Par. 1. Material Transmitted and Purpose – Transmitted with this Manual Letter are changes to Service Chapter 510-05 Medicaid Eligibility Factors. New language is in red and underlined and removed language has been struck through. This supersedes IM 5179 "Healthcare Reviews due in January, February, and March 2014" and IM 5183 "Irrevocable Burials". This manual letter includes changes mandated by the Affordable Care Act. These changes are effective October 1, 2013 unless otherwise indicated.

Definitions 510-05-05

Definitions applicable to the Affordable Care Act are added to this section. These apply to **changes** in policy.

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).

Fee for Service

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

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.

MAGI Household

A household required to be budgeted using MAGI methodologies. This includes the Adult Expansion Group, Parents, Caretaker Relatives, and their Spouses, Children, and Pregnant Women.

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.

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-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.

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.

Nondiscrimination in Federally Assisted Program 510-05-10-10

The third paragraph of this section is **updated** with the correct address at the Denver regional office for filing discrimination questions and complaints.

The Department of Human Services makes available all services and assistance without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage or public assistance, in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the North Dakota Human Rights Act of 1983. Persons who contract with or receive funds to provide services for the North Dakota Department of Human Services are obligated to abide by the provisions of these laws. The

Department of Human Services makes its programs accessible to persons with disabilities. Persons needing accommodation or who have questions or complaints regarding the provisions of services according to these Acts may contact the Civil Rights Officer, North Dakota Department of Human Services, Judicial Wing, State Capitol, 600 E. Boulevard Avenue Dept. 325, Bismarck, ND 58505 or the US Department of Health and Human Services, Office for Civil Rights, Region VIII, 999 18th Street, Suite 417 ~~Federal Office Building, 1961 Stout Street, Suite 1426,~~ Denver, Colorado 80202 ~~94~~ or call 1-800-368-1019 ~~1018 or 303-844-2024~~ (voice) or ~~303-844-3439 (TDD)~~ 1-800-537-7697 (TTY) or 303-844-2025 (FAX).

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

Language is added to subsections 2 and 6 to include the **change** to policy to send a copy of all fraud referrals to the Medicaid Eligibility Unit in addition to the SURS unit.

2. Suspected provider related errors must be reported to the Surveillance Utilization Review (SURS) Unit in the Medical Services Division using SFN 20, "SURS Referral Form"~~.~~ with a copy to the Medicaid eligibility unit. SFN 20 may be sent to SURS as described in 6 below. The SURS unit will be responsible for recoupment from any provider.

6. All recipient errors in which there is an overpayment or suspected fraud (regardless of overpayment) must be referred to the Surveillance Utilization Review (SURS) Unit in the Medical Services Division using SFN 20, "SURS Referral Form"~~.~~ with a copy to the Medicaid eligibility unit. SFN 20 may be sent to SURS by:

   a. Mail: SURS, 600 East Boulevard Avenue, Department 325, Bismarck, ND 58505;

   b. Fax: 701-328-1544; or

   c. Email: medicaidfraud@nd.gov.

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

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

Home and Community Based Services (HCBS) 510-05-15-05

Language is added to subsection 1 to include **changes** mandated under federal and state law. Language is added to subsection 5 to **clarify** the length of long term stay required for eligibility under this grant. Language is added to **update** subsection 8.

1. Waiver for Individuals with Intellectual and Developmental~~ly~~ Disab~~led~~ities: Home and Community Based Services are provided to individuals who meet the ~~developmental disability~~ eligibility criteria for early intervention services for infants and toddlers under the age of three; individuals who have an intellectual disability and/or meet the criteria for a developmental disability prior to the age of 22 and who are screened to the ICF-ID (intermediate care ~~–~~ facilities for intellectual disabilities~~ mentally retarded~~ level of care). These individuals generally meet the disability criteria of the Social Security Administration; however, the few who do not may still be eligible for these ~~wavered~~ waivered services. Waiver services include residential services, day services, employment supports, family support services, parenting supports, extended home health care and financial help with the cost of equipment, supplies and environmental modifications. The waiver covers services provided by licensed providers and some services can be directed by the waiver recipient. (Began in 1981.)

5. Money Follows the Person Grant: This Grant program assists recipients who are residing in a nursing facility or an ICF/ID who want to transition from an institutional care setting to a HCBS setting. Recipients must have been residing in the institutional setting for a period of 3 consecutive months or more, be screened as requiring care in a nursing facility or ICF/ID, and be Medicaid eligible for at least ~~30 days immediately prior to transition~~ the last day of receipt of institutionalized service. (Began June 20, 2008.)

8. Autism Spectrum Disorders Waiver for Birth Through Age 4: Provides multiple services to a family with a child from birth to their 5th birthday who are eligible for Developmentally Disabled Program Management, have a confirmed diagnosis on the Autism Disorder Spectrum, meet the ICF/IID level of care, and are eligible for Medicaid. These services build on existing services available in North Dakota. Families will also receive training, help in coordinating services, and access to in-home support staff to help provide structured activities that focus on communication, behavior, and other individual needs. The waiver also provides financial help with the cost of equipment, supplies, and environmental modifications. The waiver is limited to 30 recipients in a 12-month period. (Began November 1, 2010.)

Application and Review 510-05-25-05

Language is added to subsection 1 to include the additional applications and review procedures as prescribed by the Affordable Care Act. This is a **change** in policy. The SFN 502 is removed as it must no longer be used after October 1, 2013. Language is added to record the waiver postponing reviews for households now requiring MAGI-methodologies from the first quarter to the second quarter of 2014. **This supersedes IM 5179** "Healthcare Reviews due in January, February, and March 2014".

1. Application.

   c. An application is a request for assistance ~~on~~:

      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-MAGI households):

i. SFN 405, "Application for Economic Assistance Programs";

~~ii. SFN 502, "Application for HealthCare Coverage for Children, Families, and Pregnant Women";~~

~~iii.~~ii. SFN 641, "Title IV-E/Title XIX Application-Foster Care";

~~iv.~~iii. SFN 1803, "Subsidized Adoption Agreement";

~~v.~~iv. SFN 958, "Health Care Application for the Elderly and Disabled";

~~vi.~~v. The Department's system generated "Statement of Facts" (this may no longer be accepted as a Medicaid application after 12-31-13.);

~~vii.~~vi. The Department's online "Application for Economic Assistance Programs";

~~viii.~~vii. The Low Income Subsidy file from SSA;

~~ix.~~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);

~~x.~~ix. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or

~~xi.~~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.

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.

2. Review.

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; ~~or~~

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

vii. The on-line review through OASYS; or

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

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-MAGI households, ~~I~~in circumstances where a desk review is appropriate, such as when adding a child, moving to Transitional Medicaid Benefits, processing a change in the level of care, aligning review dates with Healthy Steps, SNAP, or TANF, or adding Medicare Savings Programs coverage; and in which the county agency has all information needed to complete a review, eligibility may be established without a review form. ~~In unique circumstances, w~~ When the county agency has all information needed to complete a review, ~~and circumstances prevent a recipient or their representative from timely returning the review form,~~ continued eligibility ~~may~~ 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 ~~should~~ 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.

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

Subsection 1 has language added to include the **new policy** as it regards to treatment of applications received for coverage under the Adult Expansion Group from October 1, 2013 through December 31, 2013. Subsection 2 has language added to **clarify** the processing of retroactive months for applications received from January 1, 2014 through March 31, 2014.

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.

Duty to Establish Eligibility 510-05-25-15

Language is added to this section to **clarify** that workers may not request information from the household that is already available to the worker through other sources.

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

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

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

Decision and Notice 510-05-25-25

An introductory paragraph is added to this section to **clarify** that clients have a choice as to how they are notified.

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

Appeals 510-05-25-30

Language is added to subsection 3 to **clarify** that continuation of benefits (when an appeal request is received prior to the effective date of the adverse action) continues even in those situations where a review of eligibility is due prior to the final decision on the appeal. This is per 42 CFR 431.230

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

Groups Covered Under Medicaid 510-05-30-05

Language is added to this section to show the **change** in coverage groups effective January 1, 2014.

Groups Covered Under Medicaid on or after January 1, 2014:

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. Categorically Needy Group:

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

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

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

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

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

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

vii. 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. 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. Optional Categorically Needy Group:

i. Uninsured women under age 65, who are not otherwise eligible for MAGI or non-MAGI 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. Workers with Disabilites (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. 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. Medically Needy Group:

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

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

d. The poverty level group includes:

i. 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. 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. 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. 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.

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.

Applicant's Choice of Category 510-05-30-10

This section is updated to **clarify** the correct treatment of SSI disabled individuals.

An individual who could establish eligibility under more than one category, such as between aged, blind, or disabled categories and family coverage 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 children and family category.

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-MAGI methodologies and only if they fail non-MAGI methodologies (such as excess assets) may they be tested under one of the MAGI groups. This also applies to SSI recipients who also may be pregnant women. See also "Blindness and Disability" 510-05-35-100 and "Budgeting for Individuals claiming to be Disabled" 510-05-90-45-05 for information as how to treat non-SSI disabled individuals.

Medicaid Unit 510-05-35-05

Language is changed to include the **change** in policy effective 01-01-14 due to ACA.

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.

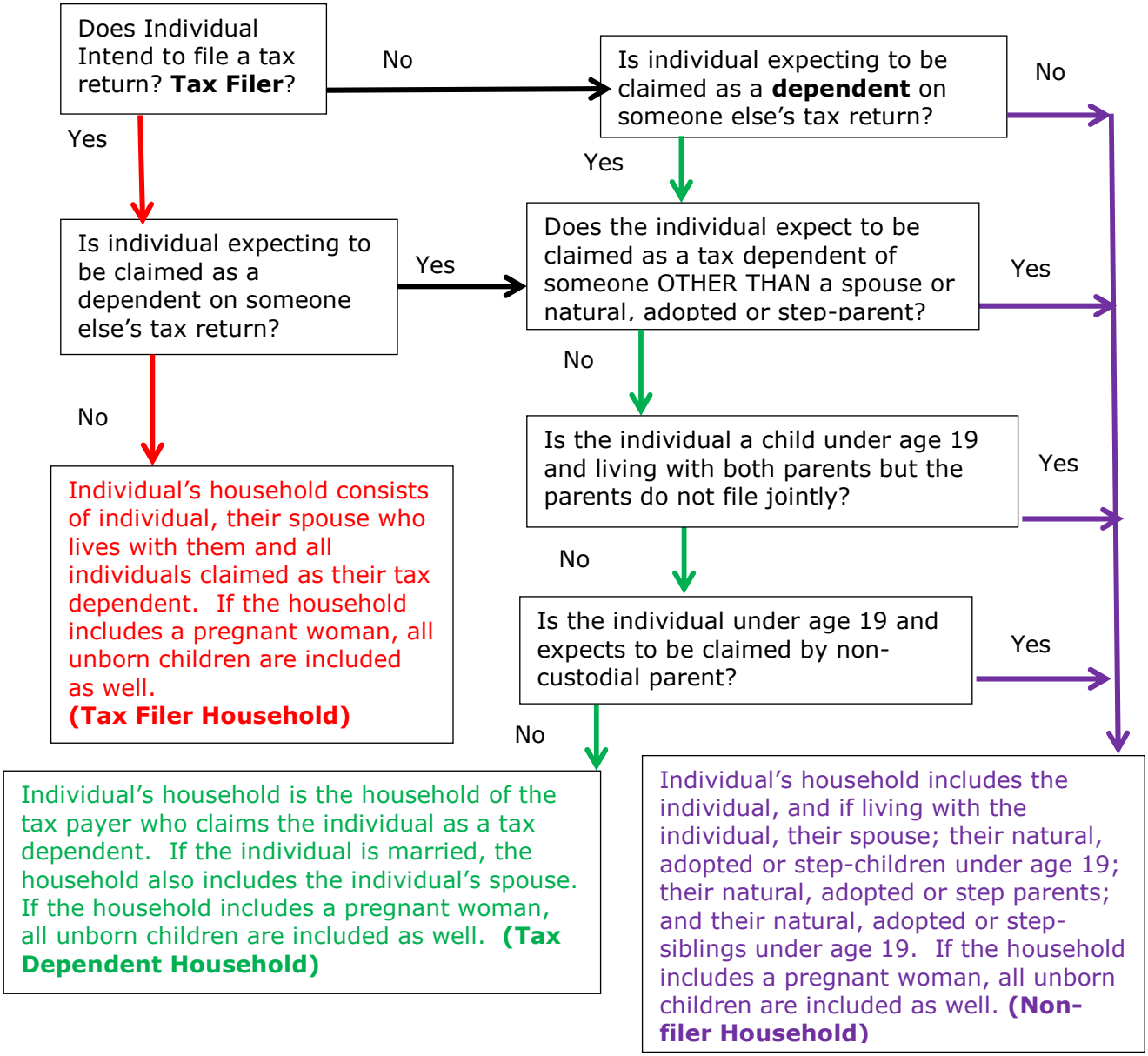
B. If "No" – the household is the household of the taxpayer that claims the individual as a tax dependent. If the individual is married, the household also includes the individual's spouse. This is known as the tax dependent household.

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



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 caretaker of children under twenty-one years of age may select the children who will 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 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.

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).

Deprivation 510-05-35-10

Subsections 1 (j), 4 and 5 are **updated** to note the change from the 'Family Coverage' Group to the 'Parents, Caretakers and their Spouse's' Group.

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:

   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.)

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).

Relative Responsibility 510-05-35-20

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

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.

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. 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.

Screening for Nursing Care, ICF-ID or HCBS Recipients 510-05-35-25

Subsection 3 is updated to include the **change** made by the Affordable Care Act.

3. Applicants or recipients who seek nursing care services in the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other institution for mental disease (IMD) and who are:

   a. Age 65 or older are not required to be screened.
   b. Age 22 to 65 are not eligible for Medicaid~~.~~ until January 1, 2014, when individuals 19 to 64 will be covered under the adult expansion group. Because this group will have insurance, these individuals will be subject to the requirements of the insurance plan.
   c. Under age 22 who have obtained a certification of need may be eligible as described in 05-35-30.

Non-Qualified Aliens 510-05-35-55

Subsection 1 is changed to comply with the **change** in the state residence rules mandated in the Affordable Care Act that allows ineligible aliens to be covered for emergency services.

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

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

Subsection 1 is changed to comply with the **change** in the state residence rules mandated in the Affordable Care Act that allows ineligible aliens to be covered for emergency services.

Non-Qualified aliens—Ineligible aliens, ~~I~~illegal aliens, permanent non-immigrants (identified in subsection 3 of 05-35-55), and qualified aliens, who are not eligible for Medicaid because of the time limitations or forty qualifying quarters of social security coverage requirement, may be eligible to receive

emergency services that are not related to an organ transplant procedure, if all of the following conditions are met:

1. The alien has a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a. Placing health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.

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

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

State Residence 510-05-35-85

Subsections 2(a) and 3(a) have the "permanently or for an indefinite period" language remove as mandated by ACA. This **change** is effective January 1, 2014.

An individual must be a resident of North Dakota to be eligible for Medicaid through this state. A resident of the state is an individual who is living in the state voluntarily and not for a temporary purpose. Temporary absences from the state with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished, do not interrupt continuity of residence. Residence is retained until abandoned or established in another state.

1. For individuals entering the state, the earliest date of residency is the date of entry. Residence may not be established for individuals who claim residence in another state.

   An individual's Medicaid case may remain open in the other state for a period of time after the individual moves, however, most states will not cover out-of-state care so eligibility may be determined as of the date the individual entered the state. If the other state will pay for the care in North Dakota, wait to open the case until the other state stops the coverage. Likewise, when an individual leaves the state, eligibility is ended as soon as, and in accordance with, proper notice. North Dakota Medicaid will no longer extend coverage through the month in which an individual moves out of the state. This information must be documented in the casefile.

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.

   b. For any individual who is receiving foster care or adoption assistance payments, under Title IV-E, from another state and is living in North Dakota, North Dakota is the state of residence for Medicaid purposes.

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

member state and which state is responsible for the medical coverage per the agreement.

c. For any individual under age twenty-one not residing in an institution, whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

d. For any other non-institutionalized individual under age twenty-one, the state of residence is the state in which the child is living with the child's parent or another caretaker relative on other than a temporary basis. A child is normally considered to be living in the state temporarily if:

i. The child comes to North Dakota to receive an education, special training, or services in the Anne Carlson School, maternity homes, vocational training centers, etc. if the intent is to return to the child's home state upon completion of the education or service;

ii. The child is placed by an out-of-state court into the home of relatives or foster parents in North Dakota on other than a permanent basis or on other than an indefinite period; or

iii. The child entered the state to participate in Job Corps or other specialized services if the intent is to return to the child’s home state upon completion of the activity or service.

e. For any institutionalized individual under age twenty-one, who is neither married nor living independently, residence is that of the parents or legal guardian at the time of placement or the state of residence of the parent or legal guardian at the time of Medicaid application if the child is institutionalized in the same state. Only if the parental rights have been terminated, and a guardian or custodian appointed, may the residence of the guardian or custodian be used. If the individual has been abandoned by his parents and does not have a guardian, the individual is a resident of the state in which the individual lives.

3. Individuals age twenty-one and over:

   a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period or is entering the state with a job commitment or seeking employment.

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

   b. For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.

   c. For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

4. An "individual incapable of indicating intent" means one who:

   a. Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the Division of Mental Health of the Department of Human Services;
   b. Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01;
   c. Has been found by a court of competent jurisdiction to be legally incompetent; or
   d. Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation.

5. Individuals placed in out-of-state institutions by a state agency retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. State residence ends, however, when the

competent individual leaves the facility in which the individual was placed by the state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

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

6. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.

7. For any individual on whose behalf payments for regular foster care are made, the state of residence is the state making the payment.

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.

9. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.

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

    e. Services are received during an eligible period but prior to application.

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

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.

    b. For any individual who is receiving foster care or adoption assistance payments, under Title IV-E, from another state and is living in North Dakota, North Dakota is the state of residence for Medicaid purposes.

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

c. For any individual under age twenty-one not residing in an institution, whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

d. For any other non-institutionalized individual under age twenty-one, the state of residence is the state in which the child is living with the child's parent or another caretaker relative on other than a temporary basis. A child is normally considered to be living in the state temporarily if:

i. The child comes to North Dakota to receive an education, special training, or services in the Anne Carlson School, maternity homes, vocational training centers, etc. if the intent is to return to the child's home state upon completion of the education or service;

ii. The child is placed by an out-of-state court into the home of relatives or foster parents in North Dakota on other than a permanent basis or on other than an indefinite period; or

iii. The child entered the state to participate in Job Corps or other specialized services if the intent is to return to the child’s home state upon completion of the activity or service.

e. For any institutionalized individual under age twenty-one, who is neither married nor living independently, residence is that of the parents or legal guardian at the time of placement or the state of residence of the parent or legal guardian at the time of Medicaid

application if the child is institutionalized in the same state. Only if the parental rights have been terminated, and a guardian or custodian appointed, may the residence of the guardian or custodian be used. If the individual has been abandoned by his parents and does not have a guardian, the individual is a resident of the state in which the individual lives.

3. Individuals age twenty-one and over:

   a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there or is entering the state with a job commitment or seeking employment.

   b. For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.

   c. For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

4. An "individual incapable of indicating intent" means one who:

   a. Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the Division of Mental Health of the Department of Human Services;
   b. Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01;
   c. Has been found by a court of competent jurisdiction to be legally incompetent; or
   d. Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation.

5. Individuals placed in out-of-state institutions by a state agency retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. State residence ends, however, when the competent individual leaves the facility in which the individual was placed by the state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

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

6. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.

7. For any individual on whose behalf payments for regular foster care are made, the state of residence is the state making the payment.

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.

9. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.

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 except in those cases where Medicaid has purchased an insurance policy for an individual. In such cases, transportation is arranged jointly by the insurance carrier and the individual.

    c. Individuals are absent from the state for a limited period of time to receive special services or training;

    d. It is an emergency situation; and

    e. Services are received during an eligible period but prior to application.

Blindness and Disability 510-05-35-100

Subsection 8 is added to this section to address appeals of Social Security Findings. This is a **clarification** of policy. Subsection 9 is added to this section to address the medically frail as prescribed under the Affordable Care Act effective with applications for benefits to start January 1, 2014. This is a **change** in policy.

8. All SSI or SSA denials or terminations based on disability which are reversed on appeal will automatically reverse the Medicaid disability based denial or termination if the person notifies the county agency within six months of the date of the notice informing the person that they won the SSI or SSA appeal.
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.

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

General Information 510-05-45-05

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

Eligibility for this group is based on section 1931 of the Social Security Act. Section 1931 intended to assure coverage for low-income families by requiring eligibility to follow certain policies that were in effect in the state AFDC plan as of July 16, 1996. It allows the use of less restrictive policies, however, does impose some limits. Section 1931 of the Act became effective July 1, 1997. The Affordable Care Act of 2009 changed the make-up of this group to Parents, Caretaker Relatives and their Spouses, moving children and pregnant women to their own groups effective for benefits starting January 1, 2014.

For Applications and Reviews Received From July 1, 1997 through December 31, 2013 requiring benefits prior to January 1, 2014:

All medically needy technical and financial eligibility policies apply to the Family Coverage group except as identified in section 05-45-10 through 05-45-35.

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

All policies related to the Modified Adjusted Gross Income (MAGI) methodologies apply to the Parents, Caretaker Relatives and their Spouses group.

Individuals Covered 510-05-45-10

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

For Applications and Reviews Received From July 1, 1997 through December 31, 2013 requiring benefits prior to January 1, 2014:

Caretakers, pregnant women, and children who meet the requirements of this section are eligible under the Family Coverage group.

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

Parents, caretaker relatives, and their spouses who meet the requirements of this section are eligible under the 'Parents, Caretaker Relatives, and their spouses' group.

Family Composition 510-05-45-15

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

For Applications and Reviews Received From July 1, 1997 through December 31, 2013 requiring benefits prior to January 1, 2014:

1. Families eligible under the Family Coverage group must contain a child, which can include an unborn, that is eligible under this section, or is in receipt of SSI, and that is deprived of a natural or adoptive parent's support or care. Deprivation is described at 05-35-10 and includes deprivation due to unemployment or underemployment of a parent.

2. The child described in subsection 1 must be:

   a. Living with a caretaker relative; and
   b. Under age 18, or age 18 and a student (full-time or part-time) in high school or an equivalent level of vocational or technical training if the student can reasonably be expected to complete the high school, GED, or vocational curriculum prior to or during the month the student turns age 19. A child who does not meet this age requirement is not included in any eligibility determinations for the Family Coverage group.

3. The parents of a caretaker who is at least age 18, or if under age 18 is married or is not residing with the parent(s), may not be included in the same family unit as the caretaker.

   If a teenage parent under age 18 moves out of the parental home of the teenage parent other than temporarily, the teenage parent and child(ren) must have their own case if they are eligible under the Family Coverage Group. (Living independently rules do not apply.)

   If the teenage parent and children fail Family Coverage, the living independently rules do apply.

4. In families where the only deprived child is age 18 (including disabled children in receipt of SSI benefits) and is a student anticipated to graduate prior to or during the month of the child's 19th birthday, the parent remains eligible under the Family Coverage group if all other criteria is met.

5. An individual in receipt of Social Security or SSI disability or retirement benefits may choose to be eligible as a disabled or aged individual under the medically needy coverage group, or may choose to be considered a caretaker, or child, under the Family Coverage group. These individuals are included in the unit as follows:

   a. An individual in receipt of Social Security disability or retirement benefits is included in the family unit for determining income eligibility regardless of whether the disabled individual chooses Medicaid eligibility under the medically needy coverage group or the Family Coverage group.

   b. A SSI recipient who chooses to be eligible as aged, blind, or disabled is not eligible for coverage under the Family Coverage group. The SSI recipient, however, is considered part of the family unit as described below.

(1) 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

(2) A child receiving SSI benefits is not included in the family unit for budget purposes.

c. A SSI recipient who chooses to be eligible as a caretaker or child may be eligible under the Family Coverage group, and the individual's SSI income is considered other unearned income.

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

1. Individuals and their spouses eligible under the Parent and Caretaker and their spouses group must live with a child, that is eligible under the children's group, Healthy Steps, or is in receipt of SSI, and that is deprived of a natural or adoptive parent's support or care. Deprivation is described at 05-35-10 and includes deprivation due to unemployment or underemployment of a parent.
2. The child described in subsection 1 must be:

   a. Living with a caretaker relative; and

   b. Under age 19. If a child does not meet this age requirement the parent or caretaker relative included in any eligibility determinations for the Parent and Caretaker group.

3. An individual in receipt of Social Security disability or retirement benefits may choose to be eligible as a disabled individual under the medically needy coverage group, or may choose to be considered a caretaker under the Parent, Caretaker Relative and their Spouses group. These individuals and their spouses are included in the unit as follows:

   A SSI recipient is not eligible for coverage under the Parent, Caretaker Relative and their spouse's group. The SSI recipient, however, is considered part of the family unit in accordance with the individual's tax filing status.

4. In order for the spouse of a parent or caretaker relative to be eligible under this coverage, the spouse must be living with the parent or caretaker relative.

Income Considerations for the Family Coverage Group (Parents, Caretaker Relatives, and their Spouses Group effective 01-01-14) 510-05-45-30

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

For Applications and Reviews Received From July 1, 1997 through December 31, 2013 requiring benefits prior to January 1, 2014:

Medically Needy income considerations, ownership of income, unearned income, and earned income rules apply to the Family Coverage group except when a caretaker does not live with his or her parents, the parents' income is not considered.

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

MAGI methodologies apply to the Parent Caretaker Relatives and their Spouses group for benefits on or after January 1, 2014.

Income Disregards and Deductions for the Family Coverage Group (Parents, Caretaker Relatives, and their Spouses Group effective 01-01-14) 510-05-45-35

Language is added to this section to include the **changes** from the Affordable Care Act effective January 1, 2014.

For Applications and Reviews Received From July 1, 1997 through December 31, 2013 requiring benefits prior to January 1, 2014:

Medically needy income disregards and deductions are allowed for the Family Coverage group except as specified in this section.

1. The following medically needy deductions are not allowed:

   a. The $30 work training allowance; and
   b. The earned income deductions available to applicants and recipients who are not aged, blind, and disabled.

2. The following disregards and deductions are allowed from earned income:

   a. An employment expense allowance equal to $120 of earned income is deducted from the gross earned income of each employed member of the Medicaid unit;

   b. For each employed member of the unit, a disregard equal to 1/3 of the balance of earned income (after deducting the employment expense allowance) is disregarded.

3. The following additional deductions are allowed from earned or unearned income:

   a. The cost of an essential service considered necessary for the well-being of a family is allowed as a deduction as needed. The service must be of such nature that the family, because of infirmity, illness, or other extenuating circumstance, cannot perform independently. An essential service is intended to refer to such needs as housekeeping duties or child care during a parent's illness or hospitalization, attendant services, and extraordinary costs of accompanying a member of the family unit to a distant medical or rehabilitation facility, etc. This deduction is not allowed if any third party, including TANF, pays it; and

   b. When the case includes a stepparent who is not eligible, or when a caretaker who is under age 18 lives at home with both parents and the parents are not eligible under the Family Coverage group, a deduction is allowed for amounts actually being paid by the stepparent or parents to any other persons not living in the home who are, or could be, claimed by the stepparent/parents as dependents for federal income tax purposes.

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

As with all groups covered under the Modified Adjusted Gross Income (MAGI) methodologies 5% **of the Federal Poverty Level** will be disregarded from the modified adjusted gross income. To apply this uniformly, the appropriate income levels are increased by 5% of the Federal Poverty Level.

Note: The 5% disregard is applied only to the highest income level under which the individual may be eligible.

Example: Mary Smith applies for herself and her daughter, Maggie. Mary's income is 55% of the federal poverty level. The first coverage Mary may be eligible under would be the Parents, Caretakers and their Spouses group, which has a 54% federal poverty level. Because Mary Smith can also qualify for the single adult group, which has an income level of 133% poverty, the 5% is not added to the Parent, Caretaker and spouse income level but rather to the adult group, which would increase that income level in Mary's case to 138% federal poverty level.

Extended Medicaid Benefits 510-05-50-10

A new sub-section is added to this section due to **changes** under the Affordable Care Act.

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

Families that cease to be eligible under the Family Coverage group, and who meet the requirements of this section, may continue to be eligible for Medicaid benefits without making further application for Medicaid.

1. Families who were eligible (at least one individual) under the Family Coverage group in at least three of the six months immediately preceding the month in which the family 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 if:

   a. The family has a child living in the home that meets the Family Coverage group age requirements; and

   b. The caretaker relative remains a resident of the state.

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

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

4. If an individual was included as eligible in the Family Coverage case the month the Family Coverage eligibility ended, that individual is included in the Extended Medicaid Benefits. No individuals may be added in to Extended Medicaid Benefits.

5. Children who no longer meet the age requirements under the Family Coverage group are not eligible for Extended Medicaid Benefits.

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

Parents, caretaker relatives and their spouses that cease to be eligible under the Parents, caretaker relatives and their spouses group, and who meet the requirements of this section, may continue to be eligible for Medicaid benefits without making further application for Medicaid.

1. Parents, caretaker relatives and their spouse who were eligible (under the Parents, caretaker relatives and their spouses group in at least three of the six months immediately preceding the month in which the parent/ caretaker relative became ineligible as a result (wholly or partly) of the collection or increased collection of spousal support (alimony) continue eligible for Medicaid for four calendar months if:

    a. The family has a child living in the home that meets the Children's group age requirements; and

    b. The parent/caretaker relative remains a resident of the state.

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

3. A family that seeks to demonstrate eligibility in at least three of the six months immediately proceeding the month in which the family became ineligible must have been eligible in this state in the month immediately preceding the month in which the family became ineligible. Eligibility from

another state may be substituted for the other two months. Verification of eligibility in another state is required.

4. If a parent, caretaker relative, or their spouse was included as eligible in the Parents, caretaker relatives and their spouses' group case the month the Parents, caretaker relatives and their spouses' group eligibility ended, that individual is included in the Extended Medicaid Benefits. No individuals may be added in to Extended Medicaid Benefits.

Foster Care Financial Eligibility Requirements 510-05-55-10

A new sub-section is added to this section due to **changes** under the Affordable Care Act.

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 MAGI methodology.

Former Foster Care Children through Age 26 510-05-55-10-05

This is a new manual section added by the Affordable Care Act mandating the **change** in policy mandating coverage of former foster care children through the month in which they turn age 26.

Individuals who are not eligible under the Parent, Caretaker Relative and their Spouse coverage, the Pregnant Women Coverage or the Adult coverage group, 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.

~~Casey Family Foster Care 510-05-55-13~~

This section is discontinued as there are no longer any kids covered under Casey Family.

~~The Casey Family Foster Care program is not considered foster care for Medicaid purposes because a public agency does not have care, custody, and control.~~

~~Occasionally, a child may go from foster care directly into the Casey Family Foster Care program. In these situations, as long as a public agency still has care, custody, and control, the child is still considered to be in foster care. Casey Family homes are licensed foster homes so all of the foster care requirements are still met. The state does not make a foster care payment so it is considered to be a free foster care placement. Once care, custody, and control are given to Casey Family, the child is no longer considered to be in foster care for Medicaid. Parental income needs to be considered in determining continued eligibility. Parental assets must also be used if the child is eligible as a disabled individual.~~

Volunteer Placement Program 510-05-55-15

Language is added to this subsection to include the **change** in policy that applies the MAGI methodologies to this group effective January 1, 2014.

Children in the Volunteer Placement Program are not considered to be in foster care. The parents retain care, custody, and control of the child; and the income of the child and parents is considered. 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.

The child must be Medicaid eligible to cover medical expenses and the cost of treatment. The Volunteer Placement Program pays the room and board for the

child to the county foster home or to the facility. The Administrators of the Volunteer Placement Program, and Mental Health and Substance Abuse must approve any placement in the Volunteer Placement Program.

Subsidized Guardianship Project 510-05-55-20

Language is added to this section to **clarify** the subsidized guardianship payments are the child's income. Language is also added to differentiate this state funded program from a program funded through Title IV-E with a similar name.

The(insert space here)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(insert space here)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(insert space here)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. 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.

Community Spouse Asset Allowance 510-05-65-20

Language is added to subsection 3 to **clarify** that, while the community spouse is no longer subject to the community spouse asset allowance, the community spouse may not give away or transfer any of their assets without being subject to the disqualifying transfer provisions.

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

Breast and Cervical Cancer Early Detection Program 510-05-67

General Information 510-05-67-05

A note is added to this section to **clarify** coverage under this coverage due to the mandates of the Affordable Care Act.

The breast and cervical cancer early detection group consists of women under age sixty-five who:

1. Are uninsured and not otherwise eligible for Medicaid (If otherwise eligible for Medicaid with a client share (recipient liability), the woman can choose coverage as Medically Needy with a client share or through the Women's Way program);

   Note: Effective with applications received starting October 1, 2013 for benefits to start January 1, 2014 and reviews starting January 1, 2014,

individuals will be first tested under the MAGI methodologies. If an individual is referred by the Health Department for Women's Way treatment and has failed Medicaid under the Parents, Caretaker Relatives, and their Spouses group, and the new Adult Group, the individual may be eligible under the Women's Way treatment program up to two hundred percent of the poverty level. If income is above 200 percent of the poverty level, the individual will be referred to the Federally Facilitated Marketplace to choose a health insurance plan.

2. Have been screened for breast and cervical cancer through the Women's Way Screening Program under the Centers for Disease Control and Prevention's breast and cervical cancer early detection program and have been found to require treatment for breast cancer, cervical cancer, or a precancerous condition relating to breast cancer or cervical cancer;

3. Have family income below 200% of the poverty level; and

4. Meet the residence, citizenship, social security number, and inmates of public institutions requirements.

Assets 510-05-70

General Information 510-05-70-05

Language is added to this section to **clarify** that there is no asset test required for those subject to MAGI methodologies.

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, ~~or~~ the Children with Disabilities coverage, or subject to MAGI methodologies so the asset provisions do not apply to those individuals.

Excluded Assets 510-05-70-30

The examples at subsection 8(a) are rewritten to include the correct treatment of an irrevocable burial. **This supersedes IM 5183.**

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

Example: In 2013, the burial asset exclusion is $6,000 and, while it is not wise to do so, the individual may put the remaining $3,000 of their asset limit into burial funds. If the individual puts $9,000 into an irrevocable burial fund, ~~the whole amount is excluded as an asset because irrevocable burial funds are not countable. The individual may still keep $3,000 in other countable assets. Any further burial funds would be countable towards the $3,000 asset limit.~~ the $9,000 is applied to the $6,000 burial exclusion and the $3000 that exceeds the burial exclusion is a countable asset. This individual may not have one cent in additional assets and be eligible for Medicaid.

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

Example: John Smith purchased a prepaid burial in the amount of $7500 with his local funeral home. The funeral home is the owner of the burial fund, and it is irrevocable. John has also designated $2500 in a CD for his burial. Because irrevocable burial funds ~~are excluded as assets, $7,500 is not a countable asset but must be applied to the $6000 burial exclusion. The $2500 CD designated for burial is a~~

~~countable asset allowing the individual $500 in other assets.~~ must first be applied to the $6000 burial exclusion, $6000 is not a countable asset, but the excess $1,500 is. The $2500 CD designated for burial is also a countable asset which makes John exceed the asset test by $1000 and be ineligible for Medicaid.

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

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

~~This rule prevents sheltering of assets. In the example above, if we were able to apply the countable asset, the savings account toward the $6000 burial exclusion, the full irrevocable amount would be an excluded asset. This would allow too large an amount designated for burial.~~

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

Language is added to subsection 2 to include the **change** in how income is determined for those subject to MAGI methodologies effective with the benefit month of January 1, 2014.

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.

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

Language is added to subsection 2 to include the **change** in how CRP income is determined for those subject to MAGI methodologies effective with the benefit month of January 1, 2014.

2. Income. ~~CRP payments are considered unearned 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.

Exceptions to Disqualifying Transfer Provision 510-05-80-25

Subsection 2 is **updated** to remove the term 'exempt' asset as that term is no longer used.

2. A transfer is not disqualifying to the extent that the asset transferred was any Medicaid ~~exempt or~~ excluded asset other than:

a. The home or residence;
b. Property which is not saleable without working an undue hardship;
c. Excluded home replacement funds;
d. Excluded payments, excluded interest earned on the payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;
e. Life estate interests;
f. Mineral acres;
g. Inheritances, during the six months in which they are excluded; or
h. Annuities.

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

Income Considerations 510-05-85-05

A section is added to this section to address MAGI households and how income will be considered for that population for benefits starting on or after 01-01-14.

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 ~~do~~ 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 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.

Medical Payments 510-05-85-07

Language is added to subsections 2-4 below to include the **change** in how Veteran's Benefits are considered for MAGI households effective January 1, 2013.

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.~~; and~~

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.

MAGI Income Methodologies 510-05-85-13

This is a new section which implements the **change** to MAGI Income Methodologies mandated by the Affordable Care Act of 2009 effective January 1, 2014.

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.

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. 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. 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.

Unearned Income 510-05-85-15

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

Earned Income 510-05-85-20

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

Disregarded Income 510-05-85-30

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

Income Deductions 510-05-85-35

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

Income Levels 510-05-85-40

Subsections 2 (b) and (c) are **updated** to include the increased nursing care and ICF-ID income levels as authorized by the 2013 legislature. This is effective October 1, 2013. Other subsections are **updated** to include the change in income levels due to ACA for benefits starting January 1, 2014. A rounding error in the Medically Needy income levels is also **corrected**.

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 Relatives, 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 April 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 01-01-14		

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 01-01-14		

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
2	~~1072~~ 1073
3	~~1350~~ 1351
4	~~1628~~ 1629
5	1907
6	2185
7	~~2463~~ 2464
8	~~2741~~ 2742
9	~~3019~~ 3020
10	~~3271~~ 3298
Effective April 1, 2013	

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

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

c. ICF-ID income level. The income level for a resident of an Intermediate Care Facility for the intellectually disabled (ICF-ID), including the Anne Carlsen facility, is $100 ~~$85~~ effective ~~January 1, 2010~~ October 1, 2013.

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
2	1293
3	1628
4	1963
5	2298
6	2633
7	2968

8	3303
9	3638
10	3973
Effective April 1, 2013	

For each person in the Medicaid unit above ten, add $335 to 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.

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

Subsection 5 is **updated** to include the increased nursing care and IC-ID income level as authorized by the 2013 legislature. This is effective October 1, 2013.

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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. For an institutionalized spouse with an ineligible community spouse the sixty-five ~~fifty~~ dollar income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse, and any other family members, remaining in the home must be given the community spouse and family member income levels.

7. An individual with no spouse, disabled adult child, or child under age twenty-one at home who enters a nursing facility may receive the medically needy income level for one if a physician certifies that the individual is likely to return to the individual's home within six months. The six-month period begins with the first full calendar month the individual is in the nursing facility. If, at any time during the six-month period, the individual's status changes and the stay in the nursing facility is expected to exceed the six months, the individual is only allowed the $65 ~~$50~~ nursing care income level beginning in the month following the month of the status change.

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

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

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

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

Deeming of Income 510-05-85-50

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

Budgeting Procedures for Financially Responsible Absent Parents 510-05-90-23

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

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

Language is added in incorporate the **change** mandated under the Affordable Care Act.

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

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

When a pregnant woman, whose pregnancy has been medically confirmed, becomes eligible for Medicaid, she continues eligible, without regard to any increase in income of the Medicaid unit, for sixty days after the day her pregnancy ends, and for the remaining days of the month in which the sixtieth day falls. Decreases in income, however, will be considered to further reduce any client share (recipient liability). Likewise, a pregnant woman can move from one coverage type to another (e.g. from Family Coverage to poverty level); however, if poverty level eligible and income increases, the pregnant woman remains poverty level eligible. All other Medicaid eligibility factors continue to apply.

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

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

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

When a pregnant woman under becomes eligible for Medicaid, she continues eligible, without regard to any increase in income of the Medicaid unit, for sixty days after the day her pregnancy ends, and for the remaining days of the month in which the sixtieth day falls. Decreases in income, however, will be considered to further reduce any client share (recipient liability). All other Medicaid eligibility factors continue to apply. After January 1, 2014, only pregnant women under 19 will have a client share (recipient liability).

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

For determinations made after the birth of the baby, the child's birth certificate may be used as verification of pregnancy.

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

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

1. Budgeting procedures used when adding individuals to an eligible unit. Individuals may be added to an eligible unit up to one year prior to the current month, provided the individual meets all eligibility criteria for Medicaid, the eligible unit was eligible in all of the months in which eligibility for the individual is established, and the individual was in the unit in the months with respect to which eligibility for that individual is sought. Client share (recipient liability) will be based on the unit's actual income and circumstances when adding each individual for retroactive periods. Client share must be based on the unit's income and circumstances from the base month, plus the best estimate of each individual's income and circumstances when adding each individual to the current or next month.

   Client share for other individuals in the Medicaid unit who were medically needy eligible may increase or decrease with the addition of the new member. Any client share or lack of, applied to previously paid claims will

not be adjusted; however, the new client share will be applied to any claims billed in the future.

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

2. Budgeting procedures when deleting individuals from a case. When a member of an existing unit is expected to leave the unit during the benefit month, that person may remain as a member of the unit until the end of the benefit month.

Budgeting Procedures for Stepparents 510-05-90-35

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

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. To determine eligibility when both the stepparent and natural parent have income, the county agency must first apply the stepparent's net income against the appropriate income level for the stepparent, spouse and the stepparent's children or children born of this marriage. If the stepparent's income is adequate to meet their needs, the natural parent's net income may then be considered in relation to the needs of the children for whom application is being made. If the stepparent has no income, or if it is sufficient to meet only a portion of the needs of those for whom he is legally responsible, the natural parent's net income shall first be allocated to the remaining unmet needs of

those persons (that he or she is legally responsible for) before being considered available to the children in determining client share (recipient liability).

If the stepparent refuses to provide income or assets, all of the natural parent's income and assets are used to determine the children's need and the natural parent's needs cannot be met.

In double stepparent cases (each spouse has children from a previous relationship) the parents are first budgeted in the unit with their spouse and common children. Any income of the common children is first used to meet the needs of the budget unit of the parents and common children. The budget units unmet needs are then split evenly between the parents, and the parents' income is used to meet the remaining unmet needs. If one parent does not have sufficient income to meet their half of the unmet need, the remaining need for the budget unit can be met with the other parent's income. Any excess income from each parent is then deemed to meet the needs of their own (not common) child(ren).

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

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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.

When budgeting for children whose parents are living together, but are not married:

1. If paternity has not been legally established, but the father's name is on the birth certificate or he has signed the "North Dakota Acknowledgment of Paternity" form, SFN 8195, with a revision date of 4/98 or later, the income of the father must be used to determine Medicaid eligibility. The

assets of the father must also be used if the child is eligible as a disabled individual.

For the month of birth a child's eligibility follows that of the mother. If the mother is eligible for the 60 free days after birth, the child is too. The father's income and, if appropriate, assets are used beginning with the month of birth, however, if they would cause Medicaid ineligibility for the child, the child will remain eligible through the month in which the 60th day falls.

Child care expenses for the child are split between the two parents; however, if half of the deduction is more than one parent's available income, the unused amount of the expense can be deducted from the other parent's income.

2. If paternity has not been legally established, and the father's name does not appear on the birth certificate or he has not signed the "North Dakota Acknowledgement of Paternity" form, SFN 8195, with a revision date of 4/98 or later, the income and assets of the father will not be used to determine eligibility.

3. When the only child in common is an unborn and the prospective parents are unmarried but living together, the unborn's father should be added to the case as of the month in which he joins the household or when paternity is established, whichever is later.

Budgeting Procedures for SSI Recipients 510-05-90-45

Language is added to this section to incorporate the **change** in policy mandated by the ACA.

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.

   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.

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

This is a new section and policy **change** under the ACA as it regards to applications made by the medically frail.

1. Under final rules for the Affordable Care Act published on July 15, 2013, anyone claiming to be disabled is considered to 'medically frail'. Individuals considered medically frail MUST be provided coverage similar to that provided under Medicaid.

2. When an individual applies for Healthcare coverage and states on their application that they are disabled, and neither disability nor assets have been verified, but that individual's MAGI household income is below the income level for the Expansion group, that individual MUST be covered under the expansion group.

   EXCEPTION: If the individual is a Medicare beneficiary and not eligible under the parents, caretaker relative's and their spouses group, that individual must be tested as Non-MAGI under the Aged, Blind and Disabled group.

   Once eligibility under the expansion group is determined, a notice must be sent to the individual asking for verification of their disability and assets in order to determine eligibility under Non-Magi. It is Medicaid's obligation to screen for the disability.

   To facilitate this between the systems, a 'pending' disability case must be established in Vision for the individual, as well as the MAGI case.

   a. If the individual is determined disabled AND passes the asset test, we must move them to Non-MAGI as a disabled individual. This individual receives full Medicaid coverage. If the individual has a client share under Non-MAGI, they have the following options:
      i. Stay non-MAGI (Medicaid state plan) with the calculated client share; or
      ii. Request Workers with Disabilities or Children with Disabilities (Medicaid state plan) with some premium cost; or
      iii. Choose to be covered under the adult expansion group.

Note that coverage under the adult expansion group is only for those individuals not eligible for Medicare A and/or B, and that the insurance coverage under the adult expansion group is not the same as under the Medicaid State plan.

b. If the individual is disabled and fails the asset test, we continue coverage under the Expansion group. This individual will be covered under either the Medicaid state plan or under an insurance plan that covers these individuals as if they were covered under Medicaid -- Medicaid would just pay the premium.

Note: The decision has not as yet been made whether these individuals will have the Medicaid coverage or an insurance plan. That information should be available by mid-October.

Note that coverage under the adult expansion group is only for those individuals **not** eligible for Medicare A and/or B.

c. If not disabled, we continue coverage under the Expansion group. This individual would be covered under the insurance plan that will be provided for all others in the Expansion group. Medicaid will pay the premium, and the coverage will be consistent with the Alternative Benefit Plan, selected for the Expansion population. This coverage is not the same as the Medicaid state plan.

d. If the individual does not cooperate, does not provide verification of disability or assets, or refuses to do so, but is otherwise eligible for Medicaid, we continue coverage under the Expansion group. Medicaid will pay the premium, and the coverage will be consistent with the Alternative Benefit Plan, selected for the Expansion population. This coverage is not the same as the Medicaid state plan.

3. If the countable income exceeds the income level for the expansion group (133% FPL) plus another 5% for disregards (bringing it to 138% FPL), the individual is referred to the Federally Facilitated Marketplace (FFM) to choose a plan and possibly qualify for Advance Premium Tax Credits (APTC).

Budgeting Procedures for the Family Coverage Group 510-05-90-50

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households.

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 Parents, Caretaker Relatives and their Spouses subject to MAGI methodologies. For treatment of income under MAGI methodologies, see MAGI Income Methodologies 510-05-85-13.

All income of the Medicaid unit must be considered. All members of the unit are budgeted under the Family Coverage income levels to determine if Family Coverage eligibility exists.

A budget worksheet for the Family Coverage group can be found at 05-100-85.

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

An introductory paragraph is added to this section to show the **change** in policy that this section does not apply to MAGI households and to incorporate the **change** effective October 1, 2013 in the personal needs allowances for long term care and ICF-ID facilities.

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.

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

   A budget worksheet for the medically needy and poverty level can be found at 05-100-90.

2. Recipients screened for and receiving services in a nursing facility, the state hospital, the Prairie at Saint John's Center, the Stadter Center, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: The recipient is allowed the ~~$50~~ $65 nursing care income level. Individuals age 65 and over who have entered an IMD do not require a screening. Those admitted for a temporary stay keep the same living arrangement they had prior to being admitted to the IMD and remain at the same income level for that living arrangement. Those admitted for an indefinite stay are allowed the ~~$50~~ $65 nursing care level for one.

   Recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID) (including the Anne Carlsen facility): The recipient is allowed the ~~$85~~ $100 ICF-ID income level.

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

   If the individual has no source of income, and is ineligible for SSI, the income of the spouse or parents may be deemed in the amount of ~~$50~~ $65 (or ~~$85~~ $100 if the individual is in an ICF-ID) to meet the maintenance needs of the individual.

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

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

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

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

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

If the individual in the specialized facility is not eligible for SSI and has no source of income or insufficient income, the family at home may deem income to the individual up to the medically needy income level for one.

Remedial services provided in a specialized facility cannot be paid through Medicaid, but can be allowed as a deduction. Remedial services are determined by subtracting the medically needy income level for one from the recipient's remedial cost of care at the specialized facility. The resulting amount is deducted from the individual's income to determine client share. If the actual remedial expense is less than the calculated amount, use the actual amount.

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

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

   The recipient must be screened for and receiving HCBS.

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.

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

Language is added to this section to incorporate the **changes** from the ACA.

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 ~~$50~~ $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 ~~$85~~ $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 ~~$50~~ $65, (or ~~$85~~ $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).

   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.

Primary Care Provider Program 510-05-95-30

The age of children to be enrolled under the PCP program is **changed** effective January 1, 2014, as they will be enrolled in an insurance plan and no longer under Medicaid fee-for-service coverage.

The Department has elected mandatory enrollment of eligible caretaker relatives, poverty level pregnant women, and children ~~21~~ 19 (effective 01-01-14) years of age and under, into managed care. The purpose of this mandatory enrollment is to assure adequate access to primary care, improve the quality of care, promote coordination and continuity of health care, reduce costs, and to assist recipients to use the health care system appropriately. The Primary Care Provider Program also establishes co-payments for certain services. Information about the program can be found in Service Chapter 510-06.

State LTC Subsidy Program 510-05-95-45

This section is updated to reflect the **change** in the long-term care income level and the corresponding increase in the state long term care subsidy to $35 effective October 1, 2013.

1. To qualify, an individual must:

   a. Be a Medicaid recipient;

   b. Be a SSI recipient who receives a SSI payment of $30 per month or less;

   c. Reside in a nursing facility, the state hospital, the Anne Carlsen Center; Prairie at St. John's Center; the Stadter Center; a Psychiatric Residential Treatment Facility (PRTF), an Intermediate Care Facility for the intellectually disabled (ICF-ID); or receive swing bed care in a hospital;

   d. Have total income, between SSI and any other source, of less than $~~50~~ 65 per month; and

   e. Be expected to reside in the facility for the entire calendar month.

2. Determining the amount of the subsidy payment:

   a. The subsidy payment is the difference between the $30 SSI payment level and $~~50~~ 65, less any other income available to the recipient. The maximum subsidy cannot exceed ~~$20~~ $35 per month.

   b. If a recipient receives less than $30 in SSI benefits due to a SSI overpayment, because SSI benefits have not yet been paid, because of other income received by the recipient, because the SSI recipient is eligible under 1619(b), or for any other reason, the subsidy does not increase due to the lower SSI payment. For subsidy calculation purposes, the SSI benefit is calculated at ~~$20~~ $35, even if the amount actually paid is less than that amount.

When a child who is a SSI recipient chooses to be eligible for Medicaid under a children and family eligibility category instead of as a disabled child, the child can still qualify for the subsidy.

Par. 2. **Effective Date** -- This manual letter is effective for the benefit month of **October 2013 except as indicated.**