Typo Correction Needed

Bismarck, North Dakota MANUAL LETTER #3406 Date July 1, 2014

Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to the renamed Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid. This Manual Letter removes all policies for ACA (Affordable Care Act) Medicaid as a new Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid, has been created to include that policy.

Note: New language is underlined and removed language has been struck through.

This Manual Letter incorporates changes made with the following IM's:

- IM 5189 -"Average Cost of Long Term Care"
- IM 5193 - "2014 – Home Equity Limit"
- IM 5194 – "2014 – Medicare Savings Program Asset Limits"
- IM 5195 – "2014 – Spousal Impoverishment Asset Levels"
- IM 5198 - "Average Cost of Long Term Care – 2014;
- IM 5201 - "Annuity Income Changes"
- IM 5200 - "2014 Income Levels".
- IM 5206 – "Changes Affecting Aged, Blind, Disabled Cases"

Par. 2. **Medicaid Policy prior to January 1, 2014 – can be found in the Archived Sections of Manual Chapter 510-05.**

Par. 3. **Effective Date** -- This manual letter is effective for the benefit month of **July 2014 except as indicated.**

Definitions 510-05-05

1. 510-05-05 – Definitions:
   - Added a definition for ACA, ACA Individual, Non-ACA Individual, Non-ACA Medicaid
   - Removed definitions relating to ACA Medicaid from this section as they are being added to new ACA Medicaid Service Chapter 510-03.
   - Added a new Definition for Attorney in Fact.

Typo Correction Needed

Definitions 510-05-05

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

ACA Individual
An individual required to be budgeted using ACA MAGI-based methodologies as defined in Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid. ~~This~~ Individuals include: ~~s:the Adult Expansion Group, Parents, Caretaker Relatives, and their Spouses, Children, and Pregnant Women.~~

1. Parents and Caretakers of deprived children and their spouses

2. Parents and Caretaker Relatives of deprived children and their spouses who were eligible under the Parents and Caretaker Relatives and their spouses group in at least three of the six months immediately preceding the month in which the Parents or Caretakers lose coverage under the Parents and Caretaker Relatives and their spouses group due to increased earned income or hours of employment, and their dependent children for up to 12 months (Transitional);

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

4. Pregnant Women

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

6. Children born to pregnant women who applied for and were found eligible for Medicaid on or before the day of the child's birth, for one year,

beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls;

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

8. Single adults ages 19 through 64 not eligible for Medicare (Adult Expansion group)
   Note: This may include SSI recipients who fail eligibility under Non-ACA Medicaid, other disabled individuals who fail the Medicaid asset limits and individuals who are disabled with a large client share.

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

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

~~Adjusted Gross Income~~
~~The amount at the bottom line of the front page of IRS Form 1040. This is also a line on the 1040A~~

~~Advance payments of the Premium Tax Credit (APTC)~~
~~Individuals who are not eligible for Medicaid or Healthy Steps under the Affordable Care Act may be eligible for tax credits for the health care insurance premiums they pay out of pocket.~~

~~Adult Expansion Group~~
~~Individuals age 19 through 64 and who are not eligible for Medicaid under other categories. As of 01-01-2014, North Dakota Medicaid is expanded to cover these individuals. These individuals will be covered under an Alternative Benefit Plan.~~

~~Affordable Care Act (ACA)~~
~~The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, as amended by the Three Percent Withholding Repeal and Job Creation Act. Also known as Healthcare Reform.~~

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

~~Essential Health Benefits~~
~~A set of health care service categories that must be covered by certain plans, starting in 2014. Essential health benefits must include items and services within at least 10 specified categories. Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace and all Medicaid state plans must cover these services.~~

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

Attorney in Fact
An agent authorized to act on behalf of another person, but not necessarily authorized to practice law, e.g. a person authorized to act by a power of attorney. An attorney in fact is a fiduciary.

Living independently
In reference to a single individual ~~under the age of twenty-one, or if~~ who is blind or disabled and under age eighteen, a status which arises in any of the following circumstances:

1. The individual has served a tour of active duty with the armed services of the United States and lives separately and apart from the parent.

2. The individual has married, even though that marriage may have ended through divorce or separation. A marriage ended by legal annulment is treated as if the marriage never occurred.

3. The individual has lived separately and apart from both parents for at least three consecutive full calendar months after the date the individual left the parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. Periods in which a child is included in the parent's Medicaid unit are deemed to be periods in which the parents are providing support. Providing health insurance coverage or paying court ordered child support payments for a child is not considered to be providing support or assistance. For purposes of this paragraph, periods when the individual is attending an educational or training facility, receiving care in a specialized facility, or is an institutionalized person are deemed to be periods when the individual was living with a parent, unless the individual had already established that the individual was living independently.

4. The individual has left foster care and established a living arrangement separate and apart from either parent and received no support or assistance from either parent. Providing health insurance coverage or paying court ordered child support payments for a child is not considered to be providing support or assistance.

5. The individual lives separately and apart from both parents due to incest, continues to live separately and apart from both parents, and receives no support or assistance from either parent while living separately and apart. Providing health insurance coverage for a child is not considered to be providing support or assistance.

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

~~Medically Frail~~
~~Under the Affordable Care Act, anyone claiming to be disabled must be considered to be medically frail and provided coverage similar to that in the Medicaid state plan if covered through the adult expansion group.~~

Typo Correction Needed

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

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

No Wrong Door
The federal mandate that allows individuals to apply for Medicaid through any means, may be through the Federal Facilitated Marketplace, the State eligibility portal, by telephone, through the OASYS application, by FAX or in-person.

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

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

2. Individuals eligible for:
    a. HCBS or Waivered Services
    b. Workers with Disabilities
    c. Children with Disabilities

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

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

5. Individuals who request eligibility under Spousal Impoverishment,

6. SSI individuals who pass the Medicaid asset test,

7. Individuals who are eligible under the Women's Way Program.
   Note: These individual must first be tested and fail the ACA and Non-ACA Medicaid methodologies.

8. Individuals who are eligible under Refugee Medical Assistance.

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

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

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

Non-ACA Medicaid
The Medicaid policies and procedures used to determine eligibility for individuals whose eligibility cannot be determined based on methodologies of the Affordable Care Act (ACA).

~~Non-filer~~
~~An individual who neither files an income tax return nor is claimed as a dependent by another tax filer unless:~~
- ~~They are claimed as a tax dependent by someone other than a spouse, or natural, adoptive or stepparent;~~
- ~~They are a child under age 19 living with both parents but the parents do not file a joint return; or~~
- ~~A child under age 19 who expects to be claimed by a non-custodial parent.~~

~~Non-MAGI Household~~
~~Households required to be budgeted using original Medicaid methodologies. Such households include aged individuals, disabled individuals qualifying as disabled under original Medicaid requirements, MEDICARE recipients who choose to be treated as disabled, individuals who request or are eligible for coverage under the Medicare Savings Programs, SSI individuals who pass the Medicaid asset test, Title IV-E sub-adopt, foster care and kinship guardianship children.~~

~~Individuals who are required to be budgeted using original Medicaid methodologies as defined in Service Chapter 510-05, Non-MAGI Medicaid. Such Individuals include:~~

~~12. Aged and disabled individuals who choose to be treated as aged or disabled, including individuals eligible for Workers with Disabilities and Children with Disabilities~~
~~13. Disabled Individuals qualifying as disabled under original Medicaid requirements,~~
~~a. Individuals receiving HCBS or Waivered Services~~
~~b. Workers with Disabilities~~
~~c. Children with Disabilities~~
~~14. MEDICARE recipients who choose to be treated as aged or disabled,~~

~~15. Individuals who request or are eligible for coverage under the Medicare Savings Programs,~~

~~16. Individuals who request eligibility under Spousal Impoverishment,~~

~~17. SSI individuals who pass the Medicaid asset test,~~

~~18. Individuals who are eligible under the Women's Way Program.~~
~~**Note:** These individual must first be tested and fail the Affordable Care Act and Aged, Blind and Disabled Medicaid methodologies.~~

~~19. Individuals who are eligible under Title IV-E and Non IV-E Subsidized Adoption Program~~

~~20. Individuals who are eligible under Title IV-E foster care,~~

~~21. Individuals who are eligible under Title IV-E Kinship Guardianship Program.~~

~~Qualified Health Plan~~
~~An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments and out-of-pocket maximums) and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.~~

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

Application and Decision 510-05-25

2. 510-05-25-05 – Application and Review – Removing all information regarding reviews for ACA Medicaid from this section as they are being added to new ACA Medicaid Service Chapter 510-03.

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:

      ~~For adults, families with children and pregnant women (MAGI households):~~
      ~~i. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application;~~
      ~~ii. The single streamlined application as submitted through the North Dakota client portal;~~
      ~~iii. The SFN 1909 paper "Application for Health Coverage and Help Paying Costs";~~
      ~~iv. Telephonic applications;~~
      ~~v. SFN 405, "Application for Assistance"; or~~
      ~~vi. The Department's online "Application for Assistance".~~

      For ~~aged and disabled individuals; Medicare Savings Programs, Foster Care, Subsidized Adoption~~ Non-ACA Medicaid households:
         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 system generated "Statement of Facts" (this may no longer be accepted as a Medicaid application after 12-31-13);~~
vi. The Department's online "Application for Economic Assistance Programs";
vii. The Low Income Subsidy file from SSA;
viii. 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);
ix. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or
x. 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, 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.
   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~~ ACA Medicaid reviews.

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.

~~When a MAGI household is requested to provide information or a review form and loses eligibility for failure to provide a renewal form or required information, **if the renewal form is submitted within 90 days after the termination, eligibility must be reconsidered back to the termination date**.~~

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

Ex Parte review.
~~Passive Reviews: For MAGI households only, the county agency must make a review of eligibility without requiring information from the~~

~~MAGI individual or MAGI household if able to do so based on reliable information available in the individual's account or other more current information available such as through any available data bases. In these cases, the individual/household must be notified of the eligibility determination and basis and that the individual/household must inform the agency if any of the information contained in the notice is inaccurate. The individual is not required to sign and return such notice if all information in the notice is accurate.~~

~~In order to facilitate and simplify the implementation of the Affordable Care Act, a waiver has been approved to postpone reviews for households required to be processed under MAGI methodologies in the first quarter of 2014 to the corresponding month in the second quarter of 2014. Those households that are required to continue to be processed as non-MAGI will have their reviews due at the normal time. Mixed households of both MAGI and non-MAGI individuals are subject to the postponed reviews.~~

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. ~~Transitional Medicaid Benefits~~ SSI to non-SSI), or when adding an individual to an existing Medicaid case. When the county agency has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be completed. When additional information is needed one of the forms identified in b. must be used.
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. ~~an 18 year old caretaker moves to her own case;~~ a disabled child turns age 18~~; or a child goes into foster care~~).
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.

Typo Correction Needed

3. 510-05-25-10 – Eligibility – Current and Retroactive – Removing all reference to Adult Expansion Group/MAGI Medicaid from #'s 1, 2 and 3 of this section as they are being added to new ACA Medicaid Service Chapter 510-03.

Eligibility – Current and Retroactive – 510-05-25-10

1. Current eligibility may be established from the first day of the month in which the signed application was received, or in the case of an application received through the Low Income Subsidy file of the Medicare Savings Program, the date the Social Security Administration received the Low Income Subsidy application. This provision does not apply to Qualified Medicare Beneficiaries. ~~Eligibility for those applying under the Adult Expansion Group received between October 1, 2013 and December 31, 2013 will be determined for coverage to begin January 1, 2014~~.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the signed application was received. Eligibility can be established if all factors of eligibility are met during each month of retroactive benefits. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application. This provision does not apply ~~to individuals eligible only under the Adult Expansion group for the months of October, November, or December 2013 or~~ to Qualified Medicare Beneficiaries.

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

   ~~Applications for MAGI households received in January, February or March, 2014 that request prior month coverage for October, November or December will have their prior month eligibility processed under non-MAGI rules.~~

   ~~Retroactive eligibility for the expansion group will be covered as fee for service by the participating insurance carrier. Individuals eligible only under the adult expansion group do not have eligibility for October, November, or December, 2013.~~

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

   ~~a. An individual is born in the month, in which case the date of birth is the first date of eligibility;~~
   ~~b.~~ a. An individual enters the state, in which case the earliest date of eligibility is the date the individual entered the state unless still receiving Medicaid benefits from another state. Information regarding the date Medicaid benefits from the other state are no longer available should be established in order to determine the beginning date of eligibility in North Dakota; or
   ~~c.~~ b. An individual is discharged from a public institution, in which case the earliest date of eligibility is the date of discharge.

4. 510-05-25-25 – Decision and Notice – Removing all reference to Children and Families from #6 of this section as this is being added to new ACA Medicaid Service Chapter 510-03.

Decision and Notice – 510-05-25-25

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; and
   ~~c. The last day of eligibility for a recipient eligible as a caretaker relative is the date the last child in the Medicaid unit enters foster care or the date parental rights are terminated.~~

   Reminder: When eligibility is terminated due to death, the eligibility of other individuals in the case cannot be reduced or terminated without appropriate notice. ~~Likewise, when a caretaker relative is no longer eligible because the last child entered foster care, or parental rights were terminated, the caretaker relative's eligibility cannot be ended without appropriate notice.~~

Covered Groups 510-05-30

5. 510-05-30-05 – Groups Covered Under Medicaid
   - Added wording to the title to clarify this Manual Section is for Non-ACA Medicaid only.
   - Removed all reference to MAGI Medicaid covered groups as these are being renamed and added to new ACA Medicaid Service Chapter 510-03
   - Removed the section 'Groups Covered Under Medicaid prior to January 1, 2014 as this information is included in the Archived Sections of Manual Chapter 510-05

Groups Covered Under Non-ACA Medicaid 510-05-30-05:

~~1. MAGI Group:~~

~~a. Parents and Caretakers of deprived children and their spouses up to 54% FPL;~~

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

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

~~d. Pregnant Women up to 147% FPL;~~

~~e. Children Ages 0 through 5 up to 147% FPL;~~

~~f. Children Ages 6 through 18 up to 133% FPL;~~

~~g. Adult Expansion group – single adults ages 19 through 64 not eligible as children, parents, caretakers or pregnant women whose income does not exceed 133%. This may include SSI recipients and other disabled individuals who fail the Medicaid asset limits, and individuals who are disabled with a large client share;~~

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

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

~~j. Individuals under age nineteen who are residing in adoptive homes and who have been determined under the state subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the Department;~~

~~k. Individuals under age nineteen who meet the financial requirements of the Children's group and who are residing in foster homes or private child care institutions licensed or approved by the Department, irrespective of financial arrangements, including children in a "free" foster home placement;~~

~~2. Non-MAGI Group:~~

~~a.~~ 1. Categorically Needy Group:

~~i.~~ a. Children for whom adoption assistance maintenance payments are made under title IV-E or non-IV-E.

~~ii.~~ b. Children for whom foster care maintenance payments are made under title IV-E.

~~iii.~~ c. Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state.

~~iv.~~ d. Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state.

Note: Medicaid eligibility for all regular foster care (non-Title IV-E) children is determined under ACA Medicaid policies.

~~v.~~ e. Children who are living in North Dakota and are receiving title IV-E kinship guardianship assistance payments from another state.

~~vi.~~ f. Children who were in foster care at age 18 up through the month they turn 26.

~~vii.~~ g. Aged, blind, or disabled individuals who are receiving SSI payments or who appear on ND Verify – Other Benefits as zero payment as a result of SSI's recovery of an overpayment or

who are suspended because the individuals do not have a protective payee, provided that the more restrictive Medicaid criteria is met.

- Individuals under age 21 who have been approved for SSI may be categorically eligible beginning with the month of the SSI application.
- Individuals age 21 or older who have been approved for SSI may be categorically eligible beginning the month following the month of SSI application. (If disabled in the month of SSI application, the individual age 21 or older may be medically needy eligible for that month.) Individuals who qualify under this category who are also eligible for Medicare Part B are also eligible for coverage of their Medicare Part B premium (SSI Buy-In).

~~viii.~~ h. Individuals who meet the more restrictive requirements of the Medicaid program and qualify for SSI benefits under section 1619(a) or 1619(b) of the Act.

Section 1619 of the Social Security Act provides continued Medicaid eligibility for certain disabled or blind persons who lose SSI benefits because they are performing substantial gainful activity. These benefits may continue beyond the age of sixty-five.

Section 1619a: These individuals continue to receive a special SSI payment, and may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).

Section 1619b: These are blind and disabled individuals who lose SSI benefits because of their earnings, and whose ability to continue employment or self-employment would be seriously impaired by termination of Medicaid and whose earnings are insufficient to provide the reasonable equivalent of the cash payments and Medicaid benefits (and in the case of determinations made under this law before October 1, 1981, Title XX Social Services) which would be available to them in

the absence of such earnings. These individuals will not receive any cash assistance but may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).

~~b.~~ 2. Optional Categorically Needy Group:

~~i.~~ a.Uninsured women under age 65, who are not otherwise eligible for ACA or Non-ACA Medicaid, who have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix, and whose family income is at or below 200% of the poverty level. Effective July 1, 2001. (Women's Way Treatment Program),

~~ii.~~ b. Workers with Disabilities (Gainfully employed individuals with disabilities) ages sixteen through sixty-four who meet medically needy non-financial criteria, have countable assets within the medically needy asset levels + $10,000, have income below 225% of the poverty level, and are not eligible for Medicaid under any other provision other than as a Qualified Medicare Beneficiary or a Special Low-income Medicare Beneficiary. Effective June 1, 2004.

~~iii.~~ c. Children with Disabilities under age 19 (including the month attaining age 19) who meet medically needy nonfinancial criteria, have income at or below 200% of the poverty level, and are not eligible for full Medicaid benefits under any other provision. Effective April 2008.

~~c.~~ 3. Medically Needy Group:

~~i.~~ a. Pregnant women ~~under age 19~~ whose pregnancy has been medically confirmed and who qualify on the basis of financial eligibility.

Example—Mom had been on Healthy Steps, which does not cover labor and delivery. Mom chooses to be Medically Needy for the month of birth rather than be referred to the exchange for month of birth.

~~ii.~~ b. Eligible pregnant women ~~under age 19~~ who applied for Medicaid during pregnancy, and for whom client share (recipient liability) for the month was met no later than on the date each pregnancy ends, continue to be eligible without regard to financial circumstances, for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.

~~iii.~~ c. Children born to eligible pregnant women ~~under age 19~~ who have applied for and been found eligible for Medicaid on or before the day of the child's birth, for one year, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.

~~iv.~~ d. Aged, blind, or disabled individuals who are not in receipt of SSI benefits.

~~v.~~ e. Individuals under age twenty-one who have been certified as needing the service, or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.

~~vi.~~ f. Individuals who are screened as and receiving Home and Community Based Services at home or in a specialized facility.

~~d.~~ 4. The poverty level group includes:

~~i.~~ a. Qualified Medicare Beneficiaries (QMB), who are entitled to Medicare part A benefits regardless of age or disability status, and who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare part D Low Income Subsidy, and have income at or below one hundred percent of the poverty level. Effective January 1, 1991 (90% of the poverty level from April 1, 1990, through December 31, 1990).

~~ii.~~ b. Qualified Disabled and Working Individuals (QDWI), who are individuals entitled to enroll in Medicare part A under section 1818a of the Social Security Act, and who have income no greater than two hundred percent of the poverty level, have assets no greater than twice the SSI resource standard, and who are not eligible for Medicaid under any other provision. The SSI program income and asset methodologies must be used and none of the more restrictive 209b criteria may be applied. (The eligibility determination for this group will temporarily be done by the Medicaid Eligibility Division of the North Dakota

Department of Human Services.) Coverage for this group began July 1, 1990.

~~iii.~~ c. Special Low-Income Medicare Beneficiaries (SLMB), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, and have income above one hundred percent of the poverty level but not in excess of one hundred twenty percent of the poverty level. Effective January 1, 1993.

~~iv.~~ d. Qualifying Individuals (QI-1), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy nonfinancial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, have income above 120% of the poverty level, but not in excess of 135% of the poverty level, and are not eligible for Medicaid under any other provision. Effective January 1, 1998.

~~**Groups Covered Under Medicaid prior to January 1, 2014:**~~

~~1. The categorically needy group includes:~~

~~a. Children for whom adoption assistance maintenance payments are made under title IV-E.~~

~~b. Children for whom foster care maintenance payments are made under title IV-E.~~

~~c. Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state.~~

~~d. Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state.~~

~~e. Caretakers, pregnant women, and children who meet the Family Coverage (section 1931 of the Act) eligibility criteria.~~

~~f. Families who were eligible under the Family Coverage group in at least three of the six months immediately preceding the month in which the family became ineligible because of the caretaker relative's hours or earnings from employment.~~

~~g. Families who were eligible under the Family Coverage group in at least three of the six months immediately preceding the month in which they became ineligible as a result, wholly or partly, of the collection or increased collection of child or spousal support continue eligible for Medicaid for four calendar months.~~

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

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

j. Aged, blind, or disabled individuals who are receiving SSI payments or who appear on the state data exchange (SDX) as zero payment as a result of SSI's recovery of an overpayment or who are suspended because the individuals do not have a protective payee, provided that the more restrictive Medicaid criteria is met. Individuals under age 21 who have been approved for SSI may be categorically eligible beginning with the month of the SSI application. Individuals age 21 or older who have been approved for SSI may be categorically eligible beginning the month following the month of SSI application. (If disabled in the month of SSI application, the individual age 21 or older may be medically needy eligible for that month.) Individuals who qualify under this category who are also eligible for Medicare Part B are also eligible for coverage of their Medicare Part B premium (SSI Buy-In).

k. Individuals who meet the more restrictive requirements of the Medicaid program and qualify for SSI benefits under section 1619(a) or 1619(b) of the Act.

Section 1619 of the Social Security Act provides continued Medicaid eligibility for certain disabled or blind persons who lose SSI benefits because they are performing substantial gainful activity. These benefits may continue beyond the age of sixty-five.

Section 1619a: These individuals continue to receive a special SSI payment, and may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).

Section 1619b: These are blind and disabled individuals who lose SSI benefits because of their earnings, and whose ability to continue employment or self-employment would be seriously impaired by

~~termination of Medicaid and whose earnings are insufficient to provide the reasonable equivalent of the cash payments and Medicaid benefits (and in the case of determinations made under this law before October 1, 1981, Title XX Social Services) which would be available to them in the absence of such earnings. These individuals will not receive any cash assistance but may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).~~

~~2. The optional categorically needy group includes:~~

~~a. Individuals under age twenty-one whose income is within the Family Coverage group levels, but who are not otherwise eligible under the Family Coverage group.~~

~~b. Individuals under age twenty-one who are residing in adoptive homes and who have been determined under the state-subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the Department.~~

~~c. Individuals under age twenty-one who meet the financial requirements of the Family Coverage group and who are residing in foster homes or private child care institutions licensed or approved by the Department, irrespective of financial arrangements, including children in a "free" foster home placement.~~

~~d. Uninsured women under age 65, who are not otherwise eligible for Medicaid, who have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix, and whose family income is at or below 200% of the poverty level. Effective July 1, 2001.~~

~~e. Gainfully employed individuals with disabilities age sixteen to sixty-five who meet medically needy non-financial criteria, have countable assets within the medically needy asset levels, have income below 225% of the poverty level, and are not eligible for Medicaid under any other provision other than as a Qualified Medicare Beneficiary or a Special Low-income Medicare Beneficiary. Effective June 1, 2004.~~

~~f. Children with Disabilities under age 19 (including the month attaining age 19) who meet medically needy nonfinancial criteria, have income~~

~~at or below 200% of the poverty level, and are not eligible for full Medicaid benefits under any other provision. Effective April 2008.~~

~~3. The medically needy group includes:~~

~~a. Eligible caretaker relatives and individuals under age twenty-one in families with deprived children who qualify and require medical services on the basis of insufficient income, but who do not meet income or age Family Coverage group requirements, or who do not qualify as optional categorically needy or poverty level.~~

~~b. Individuals under the age of twenty-one who qualify for and require medical services on the basis of insufficient income, but who do not qualify as categorically needy, optional categorically needy, or poverty level, including children in common in stepparent families who are ineligible under the Family Coverage group and foster care children who do not qualify as categorically needy or optional categorically needy.~~

~~c. Pregnant women whose pregnancy has been medically confirmed and who qualify on the basis of financial eligibility.~~

~~d. Eligible pregnant women who applied for Medicaid during pregnancy, and for whom client share (recipient liability) for the month was met no later than on the date each pregnancy ends, continue to be eligible without regard to financial circumstances, for sixty days, beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls.~~

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

~~f. Aged, blind, or disabled individuals who are not in receipt of SSI benefits.~~

~~g. Individuals under age twenty-one who have been certified as needing the service, or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.~~

~~4. The poverty level group includes:~~

~~a. Pregnant women whose pregnancy has been medically verified and who meet the nonfinancial requirements of the Medicaid program and whose family income is at or below one hundred thirty-three percent~~

~~of the poverty level. Effective April 1, 1990 (75% of the poverty level from July 1, 1988, through March 31, 1990).~~

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

~~c. Children under the age of six who meet the nonfinancial requirements of the Medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level. Effective April 1, 1990 (75% of the poverty level from July 1, 1988, through March 31, 1990, for children up to the age of one).~~

~~d. Children, age six to nineteen, who meet the nonfinancial requirements of the Medicaid program and whose family income is at or below one hundred percent of the poverty level. Effective July 1, 1991.~~

~~e. Qualified Medicare Beneficiaries~~(QMB), ~~who are entitled to Medicare part A benefits regardless of age or disability status, and who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare part D Low Income Subsidy, and have income at or below one hundred percent of the poverty level. Effective January 1, 1991 (90% of the poverty level from April 1, 1990, through December 31, 1990).~~

~~f. Qualified Disabled and Working Individuals (QDWI), who are individuals entitled to enroll in Medicare part A under section 1818a of the Social Security Act, and who have income no greater than two hundred percent of the poverty level, have assets no greater than twice the SSI resource standard, and who are not eligible for Medicaid under any other provision. The SSI program income and asset methodologies must be used and none of the more restrictive 209b criteria may be applied. (The eligibility determination for this group will temporarily be done by the Medicaid Eligibility Division of the North Dakota Department of Human Services.) Coverage for this group began July 1, 1990.~~

~~g. Special Low-Income Medicare Beneficiaries (SLMB), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, and have income above one hundred percent of the poverty level but not in excess of one hundred twenty percent of the poverty level. Effective January 1, 1993.~~

~~h. Qualifying Individuals (QI-1), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy nonfinancial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, have income above 120% of the poverty level, but not in excess of 135% of the poverty level, and are not eligible for Medicaid under any other provision. Effective January 1, 1998.~~

6. 510-05-30-10 – Applicant's Choice of Category
   - Changed wording from aged, blind, or disabled to Non-ACA categories and family coverage categories to ACA categories.
   - Removed the 'For Applications and Reviews Received on or After October 1, 2013 for benefits beginning January 1, 2014:'

Applicants Choice of Category 510-05-30-10

An individual, who could establish eligibility under more than one category, such as between ~~aged, blind or disabled~~ Non-ACA categories and ~~family coverage~~ ACA categories, may have eligibility determined under the category the individual selects. An individual may establish eligibility under only one category except for QMBs and SLMBs. Individuals eligible as QMBs and SLMBs are eligible as aged, blind or disabled for that coverage but may also establish eligibility under the ACA categories, (but not the Adult Expansion Group).

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

SSI recipients must first be tested for eligibility under Non-ACA Medicaid methodologies and only if they fail Non-ACA methodologies (such as excess assets) may they be tested under one of the ACA ~~groups~~ categories. This also applies to SSI recipients who ~~also~~ may be pregnant women. See also "Blindness and Disability" 510-05-35-100 and 'Disability and Medically Frail 510-03-35-100, for information as how to treat non-SSI disabled individuals.

Typo Correction Needed

Basic Factors of Eligibility 510-05-35

7. 510-05-35-05 – Medicaid Unit
   - Removing all reference to 'MAGI' Medicaid as they are being added to new ACA Medicaid Service Chapter 510-03.
   - Removed the wording 'For Applications and Reviews Received on or After October 1, 2013 for benefits beginning January 1, 2014:' and 'for Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014 for children and families:' as Manual Section 510-05 pertains to Non-ACA Medicaid only.

Medicaid Unit 510-05-35-05

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

~~1. MAGI Methodologies~~

~~Each individual will have his/her own Medicaid household determined as follows in the following order:~~

~~a. Does this individual expect to file taxes?~~

~~i. If "No", continue to step b below.~~

~~ii. If "Yes" – Does the individual expect to be claimed as a tax dependent by someone else?~~

~~A. If "Yes" – Continue to step b below.~~

~~B. If "No" – The individual's Medicaid household consists of the taxpayer, the spouse living with the taxpayer, and all persons whom the taxpayer expects to claim as a tax dependent. This is known as the tax filer household.~~

~~b. Does the individual expect to be claimed as a tax dependent?~~

~~i. If "No" – Continue to step c below.~~

~~ii. If "Yes" – Does the individual meet any of the following exceptions?~~

~~• The individual expects to be claimed as a tax dependent of someone other than a spouse, or natural, adopted or step parent.~~

~~• The individual is a child under age 19 and is living with both parents but the parents do not file a joint tax return.~~

~~• The individual is a child under age 19 and expects to be claimed by a non-custodial parent.~~

~~A.If "Yes" – continue to step c.~~

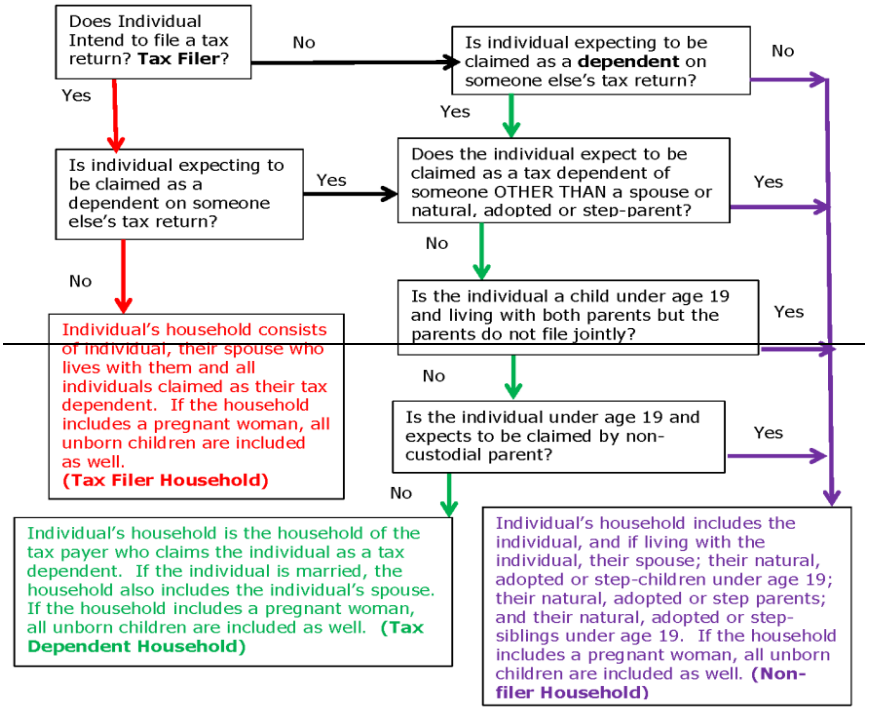
~~B. If "No" – the household is the household of the taxpayer that claims the individual as a tax dependent. If the individual is married, the household also includes the individual's spouse. This is known as the tax dependent household.~~

~~c. For individuals who neither expect to file a tax return nor expect to be claimed as a tax dependent, or who meet one of the exceptions under 1(b)(ii), the household consists of the individual, and if living with the individual—~~

- ~~The individual's spouse~~
- ~~The individual's natural, adopted or step children under age 19; and~~
- ~~The individual's natural, adopted or step parents, and natural, adopted or step siblings under age 19. This is known as the non-filer household.~~

~~The following flow chart illustrates this:~~

Household Determination for MAGI Individuals



Typo Correction Needed

~~**NOTE:** Under MAGI Methodologies, individuals may no longer be opted out of a household.~~

~~2. Non-MAGI Methodologies:~~

~~When a child is included in the Medicaid unit eligibility is pursued for the child unless:~~

~~a. The child is eligible under the Healthy Steps Program;~~

~~b. The child is an ineligible alien or the child's US citizenship or identity has not been verified after allowing a reasonable opportunity to provide the verifications;~~

~~c. The child's Social Security Number (SSN) has not been provided; or~~

~~d. The child is receiving services in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other institution for mental disease (IMD), and has not obtained certification of need for services in that facility.~~

~~When a caretaker chooses not to include a child in the Medicaid unit, the child is not included in the unit for any other purpose. This applies to non-MAGI households only.~~

~~Non-MAGI Medicaid Households and for Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014 for children and families:~~

1. A Medicaid unit may be one individual, a married couple, or a family with children under twenty-one years of age, or if blind or disabled under age eighteen, whose income and assets are considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

   ~~A single 18 year old disabled individual is included in the parental Medicaid unit if choosing to be treated as a child, or in a separate case and not included in the parental Medicaid unit if choosing to be eligible as a disabled individual.~~

2. An applicant or recipient who is ~~also a~~ the caretaker of a blind or disabled child~~ren~~ under ~~twenty-one~~ eighteen years of age may select any of their non-blind or disabled ~~the~~ children ~~who will~~ to be included in the Medicaid unit. Anyone whose needs are included in the unit for any month is subject

to all Medicaid requirements which may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

When a child is included in the Non-ACA Medicaid unit eligibility is pursued for the child unless:

a. The child is eligible under the Healthy Steps Program;
b. The child is an ineligible alien or the child's US citizenship has not been verified;
c. The child is ineligible due to no medical need (client share (recipient liability) exceeds need);
d. The child is receiving services in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other institution for mental disease (IMD), and has not obtained certification of need for services in that facility; or
e. The child's identity has not been verified.
f. The child is eligible under ACA Medicaid.

When a caretaker chooses not to include a child in the Medicaid unit, the child is not included in the unit for any other purpose (e.g. in the budget, in the asset test, or to create eligibility for a caretaker).

8. 510-05-35-10 – Deprivation - Removing this section as this provision is utilized for ACA Medicaid eligibility and is being added to new ACA Medicaid Service Chapter 510-03.

~~**Deprivation 510-05-35-10**~~

~~1. A child is considered deprived of a natural or adoptive parent's support or care due to continued absence of a parent or inability of a parent to meet the child's needs. A child may be considered deprived for the following reasons:~~

~~a. Death of a parent;~~
~~b. Divorce or legal annulment;~~
~~c. Separation, legal or mutual, as long as there was no collusion between the parents to render the family eligible;~~
~~d. Imprisonment of one or both parents. To establish continued absence, the parent must be sentenced to a minimum of a thirty-day jail term.~~

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

e. Unmarried parenthood (when not residing together);

f. Abandonment;

g. A parent is age sixty-five or older;

h. Disability of a parent;

i. Incapacity of a parent; or

j. Unemployment, or underemployment, of a parent. (Applies to Family Coverage only prior to January 1, 2014 and to the Parents, Caretaker Relatives and their Spouses group only on or after January 1, 2014.)

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

A parent temporarily living apart from the child(ren) due to employment, education, training, medical care, uniformed service, or any other temporary reason is not considered "Absent from the home" as long as the parent continues to function as a parent, even if the level of support or care is somewhat deficient. An exception is made when there is evidence that continued absence would have existed irrespective of the above reasons.

3. Divorce courts often award custody of children to both parents, however, legal custody orders have no bearing on whether or not a child is considered

~~"deprived." It is the parent's absence from the home and the child's physical presence rather than legal custody that is relevant.~~

~~4. A family may also establish deprivation, for the Family Coverage group only prior to January 1, 2014 and to the Parents, Caretaker Relatives and their Spouses group only on or after January 1, 2014, if the caretaker who is the primary wage earner is:~~

~~a. Employed less than one hundred hours per month (based on pay stub hours, including holiday and sick pay hours; or if self-employed, in the absence of other credible information, by dividing the gross monthly income by minimum wage); or~~

~~b. Employed more than one hundred hours in the current month, but employed less than one hundred hours in the previous month and is expected to be employed less than one hundred hours in the following month.~~

~~5. The primary wage earner is the caretaker with the greater current earnings UNLESS the family or agency establishes that the other caretaker had the greater total earnings in the twenty-four month period ending immediately before the month the family became eligible for the Family Coverage group (prior to January 1, 2014 and to the Parents, Caretaker Relatives and their Spouses group on or after January 1, 2014). Total earnings from a period of less than twenty-four months is used when the earnings for the full twenty-four month period are not available. A primary wage earner, once established, remains the primary wage earner as long as the family remains eligible for the Family Coverage group (prior to January 1, 2014 and to the Parents, Caretaker Relatives and their Spouses group on or after January 1, 2014).~~

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

9. 510-05-35-15 – Caretaker Relatives - Removing all reference to eligibility for Caretaker relatives as that information is being added to new ACA Medicaid Service Chapter 510-03.

Caretaker Relatives 510-05-35-15

1. ~~Caretaker relatives may be eligible for Medicaid when they have a deprived child living with them. Caretaker relatives who are not a natural or adoptive~~

~~parent, however, can only be eligible if the child is actually "living" with them, and is not just temporarily absent from the parental home, and if the caretaker relative is married and not residing with their spouse or is an unmarried individual.~~ The following individuals may be considered a caretaker relative of a child seeking eligibility under Non-ACA Medicaid policies:

a. A natural or adoptive parent;
b. A grandparent (including a great, great-great, or great-great-great-grandparent);
c. A sibling (if age sixteen or older);
d. An aunt or uncle (including a great or great-great aunt or great or great-great uncle);
e. A niece or nephew (including a great or great-great niece or great or great-great nephew);
f. A first cousin (an aunt or uncle's child) or first cousin once removed (an aunt or uncle's grandchild);
g. A second cousin (a great aunt or great uncle's child);
h. A stepparent (if natural or adoptive parent is not in the home);
i. A stepbrother or stepsister; or
j. A spouse of any of the above individuals even after the marriage is terminated by death or divorce.

~~2. A caretaker relative may only be eligible for Medicaid when:~~

~~a. A child who is eligible for Medicaid is included in the Medicaid unit; or~~
~~b. When a caretaker relative requests Medical coverage and is otherwise eligible for Medicaid for a month in which all the children in the unit are covered under Healthy Steps, the caretaker relative may be eligible for Medicaid coverage for that month, coverage for future months requires at least one eligible child included in the Medicaid case.~~

~~3.~~ 2. A child is considered to be living with a caretaker relative when away at school or when otherwise temporarily absent from the home. A child is not considered to be living with a caretaker relative when either the child or the caretaker is residing in a nursing care facility, an intermediate care facility for the mentally retarded, or a specialized facility on other than a temporary basis.

~~4.~~ 3. A child may not be considered to be living with more than one caretaker relative in more than one Medicaid unit for the same time period.

~~5. When the only child in common in a Medicaid unit is unborn and there is deprivation of unemployment/underemployment, incapacity, or disability, the prospective parents must be married, and in the same Medicaid unit, in order for the father to be eligible as a caretaker relative.~~

~~6.~~ 4. Termination of parental rights removes all relationships and responsibilities between the parent and the child(ren). The parent becomes a "legal stranger" to the child(ren). However, for Medicaid purposes, the blood relatives of a parent whose parental rights have been terminated continue to be treated as relatives of the child(ren).

~~7. A child other than a natural or adoptive child cannot create eligibility for a caretaker when a natural or adoptive child under age 21, or 18 if blind or disabled, resides in the home of the caretaker.~~

10. 510-05-35-20 – Relative Responsibility -
    - Removing all reference to Relative Responsibility that pertains to ACA Medicaid, as that information is being added to new ACA Medicaid Service Chapter 510-03.
    - Removed wording that differentiates between Family Coverage group only prior to January 1, 2014 and to the Parents, Caretaker Relatives and their Spouses group only on or after January 1, 2014, as policies prior to January 1, 2014 are in the Archived Sections of Manual Chapter 510-05.

Relative Responsibility 510-05-35-20

~~For Applications and Reviews Received and Processed on or before December 31, 2013 requiring benefits prior to January 1, 2014:~~

1. As a condition to receiving Medicaid, no support may be required of relatives other than from spouses and from natural or adoptive parents for children ~~under age 21, or if blind or disabled,~~ under age 18, who are blind or disabled.

2. Under North Dakota law, a stepparent has no legally enforceable obligation to support stepchildren. Therefore, the stepparent's own personal income

and assets cannot be considered available in determining Medicaid eligibility for the stepchildren. The natural parent, however, is legally responsible for supporting the children. The income of the natural parent cannot be first applied to the children if by doing so other members of the family are deprived of basic necessities.

~~3. If a caretaker relative other than a natural or adoptive parent becomes eligible for Medicaid solely because they have a deprived child living with them, the caretaker relative is treated as a natural parent for purposes of relative responsibility. Refer to Section 05-35-15 to determine who can be a caretaker relative.~~

~~4.~~ 3. If a child resides with a caretaker other than the parent, and the parent's whereabouts are known, an attempt must be made to obtain the parent's financial information. If the parent's income is made available, follow the budgeting procedures outlined in section 05-90-23, Budgeting Procedures for Financially Responsible Absent Parents. If unable to obtain the information, document the efforts made, determine the child's eligibility without the parental information, and refer the case to the Child Support Enforcement Unit.

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

~~Eligibility will be based on the MAGI methodologies. Each person's financial responsibility depends upon their tax filing status which also determines the budgeting.~~

~~1. In taxpayer households, the taxpayer is financially responsible for themselves, their spouse, if living with them, and anyone they claim as a dependent, plus the individual's spouse that lives with them and any unborn children if a pregnant woman is in the household. This is the same as their Medicaid household unit determination.~~

~~2. If the taxpayer may also be claimed as a dependent, the dependent rules are applied --~~

~~If the individual meets any of the following conditions, he/she is treated as a non-filer:~~

- ~~Is the individual claimed as a dependent of someone other than a spouse, or natural, adopted or step parent?~~

- ~~Is the individual under 19 and living with both parents but the parents are not filing a joint return?~~
- ~~Is the child under 19 to be claimed as a dependent by a non-custodial parent?~~

~~If these conditions are not met, the individual's financial responsibility is the same as the household that claims the individual as a dependent, plus the individual's spouse that lives with them and any unborn children if a pregnant woman is in the household. This is the same as their Healthy Steps household unit determination. The above policy also applies to individuals claimed as tax dependents. These are known as dependent households.~~

~~3. If the individual is not a tax filer, nor expected to be claimed as a dependent, or meets one of the 3 bullets above, the individual is subject to the non-filer rules. Non-filers' financial responsibility is for themselves, and, if living with them, their spouse, their natural, adopted or step-children under age 19, and the individual's natural adopted or step-parents or natural adopted or step-siblings under 19 , plus the individual's spouse that lives with them and any unborn children if a pregnant woman is in the household. These are known as non-filer households.~~

11. 510-05-35-40 – Age and Identity
    - Removing all reference to Age and Identity requirements in #'s 2, 3, and 5, for individuals whose eligibility must be determined under ACA Medicaid policies, as that information is being added to new ACA Medicaid Service Chapter 510-03.
    - Updated the last row of the 'Documents Verify Both Citizenship and Identity' and the 'Explanatory Information:' to reflect the verifications of citizenship and identity being received through NDVerify system and the Federally Facilitated Marketplace (FFM).

Age and Identity 510-05-35-40

2. ~~An individual who is eligible upon reaching age twenty-one remains eligible for Medicaid through the month in which the individual reaches that age. An exception to this general rule permits e~~ Eligibility may ~~to~~ continue for a person who attains age twenty-one while receiving treatment and continues to receive treatment as an inpatient in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, or the

Stadter Psychiatric Center,~~. Eligibility may continue~~ through the month the individual attains the age of twenty-two.

3. Blind ~~individuals,~~ and disabled individuals, ~~and caretaker relatives,~~ are not subject to any age requirements for purposes of Medicaid eligibility.

5. Identity must be established and documented as provided in this section.

    a. The following individuals are exempt from the identity verification requirements
        i. SSI recipients who claim that they are US Citizens and that claim is not questionable (can prove using the SDX or TPQY SSI match);
        ii. Medicare beneficiaries who claim that they are US Citizens and that claim is not questionable (can prove using the TPQY SSA match);
        iii. Individuals receiving SSA disability insurance benefits based on their own disability;
        iv. Individuals receiving Foster Care maintenance payments;
        v. Individuals receiving Subsidized Adoption payments; and
        vi. Individuals receiving Subsidized Guardianship payments.

    ~~b. Newborn children: A child, born to a woman who has applied for and been determined Medicaid eligible and is in receipt of Medicaid when the child is born, may be eligible without verifying identity. This provision also applies in instances where labor and delivery services were furnished prior to the date of the Medicaid application and covered based on retroactive eligibility.~~

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

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

~~c.~~ b.Reasonable Opportunity Period. Applicants who claim they are U.S. citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual's eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual's eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

A 'reasonable opportunity period' is defined as 90 days from the date the application is submitted and for the remaining days of the month in which the 90th day falls. An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence they have been making a good faith effort to obtain the verifications, but still have not received them.

An example of a good faith effort would be a letter from another state's vital statistics office that the documentation was requested timely (no later than 10 days after the latter of the application date or the earliest date the verification was requested by the county or state agency), but there will be a delay in providing the documentation.

Example: Mr. Brown applies for Medicaid on May 11, 2010. He has verification of citizenship; however he has nothing to prove identity. He does not meet any of the exemptions from the verification requirements that are listed in the manual. Mr. Brown is determined to be eligible for Medicaid and the application approved for the prior months of March and April, the application month of May, and the future month of June. Mr. Brown claims he is a member of a federally-recognized Indian tribe in California. The worker has assisted him in requesting identifying tribal documents from the tribe in California. The worker sets an alert to

follow up in early August. The worker does not receive a response by August 20, so sends an advance notice to close. On August 23, Mr. Brown brings in a recent letter from the tribal enrollment office in California, acknowledging receipt of his request for his tribal enrollment verification, and stating that it will take another 6 weeks for them to process it. In this case, an additional 2 month period may be granted. The worker would set an alert for a secondary follow up for October 2010. If not received by October 20, 2010, advance notice to close must be sent.

A reasonable opportunity can only be allowed once for any individual. If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated, a second reasonable opportunity period is not allowed at a later application.

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

Primary Verifications of Identity
(Level One)

These Documents Verify Both Citizenship and Identity:	Explanatory Information:
US Passport or US Passport Card Issued since 2007	• Issued by the Department of State • Does not have to be currently valid, as long as it was issued without limitation; (any passport issued with a limitation cannot be used to verify citizenship, but CAN be used to verify identity). • Through 1980, spouses and children were often included on one passport; after that each person is issued his own passport. • The passport card is for frequent travelers by land or sea between the

	US and Canada, Mexico, the Caribbean and Bermuda.
Certificate of Naturalization (DHS/INS Forms N-550 or N-570)	• Department of Homeland Security or Immigration and Naturalization Service (INS) issues for naturalization.
Certificate of US Citizenship (DHS/INS Forms N-560 or N-561)	• Department of Homeland Security or INS issues certificates of citizenship to individuals who derive citizenship through a parent.
Tribal Enrollment Card Certificate of Degree of Indian Blood Or other documents issued by a federally recognized Indian tribe that evidences membership or enrollment with such tribe	• A Document issued by a federally recognized Indian tribe evidencing membership or enrollment or affiliation with, such tribe. See following table for acceptable verification from ND tribes.
~~Social Security's TPQY Online Query Response (TPOR)~~ Citizenship verification received from using the "Other Benefits" inquiry in the NDVerify system or from the citizenship verification system available through the Federally Facilitated Marketplace (FFM) – as automated through the Streamlined application process	• Acceptable codes are: ○ ~~"Verified with positve citizenship" or~~ "Citizenship Verified" ○ "Verified with positive citizenship; Deceased."

12. 510-05-35-45 – Citizenship and Alienage
    - Removing all reference to Citizenship and Alien requirements for individuals whose eligibility must be determined under ACA Medicaid, as that information is being added to new ACA Medicaid Service Chapter 510-03.
    - Updated the last row of the 'Documents Verify Both Citizenship and Identity' and the 'Explanatory Information:' to reflect the verifications of citizenship and identity being received through NDVerify system and the Federally Facilitated Marketplace (FFM).

Citizenship and Alienage 510-05-35-45

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

   For aliens, apply the appropriate policy identified in sections 510-05-35-50 through 510-05-35-70.

~~3. Newborn children. A child, born to a woman who has applied for and been determined Medicaid eligible and is in receipt of Medicaid when the child is born, may be eligible without verifying citizenship. This provision also applies in instances where labor and delivery services were furnished prior to the date of the Medicaid application and covered based on retroactive eligibility.~~

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

~~Children who are born to a woman who is not eligible for regular Medicaid must comply with the verification requirements if Medicaid is requested.~~

~~4.~~ 3. Verification Requirements: Applicants must provide satisfactory documentary evidence of citizenship or naturalization.
   a. The only acceptable verifications from individuals must be either originals or copies certified by the issuing agency. Photocopies or notarized copies may not be accepted; however, a photocopy of the original document must be maintained in the casefile.

b. Verifications may be accepted from another state agency that may have already verified citizenship, but a photocopy must be obtained for the casefile.
c. Once an individual's citizenship is documented and recorded, subsequent changes in eligibility do not require repeating the documentation unless questionable, or there is no verification in the casefile.

   Example: John Doe applies for Medicaid and supplies his citizenship verifications and his case closes. If his casefile is purged after the three year retention period and he reapplies, he will need to again provide his verifications so that his casefile is complete.
d. If an individual has made a good faith effort to obtain verifications, but cannot obtain them within the processing timeframes , or because the documents are not available, assistance must be provided to the individual in securing evidence of citizenship. Matches with other agencies may be used to assist the individual.
e. Reasonable Opportunity Period. Applicants who claim they are U.S. Citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual's eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual's eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

   A 'reasonable opportunity period' is defined as 90 days from the date the application is submitted and for the remaining days of the month in which the 90th day falls. An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence they have been making a good faith effort to obtain the verifications, but still have not received them.

An example of a good faith effort would be a letter from another state's vital statistics office that the documentation was requested timely (no later than 10 days after the latter of the application date or the earliest date the verification was requested by the county or state agency), but there will be a delay in providing the documentation.

Example: Mr. Brown applies for Medicaid on May 11, 2010. He claims he was born in California. He does not meet any of the exemptions from the verification requirements that are listed in the manual. Mr. Brown is determined to be eligible for Medicaid and the application approved for the prior months of March and April, the application month of May, and the future month of June. The worker has assisted him in requesting birth verification from California. The worker sets an alert to follow up in early August. The worker does not receive a response by August 20, so sends an advance notice to close. On August 23, Mr. Brown brings in a recent letter from the State of California, acknowledging receipt of his request for a birth certificate, and stating that it will take another 6 weeks for them to process it. In this case, an additional 2 month period may be granted. The worker would set an alert for a secondary follow up for October, 2010. If not received by October 20, 2010, advance notice to close must be sent.

A reasonable opportunity can only be allowed once for any individual. If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated, a second reasonable opportunity period is not allowed at a later application.

~~5.~~ 4. Acceptable documentation for US citizens and naturalized citizens.

a. The following documents may be accepted as proof of both citizenship and identity because either the US, a state, or Tribal government has established the citizenship and identity of the individual. These documents are considered to be the primary (Level 1) and preferred verification documents.

Primary Verifications
(Level 1)

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

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

13. 510-05-35-58 – Qualified Alien - Language is added to the first paragraph of this section to **clarify** that qualified aliens, other than some legally admitted for permanent residence are eligible from their date of arrival in the US.

Qualified aliens are aliens that have been legally admitted and may be eligible for Medicaid if they meet all other Medicaid eligibility criteria. Some qualified aliens may be eligible under the Refugee Medical Assistance Program, 510-05-95-20, if they do not meet all other Medicaid eligibility criteria. The following categories of individuals are qualified aliens: (Forms indicated below are USCIS or INS forms and the sections refer to the Immigration and Nationality Act (INA). Individuals with the documents described in subsections 2 through 13 below may be eligible for Medicaid from their date of arrival in North Dakota, without being subject to the five-year ban or meeting the forty qualifying quarters of social security coverage, as long as they meet other Medicaid criteria:

1. Aliens who are lawfully admitted for permanent residence (LPR) may be eligible as described in sections 510-05-35-60 and 510-05-35-65.

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

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

e. Form I-551 or I-151 (Permanent Resident Card) with codes R8-6; RE6, RE7, RE8, RE9.

4. Asylees who have been granted asylum (not applicants for asylum):
   a. Form I-94 showing "208" or "asylee" and/or codes of AS1, AS2, or AS3);
   b. Form I-688B annotated 274.a12(a)(5);
   c. Form I-766 annotated A5;
   d. Grant letter from Asylum office of USCIS;
   e. Order from immigration judge granting asylum;
   f. Form I-571;
   g. Form I-551 or I-151 with codes AS6, AS7, AS8, AS9, GA-6 to GA-8.

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

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

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

8. Aliens admitted as an Amerasian immigrant:
    a. I-94 showing National of Vietnam and AM1, AM2, or AM3;
    b. I-151 or I-551 showing National of Vietnam and AM-1, AM-2, AM-3, AM-6, AM-7; or AM-8.

9. American Indians born in Canada as described in 510-05-35-50.

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

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

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

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

Typo Correction Needed

14. 510-05-35-70 – Emergency Services for Non-Citizens – Added policy in this section that pregnant women who are aliens covered by Medicaid for emergency services are not eligible for the Extended Medicaid for Pregnant Women and Newborns coverage defined in Service Chapter 510-03-45-05 ~~35-110~~.

    A non-citizenship who is eligible for Emergency Services as a result of their pregnancy and subsequent birth of their child is not eligible for 60 free days of Medicaid and for the remaining days of the month in which the 60th day falls as defined in Service Chapter 510-03-45-05 ~~35-110~~.

15. 510-05-35-80 – Social Security Numbers
    - Removing all reference to Social Security Numbers for those individuals whose eligibility must be determined under ACA Medicaid policies, as that pollicy is being added to new ACA Medicaid Service Chapter 510-03.
    - Adding NDVerify as a source to verify Social Security Numbers electronically in #5.

Social Security Numbers 510-05-35-80

1. A valid social security number (SSN), or verification of application for SSN, must be furnished as a condition of eligibility, for each individual for whom Medicaid benefits are sought except a non-qualified alien seeking emergency services. (see 05-35-70 for a description of emergency services.) ~~the following individuals do not have to provide a SSN, or verification of application for SSN:~~
    ~~a. A newborn child for the first sixty days, beginning on the date of birth and for the remaining days of the month in which the sixtieth day falls, or if the newborn is continuously eligible, for the remaining days of the newborn's first eligibility period;~~
    ~~b. An individual who is currently eligible for Transitional or Extended Medicaid Benefits; and~~
    ~~c. An illegal alien seeking emergency services. (see 05-35-70 for a description of emergency services.)~~

    When the exempt period ends, a social security number or verification of application for SSN must be provided to continue Medicaid coverage.

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

2. Persons who do not have a number must be referred to the Social Security Administration to apply for one. The county agency may assist the applicant as needed.

3. ~~A copy of the enumeration at birth form (SSA 2853) that is completed at the hospital, or any other receipt from the Social Security Administration is adequate verification of application for SSN.~~

~~4.~~ 3.The Medicaid household must be informed, at the time of application that the agency will use the SSN in the administration of the Medicaid Program. The SSN will be used to verify income and asset information from the Social Security Administration, Internal Revenue Service, Job Service, Unemployment Compensation, SNAP, TANF Program, Child Support Enforcement, State Motor Vehicle, Department of Vital Statistics and other states.

The informing requirement is met by the appropriate language found on the Application for Assistance.

~~5.~~ 4.Social Security numbers are electronically verified through the NUMIDENT and the NDVerify system for all recipients. When a number is reported as not valid, the recipient must provide their valid SSN in order to continue eligible for Medicaid.

NUMIDENT - This interface is used to verify an individual's social security number, age and sex. Administrative Manual Section 448-01-50-15-60, "NUMIDENT" provides additional information regarding the NUMIDENT interface, and defines the alerts that are created when the NUMIDENT match is determined 'Invalid'.

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

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

- S – Sent to Social Security Administration for verification
- V – Valid match for social security number

If the indicator is 'I' (invalid) the SSN, name, date of birth or sex of the individual was an invalid match with the SSA information.

When the worker receives one of the following alerts, a valid or active SSN has not been provided:

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

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

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

The eligibility system may be incorrect or the individual's NUMIDENT record at SSA has incorrect information. The worker should check the information entered into the system for accuracy. If the worker is unable to determine if the information in the system is accurate, the worker must contact the household (via phone or notice) to determine the correct date of birth or sex and then correct the information in the system. If the worker contacts the household by phone, the contact must be thoroughly documented in the narrative. The worker must document the request and give the household 10 days to provide the number.

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

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

~~6.~~ 5. Except for recipients excused in Subsection 1, recipients who provide verification of application for a SSN must provide a SSN by the next review. ~~If a child is within a continuous eligibility (CE) period when the case review is being completed, and the SSN is not provided, the child is eligible through the end of the current CE period; however, the child's SSN must be provided for eligibility to continue past the end of that CE period.~~

16. 510-05-35-85 – State Residence -
    - Removed the wording 'Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014 for Children and Families' as policies prior to January 1, 2014 are in the Archived Sections of Manual Chapter 510-05.
    - Removing the reference to State Residence for those individuals whose eligibility must be determined under ACA Medicaid policies in #2.a., as that information is being added to new ACA Medicaid Service Chapter 510-03.
    - Removed Florida from the list of states with which North Dakota has long term care reciprocal agreements as we no longer have an agreement with them.

State Residence 510-05-35-85
~~Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014 for children and families:~~

2. Individuals under age twenty-one.
    a. For any individual under age twenty-one who is living independently from his parents or who is married and capable of indicating intent, the state of residence is the state where the individual is living with the intention to remain. ~~there permanently~~ ~~or for an indefinite period~~.

8. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of an affected individual is the state determined under that agreement.

   North Dakota has an interstate reciprocal residency agreement with nine states. The agreement provides that individuals of any age institutionalized

in one of these states are considered a resident of the state in which they are institutionalized.

The states with whom we have the agreement are:

California	New Mexico	Tennessee
~~Florida~~	Ohio	Texas
Kentucky	Pennsylvania	Wisconsin

North Dakota also has a specific agreement with the State of Minnesota. The agreement states that individuals who enter a nursing facility in the other state remain a resident of the state they were a resident of prior to admission into the nursing facility for 24 months following admission, and if the individual has a community spouse, they continue to be a resident of the state the community spouse lives in beyond the 24 month time limit. This agreement terminates at the point the individual is discharged from a nursing facility unless the individual is being transferred to a different nursing facility.

10. North Dakota residents will be provided Medicaid outside the state when:
    a. It is a general practice for residents of a particular locality to use medical resources outside the state;
    b. The availability of medical resources requires an individual to use medical facilities outside the state for short or long periods. Prior approval from the Medical Services Division must be obtained when an individual is being referred for out-of-state medical services.

       Transportation for approved out-of-state medical services will be arranged jointly by the individual and the county agency.

    c. Individuals are absent from the state for a limited period of time to receive special services or training;
    d. It is an emergency situation; and
    ~~c.~~ **e.** Services are received during an eligible period but prior to application.

17. 510-05-35-90 – Application for Other Benefits - Removing all reference for those individuals whose eligibility must be determined under ACA Medicaid policies, as that information is being added to new ACA Medicaid Service Chapter 510-03.

Application for Other Benefits – 510-05-35-90

1. As a condition of eligibility, applicants and recipients (including spouses and financially responsible absent parents) must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits, to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions; old age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation.

2. Good cause under this section exists if:
   ~~a. The recipient is a pregnant woman or a newborn who is within the 60 days of free Medicaid;~~
   ~~b. The recipient is eligible for Transitional or Extended Medicaid Benefits;~~

   ~~c.~~ a. Receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage; or
   ~~d.~~ 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.

   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.

18. 510-05-35-100 – Blindness and Disability - Removing #9 from this section as this makes reference to 'Medically Frail' provisions allowable under the Affordable Care Act. This information is being added to new ACA Medicaid Service Chapter 510-03.

Blindness and Disability 510-05-35-100

~~9. Under final rules for the Affordable Care Act published on July 15, 2013, anyone claiming to be disabled is considered to be 'medically frail'. Individuals considered medically frail MUST be provided coverage similar to that provided under the Medicaid state plan. For proper budgeting procedures, please see "Budgeting for those claiming to be Disabled" at 510-05-90-45-05.~~

19. 510-05-35-105 – Incapacity of a Parent - Removing this section as this provision is utilized to determine eligibility under ACA Medicaid and is being added to new ACA Medicaid Service Chapter 510-03.

~~**Incapacity of a Parent 510-05-35-105**~~

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

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

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

4. The county agency is responsible for determining all eligibility factors except for incapacity which is determined by the State Review Team. Since the State Review Team does not see the person, it must depend on the examining physician's medical report to document the individual's physical or mental condition. In addition, the State Review Team must rely on the county agency's report which is based on both observation and the applicant's or recipient's judgment of how the incapacity affects the family in terms of employment or ability to discharge homemaking and child care responsibilities. Pertinent information about the person's past employment or homemaking adjustments, type of housing, method of heating the home, the availability or lack of modern conveniences in the home, ability to manage personal needs and affairs, attitudes and behavior, motivation, etc., is invaluable to the State Review Team. This information, which is reported on SFN 451, "Eligibility Report on Disability/Incapacity" (05-100-40), is forwarded along with any other medical reports to the State Review Team for evaluation and decision.

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

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

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

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

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

20. 510-05-35-110 – Extended Medicaid for Pregnant Women and Newborns - Removing this section as this individuals who are subject ACA Medicaid policies and is being added to new ACA Medicaid Service Chapter 510-03.

~~Extended Medicaid for Pregnant Women and Newborns 510-05-35-110~~

~~1. A pregnant woman is considered to be eligible for Medicaid as of the last day of pregnancy when she is eligible with no client share (recipient liability), or if there is a client share (recipient liability), when the full client share is incurred as of the last day of pregnancy.~~
~~This provision applies regardless of the reason the pregnancy was terminated, and without regard to changes in income or whether a review of eligibility is due during the free eligibility period.~~

~~This provision is only available to women who are eligible for Medicaid under one of the pregnant women coverages in the family category, but is not available to women who are aliens covered by Medicaid for emergency services.~~

~~2. Children born to pregnant women who were determined to be eligible as of the last day of pregnancy, are eligible for Medicaid for one year, beginning on the date of birth, and for the remaining days of the month in which the twelfth month falls.~~

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

~~3. If the Medicaid case closes for loss of residency during the extended period and the family returns to the state and reapplies while still in the extended period, eligibility may be reestablished for the remainder of the period.~~

Child Support Enforcement 510-05-40

21. 510-05-40-05 – Child Support Enforcement - Removing wording #1 that references individuals who are subject ACA Medicaid policies, as this is being added to new ACA Medicaid Service Chapter 510-03.

Paternity 510-05-40-05

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

22. 510-05-40-10 – Medical Support - Removing wording from this section that references individuals who must have eligibility determined under ACA Medicaid, as this is being added to new ACA Medicaid Service Chapter 510-03.

Medical Support 510-05-40-10

1. An assignment of rights to medical support from any absent parent of a child who is under age eighteen and who is deprived of parental support or care is automatic under North Dakota state law. (Refer to Section 05-35-10 for the description of deprivation.)

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

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

23. 510-05-40-15 – Cooperation – Child Support - Removing wording from this section that references individuals who are subject ACA Medicaid policies, as this is being added to new ACA Medicaid Service Chapter 510-03.

Cooperation – Child Support 510-05-40-15

~~1. Pregnant women are not required to cooperate with Child Support and may remain eligible for Medicaid while pregnant and through the month in which the sixtieth day after pregnancy falls. A pregnant woman must be informed of this exception at the time of application or, in the case of a recipient, at the time the pregnancy becomes known. When Child Support is informed that an applicant or recipient is pregnant, Child Support services will continue to be provided; however, any non-cooperation by the pregnant woman will not affect her eligibility for Medicaid.~~

~~2. Recipients of Extended Medicaid Benefits and Transitional Medicaid Benefits are not required to cooperate with Child Support and remain eligible for Medicaid.~~

~~3. Caretaker relatives under age 19 who are within a continuous eligibility period are not required to cooperate with Child Support and remain eligible for Medicaid.~~

~~4.~~ Cooperation with Child Support is required for all ~~other l~~egally responsible aged or disabled caretaker relatives ~~(including aged and disabled caretakers)~~ for the purpose of establishing paternity and securing medical support. This requirement may be waived for "good cause" as described in 510-40-20.

The determination of whether a legally responsible caretaker relative is cooperating is made by the Child Support Agency. The caretaker has the right to appeal that decision.

Legally responsible aged or disabled caretaker relatives who do not cooperate with Child Support will not be eligible for Medicaid. Children in the Medicaid unit, however, remain eligible.

When a legally responsible aged or disabled caretaker relative is not eligible because of non-cooperation, the earned and unearned income of that ineligible caretaker must be considered in determining eligibility for the child(ren).

If a previously non-cooperating legally responsible caretaker relative begins cooperating in an open Medicaid case, and the caretaker is otherwise eligible that caretaker's eligibility may be reestablished. The caretaker must demonstrate that they are cooperating with Child Support before Medicaid coverage can be reestablished. When the caretaker previously stopped cooperating, the automated referral to Child Support ended.

a. If the child Support Enforcement case also closed, the aged or disabled caretaker must apply for Child Support servivces and fulfill the cooperation requirements as determined by the Child Support program (parents or other legal custodians/guardians can apply online at www.childsupportnd.com or mail a completed application to a Child Support office. Applications can be printed from the web or requested directly from a Child Support office).

b. If the Child Support Enforcement case did not also close, the caretaker may begin to cooperate with Child Support without application and confirmation of such can be secured by contacting the Child Support worker.

When child Support has confirmed that the aged or disabled caretaker is cooperating, Medicaid coverage for that caretaker can be reestablished beginning with the first day of the month in which the caretaker began cooperating.

(Confirmation of cooperation must be secured by communicating with the Child Support worker; confirmation of cooperating may not be determined based on the Cooperation indicator on the Fully Automated Child Support Enforcement System (FACSES).) Child Support has 20 days to process an application for services. However, typically, applications are processed more quickly than 20 days, and Child Support can be contacted as soon as an open case can be viewed in FACSES.

If a previously non-cooperating legally responsible aged or disabled caretaker relative reapplies for Medicaid after the Medicaid case closed, the caretaker relative is eligible for Medicaid until it is again determined that the caretaker relative is not cooperating.

24. 510-05-40-20 – Cooperation – Child Support - Removing wording from this section that references individuals who are subject ACA Medicaid policies as this is being added to new ACA Medicaid Service Chapter 510-03.

Cooperation – Child Support 510-05-40-20
The requirement to cooperate may be waived when a legally responsible caretaker relative has "good cause" not to cooperate.

1. All legally responsible aged or disabled caretaker relatives must be given the opportunity to claim "good cause". Applicants are notified of their rights to claim good cause in the SFN 405, Application for Assistance, DN 405, the Application for Assistance Guidebook, and the SFN 502, Application for Health Care Coverage for Children, Families and Pregnant Women. Applicants can indicate their request to claim good cause in either application. Recipients who become subject to the cooperation requirements may be notified by providing each legally responsible aged or disabled caretaker with SFN 443, "Notice of Right to Claim 'Good Cause'" (05-100-45). The notice briefly summarizes the legislative intent of child support enforcement, defines the caretaker's responsibility to cooperate in the support enforcement effort, and advises them of their right to claim "good cause". The notice also describes circumstances under which cooperation may be "against the best interests" of the child or caretaker and cites the kinds of evidence needed to substantiate a claim.

A legally responsible aged or disabled caretaker wishing to claim "good cause" may do so by completing SFN 446, "Request to Claim 'Good Cause'" (05-100-50).

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

2. The determination of whether there is "good cause" is made by the county agency. The county agency may waive the requirement to cooperate if it determines that cooperation is against the best interests of the child. A county agency may determine that cooperation is against the best interests of the child only if:
   a. The aged or disabled applicant's or recipient's cooperation in establishing paternity or securing medical support is reasonably anticipated to result in:
      (1) Physical harm to the child for whom support is to be sought;
      (2) Emotional harm to the child for whom support is to be sought;
      (3) Physical harm to the parent or caretaker relative with whom the child is living which reduces such person's capacity to care for the child adequately; or
      (4) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately; or

   b. At least one of the following circumstances exists, and the county agency believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure medical support would be detrimental to the child for whom support would be sought.
      (1) The child for whom support is sought was conceived as a result of incest or forcible rape;
      (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or
      (3) The aged or disabled applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep or relinquish the child for adoption, and the discussions have not gone on for more than three months.

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

   It is the aged or disabled caretaker relative's responsibility to provide the county agency with the evidence needed to establish "good cause." The caretaker is normally given twenty days from the date of claim to collect the evidence. In exceptional cases, the county agency may grant reasonable additional time to allow for difficulty in obtaining proof. Records of law enforcement, social service, or adoption agencies may be readily available to document instances of rape, physical harm, or pending adoption, perhaps without requiring further investigation. Documentation of anticipated emotional harm to the child or caretaker, however, may be somewhat more elusive. Whenever the claim is based in whole or in part on anticipated emotional harm, the county agency must consider the following:
   a. The present emotional state of the individual subject to emotional harm;
   b. The emotional health history of the individual subject to emotional harm;
   c. The intensity and probable duration of the emotional impairment;
   d. The degree of cooperation to be required; and
   e. The extent of involvement of the child in establishing paternity or health insurance coverage.

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

5. The county agency is directly responsible for investigating a "good cause" claim when it believes that the aged or disabled caretaker's claim is

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

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

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

   b. Child Support Enforcement – The automated referral process notifies Child Support of the status of all "good cause" claims by:

(1) Informing them of all aged or disabled caretaker relatives who claim "good cause" exemptions which suspend child support activity pending a determination;
(2) Informing them of all cases in which it has been determined that there is "good cause" for refusal to cooperate. Once the exemption is established, no child support activity may be pursued unless at a future time it is determined that "good cause" no longer exists; and
(3) Informing them of all cases in which it has been determined that "good cause" for refusing to cooperate does not exists and that child support enforcement activity can begin or resume.

7. The county agency must review the "good cause" decision at least every twelve months. If "good cause" continues to exist, the aged or disabled caretaker must again be informed in writing. If circumstances have changed so "good cause" no longer exists, the caretaker must be informed, in writing, and given the opportunity to cooperate, terminate the caretaker's assistance, close the case, or appeal the decision. When "good cause" no longer exists Child Support will commence its child support activity.

~~Family Coverage Group (Parents, Caretaker Relatives, and their Spouses – effective January 1, 2014)(1931) 510-05-45~~

25. This section, which includes the following subsections, is being removed as the entire section is being moved to the new ACA Medicaid Service Chapter 510-03:
    - 510-05-45-05 – General Information
    - 510-05-45-10 – Individuals Covered
    - 510-05-45-15 - Family Composition
    - 510-05-45-30 - Income Considerations for the Family Coverage Group (Parents, Caretaker Relatives, and their Spouses Group - effective 01-01-14)
    - 510-05-45-35 - Disregards and Deductions for the Family Coverage Group (Parents, Caretaker Relatives, and their Spouses Group - effective 01-01-14
    - 510-05-45-40 - Income Levels for the Family Coverage Group

~~Transitional and Extended Medicaid Benefits 510-05-50~~

26. This section, which includes the following subsections, is being removed as the entire section is being moved to the new ACA Medicaid Service Chapter 510-03:
    - 510-05-50-05 – Transitional Medicaid Benefits
    - 510-05-50-10 – Extended Medicaid Benefits

Continuous Eligibility for Children 510-05-53

27. 510-05-53-10 – Individuals Covered - Removing wording from this section that references individuals who are subject ACA Medicaid policies, as this is being added to new ACA Medicaid Service Chapter 510-03.

Individuals Covered 510-05-53-10

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

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

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

28. 510-05-53-15 – Continuous Eligibility Periods - Removing wording from this section that references individuals who must be covered under ACA Medicaid, as this is being added to new ACA Medicaid Service Chapter 510-03.

1. Continuous eligibility may be established from the first day of the application month, or if later, the first day that the individual becomes eligible for Medicaid under a coverage group other than medically needy. Continuous eligibility periods cannot be established when re-working a prior

month ~~except when adding a newborn child to a prior month and the newborn child is eligible.~~

Example 1: A child applies for Medicaid on June 8 and is determined to be ~~poverty level~~ categorically needy eligible. The child becomes continuously eligible effective June 1.

~~**Example 2:** A child is eligible for Medicaid as medically needy. When determining eligibility for August, the family's income decreased so the child becomes poverty level eligible for August. The child becomes continuously eligible effective August 1.~~

~~**Example 3:** An application was taken for the month of September and the child was determined medically needy for September and October. When determining eligibility for November, the family's income decreased so the child becomes poverty level eligible for November. The child becomes continuously eligible effective November 1 and their continuous eligibility period end date would be equal to the review due date of August 31. In November the parents provide verification of decreased income for October and when re-working the month of October the child is now poverty level eligible. The child's continuous eligibility period would remain November thru August.~~

~~**Example 4:** An application was taken in October. The household consists of a woman who gave birth in August and is requesting coverage of her labor and delivery costs. The woman was poverty level eligible in August. The newborn became continuously eligible for Medicaid beginning in August and the continuous eligibility period runs through July 31, the end of the month prior to the month of its first birthday. The woman is not entitled to 60 days of extended coverage because she applied after the birth.~~

2. ~~Except for newborn children, if~~ When retroactive eligibility is approved for an applicant, the continuous eligibility period does not begin during any of the retroactive months. An individual may be Medicaid eligible during the retroactive months; however, their eligibility is based on their actual circumstances during those months.

   Example: A family with a disabled child~~ren~~ applies for Medicaid for the child only on October 9 and requests Medicaid for the three prior months. The application is processed and it is determined that the child~~ren are poverty level~~ is categorically eligible for October, and ~~they are eligible~~ for the three prior months. The child~~ren~~ become

continuously eligible effective October 1 regardless of their coverage group status during the three prior months.

3. Except as identified in subsection 5, once an individual becomes continuously eligible, they remain eligible for Medicaid without regard to changes in circumstances, until they have been on Medicaid for 12 consecutive months. They do not have to have been continuously eligible for the entire 12 months.

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

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

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

Foster Care and Related Groups 510-05-55

29. 510-05-55-10 – Foster Care Financial Eligibility Requirements
    - Removed the section 'For Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014 as this information is included in the Archived Sections of Manual Chapter 510-05.

Foster Care Financial Eligibility Requirements 510-05-55-10
~~**For Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014:**~~

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

~~2. Medicaid eligibility for all regular foster care (non-Title IV-E) children is determined using medically needy eligibility rules. Financial eligibility is determined by considering the income of the child. The parents' income is considered as stipulated in the foster care court order.~~

~~a. When the court order is silent regarding the parents' responsibility for medical care, the parents' income is not considered; and a referral to Child Support is made.~~

~~b. When the court order states that the parents pay "to the best of their ability," or "as determined by the county agency," or when the court orders the parents to assume all responsibility for the child's medical care, (e.g. the first $100 per month), the parents' income must be considered.~~

~~c. When the court orders a specific amount of medical care (e.g. the first $100 per month), that amount is the parents' responsibility.~~

~~d. In the rare instances when the parent(s) cannot be located or absolutely refuse to cooperate, eligibility can be established for the~~

~~child without using parental income. In these cases, a referral must be made to Child Support.~~

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

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

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

30. 510-05-55-10-05 – Added reference to the new ACA Medicaid Service Chapter 510-03.

Former Foster Care Children through Age 26 510-05-55-10-05
Individuals who are not eligible under the Parent, Caretaker Relative ~~and their Spouse coverage, the~~ or Pregnant Women categories ~~Coverage or the Adult coverage group~~ as defined in Service Chapter 510-03, who were in North Dakota foster care (Title IV-E, state-funded (non-IV-E) or tribal) in the month they turned age 18 must be covered through the month in which they turn age 26 with no budget test.

31. 510-05-55-15 – Reworded and removed the reference to MAGI methodology as this is being added to new ACA Medicaid Service Chapter 510-03.

Volunteer Placement Program 510-05-55-15
Children in the Volunteer Placement Program are not considered to be in foster care. The parents retain care, custody, and control of the child. ~~; and~~ When the child is eligible as a disabled individual the income and assets of the child and parents is considered. ~~MAGI methodology is used in the Medicaid eligibility determination effective January 1, 2014. Parental assets must also be used if the child is eligible as a disabled individual~~. The child could be placed in a facility that is not in-patient care including PATH and county foster families or

facilities, i.e. Manchester House, Dakota Boys Ranch, Prairie learning Center, etc. For a child to qualify under this program, there must not be a delinquency, abuse and/or neglect issue.

Note: If the child is not disabled, MAGI methodology is used in the Medicaid eligibility determination.

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

32. 510-05-55-20 – Subsidized Guardianship Project
    - Reworded and moved the reference to MAGI Medicaid.
    - Deleted a portion of the note as this applies to ACA Medicaid children only and will be moved to the new ACA Medicaid Service Chapter 510-03.

Subsidized Guardianship Project 510-05-55-20

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

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

When the child is eligible as a disabled individual ~~When determining Medicaid eligibility,~~ the child's income is considered, and parental income is not used unless the guardianship court order specifies that the parents are responsible for the child's needs. The assets of the child and parents are also ~~used if the child is eligible as a disabled individual~~ considered.

Note: If the child is not disabled, eligibility is determined under ACA Medicaid policy.~~MAGI methodology is used in the Medicaid eligibility determination on or after January 1, 2014~~.

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

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

Workers with Disabilities 510-05-57

33. 510-05-57-10 – Individuals Covered (Workers with Disabilities) – added the new ACA Medicaid Chapter 510-03 to #1.d. as Medicaid policy will be included in two different Medicaid Manual Service Chapters.

Individuals Covered (Workers with Disabilities) 510-05-57-10

1. An individual may be enrolled under the Workers with Disabilities coverage if he or she:
   a. Is gainfully employed;
   b. Is at least sixteen, but less than sixty-five, years of age;
   c. Is disabled;
   d. Is not in receipt of any other Medicaid benefits under ~~this chapter~~ Service Chapter 510-03 or 510-05, other than coverage as a QMB or SLMB; and
   e. Pays a one-time, per lifetime, enrollment fee of $100. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.

Typo Correction Needed

Children with Disabilities 510-05-58

34. 510-05-58-10 – Individuals Covered (Children with Disabilities) – added the new ACA Medicaid Chapter 510-03 to #1.c. as Medicaid policy will be included in two different Service Chapters.

Individuals Covered (Children with Disabilities) 510-05-58-10

1. An individual may be enrolled under the Children with Disabilities coverage if he or she:
    a. Is under age 19 (including month individual turns age 19);
    b. Is disabled; and
    c. Except for Qualified Medicare Beneficiary or Special Low-income Medicare Beneficiary coverage, is not in receipt of any other Medicaid benefits under ~~this chapter~~ Service Chapter 510-03 or 510-05.

Medicare Savings Programs 510-05-60

35. 510-05-60-20 – Asset Limits for the Medicare Savings Program – This section is updated to include the **change** in the asset limits for the Medicare Savings programs effective with the benefit month of January, 2014. This **supersedes IM 5194** – "2014 – Medicare Savings Program Asset Limits".

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 ~~2013~~, the limits are:

1. $7,160 ~~$7,080~~ for a one-person unit ($7,080 ~~6,940~~ in ~~2012~~ 2013); or
2. $10,750 ~~$10,620~~ for a two-person unit ($10,620 ~~$10,410~~ in ~~2012~~ 2013).

Eligibility Under Spousal Impoverishment 510-05-65

36. 510-05-60-20 – Community Spouse Asset Allowance – Subsection 2 is **updated** to reflect the change in the minimum and maximum community

spouse asset allowance for spousal impoverishment protection cases. This **supersedes IM 5195** – "2014 – Spousal Impoverishment Asset Levels"

Community Spouse Asset Allowance 510-05-65-20

2. 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's 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 ~~$23,184~~ , and not more than $117,240 ~~$115,920~~ , effective January 2014 (~~$22,728~~ $23,184 and ~~$113,640~~ $115,920 effective January ~~2012~~ 2013).

Example:

If the spousal share is:	The community spouse asset allowance is:
$12,500	$23,448 ~~$23,184~~ (at least the minimum)
$45,000	$45,000
$125,000	$ 117,240 ~~$115,920~~ (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.

Assets 510-05-70

37. 510-05-70-05 – General Information – Reference to Asset tests for children and family categories and MAGI Medicaid are being removed and this policy will be included in the new ACA Medicaid Service Chapter 510-03.

General Information 510-05-70-05
These medically needy asset provisions apply to all aged, blind, and disabled applicants and recipients of Medicaid unless otherwise specified in this chapter.

There is no asset test for applicants and recipients who are ~~applying, or are~~ eligible under ~~the children and family categories,~~ the Children with Disabilities, Women's Way, Foster Care and Subsidized Adoption coverage's ~~, or subject to MAGI methodologies so the asset provisions do not apply to those individuals~~.

38. 510-05-70-27 – Home Equity Limit – This section is **updated** to include the change in the Home Equity Limit effective January 1, 2014. This **supersedes IM 5193** "2014 – Home Equity Limit"

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 ~~$536,000~~ effective January 1, ~~2013~~ 2014 (~~$525,000~~ $536,000 effective January ~~2012~~ 2013). 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.

39. 510-05-70-30 – Excluded Assets – Added clarification to #22 relating to employer sponsored retirement plans. This supersedes IM 5206

Excluded Assets – 510-05-70-30

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
- Roth IRA's Roth Individual Retirement Plan

40. 510-05-70-40 – Contractual Rights to Receive Money Payments – Incorporated changes to valuating Contractual Rights to Receive Money Payments as identified in IM 5206.

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

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, 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. A debtor is judgment proof when money judgments have 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 ~~not satisfied. An applicant or recipient may show a debt has no value as long as a money judgment obtained by any creditor (including the applicant or recipient) has been on file in a county in which the debtor lives, or owns property, for at least 60 days and has not been satisfied~~; or

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.

41. 510-05-70-45-20 – Annuities Purchased Before August 1, 2005 - Subsection 2(c)(v) is **updated** to reflect the change in the maximum monthly payments allowed for an annuity to be excluded. This supersedes IM 5201.

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

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;
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 ~~$2898~~ effective January ~~2013~~ 2014 (~~$2841~~ $2898 for ~~2012~~ 2013).

42. 510-05-70-45-25 – Annuities Purchased from August 1, 2005 Through February 7, 2006 - Subsection 2(c)(v) is **updated** to reflect the change in the maximum monthly payments allowed for an annuity to be excluded. This supersedes IM 5201.

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

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;

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 $2931 ~~$2898~~ effective January ~~2013~~ 2014 (~~$2841~~ $2898 for ~~2012~~ 2013 and, when combined with the annuitant's other income at the time of application for Medicaid, does not exceed $4396 ~~4347~~ effective January ~~2013~~ 2014 (~~$4347~~ ~~$4261~~ effective ~~2012~~ 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.

43. 510-05-70-45-30 – Annuities Purchased or Changed on or After February 8, 2006 - Subsection 3(c)(v) is **updated** to reflect the change in the maximum monthly payments allowed for an annuity to be excluded. This supersedes IM 5201.

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

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;

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 $2931 ~~$2898~~ effective January ~~2013~~ 2014 ($~~2841~~ $2898 for ~~2012~~ 2013 and, when combined with the annuitant's other income at the time of application for Medicaid, does not exceed $4396 ~~$4347~~ effective January ~~2013~~ 2014 ($4347 ~~$4261~~ effective ~~2012~~ 2013); and

vi. 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.

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.

44. 510-05-70-60 – Valuation of Assets – Added changes to the Valuation of Mineral Interests as defined in IM 5206.

Valuation of Assets 510-05-70-60

3. Real property:

a. With respect to mineral interests:

i. If determining current value (for sale or pending transfer):

(1) Fair market value is the value established by good faith effort to sell. The best offer received establishes the value.

(2) A good faith effort to sell means offering the mineral interests to at least three companies purchasing mineral rights in the area, or by offering for bids through public advertisement.

ii. If determining a previous value for mineral rights sold or transferred in the past, fair market value is:

(1) If producing, the value is an amount equal to any lease income received after the transfer plus three times the annual royalty income.

(a) Based on actual royalty income from the ~~36~~ 60 months following the transfer; or

(b) If ~~36~~ 60 months have not yet passed, based on actual royalty income for the months that have already passed, and an estimate for the remainder of the ~~36~~ 60 month period.

(2) If not producing, but mineral rights are leased, two times the lease amount (based on the actual lease and not the yearly lease amount) that was in place at the time of the transfer.

Example: John Oilslick leased his mineral acres in 2008 for $3000. He transferred his mineral rights to his adult children in January 2010. The children

have a new lease on these acres effective January 2011 for $10,000. The disqualifying transfer is equal to two times the $3,000 lease that was in place at the time of the transfer.

(3) If not leased, the greater of two times the estimated lease amount, or the potential sale value of the mineral rights, as determined by a geologist, mineral broker, or mineral appraiser at the time of the transfer, whichever is greater.

Example: Don Goldmine had his mineral acres valued at $50,000 in 2010 when he transferred them to his children. Today those minerals are valued at $20,000. The amount of the disqualifying transfer would be $50,000, the value at the time of the transfer.

iii. In determining current or previous value, an applicant or recipient may provide persuasive evidence that the value established using the above process is not accurate. Likewise, if an established value is questionable, the Department may require additional evidence be provided to establish estimated fair market value.

Example: Mary Golddigger leased her mineral acres in June 2008 for $5,000 under a 3-year lease. Two months before the lease expired -- April 2011, she transferred those acres to her daughter, Nugget Golddigger. Nugget then leased those acres for $20,000. In this situation, at the time of transfer, Mary probably reasonably would be aware of the lease renewal amounts. Even if she didn't know, it is likely that the value was closer to the $20,000 than $5,000. The eligibility worker must get information of the estimated value as of the date of the transfer. The value of the disqualifying transfer at 2 X the newer lease amount of $20,000 equals $40,000.

b. With respect to agricultural lands: appraisers, real estate agents dealing in the area, loan officers in local agricultural lending institutions, and other persons known to be knowledgeable of land

sales in the area in which the lands are located, but not the "true and full" value from tax records.

c. With respect to real property other than mineral interests and agricultural lands: market value or "true and full" value from tax records, whichever represents a reasonable approximation of market value; real estate agents dealing in the area; and loan officers in local lending institutions. If a valuation from a source offered by the applicant or recipient is greatly different from the true and full value established by tax records, an explanation for the difference must be made, particularly if the applicant or recipient may be able to influence the person furnishing the valuation.

Income and Asset Considerations in Certain Circumstances 510-05-75

45. 510-05-75-05 – Ownership in a Business Entity
    - Reference to MAGI Households when defining income in #2 has been removed as this policy will be included in the new ACA Medicaid Service Chapter 510-03.
    - Removed the 'title' 'Non-MAGI Households' as it is not needed as this Service Chapter includes the Non-ACA Policy.

Ownership in a Business Entity 510-05-75-05

2. Income: Countable income from a business entity (e.g. a corporation or partnership) that employs anyone whose income is used to determine eligibility is established as follows:

   ~~MAGI Households:~~
   ~~The net income from the entity as reported on Schedule E of IRS Form 1040 is countable income.~~
   ~~If the individual does not file taxes, the net income from the individual's schedule K-1 will be used, plus any wages paid to the individual in addition to the net income.~~

   ~~If the K-1 is not prepared, ledgers must be provided.~~

   ~~Non-MAGI Households:~~

a. If the applicant or recipient and other members of the Medicaid unit own the controlling interest in the business entity, calculate income using the medically needy self-employment rules described in 05-85-20; or
b. If the applicant or recipient and other members of the Medicaid unit own less than a controlling interest, but more than a nominal interest in the business:
    i. From the business entity's gross income, subtract any cost of goods for resale, repair, or replacement, CRP payments and patronage or cooperative dividends, and subtract any wages, salaries, or guarantees (but not draws), paid to actively engaged owners to arrive at the business entity's adjusted gross income; and
    ii. From the adjusted gross income, establish the applicant or recipient's income share based on the Medicaid unit's proportionate share of ownership in the business entity; and
    iii. Add any wages, salary, or guarantee paid to the applicant or recipient to the applicant or recipient's income share; and
    iv. Apply the medically needy self-employment income disregards described in 05-85-20; and
    v. Based on the applicant's or recipient's proportionate share of ownership in the business entity, establish the individual's share of the CRP payments and patronage or cooperative dividends as unearned income; or
c. If the applicant or recipient and other members of the Medicaid unit, in combination, own a nominal interest in the business entity, and are not able to influence the nature or extent of employment by that business entity, the individual's earned income as an employee of that business entity, plus any unearned income gained from ownership of the interest in the business entity.

46. 510-05-75-10 – Treatment of Conservation Reserve Program Property and Payments:
    - Reference to MAGI Households when defining income in #2 and expenses in #3 has been removed as this policy will be included in the new ACA Medicaid Service Chapter 510-03.
    - Removed the title 'Non-MAGI Households' as it is not needed as this Service Chapter includes the Non-ACA Medicaid Policy.

Treatment of Conservation Reserve Program Property and Payments
510-05-75-10

2. Income.

~~a. MAGI Households:~~

~~CRP payments are considered income. They will be included in the net income amounts from schedule C, E, or F. If the individual does not file taxes, use the gross amount from the form 1099 less all related expenses including property taxes, insurance and other expenses a for the land. CRP payments no longer need to be segregated from farm income for MAGI households.~~

~~b. Non-MAGI Households:~~

CRP payments are considered unearned income.

When a CRP contract is set up, the full payment may be received by the landlord or operator, or a portion of the payment may be paid to a tenant of the farm. A portion of the payment is allowed to be paid to a tenant if the tenant was farming the land, or had an interest in the property (e.g. was on the previous contract), in the year before the contract was signed. The CRP contract specifies the amount of the payment and to whom the payment is made.

For purposes of determining eligibility, only count the share the applicant or recipient receives per the CRP contract.

3. Expenses.

~~MAGI:~~

~~Actual expenses for maintaining the CRP contract must be allowed including those expenses for property ownership such as taxes and insurance. They will already be included on the appropriate tax schedules (C, E, or F) if the individual files taxes. If the individual does not file taxes, they will need to provide ledgers.~~

~~Non-MAGI:~~

Actual maintenance expenses, up to $5 per acre per year, which are not reimbursed (e.g. by ASCS), may be deducted from the gross CRP payments. Actual maintenance expenses are those expenses necessary to

maintain the property according to the CRP contract, such as seed, spray, etc. Allowable maintenance expenses do not include property taxes or insurance.

When the CRP contract requires more extensive maintenance or preparation, the $5 per acre can be exceeded by actual verified expenses up to the NDSU Extension rate established for the area.

When the applicant or recipient receives 100% of the payment, the allowable expenses that are not reimbursed are allowed. When the applicant or recipient only receives a percentage of the payment, that same percentage of the allowable expenses is allowed. For example, if 90% of the payment is received by the applicant, then only 90% of the allowable expenses can be allowed as a deduction.

Disqualifying Transfers 510-05-80

47. 510-05-80-05 – Definitions - Subsection 9 is **updated** with the average cost of nursing care effective July 1, 2013 and January 1, 2014. This **supersedes IM 5189** "Average Cost of Long Term Care" and **IM 5198** "Average Cost of Long Term Care – 2014"

Definitions 510-05-80-05

9. The average cost of nursing facility care is:

Year	Daily Rate	Monthly Rate
2014	238.94	7268
July – Dec 2013	231.39	7038
Jan – June 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-Dec 2001	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

48. 510-05-80-15 – Penalty Periods- Subsection 1 is **updated** with the new policy effective April 1, 2013. This supersedes IM 5206.

Penalty Periods 510-05-80-15

1. The number of months and days of ineligibility for an individual shall be equal to the total uncompensated value of all income and assets transferred by the individual, or individual's spouse, on or after the look-back date, divided by the average monthly cost, or daily cost as appropriate, of nursing facility care in North Dakota at the time of the individual's ~~first~~ application during which the disqualifying transfer was determined.

   The following example demonstrates how the monthly and daily period of ineligibility is calculated:

Example: Mr. Brown applied for Medicaid on December 10, ~~2002~~ 2011 and it was determined Mr. Brown made a disqualifying transfer of $70,000 in November of 2010. The December 2011 application was denied.

~~He~~ Mr. Brown re-applied for Medicaid on July 18, ~~2003~~ 2013. The average cost of nursing facility care at the time ~~of application~~ the disqualifying transfer was determined (12-2011) is $6238 per month and $205.07 per day. $70,000 divided by $6238 is 11.22 months. Eleven months at $6238 per month is $68618, leaving $1382 to which the daily rate is applied. $1382 divided by $205.07 is 6.73 days. Mr. Brown's penalty period is 11 months and 7 days (partial days are rounded up).

~~Since the average cost of care used is the amount from when an individual first applies for Medicaid, if Mr. Brown had previously applied for Medicaid in July 2001 (regardless of the action taken on that application) the average cost of care used to calculate the penalty period would be $3652 per month and $120.08 per day. Mr. Brown's penalty period would have been 19 months and 6 days.~~

49. 510-05-80-37 – Payment for Services to an Attorney-in-Fact – This is a new section that is being added with an effective date of April 1, 2013. This supersedes IM 5206.

Payment for Services to an Attorney-in-Fact 510-05-80-37

(N.D.A.C. Sections 75-02-02.1-43)

When an individual makes a payment to their Attorney-in-Fact for services or assistance furnished to the individual by the Attorney in Fact, the services or assistance furnished may not be treated as consideration for transferred income or assets, unless:

1. There is a valid written contract:

a. Entered between the individual and the Attorney in Fact prior to the Attorney in Fact rendering the services, and payment is made pursuant to the valid written contract; and

b. The contract was executed by the individual or the individual's Attorney in Fact who is not a provider of services or assistance under the contract; and

Example: It is acceptable for a Medicaid recipient's Attorney in Fact to sign the contract to have a third party provide the services.

Example: It is not acceptable for a Medicaid recipient's Attorney in Fact to sign the contract to have the Attorney in Fact provide the services.

Example: It is acceptable for a competent Medicaid recipient to sign the contract to have the Attorney in Fact provide the services.

c. Compensation is reasonable and consistent with rates paid in the open market for the services actually provided; and

d. The services are necessary and reasonable, or

Example: Mary has had Power of Attorney for both her parents for the past 3 years. Her parents' health has been steadily deteriorating over the past two years. Mary's Mother has always told her children she never wants to go to a nursing facility, so Mary, as outlined in the Power of Attorney agreement, provides round the clock nursing care for her parents for $2000 per month including her room and board. The worker has verified that both parents need a nursing home level of care and has needed it for at least the past year. Now, Mary's Father has fallen and it is just too much for Mary to care for both parents, so they are applying for nursing care for Mary's Father. We would consider the $2000 per month plus room and board payments to be reasonable. If the parents had gone directly to

long term care, it would have cost them in excess of $14,000 per month. If they'd have hired a private nurse, it would have cost approximately $9,000 month.

Reasonableness is dependent upon the type of service provided, whether the service is necessary, the size and scope of the services and what the going rate is in the community for such services.

Example: John has held a Power of Attorney for his father for the past 3 years. John's Dad lost his eyesight and the largest part of his Power of Attorney duties was to pay bills once per month. The agreement had a stated value for these services of $500 per month. John's Dad at this time had minimal assets, and expenses. Most bills were set up as automatic withdrawals from his bank account. John usually spends 1 hour per month paying his Dad's bills. $500 per hour for writing checks is not reasonable. If Dad, for example would have several pieces of property in which he had a life estate interest, and was collecting rents, and John was spending 30 – 50 hours per month doing this, it would be reasonable.

2. If there is not a written contract, the prior course of dealings between the individual and Attorney in Fact included the individual paying compensation upon rendering services or assistance, or within 30 days thereafter.

   Example: Deb is a 'snowbird' who winters in New Mexico 5 months of the year. There is a history of Deb paying Tim to manage her properties while she is in New Mexico during those months. Deb has been fully capable, so Tim does not conduct everything for her, just intermittently. In such a case, a written contract would not be required as there is an established history of payments made for services. We would require verification of past payments made and for which services.

   Reasonable payments are allowed as a spend down of assets but not as a deduction from income.

Income 510-05-85

50. 510-05-85-05 – Income Considerations:
    - MAGI Households Income section has been removed as this policy will be included in the new ACA Medicaid Service Chapter 510-03.
    - Removed the title 'Non-MAGI Households' as it is not needed as this Service Chapter includes the Non-ACA Medicaid Policy.

Income Considerations 510-05-85-05

Income is defined as any cash payment, which is considered available to a Medicaid unit for current use. Income must be reasonably evaluated.

~~**MAGI households:**~~

~~1. MAGI income methodologies must be applied to all MAGI households.~~
~~2. Current, point-in-time income must be used.~~
~~3. All income which is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible individual; when the applicant, recipient, or responsible individual has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible individual has the lawful power to make the income available or to cause the income to be made available.~~

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

~~Income that is withheld because of garnishment or to pay a debt or other legal obligation is still considered available.~~
~~Title II and SSI overpayments being deducted from Title II benefits are normally considered to be available because the applicant or recipient can pursue a waiver of the overpayment. Only if the waiver has been denied after a good faith effort, can the Title II or SSI overpayment deductions be considered unavailable.~~

~~Occasionally other delinquent debts owed to the federal government may be collected from an individual's federal payment benefit (i.e. Title II, Civil~~

Service, and Railroad Retirement). These other reductions of federal benefits are not allowed to reduce the countable benefit amount. The award amount of the federal 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.

4. Financial responsibility of any individual for any applicant or recipient is subject to their tax filing status as defined at "Medicaid Unit" 510-05-35-05.
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 redetermined 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 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), 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). All other such payments are counted as income.~~

~~Non-MAGI households:~~

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

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

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

Occasionally other delinquent debts owed to the federal government may be collected from an individual's federal payment benefit (i.e. Title II, Civil Service, and Railroad Retirement). These other reductions of federal benefits are not allowed to reduce the countable benefit amount. The award amount of the federal 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) ~~or when budgeting for Transitional Medicaid Benefits as described in 05-50-05(7)~~).

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.

51. 510-05-85-07 – Medical Payments – Removed reference to MAGI Households as this policy will be included in the new ACA Medicaid Service Chapter 510-03.

Medical Payments 510-05-85-07

Payments from any source, which are or may be received as a result of a medical expense or increased medical need, are not income, but are considered to be medical payments which must be applied towards the recipient's medical costs. These payments include health or long-term care insurance payments, Veteran's Administration aid and attendance, Veteran's Administration reimbursements for unusual medical expenses, and Veteran's Administration homebound benefits intended for medical expenses. Medical payments from the Veteran's Administration are based on the individual's level of care and may be received regardless of the individual's living arrangement. This section does not apply to the Medicare Savings Programs.

1. Health or long-term care insurance payments must be considered as payments received in the months the benefit was intended to cover and must be applied to medical expenses incurred in those months;

2. Veteran's Administration aid and attendance benefits must be considered as payments received in the months the benefit was intended to cover and must be applied to the medical expense incurred in those months. ~~Effective January 1, 2014, Veteran's Administration aid and attendance benefits are excluded in determining eligibility for MAGI households only~~.

3. Veteran's Administration reimbursements for unusual medical expenses must be considered as payments received in the months in which the increased medical expense occurred and must be applied to the medical expense incurred in those months. ~~Effective January 1, 2014, Veteran's Administration reimbursements for unusual medical expenses are excluded in determining eligibility for MAGI households only.~~

4. Veteran's Administration homebound benefits intended for medical expenses must be considered as payments received in the months the benefit was intended to cover and must be applied to the medical expense incurred in those months. This does not apply to homebound benefits which are not intended for medical expenses. ~~Effective January 1, 2014, Veteran's Administration homebound benefits are excluded in determining eligibility for MAGI households only~~.

52. 510-05-85-13 – MAGI Income Methodologies – Removed this section as this policy will be included in the new ACA Medicaid Service Chapter 510-03.

~~**MAGI Income Methodologies 510-05-85-13**~~

~~Effective for the benefit month of January, 2014, the following MAGI Income Methodologies will be used in determining income eligibility for the Medicaid Program MAGI groups of Parents, Caretaker Relatives and their Spouses, Pregnant Women, Children, and the Expansion group. For benefit months prior to January 2014, please see the appropriate section under "Income" at 510-05-85-05.~~

~~1. Income is based on household composition and tax filer rules.~~
~~2. Monthly income is used prospectively.~~
~~3. Current, point in time income is used – prospecting reasonable expected changes.~~
~~4. A tax dependent child's income does not count in a taxpayer parent's or caretaker's household if the child is not required to file a tax return. The child's needs are included in the taxpayer's household.~~
~~a. If the taxpayer parent or taxpayer caretaker is in the child's Medicaid household, the child's income does not count in the child's household, either.~~
~~b. If the taxpayer parent or taxpayer caretaker is not in the child's Medicaid household, the child's income DOES count in the child's household. For example, the child is in (non-IV-E) foster care or receiving HCBS services in a specialized facility.~~
~~c. Filing requirements change every year and this information may be found in the instructions for Form 1040 at http://www.irs.gov/.~~

d. If the child is not required to file a tax return, however, files a return in order to get a refund of taxes withheld, that child's income is not counted in either the tax filer's or the child's household.

e. If the child IS required to file a tax return, the child's income is counted in all the households in which the child is included.

5. If using an individual's federal tax return:

MAGI Income is:

MAGI = Adjusted Gross Income (AGI) **plus**:

a. Any foreign earned income excluded from taxes

b. Tax-exempt interest

c. Tax-exempt Social Security income

Minus:

a. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

b. Certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income.

This MUST be updated using current data.

6. If **not** using an individual's federal tax return:

MAGI Income is:

a. Gross taxable wages (must deduct pre-tax deductions) plus

b. Gross Interest income plus

c. Gross Dividend income plus

d. Taxable refunds of state or local income taxes plus

e. Gross Alimony received plus

f. Net Business income or loss from self-employment plus

g. Capital Gains or losses plus

h. Taxable amounts of IRA distributions plus

i. Taxable Amount of Pensions and annuities plus

j. Net rents, royalties, partnerships, S corporation or trust income plus

k. k. Net farm income or loss plus

l. Gross unemployment compensation plus

m. Gross Social Security income plus

n. Gross foreign earned income plus

o. Other income

Minus:

a. Educator expenses

~~b. Business expenses of reservist, performing artists and fee-basis government officials~~
~~c. Health savings account deduction~~
~~d. Moving expenses~~
~~e. Deductible portion of self-employment tax~~
~~f. Contributions to Self-employed SEP, SIMPLE and qualified plans~~
~~g. Self-employed health insurance deduction~~
~~h. h. Penalty on early withdrawal of savings~~
~~i. Alimony paid~~
~~j. Contributions to IRA~~
~~k. Student loan interest deduction~~
~~l. Tuition and fee~~
~~m. Domestic production activities deduction~~
~~n. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses~~
~~o. Certain distributions, payments and student financial assistance for American Indians/Alaska Natives.~~

~~7. The following income types are not reported on Form 1040 and are not countable income under MAGI methodologies:~~
~~a. Child support income~~
~~b. Veteran's benefits (aid and attendance, homebound benefits and reimbursements for unusual medical expenses)~~
~~c. SSI income~~

~~8. Instead of itemized disregards and deductions, a standard disregard equal to 5% of the Federal Poverty Level is allowed under MAGI Methodology.~~

53. 510-05-85-15 – Unearned Income – Removed the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA Medicaid policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Unearned Income 510-05-85-15

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals~~

~~subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

54. 510-05-85-20– Earned Income – Removed the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA Medicaid no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03 Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Earned Income 510-05-85-20

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

55. 510-05-85-30– Disregarded Income – Removed the **introductory** paragraph and reworded the **second** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Disregarded Income 510-05-85-30

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

This section applies to an individual residing in his or her own home or in a specialized facility, to the Medicare Savings Programs, and to the Workers with Disabilities and Children with Disabilities coverages. It does not apply to ~~Transitional Medicaid Benefits (refer to 05-50-05), or~~ to an individual 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, 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).

56. 510-05-85-35– Disregarded Income – Removed the **introductory** paragraph and reworded the **second** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Income Deductions 510-05-85-35

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

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, ~~but does not apply to Transitional Medicaid Benefits~~. 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, 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.

57. 510-05-85-40–Income Levels
    - Removed 1.a. as the income level for the Family Coverage Group will be retained in the Archived Sections of Manual Chapter 510-05.
    - Removed the "Parents, Caretaker Relative's and their Spouses' group income levels from 1.b. as this information is being moved to the new ACA Service Chapter 510-03.
    - Removed 1.c. and 1.d. as this information is being moved to the new ACA Service Chapter 510-03.

- Removed reference to Poverty Levels for Children and Families in #3.c. and 3.e. as this information is being moved to the new ACA Service Chapter 510-03. (3.d. has been re-lettered to 3.c. and 3.f. and 3.g. have been re-lettered to 3.d. and 3.e.).
- Added the updated Income Levels. This supersedes IM 5200.

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 income levels.

~~a. Family Coverage group. The family size is increased for each unborn when determining the appropriate family size. This is for households who applied and were found eligible for benefits starting prior to January 1, 2014.~~

~~Number of Persons~~	~~Monthly Income Level~~
~~1~~	~~$311~~
~~2~~	~~417~~
~~3~~	~~523~~
~~4~~	~~629~~
~~5~~	~~735~~
~~6~~	~~841~~
~~7~~	~~947~~
~~8~~	~~1053~~
~~9~~	~~1159~~
~~10~~	~~1265~~
~~Effective April 1, 2004~~	

~~For each person in the unit above ten, add $107.~~

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

~~Effective for benefits starting January 1, 2014, this group will be the "Parents, Caretaker Relative,s and their Spouses" group. The income level changes for them as follows:~~

~~Number of Persons~~	~~Monthly Income Level~~
~~1~~	~~$ 517~~
~~2~~	~~698~~
~~3~~	~~879~~
~~4~~	~~1060~~
~~5~~	~~1241~~
~~6~~	~~1422~~
~~7~~	~~1602~~
~~8~~	~~1783~~
~~9~~	~~1964~~
~~10~~	~~2145~~
~~Plus - 1~~	~~181~~
~~Effective January 1, 2014~~	

~~c. Effective for benefits starting January 1, 2014, the Adult Expansion group and the Children's group are Categorically Needy Groups. Children ages 6 through 18 and individuals eligible for the Expansion group are covered up to one hundred thirty-three percent of the federal poverty level. They are allowed a disregard of 5% of the federal poverty level. The following table includes this information.~~

~~Number of Persons~~	~~Monthly Income Level~~ ~~133%~~	~~Monthly Income Level Plus 5% Disregard~~ ~~138%~~
~~1~~	~~1274~~	~~1322~~
~~2~~	~~1720~~	~~1784~~
~~3~~	~~2165~~	~~2246~~

4	2611	2709
5	3056	3171
6	3502	3633
7	3947	4096
8	4393	4558
9	4838	5020
10	5284	5483
Plus - 1	446	463
Effective January 1, 2014		

d. Effective for benefits starting January 1, 2014, the Pregnant Women group and the Children's group are Categorically Needy Groups. Children ages 0 through 5 and Pregnant Women are covered up to one hundred forty-seven percent of the federal poverty level. They are allowed a disregard of 5% of the federal poverty level. The following table includes this information.

Number of Persons	**Monthly Income Level** 147%	**Monthly Income Level Plus 5% Disregard** 152%
1	1408	1456
2	1900	1964
3	2392	2474
4	2885	2983
5	3377	3492
6	3870	4001
7	4362	4511
8	4855	5020
9	5347	5529
10	5840	6038
Plus - 1	492	509
Effective January 1, 2014		

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

2. Medically needy income levels.

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

Number of Persons	Monthly Income Level
1	~~$795~~ 807
2	~~1073~~ 1088
3	~~1351~~ 1369
4	~~1629~~ 1650
5	~~1907~~ 1930
6	~~2185~~ 2211
7	~~2464~~ 2492
8	~~2742~~ 2773
9	~~3020~~3054
10	~~3298~~3335
Effective April 1, 2014	

   For each person in the medically needy unit above ten, add ~~$279~~ $281 to the monthly amount.

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

Number of Persons	Monthly Income Level
1	$ ~~958~~ 973
2	~~1293~~ 1311
3	~~1628~~ 1649
4	~~1963~~1988
5	~~2298~~2326
6	~~2633~~ 2664
7	~~2968~~ 3003
8	~~3303~~ 3341
9	~~3638~~ 3679
10	~~3973~~ 4018
Effective April 1, 2014	

For each person in the Medicaid unit above ten, add $~~335~~ 338 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 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~~1167
2	~~1551~~ 1573
3	~~1953~~ 1979
4	~~2355~~ 2385
5	~~2757~~ 2791
6	~~3159~~ 3197
7	~~3561~~ 3603
8	~~3963~~ 4009
9	~~4365~~ 4415
10	~~4767~~ 4821
Effective April 1, 2014	

For each person in the Medicaid unit above ten, add $~~402~~ 406to the monthly amount.

~~c. Pregnant women and children under age six. The income level is equal to one hundred and thirty-three percent of the poverty level, applicable to a family of the size involved. The family size is increased for each unborn when determining the appropriate family size. Effective with new applicants and reviews for benefits starting January 1, 2014, pregnant women and children under age 6 will not be covered under this income level. They are also no longer considered to be in the poverty level group. Those approved whose benefits started prior to January 2014 are subject to this income level until their next review.~~

~~Number of Persons~~	~~Monthly Income Level~~
~~1~~	~~$ 1274~~
~~2~~	~~1720~~
~~3~~	~~2165~~
~~4~~	~~2611~~
~~5~~	~~3056~~
~~6~~	~~3502~~
~~7~~	~~3947~~
~~8~~	~~4393~~
~~9~~	~~4838~~
~~10~~	~~5284~~
~~Effective April 1, 2013~~	

~~For each person in the Medicaid unit above ten, add $446 to the monthly amount.~~

d. Qualifying Individuals. The income level is equal to 135% of the poverty level applicable to a family 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	$ ~~1293~~ 1313
2	~~1745~~ 1770
3	~~2198~~ 2226

4	~~2650~~ 2683
5	~~3102~~ 3140
6	~~3554~~ 3597
7	~~4007~~ 4053
8	~~4459~~ 4510
9	~~4911~~ 4967
10	~~5363~~ 5424
Effective April 1, 2014	

For each person in the Medicaid unit above ten, add $~~453~~ 457 to the monthly amount.

~~e. Transitional Medicaid Benefits. The income level is equal to one hundred and eighty-five percent of the poverty level applicable to a family of the size involved.~~

~~Number of Persons~~	~~Monthly Income Level~~
~~1~~	~~$1772~~
~~2~~	~~2392~~
~~3~~	~~3011~~
~~4~~	~~3631~~
~~5~~	~~4251~~
~~6~~	~~4871~~
~~7~~	~~5490~~
~~8~~	~~6110~~
~~9~~	~~6730~~
~~10~~	~~7350~~
~~Effective April 1, 2013~~	

~~For each person in the Medicaid unit above ten, add $620 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 of the size involved.

Number of Persons	Monthly Income Level
1	$ ~~2155~~ 2188
2	~~2909~~ 2949
3	~~3662~~ 3711
4	~~4416~~ 4472
5	~~5170~~ 5233
6	~~5924~~ 5994
7	~~6677~~ 6756
8	~~7431~~ 7517
9	~~8185~~ 8278
10	~~8939~~ 9039
Effective April 1, 2014	

For each person in the Medicaid unit above ten, add $~~754~~ 761 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 involved.

Number of Persons	Monthly Income Level
1	$ ~~1915~~ 1945
2	~~2585~~ 2622
3	~~3255~~ 3298
4	~~3925~~ 3975
5	~~4595~~ 4652
6	~~5265~~ 5328
7	~~5935~~ 6005

8	~~6605~~ 6682
9	~~7275~~ 7358
10	~~7945~~ 8035
Effective April 1, 2014	

For each person in the Medicaid unit above ten, add $~~670~~ 677to the monthly amount.

58. 510-05-85-45 – Determining the Appropriate Income Level in Special Circumstances - Reworded the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

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

This section applies to individuals who ~~applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who~~ are subject to the ~~non-MAGI methodologies~~ Non-ACA Medicaid policies. ~~This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

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 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.

59. 510-05-85-50 – Deeming of Income - Reworded the **introductory** paragraph in this section as this Service Chapter 510-05, Medicaid Eligibility Factors for Non-ACA Medicaid, no longer includes ACA Medicaid policy. ACA Medicaid Policy has been moved to Service Chapter 510-03.

Deeming of Income 510-05-85-50

This section applies to individuals who ~~applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who~~ are subject to the ~~non-MAGI methodologies~~ Non-ACA Medicaid policies. ~~This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

Budgeting 510-05-90

60. 510-05-90-23 – Budgeting Procedures for Financially Responsible Absent Parents - Reworded the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures for Financially Responsible Absent Parents

This section applies to individuals ~~who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals~~ who are subject to the ~~non-MAGI methodologies~~ Non-ACA Medicaid policies. ~~This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

When a **disabled** child resides with a caretaker other than the parent, and the parent's whereabouts are known, an attempt must be made to obtain the parent's income information. When the parent's income information is received,

it is necessary to determine the amount of income that is available to meet the child's needs. The following steps describe the procedure.

~~1. Compute a Family Coverage budget for the parent(s) and their children "living" with them, allowing the appropriate time limited income disregards. (The child who is residing with a caretaker other than the parent is not included in the parent's budget. Refer to 05-35-15(2) for a description of who is considered to be "living" with the parents.) If they pass the family Coverage budget, document that there is no excess income available to the child for whom eligibility is being pursued. The child's case can then be processed without further computations of the parent's income.~~

~~2. If the parent's unit fails the Family Coverage budget, compute a poverty level budget using the appropriate poverty level (100% or 133%) based on the age of the child for whom eligibility is being pursued. If they pass the poverty level budget, document that there is no excess income. The child's case can then be processed without further computations of the parent's income.~~

3. ~~If the parent's unit fails the poverty level budget, c~~Compute a ~~medically needy~~ Affordable Care Act Medicaid budget based on the absent parents household. All ~~excess~~ income ~~(client share (recipient liability)) from the medically needy budget~~ in excess of the highest poverty level utilized in the absent parents household is considered unearned income for the child and is used in the child's budget.

61. 510-05-90-23 – Budgeting Procedures for Pregnant Women – Removed this entire section as it is being moved to the new Service Chapter 510-03.

~~**Budgeting Procedures for Pregnant Women 510-05-90-23**~~

62. 510-05-90-30 – Budgeting Procedures When Adding and Deleting Individuals – Removed the **introductory and second** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures When Adding and Deleting Individuals 510-05-90-30

~~When an individual is added to a MAGI household, a new application for that individual is processed. This may affect the established household.~~

~~The following applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

63. 510-05-90-35 – Budgeting Procedures for Stepparents – Removed the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures for Stepparents 510-05-90-35

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13 and Relative Responsibility 510-05-35-20.~~

64. 510-05-90-40 – Budgeting Procedures for Unmarried Parents with Children – Removed the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures for Unmarried Parents with Children 510-05-90-40

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals~~

~~subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

65. 510-05-90-45 – Budgeting Procedures for SSI Recipients – Removed wording that differentiates between non-MAGI and MAGI as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures for SSI Recipients 510-05-90-45
~~For non-MAGI Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014:~~
For aged, blind, or disabled individuals who are categorically needy SSI beneficiaries, the following procedures apply:

1. SSI recipient living in their own home: All income, including deemable income, is normally considered by the Social Security Administration in determining the SSI benefit amount. In those situations it is not necessary to rebudget to determine Medicaid income eligibility. There are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

   A SSI recipient is considered part of the family unit as described below:
   a. A SSI recipient is included as part of the family unit when determining asset eligibility;
   b. A caretaker receiving SSI benefits is included in the family unit for budget purposes due to the caretaker's financial responsibility for spouse and children; and
   c. A child receiving SSI benefits is not included in the family unit for budget purposes.

2. SSI recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID) (including the Anne Carlsen facility) are allowed the ICF-ID income level. Those residing in a nursing facility, the state hospital, the Prairie at Saint John's Center, the Stadter Center, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital. The

SSI recipient is allowed the nursing care income level. Also see State LTC Subsidy Program 510-05-95-45.

Parental and spousal income is not considered available to the recipient.

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

3. SSI recipients living in a specialized facility: All income is normally considered by the Social Security Administration in determining the SSI benefit amount. There are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

   If the individual is under 18 years of age and enters the specialized facility from a public institution or the parental home, consider the income of the individual and parents. 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 is married, the income of the individual and of the spouse must be considered. If the Medicaid unit in the home is ineligible, a disregard of 75% of the excess income is allowed in determining client share.

4. SSI recipients electing to receive HCBS: Verification of SSI eligibility satisfies income eligibility for Medicaid, and it is not necessary to rebudget to determine Medicaid income eligibility. There are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

   The maintenance needs of the SSI recipient are considered met by virtue of receipt of SSI, so income of a spouse or parents cannot be deemed to bring the recipient up to the medically needy income level.
   The recipient must be screened for and receiving HCBS.

5. SSI recipients choosing to be eligible as a child or caretaker: The SSI recipient is not treated as aged or disabled for budgeting, but is treated as a ~~child or caretaker as described in 05-90-50, Budgeting Procedures for the Family Coverage Group, or 05-90-55, Budget Procedures for Medically Needy and Poverty Level~~ child or caretaker and budgeted using ACA Medicaid policies.

   ~~The recipient's SSI payment is counted as unearned income in the budget process.~~

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

~~1. SSI individuals must first be tested under the non-MAGI methodologies and, if eligible, budgeted under the non-MAGI rules above.~~
~~2. If the SSI recipient is not eligible under the non-MAGI methodologies (excess assets), the individual may be eligible under one of the MAGI coverages. In those cases, MAGI budgeting applies. See MAGI Income Methodologies 510-05-85-13.~~

66. 510-05-90-45-05 – Budgeting Procedures for those Claiming to be Disabled (non-SSI) – Removed this entire section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

~~Budgeting Procedures for those Claiming to be Disabled (non-SSI) 510-05-90-45-05~~

67. 510-05-90-50 – Budgeting Procedures for the Family Coverage Group – Removed this entire section as policies prior to January 1, 2014 are in the Archived Sections of Manual Chapter 510-05.

~~Budgeting Procedures for the Family Coverage Group~~

68. 510-05-90-55 – Budget Procedures for Medically Needy and Poverty Level
    - Removed the **introductory** paragraph in this section as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.
    - Removed number 5 as these individuals must be processed under ACA Medicaid Policy, which has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

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

~~This section applies to individuals who applied for and were found eligible for Medicaid benefits to start prior to January 1, 2014, and to individuals who are subject to the non-MAGI methodologies. This does not apply to individuals subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.~~

~~5. Individuals not in parental home: Parental income is not considered for a single individual under age 21 who is "living independently." Parental income must be considered for a single individual under age 21 who is only temporarily living outside the parental home.~~

~~If the individual under the age of 21 is married, the income of the individual and spouse must be considered to determine eligibility.~~

69. 510-05-90-75 – Budgeting Procedures for Continuous Eligibility for Children Under Age 19
    - Removed the wording 'For Applications and Reviews received Prior to January 1, 2014 for benefits required prior to January 1, 2014:
    - Removed the wording and information under the section titled 'For Applications and Reviews Received on or After October 1, 2013 for benefits beginning January 1, 2014:' as this Service Chapter 510-05, Eligibility Factors for Non-ACA (Affordable Care Act) Medicaid, no longer includes ACA policy. ACA Policy has been moved to Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid.

Budgeting Procedures for Continuous Eligibility for Children Under Age 19 510-05-90-75

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

1. When a child becomes continuously eligible for Medicaid, that child continues to be eligible without regard to any changes in income and/or expenses of the Medicaid unit until the next review. Likewise, a continuously eligible child can move from one coverage category to another (e.g. Foster Care to Poverty Level); however, if PL eligible and income increases to above PL, the child remains PL eligible until the end of their continuous eligibility period.

2. For a continuously eligible child residing in a nursing facility, the state hospital, the Prairie at Saint John's Center, the Stadter Center, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: the recipient is allowed the $65 nursing care income level and excess income becomes client share (recipient liability).

   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 19, parental income is not considered available during any full calendar month the recipient is in the facility. If the individual has no source of income, and is ineligible for SSI, the income of the parents may be deemed in the amount of $65, (or $100, if the individuals is in an ICF-ID) to meet the maintenance needs of the individual.

   NOTE: The premium calculation for Children/Workers with Disabilities is still required.

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

1. ~~When a child becomes continuously eligible for Medicaid, that child continues to be eligible without regard to any changes in income and/or expenses of the Medicaid unit until the next review.~~

2. ~~For a continuously eligible child residing in a nursing facility, the state hospital, the Prairie at Saint John's Center, the Stadter Center, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: the recipient is allowed the $65 nursing care income level and excess income becomes client share (recipient liability).~~

Typo Correction Needed

~~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 19, parental income is not considered available during any full calendar month the recipient is in the facility.~~

~~**NOTE:** The premium calculation for Children/Workers with Disabilities is still required.~~

Forms Appendix 510-05-100

70. 510-05-100-85 – SFN 527, Family Coverage Budget Worksheet
    - Removed this form as it has become obsolete. It can continue to be found in the Archived Sections of Manual Chapter 510-05.

~~**SFN 527, Family Coverage Budget Worksheet 510-05-100-85**~~

~~The Family Coverage Budget Worksheet is intended to serve as a basic tool to be utilized in understanding the determination of initial and continuing eligibility for the Family Coverage group.~~

~~This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (110 kb pdf)~~
~~E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader.~~

~~If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.~~

Budgeting Workbook 510-05-100-100

71. 510-05-100-100 – Budgeting Workbook
    - Removed the Family Coverage Budget Examples and Transitional Medicaid Budget Examples' as these are no longer needed and will be retained in the Archived Manual.

~~Family Coverage Budget Examples~~

~~Transitional Medicaid Budget Examples~~