarifications and Changes due to Implementation of SPACES
- IM 5265 Community Spouse Income and Asset Limits and Home Equity Limits for 2016
- IM 5270 Average Cost of Long Term Care
- IM 5271 Average Cost of Long Term Care
- Amended IM 5272 2016 Health Care Coverage Poverty Levels
  - Amended IM 5272 Attachment ACA and Non ACA Medicaid Income Level Chart
    - IM 5272 2016 Health Care Coverage Poverty Levels
    - IM 5272 Attachment ACA and Non ACA Medicaid Income Level Chart
- IM 5273 Calculation of Remedial Expenses in Excess of Medically Needy Level
  - IM 5273 Attachment Calculation of Remedial Expenses in Excess of Medically Needy Level
- IM 5275 Policy Updates for ACA and Non-ACA Medicaid and Healthy Steps
- IM 5279 Spousal Impoverishment – Additional Members Income Level
  - IM 5279 Attachment ACA and Non-ACA Medicaid Income Level Chart
- Second Amended IM 5288 – Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
  - IM 5288 Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
  - Amended IM 5288 Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities
- IM 5289 Community Spouse Income and Asset Limits and Home

Equity Limits for 2016
- Second Amended IM 5290 Average Cost of Long Term Care
  - IM 5290 Average Cost of Long Term Care
  - Amended IM 5290 Average Cost of Long Term Care
- IM 5292 2017 Health Care Coverage Poverty Levels
  - IM 5292 Attachment – ACA & Non-ACA Income Level Chart
- IM 5294 Achieving a Better Life Experience (ABLE) Accounts
- IM 5295 Medicaid Living Arrangement Updates in SPACES
  - IM 5295 Attachment – Medicaid Living Arrangement Reference Hard Card
- IM 5297 Ending Confidential Relationship Policy
- IM 5305 Spousal Impoverishment – Additional Members Income Level
  - IM 5305 Attachment - ACA and Non ACA Medicaid Income Level Chart
- IM 5306 Verification of Pregnancy for Medicaid
- IM 5310 Policy Update Regarding Achieving a Better Life Experience (ABLE) Accounts
- IM 5312 Autism Spectrum Disorders Waiver Update
- IM 5313 – New Process for Medicaid Overpayments
  - IM 5313 Attachment Letter of Recoupment

This manual letter is being amended as follows:

- **510-05-10-25(f)(ii) added clarification when an individual fails to report a disqualifying transfer and the penalty period has expired.**
- **510-05-35-95-05-15-Removed "individuals who are not aged or disabled will have their eligibility determined under this chapter" Also removed "greater than age 21 but less than age 65 will be assigned a COE of M072 and pregnant, under 21. And removed the "Note: For individuals, who are aged, blind or disabled, please refer to policy at 510-05-35-95-05-10."**
- **510-05-35-95-05-20 removed "There is no asset test for applicants and recipients whose eligibility is determined under ACA Medicaid. Asset provisions do not apply to these individuals."**
- **510-05-35-95-05-25 Added Non to ACA Medicaid and changed reference to 510-05-85.**
- **510-05-35-95-05-30-changed the reference to 510-05-85-40.**

- **510-05-35-95-10 third to the last paragraph—added Non to ACA and removed "the ~~household~~ Medicaid Unit 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."**
- **510-05-60-20 corrected the asset limit amounts**
- **510-05-70-45-30 #7 added verification--The notice must be sent and verification received back from the company, prior to approving ~~when~~ the Medicaid application ~~is approved~~, or if an ongoing case, when the annuity is reported.**
- **510-05-80-05 completely removed the rest of the 7th paragraph under #4.**

Par. 2. **Effective Date** – Policy changes included in this manual letter are effective January 1, 2018. 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.**

Definitions 510-05-05

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

Definitions 510-05-05

For the purpose of this chapter:

Spouse
~~A person of the opposite sex who is a husband or a wife. One man and one woman can become husband and wife through marriage (a legal~~

~~union). North Dakota Medicaid does not consider members of a civil union or same-sex marriage as spouses.~~
A spouse is a person who is legally married to another person.

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

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

1. ~~A Common law marriage from another state is valid in North Dakota only if it can be verified that the marriage is recognized by the other state.~~ The Marriage was legally performed in another state;
2. ~~A non-traditional marriage from another country is valid in North Dakota only if it can be verified that the union is declared valid by the other country.~~ The marriage is a common law marriage that occurred in another state and was considered a valid marriage in that state (the couple would be required to provide documentation verifying that the common-law marriage was considered valid by the state in which it took place);

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

4. Polygamous marriages are not recognized in North Dakota. In situations where polygamy has occurred, the first marriage is considered valid in North Dakota if the marriage meets the criteria in #1, 2 or 3 above. Any additional spouse (s) claimed after the first marriage are considered non-relatives.

General Provisions 510-05-10

2. 510-05-10-25 Improper Payments and Suspected Fraud.
   - Added clarification to policy to coincide with the ACA Policy for this section.
   - Incorporated policy regarding Process for Medicaid Overpayments from IM 5313

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

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

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

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" ~~with a copy to the Medicaid eligibility unit.~~ SFN 20 may be sent to SURS as described in ~~6~~ 5below. 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.

~~3.~~ 4. Recipient errors may occur as a result of:
   a. ~~Assistance~~ 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. 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.e. medical care payments);~~
      i. The months in which the payments are ~~intended for~~ 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 disclose assets, ; d.~~ or ~~Failure to report~~ 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 ~~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 result~~s~~ in ineligibility, the amount of the overpayment is the lesser of:

a. The amount of Medicaid payments paid in error on behalf of the Medicaid unit; or

b. The difference between the actual amount of excess assets and the Medicaid asset limit.

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

e. ~~Recipient misunderstanding;~~ An individual moves out of State/loses State r~~R~~esidency:

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 ~~paid out~~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 transfer~~s~~; ~~and~~

i. If the disqualifying transfer period has not yet expired, send a notice informing ~~the household~~ 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 care services;

ii. If the disqualify 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;

g. Sharing Medicaid ID card ~~card sharing~~.

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

~~4. 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.~~

~~5. The amount of a recipient error is determined as follows:~~

~~a. For ineligible cases resulting from excess assets, the amount of the overpayment is the lesser of:~~

~~i. The amount of Medicaid payments paid in error on behalf of the Medicaid unit; or~~

~~ii. The difference between the actual amount of excess assets and the Medicaid asset limit.~~

~~b. For overpayments resulting from errors 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 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 Medicaid unit.~~

~~c. 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.~~

~~6.~~ 5. ~~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:~~

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

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

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

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" ~~shall~~ 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) ~~on file~~ 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 household~~ Medicaid Unit member – meaning denying (specifically indicated no) assets or ~~employment~~ income on a certain date when there really were assets or ~~employment~~ income.
- Recipient admitted they knew they should have reported.
- Other proof or evidence there was false information given in order to receive benefits.

~~If you have any~~ For questions regarding determining a suspicion of fraud, ~~you may~~ 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 ~~household~~Medicaid Unit , regardless of the amount of the overpayment.
        Note: ~~Should an~~Any SFN 20 "SURS Referral Form" received at the state which lacks proof ~~for~~ of suspected~~potential~~ fraud, ~~it~~ will be returned to the county to send the Letter of Overpayment.

    Once a Letter of Overpayment has been sent to ~~the household~~ 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 ~~payment of 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.

~~7.~~ 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).

~~The Public Assistance Reporting Information System (PARIS) is a computer data matching and information exchange system administered by the Department of Health and Human Services (DHHS) and Administration for Children and Families (ACF). This system provides States with a tool to improve program integrity in administering Public Assistance and Medicaid programs. PARIS is designed to match State enrollment data from TANF, SNAP and Medicaid Programs with data from other participating States and from a selected group of Federal databases. See also "Public Assistance Reporting Information System (PARIS) at 448-01-50-40.~~

~~Effective May 1, 2013, processing of PARIS hits has been incorporated into the TECS eligibility system. The first hits that will appear will be for the benefit month of August, 2012. Thereafter, you will receive PARIS hits on a quarterly basis in:~~

- ~~June for the benefit month of May,~~
- ~~September for the benefit month of August,~~
- ~~December for the benefit month of November,~~
- ~~March for the benefit month of February.~~

3. 510-05-10-30 Liens and Recoveries. Added information from IM 5294 regarding the recoupment of funds from Achieving a Better Life Experience (ABLE) Accounts upon the death of the beneficiary of such funds.

Liens and Recoveries 510-05-10-30

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

2. A recovery of Medicaid correctly paid will be made from the estate of an individual who was 55 years of age or older when the recipient received such assistance or who had been permanently institutionalized regardless of

age. 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 as defined by the Social Security Administration. 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~~ Red River Behavior Health System, 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.

3. When a qualified beneficiary of an ABLE account dies (or is determined to no longer be disabled) and there are remaining funds in their ABLE account:
   - The ~~assets~~ funds in the ABLE Account are first distributed to any State Medicaid ~~plan~~ agency that provided medical assistance to the ~~designated~~ qualified beneficiary; and~~.~~
   - The amount of any such funds received by the State Medicaid agency cannot exceed the amount paid by the State Medicaid agency AFTER the creation of the ABLE Account.

Home and Community Based Services 510-05-15

4. 510-05-15-05 Home and Community Based Services. Incorporated

updated information on the various Medicaid waives from IM 5211 and updated the age of eligibility for the Autism Spectrum Disorder Waiver from IM 5312.

Home and Community Based Services 510-05-15-05

The Medicaid program provides home and community based services (HCBS) to eligible individuals who have been screened as requiring nursing care services or ICF/I~~I~~D (intermediate care facility for individuals with intellectual disabilities) level of care but who choose to receive those services in the community. Eligibility for individuals with an ineligible community spouse may be determined using the Spousal Impoverishment Provision found at 05-65. Services may be provided through one of the following waivers:

1. Traditional Waiver for Individuals with Intellectual and Developmental Disabilities: Home and Community Based Services are provided to individuals who meet the eligibility criteria for early intervention services for infants and toddlers under the age of three; individuals who have an intellectual disability and/or meet the criteria for a ~~developmental disability~~ related condition prior to the age of 22 and who are screened to the ICF-I~~I~~D (intermediate care facilities for individuals with intellectual disabilities level of care). These individuals generally meet the disability criteria of the Social Security Administration, however, the few who do not may still be eligible for these waivered services. Waiver services include residential services, day services, employment supports, family support services, parenting supports, extended home health care and financial help with the cost of equipment, supplies and environmental modifications. The waiver covers services provided by licensed providers, qualified service providers and some services can be directed by the waiver recipient. (This waiver began in 1981.)
2. Medicaid Waiver for Home and Community Based Services: Services are provided to individuals at least 18 years of age, who meet the disability criteria of the Social Security Administration, or are at least 65 years of age who are screened as requiring care in a nursing facility, but choose to receive services in the community. As of April 1, 2007, this waiver merged the Waiver for the Aged or Disabled (which began October 1, 1983) and the Waiver for the Traumatic Brain Injured (which began in 1994).
3. Waiver for Children with Medically Fragile Needs: Services are provided to children ages to 3 to 18 who have a serious illness or condition which

is anticipated to last at least 12 or more months. Eligible children have medically intensive needs and prolonged dependence on medical care or medical technology. The waiver is limited to 15 children at a time. (This waiver began June 1, 2008.)

4. PACE (Program of All-Inclusive Care for the ~~of~~ Elderly): PACE is available to Medicaid or Medicare recipients age 55 or older, who are screened as requiring care in a nursing facility. A capitated payment is made to the PACE provider who then provides health and health related services to allow individuals to remain in the community. (began August 1, 2008)
5. Money Follows the Person Grant: This Grant program assists recipients who are residing in a nursing facility or an ICF/ID who want to transition from an institutional care setting to a HCBS setting. Recipients must have been residing in the institutional setting for a period of 3 consecutive months or more, be screened as requiring care in a nursing facility or ICF/ID, and be Medicaid eligible for at least the last day of receipt of institutionalized service. (Demonstration grant began June 20, 2008.)
6. Technology Dependent Medicaid Waiver: Services are provided to individuals who are ventilator dependent for a minimum of 20 hours per day, and who are at least 18 years of age. The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. The waiver is limited to 3 recipients at a time. (This waiver began August 1, 2007.)
7. Children's Hospice Program: Provides multiple services to children from birth to their 22nd birthday who have been screened as needing Nursing Home level of care and who have less than a year of life expectancy. The services are designed to assist the family in dealing with the diagnosis and emotions a family needs to deal with when preparing for the possible death of their child. This waiver allows a family to continue to explore curative measures at the same time they are utilizing hospice services. The waiver is limited to 30 recipients in a 12-month period. If the child is 6 months to date of death, we need to use state plan services in addition to waiver services. (This waiver began July 1,2010)
8. Autism Spectrum Disorder~~s~~ Waiver for Birth ~~Through~~ to Age ~~4~~ 12~~0~~: Provides multiple services to a family with a child from birth to their ~~5th~~ 11~~0~~th birthday (through the day prior to the day of their 12~~0~~th birthday), who ~~are eligible for Developmentally Disabled Program~~

~~Management~~, have a confirmed diagnosis on the Autism Disorder Spectrum, and meet the ICF/I~~I~~D level of care. ~~, and are eligible for Medicaid.~~ These services build on existing services available in North Dakota. Children and ~~F~~families will ~~also~~ receive ~~training~~, service management, and access to respite services ~~help in coordinating services, and access to in-home support staff~~ to help provide structured activities that focus on communication, behavior, and other individual needs. The waiver also provides financial help with the cost of ~~equipment, supplies, and environmental modifications~~ assistive technology. The waiver is limited to ~~30~~ ~~59~~ 96recipients in a 12-month period. (This waiver began November 1, 2010.)

Application and Decision 510-05-25

5. 510-05-25-05 Application and Review. Incorporates the policy relating to Applications and Reviews from IM 5264 and IM 5275.

Application and Review 510-05-25-05

1. Application.
   a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.
   b. A relative or other interested party may file an application in 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 using one of the following prescribed applications:
      Non-MAGI ~~household~~Medicaid Units:
      i. SFN 405, "Application for Economic Assistance Programs";
      ii. SFN 641, "Title IV-E/Title XIX Application-Foster Care";
      iii. SFN 1803, "Subsidized Adoption Agreement";
      iv. SFN 958, "Health Care Application for the Elderly and Disabled";
      v. The Department's online "Application for Economic Assistance Programs";
      vi. The Low Income Subsidy (LIS) file from SSA;
      vii. If within one calendar month of when an applicant's Medicaid case was closed, or as part of the Healthy Steps annual review, one of the prescribed review forms (see subsection 2(b);

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.

Non-ACA individuals may also apply for assistance using one of the prescribed applications used for ACA Individuals. However, notification must be sent to the individual requesting verification of assets and any other information needed to make an eligibility determination.

d. There is no wrong door when applying for Medicaid or any of the Healthcare coverages. 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: Community spouse lives in one county, institutionalized spouse in another. If it is more convenient for the household to apply and maintain the case in the county where the community spouse resides than the county in which the institutionalized spouse is living, the community spouse's county 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~~ DHS, a disproportionate share hospital, or a federally qualified health center. 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, none are 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.

2. Review.
   a. ~~A recipient has the same responsibility to furnish information during a review as an applicant has during an application.~~
   A review requires the evaluation of all non-financial requirements affecting eligibility, which may include Medicaid Unit 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 as well as from the recipient.

   All income, assets (if individuals are subject to an asset test) and expenses must be verified at review. If the verification can be obtained through electronic sources or is already available to the worker through other sources, the information cannot be requested from the recipient.

   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.

   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. SFN 856, "Adoption Subsidy Agreement - Annual Review" for subsidized adoption, or other confirmation from a state IV-E agency

(in state or out of state) that verifies continued IV-E subsidized adoption eligibility;

vi. One of the previously identified applications completed to apply for another program;

vii. The on-line review through OASYS; or

viii. The streamlined review received through the state portal for MAGI reviews.

ix. Non-ACA individuals may also complete a review using one of the prescribed review forms used for ACA individuals. However, notification must be sent to the individual requesting verification of assets and any other information needed to make an eligibility determination.

Ex Parte Reviews: For Non-ACA Medicaid ~~households~~ Units, in circumstances where a desk review is appropriate, such as when adding an individual, processing a change in the level of care, 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. 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. Care must be used to ensure all needed information is on hand. An online narrative must document the completion of the Ex Parte review.

c. 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), when adding an individual as eligible who was previously in the Medicaid Unit as ineligible, 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.

d. A review, using one of the forms identified in b, is required to open a new Medicaid case for recipients (other than children who are adopted through the state subsidized adoption program, which requires an application) who

move from an existing case to their own case (e.g. a disabled child turns age 18).

e. A recipient may choose to have a face-to-face or telephone interview for their review; however, none are required in order to complete a review.

f. Reviews must be completed and processed no later than the last working day of the month in which they are due.

6. 510-05-25-25 Decision and Notice. Incorporates the policy relating to No or Invalid Recipient Addresses from IM 5259.

Decision and Notice 510-05-25-25

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

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

   Applications for disability-related Medicaid should be made to both the Social Security Administration and the county agency. When the Social Security Administration denies an application because of lack of disability the application for Medicaid must also be denied. The Social Security Administration's decision with regard to disability is binding. The Medicaid application should not be held pending an appeal of the Social Security decision.
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. In instances where Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) and another coverage is requested,

a decision must be made on both types of coverage and the applicant must receive one notice including both determinations.

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.

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.

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.
   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). Information reported via 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).

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.

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.

Basic Factors of Eligibility 510-05-35

7. 510-05-35-70 Emergency Services for Non-Citizens. Incorporates the policy from IM 5240 requiring submission of a completed SFN 451, Eligibility Report on Disability/Incapacity and medical reports for requests of Emergency Services for other than childbirth.

Emergency Services for Non-Citizens 510-05-35-70

Non-qualified aliens -- Ineligible aliens, illegal aliens, permanent non-immigrants (identified in subsection 3 of 05-35-55), 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.

   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'.

8. 510-05-35-90 Application for Other Benefits.

- Incorporates the policy from IM 5242 and IM 5257
- Added clarification to this section to define 'full retirement age' and 'good cause' for not making these streams of income available.

Application for Other Benefits 510-05-35-90

For purposes of this section, 'full retirement age' is determined by the income source.

- For Social Security Benefits, the individual's full retirement age is defined by SSA.
- If an individual is disabled, full retirement age is the individual's age at the time the individual becomes disabled.
- For IRA's, annuities or other retirement plans, full retirement age is the individual's age at the time the individual can withdraw funds without a penalty.

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 (including funds in an IRA), 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.

If an individual does NOT have 'good cause' as indicated in #2 below, they MUST begin drawing their benefits, the earlier of:

- Reaching their full retirement age, or
- Becoming disabled which precludes them from earning a living.

2. Individuals may have 'good cause' for not making these streams of income available as follows:
   a. Receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage; or
   b. 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; or
   c. An employed individual whose retirement benefits are through their current employer and the individual is not allowed to access the beneifts ~~m~~ while employed.

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.

9. 510-05-35-95 Public Institutions and IMDs.

- This section is being renamed to remove information regarding IMDs, as IMDs are being added to a new section, 510-05-35-97.
- Incorporates the policy relating to Coverage for Inmates who are Inpatients in certain Medical Institutions from IM 5260 and IM 5275
- Added a new section 510-05-35-95-05-15, to incorporate the policy relating to Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities from IM 5288.

Public Institutions ~~and IMDs~~ 510-05-35-95

1. An "inmate" of a public institution is not eligible for Medicaid unless the eligible individual is a child under the age of 19 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 forthe care and treatment of mental diseases. An institution for the intellectually disabled (ICF-ID) 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, the Prairie at St. John's center, 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 510-05-25-25, "Decision and Notice," for further information.

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

10. 510-05-35-95-05 Coverage for Inmates Receiving Inpatient Care in Certain medical Institutions. This new section was created to incorporate the policy for Coverage of Inmates Receiving Inpatient Care in Certain medical Institutions from IM 5260 and IM 5275.

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

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

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

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

1. Inpatient: A patient who has been admitted to a medical institution as an 'inpatient' on recommendation of a physician or dentist and:
    a. Receives room, board and professional services in the institution for a 24 hour period or longer, or
    b. Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though ~~it later develops that~~ the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.
        NOTE: An individual may be placed in a hospital under an 'observation' status, which is an 'outpatient' category. These individuals are not considered receiving inpatient medical care and not eligible for Medicaid under this provision.
2. Medical Institution means an institution that:
    a. Is organized to provide medical care, including nursing and convalescent care;
    b. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
    c. Is authorized under State law to provide medical care; and
    d. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services

must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

3. Department of Corrections and Rehabilitation includes the ND State Penitentiary and Missouri River Correctional Center in Bismarck, Dakota Women's Correctional and Rehabilitation Center in New England, James River Correctional Center in Jamestown, and the North Dakota Youth Correctional Center in Mandan.
4. County Jail means a place of confinement for persons held in lawful custody under the jurisdiction of a local government. A listing of county jails in North Dakota can be found at: http://www.nd.gov/docr/county/jails.html

Note: This does not include Tribal run jails.

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

Individuals who are not eligible for Medicaid because they are incarcerated and are inmates with the Department of Corrections and Rehabilitation (DOCR) or with a county jail are eligible for payment of their Medicaid-covered services received while an inpatient in one of the following Medical Institutions:

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

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

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

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

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

Eligibility begins on the date the inmate is admitted as an inpatient in a medical institution and ends the day they are discharged from the medical institution. Any services received before the inmate is admitted into a medical institution, 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) 510-05-35-95-05-20

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

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

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

Income calculations for those eligible under Non-ACA Medicaid are defined at 510-053-85.

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

Income levels for those eligible under ACA Medicaid are defined at 510-053-85-40.

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

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

Refer to Section 510-05-110, Policy Processing Appendix for information on how to process eligibility for these individuals.

11. 510-05-35-95-10 Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities. This new section was created to incorporate the policy for Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities from IM 5288

Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-05-35-95-10

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

Note: Different than coverage for Inmates Receiving Inpatient Services, this coverage is available for inmates who were inmates in a Tribal jail and are 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~~North Dakota has 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~~ CMS 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. wWhen determining the Medicaid Unit for this individual under Non-ACA, ~~the household Medicaid Unit 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 510-05-110

12. 510-05-35-97 Institutions for Mental Disease (IMD). This is a new section being added to incorporate policies from Section 510-05-95 relating to IMD's only.

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, 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-I~~I~~D) 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~~ Red River Behavioral Health System. Psychiatric Residential Treatment Facilities with more than 16 beds are considered IMDs. 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~~ 21who is determined to be continuously eligible for Medicaid, but who does not meet the certificate of need, remains eligible for Medicaid, however, no medical services will be covered during the stay in the IMD.

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

Foster Care and Related Groups 510-05-55

13. 510-05-55-05 Foster Care. Incorporates the policy from IM 5262.

Foster Care 510-05-55-05

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

1. There is a current foster care court order;
2. A public agency has care, custody, and control of the child;
3. ~~The child is residing in an approved licensed foster care home or facility (a Psychiatric Residential Treatment Facility (PRTF) is not a licensed foster care facility); and~~
3. ~~4.~~ The child is a foster care child in the state foster care system through the state's Children and Family Services unit, or a Tribal 638 Foster Care child.

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 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 Psychiatric Residential Treatment Ffacility ~~that is not an approved licensed foster care home or facility~~ (PRTF) and ~~do not~~ meet the ~~four~~ three (~~4~~ 3) criteria listed above are considered a foster care child. ~~Therefore, they cannot have their eligibility determined using the Foster Care eligibility criteria~~.

Children with Disabilities 510-05-58

14. 510-05-58-30 Premium Calculation for Children with Disabilities. Incorporates the policy from IM 5237

Premium Calculation for Children with Disabilities 510-05-58-30

1. Individuals eligible under the Children with Disabilities coverage are required to pay a monthly premium amount equal to 5% of the family's gross countable income.

   Note: When there is more than one child in the Medicaid Unit ~~family~~ covered under Children with Disabilities, the total premiums cannot exceed 5% of the family's gross countable income.

   Premiums are computed on a monthly basis and are rounded to the nearest dollar. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.
2. The Children with Disabilities premium is offset by any premium amount the family pays toward a family health insurance policy in which the disabled child is covered.
3. Prior to authorizing initial eligibility for any month(s) prior to the future benefit month, the individual is required to pay any premiums due for those benefit months. Premium payments received by the county must be submitted to the department's Fiscal Administration unit using the Medicaid credit form, SFN 828. Premiums for future benefit months are due on the tenth day of the future month.
4. When re-budgeting an eligible month of Children with Disabilities coverage, and the individual remains eligible, a previously established premium is not changed unless it can be changed prospectively with a ten-day advance notice, or if the original premium notice has not been mailed.
5. Monthly premium notifications will be sent informing eligible individuals of any premium amount(s) due. The notice will include a self-addressed envelope for the individual to send the premium payment directly to the Fiscal Administration unit.

   Any excess monies received by the Fiscal Administration unit will not be immediately refunded, but will be held as credit, and will be applied to future premiums due. When an individual becomes ineligible for Children with Disabilities coverage for a period of more than 30 days, Fiscal

Administration will return any credit balance to the individual in the form of a refund.

If a premium payment by check is returned due to non-sufficient funds, the premium will be considered unpaid.

6. Any individual who fails to pay the premium established under this section for three consecutive months shall be disenrolled and may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding premiums. Any month in which no premium is due shall not be counted as a month in which the individual failed to pay a premium.

   An individual who is under age 19 and is continuously eligible for Medicaid who fails to pay the premium for 3 consecutive months cannot be disenrolled prior to the end of their continuous eligibility period. They may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding premiums.

   Payments received by the Department from an individual claiming eligibility under this section shall be credited to the oldest unpaid premium. The Department shall credit payments on the day received, provided that credit for any payment made by an instrument that is not honored shall be reversed. The Department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.

Medicare Savings Program 510-05-60

15. 510-05-60-20 Asset Limits for the Medicare Savings Program. Incorporates the increase in the asset limits from IM 5230 that became effective January 1, 2015. This amount has not changed since 2015.

Asset Limits for the Medicare Savings Program 510-05-60-20

No person may be found eligible for the Medicare Savings Programs unless the total value of all non-excluded assets does not exceed the limit established for the Medicare Part D Low Income Subsidy. This amount changes annually.

Effective with the benefit month of January ~~2014 2016 2017~~ 2018, the limits are:

1. ~~$7,160 $7,280 $7,390,~~ $7,560 for a one-person unit (~~$7,080 in 2013 $7,160 in 2014 7,280 in 2016~~ $7,390 in 2017); or
2. ~~$10,750 $10,930 $11,090~~ $11,340 for a two-person unit (~~$10,620 in 2013 $10,750 in 2014 $10,930 in 2016~~ $11,090 in 2017).

Eligibility Under Spousal Impoverishment 510-05-65

16. 510-05-65-20 Community Spouse Asset Allowance.

- Incorporates Policy from IM 5242 indicating the Spousal Impoverishment provisions no longer apply UNLESS the total length of the Community Spouses stay is anticipated to be less than a full calendar month.
  - Incorporates the asset limits currently in effect from IM 5289.
  - Information in IM 5223, and IM 5265 are for previous years and will not be incorporated into the manual, but have been moved to the 'Archived IM Roster' section of the Manual for reference.

Community Spouse Asset Allowance 510-05-65-20

- The community spouse asset allowance is computed considering the assets as of the first continuous period of institutionalization of the institutionalized spouse, or as of the beginning of the first continuous period of receipt of HCBS by a HCBS spouse.
- The community spouse asset allowance is determined by first establishing a spousal share. The spousal share is an amount equal to one half of the total value of all countable assets owned (individually or jointly) by the institutionalized, HCBS, or community spouse.

Example:

If the couple's countable assets are:	The community spouse share is:
$25,000	$12,500
$90,000	$45,000
$250,000	$125,000

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 ~~$23,448~~ ~~$24,180~~$24,720, and not more than ~~$117,240~~$120,900 $123,600, effective January ~~2017~~ 2018 ~~($23,184 and $115,920 effective January 2013)~~ ~~($23,448 and $117,240 effective January 2014)~~ ($24,180 and $120,900 effective January 2017).

Example:

If the Spousal share is:	The community spouse asset allowance is:
$12,500	~~$23,448~~ $~~24,180~~ 24,720(at least the minimum)
$45,000	$45,000
$125,000	~~$117,240~~ $~~120,900~~123,600(one-half is more than the maximum allowed, so the community spouse gets the maximum)

The community spouse asset allowance may be adjusted by any additional amount transferred under a court order or established through a fair hearing.

Adjustments in the minimum and maximum allowed for a community spouse may also adjust the community spouse asset allowance.

3. After the institutionalized or HCBS spouse has been determined eligible, the community spouse is no longer subjected to the community spouse asset allowance. Assets of the community spouse are subject to the disqualifying transfer provisions and may not be given away or transferred for less than fair market value without causing ineligibility for the institutionalized spouse.

4. Should the Community Spouse require care in a medical institution, nursing facility, swing bed, or in the state hospital, the Spousal Impoverishment Provision no longer apply UNLESS the total length of the Community Spouses stay is anticipated to be less than a full calendar month.

17. 510-05-65-45 Asset Assessment Requirements. Incorporates the policy from IM 5242 and updated policy that Asset Assessment no longer need to be submitted to the State Medicaid Policy, but are scanned into File Net based on the recent Asset Assessment Training.

Asset Assessment Requirements 510-05-65-45

At the beginning of the first continuous period of institutionalization, or receipt of HCBS, an institutionalized spouse, a HCBS spouse, or a community spouse may request an assessment of their assets.

The asset assessment establishes the spousal share, the community spouse asset allowance, and the amount of assets that must be spent down before Medicaid eligibility can begin.

1. When completing an Asset Assessment:
   a. All electronic sources of asset verifications must be checked for potential countable assets (e.g. NDRIN and Motor Vehicle interface).
   b. Enter the physical or legal address of the home on the Asset Assessment. If there is a TRANSFER ON DEATH Deed (TOD) enter TOD in front of the address.
      Example: TOD 123 Main St, Bismarck, ND 58505
      A copy of the TOD deed must be attached to the Asset Assessment when scanning the Asset Assessments into File Net.

2. We are changing where complete Asset Assessments are to be sent.
   Instead of sending the Asset Assessment to the Legal Advisory Unit, please send them to ~~State Medicaid Policy~~ soeaprp@nd.gov.
   When sending in the Asset Assessment to the ~~State Medicaid Policy Unit~~ soeaprp@nd.gov, please include the completed form and ~~attach~~ all verifications used to calculate ~~/deeds of~~ the countable assets listed on the Asset Assessment.
   ~~After the State Medicaid Policy Unit reviews the Asset Assessment, a copy will be forwarded to the Legal Advisory Unit for future Estate Recovery purposes.~~
   Once the assessment has been approved, send one copy to the community spouse and one copy to the institutionalized spouse.

Asset assessments that are approved by policy are stored in FileNet using the client's social security number.

3. Upon approval of a case, the SFN 52, Spousal Asset Log MUST be completed and sent to the State Medicaid Policy Unit. Retain a copy for your case file
4. All assets, including those that are excluded must be listed on the asset assessment, but the value of these would be excluded in the 'Total Assets' Amount. Refer to Manual Section 510-05-70-30 for a complete listing of excluded assets.
5. Reminder, applicants and recipients should not be provided financial advice. They must pursue financial advice from individuals who work in that field.

If an asset assessment is not completed at the time of the first continuous period of stay by the institutionalized or HCBS spouse, the couple may later provide verification of the assets they had at that time. Only consider those countable assets that the couple can verify as owning at that time to establish the community spouse asset allowance.

Distribution of the asset assessment form requires that one copy be sent to each spouse, one copy be sent to the Economic Assistance division, and one copy is retained at the county. Economic Assistance can be contacted for a copy of the asset assessment if the institutionalized, or HCBS, spouse applies in the future and the county in which the application is filed does not have a copy.

The assessment of assets is completed using Form SFN 200, "Asset Assessment" (05-100-65). The asset assessment must include all of the couple's assets owned jointly or individually.

Part II of SFN 200, "Asset Assessment," must be completed within thirty days of receipt of the completed Part 1. The file must include documentation of all assets.

Assets 510-05-70

18. 510-05-70-10, Asset Considerations. Incorporated Policy from IM 5297

Asset Considerations 510-05-70-10

Assets, not otherwise excluded, that are available to an applicant or recipient and that are in excess of the Medicaid asset limits are considered to be available to meet the medical needs of the applicant or recipient and cause ineligibility for Medicaid. An asset is any kind of property interest, whether real, personal, or liquid.

1. All assets which are actually available must be considered in establishing eligibility for Medicaid. Assets are actually available when at the disposal of an applicant, recipient, or ~~responsible relative~~ anyone acting on behalf of an applicant or recipient, ; when the applicant, recipient, or ~~responsible relative~~ anyone acting on behalf of an applicant or recipient, 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 relative~~ anyone acting on behalf of an applicant or recipient, has the lawful power to make the asset available, or to cause the asset to be made available. Asset availability is also as follows:
   a. An individual may have rights, authority, or powers, which he or she does not wish to exercise. Examples include individuals who choose not to collect a secured debt or individuals who believe family disharmony would result from the sale of the individual's interest. It is important to distinguish the individual's desire to avoid a sale from an absence of any right, authority, or power to sell. In such cases, the value of the property will be counted as an available asset whether or not the applicant or recipient pursues selling the asset. Likewise, Medicaid does not require an individual to begin foreclosure against a note in default. However, because the individual has the authority to do so, the current value of the note will be counted as an available asset.
   b. When an applicant or recipient files bankruptcy, it is necessary to consider the terms of the bankruptcy and to determine which assets are included in the bankruptcy. Any assets that are exempt from the bankruptcy are considered available assets for Medicaid purposes.
   c. When an applicant or recipient is a creditor to someone else who files bankruptcy, determine if the applicant or recipient has any security on the debt. If there is security (e.g. the debt is a contract for deed or promissory note on real property), the asset is considered to be available. If there is no security, the asset is not considered to be available.

d. Occasionally, some children receive money through the Uniform Gift to Minors Act. These funds are considered available to the child for Medicaid purposes. A minor, or if under age 14, someone acting on their behalf, can request that the funds be made available to meet the needs of the child.
e. Funds from a loan that must be repaid, including a reverse mortgage, and that the applicant or recipient demonstrates are for a purpose unrelated to achieving Medicaid eligibility, are not considered to be available assets if identifiable as a loan and if not commingled with other assets.
f. The surrender or equity value of any money, insurance, or other property given to another person or entity to be held for the use of a member of the Medicaid unit is considered to be held in trust and is available to the extent provided in 510-05-70-50 (Trusts).
g. When an applicant or recipient has paid an entrance fee or deposit to a continuous care retirement community or a lifecare community, the entrance fee or deposit is considered an available asset to the extent that:
    i. The individual has the ability to use the funds, or the contract provides that the funds may be used, to pay for care;
    ii. The individual is eligible for a refund of any remaining funds when the individual dies or leaves the community; or
    iii. The payment or deposit does not confer an ownership interest in the community.
h. Many benefit programs deposit an individual's monthly benefit onto a debit card. Any balance remaining on these debit cards are considered a liquid asset beginning the month following the month it was deposited on the card and counted as income. Examples of these benefit programs are TANF benefits, Unemployment Insurance Benefits (UIB), Child Support benefits, Workforce Safety and Insurance (WSI), Social Security Administration Benefits (SSA), etc.
i. Individuals may either purchase for themselves or receive as gifts or bonuses items such as gift cards, debit cards, pre-paid credit cards and in-store credits. Regardless of the source, any of these items that an applicant or recipient has in the month following the month of receipt are considered available assets.
j. Payments made to a provider for an individual's client share when the client share has not as yet been applied to the individual's bill are not

considered available assets once the individual is eligible and the client share has been determined.

Example 1: Ida Maypole applied for Medicaid and was approved with a $500 client share starting in January. She is in a Basic Care facility and knows her monthly bill will exceed her client share. She pays her client share every month on the first. In July, the eligibility worker gets an alert that Ida has not incurred her client share. To date, the facility has not billed Medicaid. Because Ida was informed of her client share, what she paid at this time is not a countable asset for Ida because she was informed of her client share and paid it for services received.

NOTE: If it is later determined that Ida did not actually incur her client share due to a 3rd-party payor such as Medicare paying all or part of the bill, at the time this is discovered, the unapplied client share IS counted as an available asset.

Example 2: Donald Duck applied for Medicaid and was approved with a client share of $785 per month. Donald is in receipt of HCBS services at home, however, the wrong living arrangement was entered, and his HCBS claims are not being applied to his client share. Donald knows his client share and has been paying it to his HCBS provider monthly. His credit balance with his provider is not an available asset because once the living arrangement is corrected, claims will be adjusted and his client share will be incurred.

2. The financial responsibility of any individual for any applicant or recipient of Medicaid is limited to the responsibility of spouse for spouse and parents for a disabled child under age eighteen. Such responsibility is imposed as a condition of eligibility for Medicaid. Except as otherwise provided in this section, the assets of the spouse and parents are considered available even if those assets are not actually contributed. For purposes of this paragraph, biological and adoptive parents, but not stepparents, are treated as parents.

All spousal assets are considered actually available unless:

a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient;

b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States;
c. The applicant or recipient has been subject to marital separation, with or without court order, the parties have not separated for the purpose of securing Medicaid benefits; or
d. In cases where spousal impoverishment applies, the assets are those properly treated as belonging to the community spouse.

Pre-nuptial, or post-nuptial, agreements have no affect and do not allow spousal assets to be considered unavailable.

4. All parental assets are considered actually available to a disabled child under age eighteen unless the child is living:
   a. Independently; or
   b. With a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing Medicaid benefits. Only the assets of the parent the child is residing with must be considered.
5. Assets received from the estate of a spouse, or a parent who was providing support, are available as of the date of the person's death. Assets received from any other estate are available at the earlier of:
   a. The day on which the assets are received from the estate; or
   b. Six months after the person's death.

~~6. Transfers of an applicant or recipients property made by someone with a confidential relationship, whether to themselves or to a third party, for which 100% of fair market value was not received, are not considered to be transfers without adequate compensation when an application or recipient is not competent, or if competent, does not approve. In these situations, regardless of when the transfer was made, the uncompensated value is considered to be available to the applicant or recipient because the person who made the transfer must account for and replace any amounts lost by the applicant or recipient.~~

~~See the definition for "Someone in a Confidential Relationship, "510-05-80-05, for additional information.~~

19. 510-05-70-27 Home Equity Limits. Incorporates the current Home

Equity Limit from IM 5289. Information from IM 5222 and IM 5265 are for previous years and will not be incorporated into the manual, but have been moved to the 'Archived IM Roster' section for reference.

Home Equity Limit 510-05-70-27

The Deficit Reduction Act of 2005 established limits on the home equity an individual may have and still qualify for coverage of nursing care services through Medicaid.

Applicants or recipients who apply for Medicaid coverage on or after January 1, 2006 are not eligible for coverage of nursing care services (which include HCBS) if the individual's equity interest in the individual's home exceeds ~~$543,000~~ ~~$560,000~~ $572,000 effective January 1, ~~2017~~ 2018 ~~($536,000 effective January 2013) which is unchanged from 2015.~~ The applicant or recipient may, however, be eligible for other Medicaid benefits.

This provision does not apply if one of the following individuals lives in the home:
1. A spouse;
2. A son or daughter who is under age twenty-one; or
3. A son or daughter of any age who is blind or disabled.

20. 510-05-70-30 Excluded Assets.

- Added clarification to #7 that property must be offered for sale at 100% of fair market value, but any offers received at or above 75% of fair market value determines the property to be 'saleable without working an undue hardship'.
- Added clarification to #8 regarding irrevocable burial funds from IM 5257
- Corrected the wording in #22 for the last to types of IRA's from IM 5257
- Added a new #24 to include policy from IM 5294 and IM 5310, to disregard funds held in Achieving a Better Life Experience (ABLE) Accounts.
- All other Excluded Assets in this section remain unchanged and therefore are not included in this Manual Letter.

Excluded Assets 510-05-70-30

The following types of property interests will be excluded in determining if the available assets of an applicant or recipient exceed asset limits:

7. Property that is not saleable without working an undue hardship. Property that is not saleable without working an undue hardship means property which the owner has made a good faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value, and which is continuously for sale. Property must be offered for sale at 100% of the value and if no offer received at 100%, an offer at or exceeding 75% may be accepted. Property may not be included within this definition at any time earlier than the first day of the first month in which a good faith effort to sell is begun.

   Refer to05-05 for the definition of "good faith effort to sell" to determine the method and order in which an attempt to sell property must be made.

   a. Persons seeking to establish retroactive eligibility must demonstrate that good faith efforts to sell were begun and continued in each of the months for which retroactive eligibility is sought. If a reasonable offer has been received on the property, or the property has sold prior to eligibility determination, the property cannot be determined unsalable.

   b. Good faith efforts to sell, other than for an annuity, must be repeated at least annually.

   c. When making a good faith effort to sell real property or a mobile home, wait to determine that it is non-saleable until the third month after the month in which the good faith effort began. This provides a reasonable amount of time for offers to be received without loss of potential months of eligibility for an applicant. If the property is determined to be non-saleable without working an undue hardship, the property must remain continuously for sale, and any offers received must be reported. The three calendar months must include a good faith effort to sell through the regular market for the three calendar months. For purposes of

this provision, an offer to the regular market for real estate is made by listing the property with a professional real estate agent when the property is located in an area serviced by a professional real estate agent.

d. When making a good faith effort to sell property other than real property, a mobile home, or an annuity, wait to determine eligibility until at least 30 days after the good faith effort has been made to determine if any offers are received. If the property is determined to be non-saleable without working an undue hardship, the property must remain continuously for sale, and any offers received must be reported.

e. When making a good faith effort to sell an annuity, there is a specific market, known as the factors market, to which the good faith effort must be made. Eligibility may be determined after the good faith effort has been made and responses received from the factors that were contacted.

f. If a Medicaid unit claims that property should be excluded because it is not saleable without working an undue hardship, verification of the way in which the fair market value was established, the established value, and the good faith effort to sell must be made a part of the file. If the efforts to sell have produced no offers, the written statement of the applicant, recipient, or sales agent, stating that fact, must be made a part of the file. The county agency reviewing the efforts to sell should be alert for actions which reflect an applicant's or recipient's effort to comply with the technical requirements for exclusion without making a genuine and serious attempt to sell the excess asset.

g. In order to demonstrate that property is not saleable without working an undue hardship, an applicant or recipient must engage in sales efforts which are reasonably calculated to produce a sale. An applicant or recipient is not obliged to make a sale if a reasonable offer is received, but the property will not thereafter be excluded.

h. When offering property for sale by public advertisements, those containing substantially the following content are acceptable as a means of demonstrating a good faith effort to sell:

Example 1: Offered at 75% of value.

For Sale: An undivided ½ interest in W½ of Sec. 65, Township 130, Range 102, East of the 5th P.M., located 2 miles west of the junction of U.S. Hwy. 90 and Iron County Rd. 4. This land has a true and full value of $100,000. The minimum offer which will be considered for the undivided ½ interest is $37,500, payable upon sale. Call (701) 555-9999, or write Chaos Realty, Box 1, Tampa, ND 58990.

Example 2: Offered at 100% of value.

For Sale: An undivided ½ interest in W½ of Sec. 65, Township 130, Range 102, East of the 5th P.M., located 2 miles west of the junction of U.S. Hwy. 90 and Iron County Rd. 4. This land has a true and full value of $100,000. This undivided ½ interest is offered for $50,000, payable upon sale. Call (701) 555-9999, or write Chaos Realty, Box 1, Tampa, ND 58990.

i. It is expected that a "good faith effort to sell" will normally generate a sale. If no offer for at least 75% of the established fair market value has been received on the property as of the annual review, the county agency must review the previous efforts and determine if they truly reflect a good faith effort to sell, and may require a re-evaluation of the property value, or other appropriate action likely to produce a sale.

8. 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~~ 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 201~~3~~5, 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.

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

~~**Example:**~~ **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~~s~~ lookback period ~~of doing so~~, 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 or an annuity is designated for burial, 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 or annuity 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 an annuity with a face value of $7000. The annuity remaining cost basis is $6200 and the surrender value is $6500. Only $6000 of the remaining cost basis is excluded for burial. The remaining $200 is counted toward the asset limit. The excess surrender value of $300 is considered accrued earnings and is excluded.

Example 3: 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 three 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's statement. 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 cannot be designated 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.

22. Funds held in retirement plans that are considered qualified retirement plans and meet the qualified retirement criteria established by the Internal Revenue Service (IRS); 26 U.S.C. These include:
    - SEP-IRA (Simplified employee pension) plans
    - Employer or employee association retirement accounts
    - Employer simple retirement accounts
    - 401(k) retirement plans (which include independent (sole proprietorship) plans)
    - 403(b) retirement plans
    - 457 retirement plans
    - 401 (a) Employer-sponsored money-purchased retirement plan
    - ~~IRA's~~ Individual Retirement Plan (IRA's)
    - ~~Roth IRA's~~ Roth Individual Retirement Plan (Roth IRA's)

    While these pension plans and IRA's are an excluded asset, applicants and recipients must take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled as defined in section 510-05-35-90, Application for Other Benefits'

24. Achieving a Better Life Experience (ABLE) Accounts
    An individual with significant disabilities that meets established criteria is eligible for one ABLE account. The account may be opened at any age but the disability must have an age of onset before the age of 26 and the disability must still exist at the time the ABLE account is opened.
    - If the individual is receiving SSI and/or SSDI and meets the age criteria, that individual qualifies.
    - If not receiving SSI and/or SSDI, the individual must meet Social Security's definition and criteria regarding significant functional limitations and may be asked to provide certification from a licensed physician.

    The total annual contributions for a single tax year, regardless of the number of contributors, are $14,000. For individuals with disabilities who are recipients of SSI, the ABLE Act sets some further limitations. When the total account balance meets a Plan's maximum balance limit, additional contributions into an ABLE account will not be accepted. Each state sets its own maximum balance limit.

The funds in an ABLE account can be withdrawn to be used for a 'qualified disability expense.' A 'qualified disability expense' is any expense that results from living a life with disabilities to include education, housing, transportation, employment training and support, assistive technology, personal support services, health care expenses, financial management and administrative services and other expenses which help improve health, independence and/or quality of life.

Originally, the ABLE Act required each state to create their own ABLE plans. Since the passage, changes were made to allow individuals to open an account anywhere in the United States. With this new option, Bank of North Dakota (BND) determined that the residents would have lower expenses if they accessed other states' plans. BND is available as a resource to answer questions about the ABLE Act and will provide a list of resources and state plans. Go to Bank of North Dakota's website at bnd.nd.gov/able/ for more information.

The ABLE Act requires amounts in ABLE accounts be disregarded in determining eligibility for means-tested federal and state programs including Medicaid. This includes the exclusion of any contributions to the ABLE account of the individual and any distributions for qualified disability expenses. However, a transfer of funds into an ABLE Account is subject to the Disqualifying Transfer policy for Medicaid.

Exception: For Medicaid, an individual is allowed to transfer their own funds into an ABLE Account for themselves or their spouse and this would not be treated as a Disqualifying Transfer. If they want to set aside funds for a child who is blind or disabled, money placed into an ABLE Account would be considered a Disqualifying Transfer. However policy at Section 510-05-80-25 #3.c. does allow them to create a Trust.

Since the funds in an ABLE account can only be withdrawn to be used for a 'qualified disability expense,' funds withdrawn from the account are also disregarded.

An individual who would be receiving payment of Supplemental Security Income' benefits but for the application of housing expenses paid by the ABLE account or due to having more than $100,000 in the ABLE account" will continue to be treated as a SSI recipient for Medicaid purposes."

Refer to Section 510-05-10-30 for information regarding recovery of remaining funds in an ABLE account when the qualified beneficiary of an ABLE account dies (or is determined to no longer be disabled).

21. 510-05-70-40 Contractual Rights to Receive Money Payments. Added clarification to the determination of when a debtor is 'judgement proof'.

Contractual Rights to Receive Money Payments 510-05-70-40

1. For various reasons, but usually because an applicant or recipient has sold property with a contract to receive a series of payments, rather than one payment, an applicant or recipient may own contractual rights to receive money payments. If the applicant or recipient has sold property, and received in return a promise of payments of money at a later date, usually to be made periodically, and an attendant promise to return the property if the payments are not made, the arrangement is usually called a "contract for deed". The essential feature of the contract for deed is the right to receive future payments, usually coupled with a right to get the property back if the payments are not made. Contractual rights to receive money payments also arise out of other types of transactions. The valuable contract document may be called a note, accounts receivable, mortgage, or by some other name.

   Some contractual rights may be written so the lender has the right to demand payment at any time. If so, the note is considered a demand note and can be called in at any time. If a note is written so the lender does not have the right to demand payment but the note is in default, it also becomes a demand note. Contractual rights may or may not have collateral or security to guarantee payment.

2. A contractual right to receive money payments is considered an available asset, subject to the asset limits, unless the Medicaid unit is requesting coverage of nursing care services and the contract itself must be considered a disqualifying transfer (see subsection 4). When the penalty period is finished, and the applicant or recipient still owns the contractual right to receive the money payments, the contractual right is considered an available asset.

3. Contract values.
   a. The value of a contract in which payments are current is equal to the total of all outstanding payments of principal required to be made by the contract, unless evidence is furnished that establishes a lower value.
   b. The value of a contract in which payments are not current is an amount equal to the current fair market value of the property subject to the contract. If the contract is not secured by property, the value of the contract is the total of all outstanding payments of principal and past due interest required to be made by the contract.

   c. In situations where the contractual right to receive money payments is not collectable and is not secured and the debtor does not have any assets such as money in a bank account or real property, is not working or has a very low paying job or the only other source(s) of income are exempt from seizure by judgment creditors, the debt has no collectable value, and thus no countable asset value. An applicant or recipient can establish that a note has no collectable value if:
      i. The debtor is judgment proof which means a money judgment has been secured, an execution has been served against the debtor which has been returned as wholly unsatisfied, and the debtors affidavit and claims for exemptions exempt all of the debtors property or as determined by the department including but not limited to:

         - Has no legal rights to pursue payment of debts by garnishing wages or other sources of income that are not exempt from garnishment;
         - Cannot place a levy on bank accounts, and/or
         - Cannot place a lien against any real estate that the individual owns.

      ii. The applicant or recipient verifies the debt is uncollectible due to a statute of limitations. A satisfactory verification includes an attorney's letter identifying the statute and facts that make a debt uncollectible due to a statute of limitations.

         Applicants and recipients should be encouraged not to forgive debts that have been determined to be uncollectible. Such debts

could have a future value if the debtor ever accrues assets. At each annual review, determine whether the judgments are still on file or whether the debtor has any change in assets.

4. The purchase or establishment of a contract may be a disqualifying transfer if the owner, or the owner's spouse, is requesting coverage for nursing care services and the contract was purchased or established on or after the look-back date (as defined in 05-80-10).
   a. A disqualifying transfer will be determined to have occurred if the value of the contract at the time it was purchased or established, plus any compensation received at that time, was less than the value of the property exchanged for the contract. The difference is the amount of the transfer.

      Example: Mr. Green sells land to his children on a contract for deed. The land has a fair market value of $100,000. The contract required a $5,000 down payment and the value of the remaining payments adds up to $60,000. $100,000 less $60,000 (value of contract), and less $5,000 (down payment), leaves a difference of $35,000. Mr. Green made a $35,000 disqualifying transfer when he established the contract.

   b. Except for annuities (see 05-70-45), a contractual right to receive money payments that consists of a promissory note, loan, or mortgage is a disqualifying transfer unless:
      i. All payments due on the contract are expected to be made within the owners life expectancy as established using the tables at 05-100-75;
      ii. The contract provides for equal payments and does not provide for a balloon or deferred payment; and
      iii. The contract cannot be cancelled, or the payments diminished, upon the lender's death.

      The uncompensated value of a contract that is considered a disqualifying transfer is an amount equal to the remaining payments due from the contract.

      Example: When Mr. Green sold his land to his children on a contract for deed, the contract included a clause that no further payments would be due on the contract when he passed away. Because of this clause, the contract is

considered a disqualifying transfer. $55,000 is still due on the contract, so the amount of the transfer is $55,000.

As is shown in the above two examples, Mr. Green made two transfers. The first transfer was because he did not receive fair market value for the property, thus he made a $35,000 transfer. The second transfer was because of the cancellation clause, which results in a $55,000 transfer. These two transfers are combined for a total transfer of $90,000.

If the entire contract itself is considered a disqualifying transfer that results in a penalty period, the contract is not also considered an available asset.

5. There is a presumption that the holder's interest in contractual rights to receive money payments is saleable without working an undue hardship. This presumption may be rebutted by evidence demonstrating that the contractual rights are not saleable without working an undue hardship, or in the case of an annuity, by establishing its countable value for Medicaid purposes (see 05-70-45-15 for valuation of annuities) (see 05-70-30(2) for more information regarding property that is not saleable without working an undue hardship).

   When offering contractual rights for sale, they must first be offered to co-owners, joint owners, or occupiers. If no buyer is secured, the contract must be offered for sale by public advertisement. The following content is acceptable as a means of demonstrating a good faith effort to sell a contract for deed:

   Example 1: Offered at 75% of value.
   For Sale: Seller's interest in contract for deed. Secured by W ½ of Sec. 65-13-120. Remaining payments of $18,000 are due in annual installments on Nov. 1, 2006 through 2010. Will consider offers which exceed $13,500. Call 555-3333 or write Box 12, Tampa Gazette, Tampa, ND 58990.

   Example 2: Offered at 100% of value.
   For Sale: Seller's interest in contract for deed. Secured by W ½ of Sec. 65-13-120. Remaining payments of $18,000 are due in annual

installments on Nov. 1, 2006 through 2010. Call 555-3333 or write Box 12, Tampa Gazette, Tampa, ND 58990.

6. If an asset is sold in exchange for a contractual right to receive money payments, the principal payments received constitute a converted asset. (The interest portion of the payments is considered unearned income.)

22. 510-05-70-45-20, Annuities Purchased Before August 1, 2005. Incorporated Policy from IM 5227

Annuities Purchased Before August 1, 2005 510-05-70-45-20

1. Any payment received from the annuity is income, regardless whether the annuity itself is countable as an asset or is considered a disqualifying transfer.
2. An annuity in which a payment option was selected **before August 1, 2005** is counted as an available asset in the asset test unless:
   a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);
   b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or
   c. The annuity meets all of the following conditions:
      i. The annuity is irrevocable and cannot be assigned to another person;
      ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;
      iii. ~~The annuity provides for level monthly payments;~~ The annuity provides substantially equal ~~monthly~~ payments, no less frequently than annually, such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest
      iv. The annuity will return the full purchase price and interest within the purchaser's life expectancy; and
      ~~v. Unless specifically ordered otherwise by a court of competent jurisdiction acting to increase the amount of spousal support paid on behalf of a community spouse by an institutionalized~~

~~spouse or a home and community based services (HCBS) spouse, the monthly payments from the annuity do not exceed $2,931 effective January 2014 ($2,898 for 2013).~~

3. An annuity **purchased before August 1, 2005**, but for which the **payment option** is **selected** from **August 1 2005, through February 7, 2006,** is counted as an available asset unless the annuity is considered a disqualifying transfer and the penalty period is not finished, or the annuity is a qualified employee benefit that cannot be surrendered. State law considers any annuity in which a payment option is selected on or after August 1, 2005, as assignable unless it meets the requirements in 05-70-45-25(2)(c). To meet those requirements, the annuity would have to have been purchased on or after August 1, 2005.
4. The annuity is considered a disqualifying transfer unless:
    a. The payment option was selected prior to the individual's, or the individual's spouse's look back date;
    b. The annuity is a qualified employee benefit annuity;
    c. The annuity meets all of the requirements in (2)(c) above; or
    d. The annuity is a third party annuity.
5. The uncompensated value of an annuity that is considered a disqualifying transfer is an amount equal to the remaining payments due from the annuity (or the applicant or recipient can show the outstanding principal amounts due, if that information can be attained).
6. The date of the disqualifying transfer is the date the payment option was selected on the annuity, or if later, the date the annuity was changed so the annuity could no longer be surrendered.

23. 510-05-70-45-25, Annuities Purchased form August 1, 2005 Through February 7, 2006. Incorporated Policy from IM 5227 and added policy to require the completed and signed Annuity Beneficiary Designation document be received from the company verifying the Department has been named as the beneficiary before the application can be approved.

Annuities Purchased from August 1, 2005 Through February 7, 2006
510-05-70-45-25

1. Any payment received from an annuity is income, regardless whether the annuity itself is countable as an asset or is considered a disqualifying transfer.

2. The annuity is counted as an available asset in the asset test unless:
   a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);
   b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or
   c. The annuity meets all of the following conditions:
      i. The annuity is irrevocable and cannot be assigned to another person;
      ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;

iii. ~~The annuity provides for level monthly payments;~~ The annuity provides substantially equal ~~monthly~~ payments, no less frequently than annually, such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;

iv. The annuity will return the full principal and has a guaranteed period that is equal to at least 85% of the annuitant's life expectancy;

~~v. The monthly payments from all annuities that meet the requirements of this subsection do not exceed $2,931 effective January 2014 ($2,898 effective 2013 and, when combined with the annuitant's other income at the time of application for Medicaid, does not exceed $4,396 effective January 2014 ($4,347 effective 2013); and~~

vi. If the applicant for Medicaid is age 55 or older, the Department of Human Services is irrevocably named as the primary beneficiary of the annuity following the death of the applicant and the applicant's spouse, not to exceed the amount of benefits paid by Medicaid. If a minor child who resided and was supported financially by the applicant or spouse, or disabled child, survives the applicant and spouse, any payments from the annuity will be provided to those individuals.

Note: A copy of the completed and signed Annuity Beneficiary Designation document must be received from the

company verifying the Department has been named as the beneficiary before the application can be approved.

3. The annuity is considered a disqualifying transfer unless:
   a. The payment option was selected prior to the individual's, or the individual's spouse's look back date;
   b. The annuity is a qualified employee benefit annuity;
   c. The annuity meets all of the requirements in (2)(c) above; or
   d. The annuity is a third party annuity.
4. The uncompensated value of an annuity that is considered a disqualifying transfer is an amount equal to the remaining payments due from the annuity (or the applicant or recipient can show the outstanding principal amounts due, if that information can be attained).
5. The date of the disqualifying transfer is the date the payment option was selected on the annuity, or if later, the date the annuity was changed so the annuity could no longer be surrendered.

24. 510-05-70-45-30, Annuities Purchased or Changed on or After February 8, 2006. Incorporated Policy from IM 5227 and IM 5242 and added policy to require the completed and signed Annuity Beneficiary Designation document be received from the company verifying the Department has been named as the beneficiary before the application can be approved.

Annuities Purchased or Changed on or After February 8, 2006 510-05-70-45-30

1. Any payment received from the annuity is income, regardless whether the annuity itself is countable as an asset or is considered a disqualifying transfer.
2. An annuity is considered changed on or after February 8, 2006 if any action is taken on or after that date that changes the course of payments or the treatment of the income or principal of the annuity. These actions include additions of principal to the annuity, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, or similar actions.
3. The annuity is counted as an available asset in the asset test unless:

a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);
b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or
c. The annuity meets all of the following conditions:
   i. The annuity is irrevocable and cannot be assigned to another person;
   ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;
   iii. ~~The annuity provides for level monthly payments;~~ The annuity provides substantially equal ~~monthly~~ payments, no less frequently than annually, such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;
   iv. The annuity will return the full principal and interest within the annuitant's life expectancy and has a guaranteed period that is equal to at least 85% of the annuitant's life expectancy;
   v. ~~The monthly payments from all annuities that meet the requirements of this subsection do not exceed $2,931 effective January 2014 ($2,898 effective 2013) and, when combined with the annuitant's and the annuitant's spouses's other income at the time of application for Medicaid, does not exceed $4,396 effective January 2014 ($4,347 effective 2013); and~~
   ~~vi.~~ v. The Department of Human Services is irrevocably named as the primary beneficiary of the annuity following the death of the applicant and the applicant's community spouse, not to exceed the amount of benefits paid by Medicaid. If a minor child who resided and was supported financially by the applicant or spouse, or disabled child, survives the applicant and spouse, any payments from the annuity will be provided to those individuals.

Note: A copy of the completed and signed Annuity Beneficiary Designation document must be received from the company verifying the Department has been named as the beneficiary before the application can be approved. If

assistance is needed with the Tax ID number or having a state representative sign the document, please forward to Medicaid Policy Division to have this completed.

Example: Mr. White, who is in LTC, has an annuity that meets the criteria above and names Mrs. White, the community spouse, as the primary beneficiary and the Department as the secondary beneficiary. The annuity is excluded as an asset and is not considered a disqualifying transfer because Mrs. White is a community spouse.

Mrs. White also has an annuity that meets the criteria above and names Mr. White as the primary beneficiary and the Department as the secondary beneficiary. The annuity is not excluded as an asset. It may be considered a disqualifying transfer because Mr. White is not a community spouse. It is necessary to determine whether Mrs. White's annuity was purchased or changed within Mr. or Mrs. White's look back period. If it was, then her annuity is a disqualifying transfer equal to the annuity value. If the annuity was last changed prior to their look back periods, then it is not a disqualifying transfer.

4. The annuity is considered a disqualifying transfer unless:
   a. The payment option was selected, or the latest change to the annuity was made, prior to the individual's, or the individual's spouse's look back date;
   b. The annuity is a qualified employee benefit annuity, **and** the Department is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the annuitant or the annuitant's spouse. The Department may be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or child disposes of any such remainder for less than fair market value;
   c. The annuity:
      i. The annuity meets all of the requirements in (3)(c)(i) through (3)(c)(iii) above;
      ii. The annuity will return the full principal and interest within the annuitant's life expectancy; **and**
      iii. The Department is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of

the annuitant or the annuitant's spouse. The Department may be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or child disposes of any such remainder for less than fair market value; or

d. The annuity is a third party annuity.

5. The uncompensated value of an annuity that is considered a disqualifying transfer is an amount equal to the remaining payments due from the annuity (or the applicant or recipient can show the outstanding principal amounts due, if that information can be attained).
6. The date of the disqualifying transfer is the date the payment option was selected on the annuity, or if later, the date the annuity was changed so the annuity could no longer be surrendered.
7. When the Department is entitled to be the remainder beneficiary of an annuity purchased or changed on or after February 8, 2006, the "Notice to Insurer of Annuity" (SFN 1186) (05-100-96) must be sent to the company that issued the annuity. The notice must be sent and verification received back from the company, prior to approving ~~when~~ the Medicaid application ~~is approved~~, or if an ongoing case, when the annuity is reported.

25. 510-05-70-50 Trusts. Incorporated Policy from IM 5235 to include the form number and link to the Request for Trust Review form.

Trusts 510-05-70-50

1. A trust is an arrangement whereby a person known as the "grantor" or "trustor" gives assets to another person known as the "trustee" with instructions to use the assets for the benefit of a third person known as the "beneficiary". The positions of grantor, trustee, and beneficiary occur in all trusts, but it is not uncommon for a single trust to involve more than one grantor, trustee, or beneficiary. It is also not uncommon for a grantor to establish a trust in which the grantor is also a beneficiary or the trustee is also a beneficiary. The assets placed in trust are called the "principal" or "corpus".
2. A trust includes any legal instrument or device, whether or not written, which is similar to a trust. An unwritten trust may arise anytime someone gives property to another with instructions to use the property in a particular way, or anytime someone keeps for his own use property that

belongs to another. When this happens, the individual who owned the property is both the grantor and the beneficiary of an unwritten express or implied trust.

3. Trusts may, or may not, make income or assets available to an applicant or recipient. Also, when an applicant or recipient creates a trust, assets put into the trust may be a disqualifying transfer. A thorough review of each trust is necessary to determine its effect, if any, on eligibility. Send trusts to the Legal Advisory Unit for review. When trusts are submitted for review, include all appropriate information so the trust may be reviewed in a timely manner. When requesting a review of a trust document:
   a. Send the **complete** trust agreement (signed, dated, and notarized) and all pages and attachments;
   b. If the trust is unwritten, describe the circumstances that you believe created the trust in a letter;
   c. Provide verification of the value of each asset owned by the trust, when each asset was transferred to the trust, and who transferred the assets to the trust;
   d. Identify **who** is applying for **which** benefits (e.g. Medicaid nursing care, Medicaid no-nursing care, etc.);
   e. Provide any other documents or information you think may be relevant (like schedules, powers of attorney, financial statements, etc.); and
   f. Complete and include ~~the Trust Review Document~~ SFN 1947, "Request for Trust Review" available at http://www.nd.gov/eforms. ~~on the DHS County Intranet website under the "Medicaid-Healthy Steps/Hard Cards/Trust" folder.~~
4. Applicant as trustee.
   An applicant or recipient who is a trustee has the legal ownership of trust property and the legal powers to distribute income or trust assets which are described in the trust. However, those powers may be exercised only on behalf of trust beneficiaries. If the trustee or other members of the Medicaid unit are not also beneficiaries or grantors to whom trust income or assets are treated as available, trust assets are not available to the trustee.

Disqualifying Transfers 510-05-80

26. 510-05-80-05 Disqualifying Transfers - Definitions.

- Incorporated the amounts for the average daily and monthly cost of nursing facility care for 2015, 2016 and 2017 from IM 5231, IM 5270, IM 5271, IM 5290
- Incorporated policy from IM 5297 ending the policy relating to Confidential Relationship.

Disqualifying Transfers – Definitions 510-05-80-05

For purposes of this section:

1. Assets or income an individual disposes of means assets or income to which the individual is entitled, or would be entitled if action, or inaction, causes the individual to not receive the asset or income. Examples of actions which would cause assets or income not to be received are:
   a. Irrevocably waiving pension income;
   b. Waiving an inheritance; or
   c. Not accepting or accessing injury settlements.
2. Fair Market value means:
   a. In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and commodities, one hundred percent of apparent fair market value;
   b. In the case of real or personal property that is subject to reasonable dispute concerning its value~~:~~
      i. ~~If transferred in an arms-length transaction to someone not in a confidential relationship with the individual or anyone acting on the individual's behalf~~, 75% of estimated fair market value~~; or~~
      ii. ~~If transferred to someone in a confidential relationship with the individual or anyone acting on the individual's behalf, 100% of estimated fair market value;~~ and
   c. In the case of income, one hundred percent of apparent fair market value.

3. "Relative" means child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half-brother, half-sister, first cousin, or in-law.

~~4. "Someone in a confidential relationship" includes an applicant or recipient's power of attorney, guardian, conservator, legal custodian, caretaker,~~

~~trustee, attorney, accountant, or agent, and may include a relative or other person with a close and trusted relationship to the individual.~~

~~North Dakota state law provides that any transaction between an applicant or recipient and someone who has a confidential relationship with that individual in which the individual who has a confidential relationship gains any advantage over the applicant or recipient is presumed to be entered into without sufficient consideration and under undue influence.~~

~~Someone with a confidential relationship who can exercise control over an applicant's or recipient's income or assets has a duty to act in the highest good faith and not obtain any advantage over the applicant or recipient; to not use or deal with an applicant or recipient's property for their own profit; to refrain from transactions adverse to the applicant or recipient; and to refrain from using undue influence to obtain any advantage from the applicant or recipient.~~

~~Accordingly, transfers of an applicant or recipient's real or personal property made by an applicant or recipient to the person with the confidential relationship must be at 100% of estimated fair market value. Transfers for less than 100% of fair market value may be subject to the disqualifying transfer provisions.~~

~~Transfers of an applicant or recipient's property made by someone with a confidential relationship, for which 100% of fair market value was not received, are not considered to be transfers without adequate compensation when an applicant or recipient is not competent, or if competent, does not approve. In these situations the uncompensated value is considered to be available to the applicant or recipient because the person who made the transfer must account for and replace any amounts lost by the applicant or recipient. The individual may require return of the assets, which may include legal proceedings if necessary. There is no time limit that applies to these transfers (i.e. the disqualifying transfer look back date is not applicable).~~

- ~~**For example:** Ms. Smith has a power of attorney to act on behalf of her mother who is incompetent. She transfers property owned by her mother, and valued at $60,000, to herself and her two siblings. Medicaid will still consider $60,000 as available to Ms. Smith's mother as Ms. Smith did not act in the best interest of her mother. Ms.~~

~~Smith's mother has the legal ability to make the funds available, or to affect the return of the property.~~

~~The confidential relationship issue is closely tied to fair market value. When dealing with personal or real property, the fair market value of the property is an estimate of the property's value. "True" fair market value is established when such property sells for the highest amount possible. When selling such property to someone who has a confidential relationship with the seller, the property may not be sold for the highest amount possible, and therefore, the "true" fair market value is not established. The value of the property, for Medicaid purposes, is still an estimate. When selling such property to someone who does not have a confidential relationship with the seller, the property is more likely to~~ and must ~~be sold for the highest amount possible, which will establish "true" fair market value, and which may be more or less than the estimated fair market value~~.

~~5.~~ 3. "Uncompensated value" means the difference between fair market value as of the date of transfer and the value of any consideration received.

When the party that receives the transferred property also assumes any outstanding loan(s) on the property, the amount of the outstanding loan(s) is consideration received.

Example: Mr. Green owns property with an estimated value of $80,000. He has a mortgage for $50,000 on the property. If Mr. Green sells the property for $30,000 and the purchaser assumes the mortgage, Mr. Green is actually receiving $80,000 in compensation, and there is no disqualifying transfer. If the purchaser does not assume the mortgage, the uncompensated value is $50,000 (the difference between $30,000 and the estimated market value of $80,000).

~~6.~~ 4. "Community spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.

~~7.~~ 5. "Home and Community Based Services spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.

~~8.~~ 6. "Institutionalized spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.

~~9.~~ 7. The average cost of nursing facility care is:

Year	Daily Rate	Monthly Rate
2018	270.71	8234.10
July-Dec 2017	265.35	8071.06
Jan 2017	257.90	7844.46
2016	258.78	7871.23
2015	249.70	7595.04
2014	238.94	7268
July-Dec 2013	231.39	7038
Jan-2013	223.30	6792
2012	213.82	6504
2011	205.07	6238
2010	195.55	5948
2009	179.27	5453
2008	165.59	5037
2007	159.96	4865
2006	152.33	4633
2005	144.48	4395
2004	137.59	4185
2003	129.71	3945
2002	127.05	3864
July-Dec2001	120.08	3652
Jan-June 2001	109.98	3345
2000	104.94	3192
1999	97.68	2971
1998	94.31	2869
1997	89.00	2713
1996	85.00	2562
1995	80.00	2419
1994	74.00	2339

27. 510-05-80-25 Exceptions to Disqualifying Transfer. Incorporated Policy from IM 5225 and IM 5242.

Exceptions to Disqualifying Transfer 510-05-80-25

1. A transfer is not disqualifying to the extent the asset transferred was the individual's home or residence, and it was transferred to:
   a. The individual's spouse;
   b. The individual's son or daughter who is under age twenty-one, or blind, or disabled;
   c. The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual began receiving nursing care services; or
   d. The individual's son or daughter (other than a child described in subdivision b) who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services.
2. A transfer is not disqualifying to the extent that the asset transferred was any Medicaid excluded asset other than:
   a. The home or residence;
   b. Property which is not saleable without working an undue hardship;
   c. Excluded home replacement funds;
   d. Excluded payments, excluded interest earned on the payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;
   e. Life estate interests;
   f. Mineral acres;
   g. Inheritances, during the six months in which they are excluded; or
   h. Annuities.
   i. Retirement accounts identified at 510-05-70-30 (22).

      Note: This exception to the disqualifying transfer provision does not allow transfers of assets that are protected under the Long Term Care Partnership Program. If assets protected under the Long Term Care Partnership Program are transferred, the disqualifying transfer provisions in 05-80-10 apply.

3. A transfer is not disqualifying to the extent the income or assets were transferred:
   a. To the individual's spouse or to another for the sole benefit of the individual's spouse;
   b. From the individual's spouse to another for the sole benefit of the individual's spouse;
   c. To, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or
   d. To a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.

   An institutionalized spouse is allowed to transfer ownership of an excluded IRA to the community spouse without resulting in a Disqualifying Transfer. Once the Medicaid Unit makes application and prior to determination of eligibility, the IRA must be converted to an annuity, annuitized, and monthly income counted, if good cause does not exist. The amount of monthly income that must be counted may affect the client share as well as amount deemed to the community spouse.

   NOTE: An Individual Retirement Account (IRA) can only be owned by one person and cannot be jointly owned with a spouse. The owner cannot transfer their IRA to a spouse or another person except under two circumstances:

   1. In a divorce settlement; or
   2. Through an inheritance.

   Money can be withdrawn from the IRA which can be given to the spouse, but that involves transferring cash rather than the IRA itself.

4. A transfer is not disqualifying to the extent the individual makes a satisfactory showing that:
   a. The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;
   b. The income or assets were transferred exclusively for a purpose other than to qualify for Medicaid;
   c. The assets transferred by or on behalf of the individual, or individual's spouse, when added to the value of the individual's other countable assets would not exceed the asset limits of $3,000 for one person or $6,000 for two persons (including spousal impoverishment cases); or

d. All income or assets transferred for less than market value have been returned to the individual. If all of the income or assets of a particular transfer are returned at the time of application, and no periods of eligibility have been established for that transfer after the date of the original transfer, process the application as if the original transfer never occurred. If all of the income and assets of a particular transfer are returned after Medicaid eligibility has already been established (for a period after the date of the original transfer), the period of ineligibility for that transfer ends as of the date the income or assets are returned, but only if the returned assets do not cause the community spouse to have total countable assets in excess of the community spouse countable asset allowance allowed at the time the institutionalized or HCBS spouse became eligible. In establishing whether all of the income or assets have been returned, the income or assets transferred, or their equivalent value, must be returned.

   A partial return of the income or assets transferred does not end or shorten the period of the ineligibility. The returned income or assets may cause ineligibility for Medicaid, and in any case, can be used to cover the individual's medical needs for the remainder of the penalty period.

5. A transfer is not disqualifying to the extent that the asset was used to acquire an annuity if the annuity meets the requirements in annuity sections 05-70-45-20, 05-70-45-25, or 05-70-45-30.
6. A transfer to meet the burial needs of an individual is not disqualifying to the extent the asset transferred meets the burial exclusion and to the extent the asset is considered available to the individual.

Income 510-05-85

28. 510-05-85-05 Income Considerations. Incorporated Policy from IM 5242 and 5257

Income Considerations 510-05-85-05

1. 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 relative~~ anyone acting on behalf of an applicant or recipient; when the applicant, recipient, or ~~responsible relative~~ anyone acting on behalf of an applicant or recipient 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 relative~~ anyone acting on behalf of an applicant or recipient 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.

a. When both an institutionalized spouse and community spouse, or if only the community spouse has an excluded retirement account (as defined in #22 under section 510-05-70-30, Excluded Assets), an annuity, or other available income, all necessary steps to obtain the funds held in these accounts must be made regardless of which spouse owns the asset, unless "good cause" exists as defined under 510-05-35-90, Application for Other Benefits.

   Note: In these situations, requiring the community spouse to obtain the funds may reduce the amount of the institutionalized spouse's income that can be deemed to the community spouse.

b. If at application it is determined the ~~household~~ Medicaid Unit is required to obtain funds from a retirement account, annuity or any other source, eligibility can begin the month in which the individual started the process, provided the individual was not previously informed that they were required to obtain these funds AND submits verification of the date the process started.

   Example: An individual applies for Medicaid in June 2016 and immediately begins the process to annuitize their IRA. The process does not get completed until July 2015. The individual would be eligible for Medicaid in the month of June as long the individual was not previously informed that they were required to obtain these funds AND submits verification that the process started in June.

c. If an applicant requests coverage for the three prior months and the applicant or another ~~household~~ Medicaid Unit member has an excluded retirement account (as defined in #22 under section 510-05-70-30, Excluded Assets) eligibility can be determined for the three prior months as those retirement accounts are excluded assets. In addition, if the retirement account is not yet paying out any benefits, we would not consider any income for any of the three prior months. Any payments would be counted when they are actually received.

Example: An IRA was annuitized in June and will begin receiving monthly payments in July. The 1st month the payments would begin to be counted as income is July.

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 payment benefit 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.

2. The financial responsibility of any individual for any applicant or recipient of Medicaid will be limited to the responsibility of spouse for spouse and parents for children under age twenty-one. Such responsibility is imposed as a condition of eligibility for Medicaid. Except as otherwise provided in this section, the income of the spouse and parents is considered available even if that income is not actually contributed. Natural and adoptive parents, but not stepparents, are treated as parents (exceptions to counting a stepparent's income applies when the stepparent is the only eligible caretaker and is eligible for Medicaid because of the child, as described in 05-35-20(2) .
3. All spousal income is considered actually available unless:
   a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient;
   b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States; or
   c. The applicant or recipient is subject to marital separation, with or without court order, and there has been no collusion between the applicant or recipient and his or her spouse, to render the applicant or family member eligible for Medicaid.
4. All parental income is considered actually available to a child unless:
   a. The child is disabled and at least age eighteen;
   b. The child is living independently; or
   c. The child is living with a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing Medicaid benefits.
5. Monthly income is considered available when determining eligibility for 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 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 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 (WSI), Social Security Administration Benefits (SSA), and Supplemental Security Income (SSI) benefits. 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. These could be earned or unearned income by applying appropriate policy.

   Payments that are normally disregarded as income, such as SNAP or TANF benefits, disregarded Tribal payments (other than per capita payments from gaming revenues), Supplemental Security Income (SSI) and occasional small gifts, continue to be disregarded as income regardless of the form of payment (510-05-85-25 Post Eligibility Treatment of Income, 510-05-85-30 Disregarded Income – Medicaid, 510-07-40-30 Disregarded Income – Healthy Steps). Distributions to the beneficiary of a Special Needs Trust are NOT considered to be a 'cash or cash equivalent' distribution and are not income to the beneficiary. All other such payments are counted as income.

29. 510-05-85-35 Income Deductions. Updated the Medically Needy

Income Level in the example under #5 based on the latest income level updates identified in IM 5296.

Income Deductions 510-05-85-35

This section applies to individuals residing in their own home or in a specialized facility, to the Medicare Savings Programs, and to the Workers with Disabilities and Children with Disabilities coverages. For individuals receiving psychiatric or nursing care services in a nursing facility, the state hospital, ~~the Anne Carlsen facility~~, the Prairie at St. John's center, ~~the Stadter Psychiatric Center~~Red River Behavioral Health System, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing-bed care in a hospital, refer to the Post Eligibility Treatment of Income, Section 05-85-25**.**

The following income deductions are allowed in determining Medicaid eligibility:

1. Except in determining eligibility for the Medicare Savings Programs, the cost of premiums for health insurance may be deducted from income in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage. The Workers with Disabilities coverage enrollment fee and premium as well as the Children with Disabilities coverage premium are allowed deductions except the Workers with Disabilities premium is not allowed when determining eligibility for the Workers with Disabilities coverage and the Children with Disabilities premium is not allowed when determining eligibility for the Children with Disabilities coverage. For purposes of this deduction, premiums for health insurance include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:
   a. Limited to disability or income protection coverage;
   b. Automobile medical payment coverage;
   c. Supplemental to automobile liability insurance;
   d. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or
   e. Credit accident and health insurance.
   (If questionable, contact the Third party Liability unit for assistance in determining whether a policy fits into one of the above categories.)

2. Except in determining eligibility for the Medicare Savings Programs, medical expenses for necessary medical or remedial care claimed for deduction must be documented in a manner which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider. A medical expense may be deducted only if it is:
   a. Incurred:
      i. By a member of a Medicaid unit in the month for which eligibility is being determined; or
      ii. By a member of the Medicaid unit (or a spouse or child they were legally responsible for) in a prior month, but was actually paid in the month for which eligibility is being determined, and was not a previous month's client share (recipient liability), or was not previously allowed as a deduction or offset of client share;
   b. Provided by a medical practitioner licensed to furnish the care;
   c. Not subject to payment by any third party, including Medicaid and Medicare;
   d. Not incurred for nursing facility services, swing bed services, or HCBS during a period of ineligibility because of a disqualifying transfer; and
   e. Claimed.

   Examples of expenses that cannot be used to reduce countable income and affect client share:
      i. Extra amounts paid on glasses, such as more expensive frames, tint, etc.;
      ii. Expenses that are considered medically necessary, but are applied to client share;
      iii. Costs for Lifeline;
      iv. Over the counter medications and supplies that Medicaid does not pay for, even if prescribed*;
      v. Other medications and services that Medicaid does not pay for, such as DESI drugs, such as Midrin (for Migraines), Tigan (for nausea). (DESI drugs -- Drug Efficacy Study Implementation --are determined by the federal government to be safe but less than effective);
      vi. Expenses from visiting a provider who is not the individual's Coordinated Services Program (CSP) "lock-in" provider;
      vii. Drugs from Canada prescribed by someone other than a United States physician;
      viii. Transportation costs for out of state medical care provided to recipients that have not been prior approved;

ix. Up to 15 bed-hold days in a long term care facility that neither Medicare nor Medicaid will cover; or

x. Any amount of an expense for which the ~~household~~ Medicaid Unit will be reimbursed, to the extent of the reimbursement.

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

i. Medications and services Medicaid does not pay for only because the provider is not enrolled;

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. (http://nddrug.rxexplorer.com/ND Dept. of Human Services is a website that workers may use to inquire whether ND Medicaid covers a specified drug.);

iii. Other over-the-counter supplies that Medicaid covers, such as diabetic supplies;

iv. ~~Nicoderm~~ Nicotine patches;

v. Drugs from Canada when prescribed by a US physician;

vi. Co-pays; or

vii. Transportation costs:

(a) Lodging up to the limit. Hotels can bill the difference to the client if they stay at a hotel that charges more. (As with meals, we pay per diem and client can eat where they want.)

(b) Allow the difference to reduce client share if reasonable. (If they choose to stay in a penthouse suite when other less costly rooms are available, not reasonable.)

(c) Transportation costs are not paid or allowed as a deduction if the medical services are available locally but client travels elsewhere, even if referred by a physician. The provider must be within the nearest service area, client has choice of providers.

3. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.

4. Except in determining eligibility for the Medicare Savings programs, the cost of premiums for long term care insurance carried by an individual or the individual's spouse may be deducted from income in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage.
5. Except in determining eligibility for the Medicare Savings Programs, the cost of remedial care for an individual residing in a specialized facility is limited to the difference between the recipient's cost of care at the facility (e.g. remedial rate in a basic care facility) and the regular medically needy income level may be deducted.

Example:

Recipient's remedial rate at the facility	$980
Less the medically needy income level for one	**- ~~754~~** **- 834**
Remedial Care Deduction	$~~226~~ $146

6. Except in determining eligibility under the Medicare Savings Programs, transportation expense may be deducted if necessary to secure medical care provided for a member of the Medicaid unit. Transportation expenses are not allowed for recipients in a facility that provides nursing care services, or to the extent the transportation cost is paid by any third party. The amount to allow cannot exceed http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/fee-schedules/2016-non-emergency-transportation-fee-schedule.pdf
7. Non-voluntary child and spousal support payments (including surcharges and arrearages) may be deducted if actually paid by a member of the Medicaid unit. If the support payment is withheld from an extra check that is disregarded, the support payment withheld from that check is not allowed as a deduction.
8. Reasonable child care expenses, not otherwise reimbursed, that the Medicaid unit is responsible to pay, may be deducted if necessary to engage in employment or training. Reasonable child care expenses do not include payments to parents to care for their own children. The child must be a member of the Medicaid unit for the deduction to be allowed. This expense may only be allowed as a deduction from the income of the child or those individuals who are responsible for the child, such as a parent or caretaker.

9. Reasonable adult dependent care expenses may be deducted. These are costs for care of an incapacitated or disabled adult who is living in the home so a caretaker or a spouse can work or attend training. The incapacitated or disabled adult must be a member of the Medicaid unit for the deduction to be allowed.
10. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available. This deduction is not allowed if any third party, including TANF, pays the cost.
11. A disregard of $20 per month is deducted from any income, except income which is based on need, such as SSI, and need-based veterans' pensions. This deduction applies to all aged, blind and disabled applicants or recipients provided that:
    a. When more than one aged, blind, or disabled persons live together, no more than one $20 disregard may be deducted;
    b. When both earned and unearned income is available, apply the $20 disregard to the unearned income; and
    c. When only earned income is available, the $20 disregard must be applied before the deduction of sixty-five dollars plus one-half of the remaining monthly gross income.
12. A deduction may be made for the cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.
13. With respect to each individual in the Medicaid unit who is employed or in training, but who is not aged, blind, or disabled, thirty dollars may be deducted as a work or training allowance, but only if the individual's income is counted in the eligibility determination.
14. The deductions described in this subsection may be allowed only on earned income.
    a. For all individuals, except for aged, blind, or disabled applicants or recipients:
        i. Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
        ii. Mandatory retirement plan deductions;
        iii. Union dues actually paid; and
        iv. Expenses of a non-disabled blind person, reasonably attributable to earning income. (This provision applies to individuals who are eligible for Medicaid under the children and family category.)

b. For all aged, blind, or disabled applicants or recipients, sixty-five dollars plus one-half of the remaining monthly gross earned income; provided that, when more than one aged, blind, or disabled person lives together, no more than sixty-five dollars, plus one-half of the remaining combined earned income, may be deducted.

30. 510-05-85-40 Income Levels.

- Incorporated the increase in the Spousal Impoverishment Additional Members income level effective July 1, 2017.
- Incorporated in increase in the Poverty Levels effective April 1, 2017 from IM 5292.
- IM 5289 confirms the Community Spouse Income Level did not change for 2017.
- Information in IM 5238, IM 5256, IM 5265, IM 5272, and IM 5279 are for previous years and will not be incorporated into the manual, but have been moved to the 'Archived IM Roster' section of the Manual for reference.

Income Levels 510-05-85-40

Levels of income for maintenance must be used as a basis for establishing financial eligibility for Medicaid. The Medicaid income levels represent the amount of income reserved to meet the maintenance needs of an individual or family. The income levels applicable to individuals and units are:

1. Categorically needy
   a. Categorically needy aged, blind, and disabled recipients. Except for individuals subject to the nursing care income level, the income level which establishes SSI eligibility.

2. Medically needy
   a. Medically needy income levels are applied when a Medicaid individual or unit resides in their own home or in a specialized facility, and when a Medicaid individual has been screened as requiring nursing care, but elects to receive HCBS. The income level is equal to eighty-three percent of the poverty level applicable to a ~~family~~ Medicaid Unit of the size involved. The ~~family~~ Medicaid Unit size is increased for each unborn

when determining the appropriate ~~family~~ Medicaid Unit size.

Number of Persons	Monthly Income Level
1	~~$807~~ $834
2	~~1088~~ 1123
3	~~1369~~ 1412
4	~~1650~~ 1701
5	~~1930~~ 1990
6	~~2211~~ 2279
7	~~2492~~ 2568
8	~~2773~~ 2857
9	~~3054~~ 3147
10	~~3335~~ 3436
Effective April 1, ~~2014~~ 2017	

For each person in the medically needy unit above ten, add~~$281~~ $289 to the monthly amount.

b. Nursing care income level. The nursing care income level is sixty-five dollars per month and must be applied to residents receiving psychiatric or nursing care services in nursing facilities, the state hospital, the Prairie at Saint John's ~~Center~~, ~~the Stadter Center~~ Red River Behavioral Health System, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital.

c. ICF-ID income level. The income level for a resident of an Intermediate Care Facility for the intellectually disabled (ICF-ID)~~, including the Anne Carlsen facility,~~ is $100 effective October 1, 2010.

d. Community spouse income level. The income level for a community spouse who is eligible for Medicaid is subject to the categorically needy, medically needy, or poverty level income levels. The level for an ineligible community spouse is ~~$2267~~ $2550, or a higher amount if ordered by a court or hearing officer.

e. Family member income level. The income level for each ineligible family member in a spousal impoverishment case is ~~$655~~ $677 effective July ~~2014~~ 2017 (~~$646~~ $668 effective July ~~2013~~ 2016).

3. Poverty income levels.

a. Qualified Medicare Beneficiaries and Children age six to nineteen. Effective with new applicants and reviews for benefits starting January 1, 2014, children will not be covered under this income level. Those approved whose benefits started prior to January 2014 are subject to this income level until their next review. The income level is equal to one hundred percent of the poverty level applicable to a ~~family~~ Mediciad Unit of the size involved.

For Qualified Medicare Beneficiaries these levels apply regardless of living arrangements (i.e., in home or in a nursing facility...).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for QMBs for January, February, and March. This disregard prevents QMBs from becoming ineligible pending issuance of the new poverty levels which are effective April 1 of each year.

For individuals and families with children age six to nineteen, the ~~family~~ Medicaid Unit size is increased for each unborn when determining the appropriate ~~family~~ Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$ ~~973~~ 1005
2	~~1311~~ 1353
3	~~1649~~ 1701
4	~~1988~~ 2050
5	~~2326~~ 2398
6	~~2664~~ 2746
7	~~3003~~ 3095
8	~~3341~~ 3443
9	~~3679~~ 3791
10	~~4018~~ 4140
Effective April 1, ~~2014~~ 2017	

For each person in the Medicaid unit above ten, add $~~338~~ 348 to the monthly amount.

b. Specified Low-Income Medicare Beneficiaries. The income level is equal to one hundred twenty percent of the poverty level applicable to a ~~family~~ Medicaid Unit of the size involved. This is the maximum income level for SLMBs. Applicants or recipients who have income at or below one hundred percent of the poverty level are not eligible as a SLMB, but must be a QMB. These income levels apply regardless of living arrangements (i.e., in home or in a nursing facility).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for SLMBs for January, February, and March. This disregard prevents SLMBs from becoming ineligible pending issuance of the new poverty levels which are effective April 1 of each year.

Number of Persons	Monthly Income Level
1	$~~1149~~ 1206
2	$~~1551~~ 1624
3	$~~1953~~ 2042
4	$~~2355~~ 2460
5	$~~2757~~ 2878
6	$~~3159~~ 3296
7	$~~3561~~ 3714
8	$~~3963~~ 4132
9	$~~4365~~ 4550
10	$~~4767~~ 4968
Effective April 1, ~~2013~~ 2017	

For each person in the Medicaid unit above ten, add $~~402~~ 418 to the monthly amount.

d. Qualifying Individuals. The income level is equal to 135% of the poverty level applicable to a ~~family~~ Medicaid Unit of the size involved. This is the maximum income level for QIs. Applicants or recipients who have income at or below 120% of the poverty level are not eligible as a QI, but may

be eligible as a SLMB or QMB. These income levels apply regardless of living arrangements (i.e., in home or in a nursing facility).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for QIs for January, February, and March. This disregard prevents QIs from becoming ineligible pending issuance of the new poverty levels, which are effective April 1 of each year.

Number of Persons	Monthly Income Level
1	$~~1313~~ 1356
2	~~1770~~ 1827
3	~~2226~~ 2297
4	~~2683~~ 2767
5	~~3140~~ 3237
6	~~3597~~ 3708
7	~~4053~~ 4178
8	~~4510~~ 4648
9	~~4967~~ 5118
10	~~5424~~ 5589
Effective April 1, ~~2014~~ 2017	

For each person in the Medicaid unit above ten, add $~~457~~ 470 to the monthly amount.

f. Workers with Disabilities. The income level is equal to two hundred and twenty-five percent of the poverty level applicable to a ~~family~~ Medicaid Unit of the size involved.

Number of Persons	Monthly Income Level
1	$~~2188~~ 2261
2	~~2949~~ 3045

3	~~3711~~ 3828
4	~~4472~~ 4612
5	~~5233~~ 5396
6	~~5994~~ 6180
7	~~6756~~ 6963
8	~~7517~~ 7747
9	~~8278~~ 8531
10	~~9039~~ 9315
Effective April 1, ~~2014~~ 2017	

For each person in the Medicaid unit above ten, add $~~761~~ 783 to the monthly amount.

g. Children with Disabilities. The income level is equal to two hundred percent of the poverty level applicable to ~~a family of the size~~ the Medicaid Unit size involved.

Number of Persons	Monthly Income Level
1	$~~1945~~ 2010
2	~~2622~~ 2706
3	~~3298~~ 3403
4	~~3975~~ 4100
5	~~4652~~ 4796
6	~~5328~~ 5493
7	~~6005~~ 6190
8	~~6682~~ 6886
9	~~7358~~ 7583
10	~~8035~~ 8280
Effective April 1, ~~2014~~ 2017	

For each person in the Medicaid unit above ten, add $~~677~~ 696 to the monthly amount.

31. 510-05-85-45 Determining the Appropriate Income Level in Special Circumstances. Incorporated a reference to refer to the Medicaid Living Arrangement Reference Hard Card in the Appendix at 510-03-105-10 from IM 5295

Determining the Appropriate Income Level in Special Circumstances 510-05-85-45

This section applies to individuals who are subject to the Non-ACA Medicaid policies.

1. A child who is away at school is not treated as living independently, but is allowed the appropriate income level for one during all full calendar months. This is in addition to the income level applicable for the ~~family~~ Medicaid Unit ~~unit~~ remaining at home.
2. A child who is living outside of the parental home, but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level during all full calendar months during which the child or spouse lives outside the home.

   This does not apply to situations where an individual simply decides to live separately.
3. During a month in which an individual enters a specialized facility, or leaves one to return home, the individual will be included in the ~~family unit~~ Medicaid Unit in the home for the purpose of determining the ~~family size~~ Medicaid Unit and the appropriate income level. Individuals in a specialized facility will be allowed the medically needy income level for one during all full calendar months in which the individual resides in the facility. In determining eligibility for Workers with Disabilities and Children with Disabilities coverages, individuals in a nursing facility, or in receipt of HCBS, will be allowed the appropriate Workers with Disabilities or Children with Disabilities income level for one during all full calendar months in which the individual resides in the facility.
4. During a month in which an individual with eligible family members in the home enters or leaves a Psychiatric Residential Treatment Facility (PRTF); an Intermediate Care Facility for the intellectually disabled (ICF-ID), or a nursing facility to return home, or elects to receive HCBS or terminates that

election, the individual will be included in the ~~family unit~~ Medicaid Unit in the home for the purpose of determining the ~~family size~~ Medicaid Unit and the appropriate medically needy income level. Individuals in a Psychiatric Residential Treatment Facility (PRTF), an Intermediate Care Facility for the intellectually disabled (ICF-ID), or a nursing facility will be allowed the appropriate nursing care or Intermediate Care Facility for the intellectually disabled (ICF-ID) income level to meet their maintenance needs during all full calendar months in which the individual resides in the facility and is screened as needing that level of care. Recipients of HCBS will be allowed the medically needy income level for one during all full calendar months in which the individual receives HCBS. In determining eligibility for Workers with Disabilities and Children with Disabilities coverages, individuals in a nursing facility, or in receipt of HCBS, will be allowed the appropriate Workers with Disabilities or Children with Disabilities level for one during all full calendar months in which the individual resides in the facility.

5. For an institutionalized spouse with an ineligible community spouse the sixty-five dollar income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse, and any other family members, remaining in the home must be given the community spouse and family member income levels.
6. For a spouse electing to receive HCBS who has an ineligible community spouse, the medically needy income level for one is effective in the month the HCBS services begin, during full calendar months, and in the month the HCBS are terminated. The ineligible community spouse, and any other family members, remaining in the home must be given the community spouse and family member income levels.
7. An individual with no spouse, disabled adult child, or child under age twenty-one at home who enters a nursing facility may receive the medically needy income level for one if a physician certifies that the individual is likely to return to the individual's home within six months. The six-month period begins with the first full calendar month the individual is in the nursing facility. If, at any time during the six-month period, the individual's status changes and the stay in the nursing facility is expected to exceed the six months, the individual is only allowed the $65 nursing care income level beginning in the month following the month of the status change.

   For a married couple, budget one spouse at the medically needy income level and the other as permanent long term care when:

   a. Both spouses are admitted to a nursing facility for temporary stays, or

b. One spouse is permanently in a nursing facility and the other spouse requires temporary nursing care level services.

Only one six-month period is allowed per period of institutionalization. If an individual is discharged, then readmitted to the nursing facility, there must be a break of at least one full calendar month between the periods of institutionalization in order for the new stay to be considered a new period of institutionalization.

8. An individual who is residing in a Psychiatric Residential Treatment Facility (PRTF) or a nursing facility but who is not certified or screened as needing that level of care is allowed the medically needy income level. If the individual appeals the certification or screening and wins, the nursing care income level applies to all full calendar months the appeal covers.
9. An individual's living arrangement or income level does not change when the individual enters a hospital for a temporary stay unless the individual receives nursing care/swing bed services in the hospital.

Refer to the Medicaid Living Arrangement Reference Hard Card in the ACA Manual Appendix at 510-03-105-10 for examples of the various living arrangement types.

32. 510-05-90-25 Budget Procedures for Pregnant Women. Incorporated Policy from IM 5306 indicating self-attestation can be accepted for pregnancy even if the individual is pregnant with multiple fetuses.

~~**Budgeting Procedures for Pregnant Women 510-05-90-25**~~

~~**For Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014:**~~

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

When a pregnant woman, ~~whose pregnancy has been medically confirmed~~, becomes eligible for Medicaid, she continues eligible, without regard to any increase in income of the Medicaid unit, 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). Likewise, a pregnant woman can move from one coverage type to another (e.g. from Family Coverage to poverty level); however, if poverty level eligible and income increases, the pregnant woman remains poverty level eligible. All other Medicaid eligibility factors continue to apply.

~~Pregnancy is medically confirmed if the woman confirms that she has been determined to be pregnant by medical personnel, a public health agency, or a home pregnancy test.~~ Pregnancy must be medically confirmed ~~for all eligibility determinations made during pregnancy~~ only if questionable. ~~,however,f~~ For determinations made after the birth of the baby, the child's birth certificate may be used as verification of pregnancy.

~~**For Applications and Reviews Received on or After October 1, 2013 for benefits beginning January 1, 2014:**~~

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

~~When a pregnant woman under becomes eligible for Medicaid, she continues eligible, without regard to any increase in income of the Medicaid unit, 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. After January 1, 2014, only pregnant women under 19 will have a client share (recipient liability).~~

~~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 certificate may be used as verification of pregnancy.~~

33. 510-05-90-55 Budget Procedures for Medically Needy and Poverty Level. Incorporated Policy from IM 5295.

Budget Procedures for Medically Needy and Poverty Level 510-05-90-55

1. Individuals and Families living in their own home: All income of the individuals in the Medicaid unit is considered in determining Medicaid income eligibility. The appropriate medically needy or poverty level income level is used based on ~~household~~ Medicaid Unit size.

   A budget worksheet for the medically needy and poverty level can be found at 05-100-90.
2. Recipients screened for and receiving services in a nursing facility, the state hospital, the Prairie at Saint John's ~~Center~~, ~~the Stadter Center~~ Red River Behavioral Health System, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: The recipient is allowed the $65 nursing care income level. Individuals age 65 and over who have entered an IMD do not require a screening. Those admitted for a temporary stay keep the same living arrangement they had prior to being admitted to the IMD and remain at the same income level for that living arrangement. Those admitted for an indefinite stay are allowed the $65 nursing care level for one.

   Recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID) ~~(including the Anne Carlsen facility)~~: The recipient is allowed the $100 ICF-ID income level.

   For a single individual under age 21, or if blind or disabled under age 18, parental income is not considered available during any full calendar month the recipient is in the facility. Likewise, for a married recipient, income of the spouse is not considered available during any full calendar month, or when the community spouse is ineligible for Medicaid (spousal impoverishment case), during any full or partial month.

   If the individual has no source of income, and is ineligible for SSI, the income of the spouse or parents may be deemed in the amount of $65 (or $100 if the individual is in an ICF-ID) to meet the maintenance needs of the individual.

Individuals between the ages of 21 and 65 are not eligible for Medicaid in the state hospital.

3. Recipients living in a specialized facility: The recipient is allowed the medically needy income level for one. The members of the Medicaid unit remaining in the home are allowed the appropriate income level.

   If the individual is under age 21, or if blind or disabled under age 18, and enters the specialized facility from a public institution or the parental home, consider the income of the individual and parents.

   If the individual is married, the income of the individual and of the spouse must be considered. If the Medicaid unit in the home is not receiving Medicaid, 75% of the excess income shall be disregarded in determining client share (recipient liability).

   If the individual in the specialized facility is eligible for SSI, do not deem income from the Medicaid unit at home to the individual because the maintenance needs are considered to be met.

   If the individual in the specialized facility is not eligible for SSI and has no source of income or insufficient income, the family at home may deem income to the individual up to the medically needy income level for one. Remedial services provided in a specialized facility cannot be paid through Medicaid, but can be allowed as a deduction. Remedial services are determined by subtracting the medically needy income level for one from the recipient's remedial cost of care at the specialized facility. The resulting amount is deducted from the individual's income to determine client share. If the actual remedial expense is less than the calculated amount, use the actual amount.

4. Recipients electing to receive HCBS: The recipient is allowed the medically needy income level for one. A Medicaid unit with a HCBS individual, who has no income or inadequate income, can deem income to that individual, to the medically needy income level for one.

   Income of a parent or eligible spouse is not considered available in determining an individual's eligibility during any full calendar month in which HCBS are received. For a married recipient whose community spouse

is ineligible for Medicaid, the income of the spouse is not considered available during any full or partial month.

The recipient must be screened for and receiving HCBS.