Service Chapter: Basic Care Program 400-29, Non ACA Medicaid 510-05
Effective Date: July 1, 2026

Overview

Updating the remedial chart to reflect rate changes for all licensed Basic Care facilities.

Updating the income levels for nursing home, PRTF, ICF/ID, community spouse and family member income level in a spousal impoverishment case, SSI subsidy, and personal needs allowance.

Adding a policy for high-level care facilities.

Updating when to send 451.

Removed the criteria the State Review Team uses to make a decision.

Removed duplicative language.

Removed language regarding blindness.

Simplified language.

Description of Changes

1. Resident Payment System 400-29-40-05 – Update

Updating examples with new personal needs rate and calculations.

2. Clothing and Personal Needs Allowance 400-29-45 - Update

Updating the personal needs allowance.

3. List of Licensed Basic Care Facilities 400-29-90-10 – Update

Updating hyperlink with updated remedial rate chart.

4. Blindness and Disability 510-05-35-100 – New & Change

New - Added a policy for individuals in high-level care facilities. Medicaid eligibility does not need to be determined before sending SFN 451 or SFN 228 to the State Review Team.

Change- Medicaid applications no longer have to be pending for 45 days before sending the SFN 451 or SFN 228 to the State Review Team. The application must still be otherwise eligible for Medicaid and must have applied for disability through Social Security.

Change – Removed the section on how the State Review Team makes decisions on Blindness & Disability.

Change – Removed language regarding blindness

Change – Removed duplicative language

5. Income Deductions 510-05-85-35 – Update

Updating hyperlink and updated remedial rate chart.

6. Income Levels 510-05-85-40 – Update

Updating the level for nursing home, PRTF, ICF/ID, ineligible community spouse and the family member income level for each ineligible family member in a spousal impoverishment case.

7. State LTC Subsidy Program 510-05-95-45 - Update

Updating SSI subsidy.

Policy Section Updates

1. Resident Payment System 400-29-40-05

BUDGETING EXAMPLE -- MONTH OF ENTRY INTO A BASIC CARE FACILITY

Scenario – Mr. Jones entered the basic care facility on August 13. For the month of August, he had rent expense. The deductions in the month of entry are personal needs allowance, Medically Needy Medicaid level for one, rent expense, and the MA RL disregard in this case. Following is the example as it would appear in the resident payment system:

GROSS INCOME:		DEDUCTIONS:	
SSI:		Personal needs:	~~150.00~~ 153.00
SSA:	700.00		
VA:		MA Level for One:	~~1,174~~ 1197
OTHER:		Rent:	325.00
		MA RL Deduction:	128.00
TOTAL:	$700.00	Total:	$~~1777.00~~ 1803
		Resident Payment Amt:	00.00

Computation: $700.00 income minus $~~1,777.00~~ 1803 deductions equals $0 recipient responsibility towards room and board expense.

In the month of entry, allow the deduction of Medicaid level for one and reasonable living expenses.

BUDGETING EXAMPLE OF AN INDIVIDUAL IN A BASIC CARE FACILITY

Scenario -- Ongoing case for George Dakota who entered the basic care facility August 29, and the benefit month is December. George receives SSA of $1,033.00 monthly. The deduction allowed is ~~$150.00~~ personal needs allowance (zero MA RL). Following is an example of how the system would budget this situation.

GROSS INCOME:		DEDUCTIONS:	
SSI:		Personal Needs:	~~135.00~~ 153.00
SSA:	1,033.00		
VA:			
OTHER:			
TOTAL:	$1,033.00	Total:	$~~150.00~~ 153.00
Resident Payment Amt:			$880.00

Computation: Income is $1,033.00, minus the allowable deduction of ~~$150.00~~ 153.00 equals the basic care recipient responsibility of ~~$883.00~~ 880.00. The resident is responsible for paying $883 to the basic care facility for room and board.

BUDGETING EXAMPLE – TEMPORARY STAY OF LESS THAN SIX MONTHS

Scenario -- Tom Jones is in a licensed basic care facility recovering from surgery. He will return home within six months. Mr. Jones' stay is temporary; therefore, he is allowed additional deductions such as rent, utilities, and the Medically Needy Medicaid level for one. The additional deductions are allowed in these cases so the individual can maintain their residence while residing temporarily in a basic care facility.

GROSS INCOME:		DEDUCTIONS:	
SSI:	129.00	Personal Needs:	~~150.00~~ 153.00
SSA:	450.00	MA Level for one:	~~1,174~~ 1197
VA:		BC/BS Prc:	319.00
OTHER:			
TOTAL:	579.00	Total:	~~$1643.00~~ 1669.00

Computation: Monthly Income $579.00, a deduction of ~~$1,643.00~~ 1669.00 leaving a recipient responsibility of $0 for room and board.

2. Clothing and Personal Needs Allowance 400-29-45

Each recipient of the Basic Care Assistance Program shall retain ~~$150.00~~ 153.00 per month for clothing and personal needs.

3. List of Licensed Basic Care Facilities 400-29-90-10

Click this link to view and/or print this document.

Blindness and Disability 510-05-35-100

~~1. The definition of blindness in the Social Security Act, Section 1614, for Title II benefits as set forth below, is the definition used in the SSI Program under Title XVI and will be utilized in determining eligibility for applicants for Medicaid who are basing their eligibility on blindness.~~
~~An individual shall be considered to be blind for purpose of this title, if he has central~~

visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central vision acuity of 20/200 or less.

2. The definition of disability in the Social Security Act, Section 1614, for Title II benefits as set forth below, is the definition used in the SSI Program under Title XVI and will be utilized in determining eligibility for applicants for Medicaid who are basing their eligibility on a disability.
An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

3. SSA and SSI final determinations of blindness and disability are binding (42 CFR 435.541) and serve as evidence of the presence or absence of statutory blindness or of disability. An exception to this provision is if the individual has applied for Workers with Disabilities coverage and Social Security's decision established that the individual is not disabled due to substantial gainful activity. In these situations, the State Review Team may make an independent decision.
Presumptive determinations of blindness and disability are not final determinations for Medicaid purposes. Eligibility for Medicaid cannot be determined until a final determination is made. If a final determination will not be made by the Social Security Administration within 90 days after the date of application for Medicaid, the State Review Team will make a determination.

In Title II benefit approvals, the evidence from the Social Security Administration contains the onset of disability for benefits. The onset of disability month for Title II benefits would be the earliest medical approval month provided all other eligibility factors are met.

In SSI approvals, disability determinations are not made prior to the month of SSI application. If the medical request date is prior to the eligibility month for SSI, medical and social information must be submitted to the State Review Team for a disability determination for the period prior to the SSI approval month.

4. The county agency will need to obtain and submit medical and social information to

~~the State Review Team for their evaluation if:~~

~~a. The applicant is requesting assistance for a month prior to the SSI application and Title II (SSA) has not made a disability determination;~~

~~b. The applicant is not eligible for SSI because of the SSI income and resource levels; or, if a Medicaid recipient and the individual has had a non-pay SSI reason of "N01" or "N04" for one year;~~

~~Note: If the individual is "N01" AND is 1619(b) eligible, the individual is still disabled and no evaluation by the State Review team is required.~~

~~c. The applicant refuses to apply for SSI;~~

~~d. The applicant is not eligible for SSA disability due to not being insured;~~

~~e. The applicant is applying for Workers with Disabilities coverage and is not eligible for SSA disability due to substantial gainful activity;~~

~~f. The applicant has applied for SSA disability and a determination is not made within 45 days of the Medicaid application;~~

~~g. The applicant is within six months of reaching full retirement age;~~

~~h. The applicant is requesting assistance under the Children with Disabilities coverage and has not been determined disabled by SSA; or~~

~~i. The individual has been found disabled by either the Veteran's Administration (VA), Workforce Safety and Insurance, or the Railroad Retirement Board (RRB) and a determination by the Social Security Administration has not been made.~~

~~The medical and social information is generally submitted along with SFN 451, "Eligibility Report on Disability/Incapacity" (05-100-40), and if the individual is applying for Workers with Disabilities coverage, SFN 228, "Workers with Disability Report Part II" (05-100-41).~~

~~An individual refusing to apply for SSI should be informed of potential eligibility for SSI and that receipt of SSI may yield a larger amount of total income for the family.~~

~~The State Review Team shall decline to determine blindness or disability for a period of time that such a determination is made for SSI (Title XVI) or Title II disability benefits by the Social Security Administration, except that the State Review Team shall make a decision in those situations in which the individual has applied for Workers with Disabilities coverage and Social Security's decision established that the individual is not disabled due to substantial gainful activity.~~

~~The State Review Team will use the following in determining blindness or disability:~~

1. ~~DETERMINATION OF BLINDNESS: In any instance in which a determination is to be made whether an individual is blind, the individual shall be examined by a physician skilled in the diseases of the eye, or by an optometrist, whichever the individual may select. The State Review Team shall review and compare that report with the state's definition of blindness and determine:~~

~~(1) Whether the individual meets the definition of blindness; and~~
~~(2) Whether and when reexaminations are necessary for periodic reviews of eligibility.~~

~~Redeterminations of blindness are established at the recommendation of the State Review Team, or at such time that activity or behavior on the part of a blind recipient raises doubts about his visual status. The same procedure is utilized in reviews of blindness as in the original determination.~~

2. ~~DETERMINATION OF DISABILITY: In any instance in which a determination is to be made as to whether any individual is disabled, each medical report form and social history will be reviewed by a review team consisting of technically competent persons, not less than a physician and an individual qualified by professional training and pertinent experience, acting cooperatively, who shall determine if the applicant meets the appropriate definitions of disability.~~

5. ~~The state agency may not make an independent determination of disability if the Social Security Administration has made a disability determination or will make a disability determination within ninety days after the date of application for Medicaid.~~

- ~~When a Medicaid application, based on disability, is pending for 45 days, the SFN 451 or the SFN 228 must be sent to the State Review Team. The State Review Team will request the medical information from the applicant. A copy of the request will be sent to the county agency. A decision regarding disability will then be made within the 90 day time period if DDS has not made a decision. However, once the Social Security Disability Determination Services Unit (DDS) eventually makes a disability determination, Medicaid must follow that decision.~~

6. ~~Any medical bills incurred by an applicant upon request of the State Review Team to obtain medical information to determine eligibility will be paid through Medicaid. If the applicant is determined to be ineligible for Medicaid, the medical bills, which are sent to the State Review Team, will be paid through administrative costs.~~

~~7. If an applicant or recipient of SSA/SSI disability is determined by the Social Security Administration to not be disabled or no longer continues to meet the disability criteria, the county agency must then deny or send a ten-day advance notice to close the Medicaid case.~~

~~Occasionally, individuals attending school or receiving vocational rehabilitation services will continue to receive a Social Security benefit though they no longer meet the disability criteria. These individuals are not considered disabled and therefore are not eligible for Medicaid.~~

~~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.~~

Disability 510-05-35-10
(N.D.A.C. Section 75-02-02.1-14)

1. The definition of disability in the Social Security Act, Section 1614, for Title II benefits as set forth below, is the definition used in the SSI Program under Title XVI.

   a. An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

2. SSA and SSI final determinations of disability are binding (42 CFR 435.541) and serve as evidence of the presence or absence of disability. An exception to this provision is if the individual has applied for Workers with Disabilities coverage and Social Security's decision established that the individual is not disabled due to substantial gainful activity. In these situations, the State Review Team may make an independent decision.

3. Presumptive determinations of disability are not final determinations for Medicaid purposes. Eligibility for Medicaid based on disability cannot be determined until a final determination is made. If a final determination will not be made by Social Security within a reasonable period of time after the date of the Medicaid application, the State Review Team will make a disability determination.

4. Social Security records show the start date of the individual's disability. The start date of the disability is the earliest date an individual can be eligible for Medicaid as a disabled person as long as they meet all other Medicaid rules in those months.

5. For SSI, Social Security does not determine a person's disability for any month prior to the month they applied for SSI. If the individual has a medical need in the months prior to the start date of their SSI eligibility and they are otherwise eligible for Medicaid in those months, the zone agency must send the information to the State Review Team so they can make a disability determination.

6. If Social Security determines a person is not disabled or is no longer disabled, the zone agency must determine if the individual is eligible for a different coverage type. Sometimes, individuals in school or job training still get Social Security benefits even if they no longer meet the disability rules. These individuals are not considered disabled and cannot get non-ACA Medicaid.

7. The State Review Team can make a disability determination when an individual has applied for or is requesting Medicaid based on disability. If they have applied for disability but the SSA has not yet made a determination or will not make a decision, the zone agency will complete and send an SFN 451 to the SRT. Note: If a child is applying for CWD, an SFN 451 and an SFN 228 must both be sent to the SRT. The SRT will make an interim disability determination when:

   a. The individual has applied for or is requesting Medicaid, they are otherwise eligible for a disability-based Medicaid coverage, and they have a pending SSA disability application.

   b. The applicant is in a high-level facility such as a hospital and it's necessary to move them to a different facility such as a nursing home, group home, or into

the community. In these instances, the SFN 451 can be sent to the State Review Team without verifying they applied for disability or if they are otherwise eligible for Medicaid. However, if the individual has not already applied for disability through SSA, the State Review Team determination may be delayed until verification is received that they applied for disability through the SSA.

c. SSA did not make an SSI disability determination for a month prior to the SSI application month and the applicant requested Medicaid and is otherwise eligible for that month.

d. The applicant may be disabled but SSI did not make a determination because the individual exceeds the SSI income and resource levels.

e. The Medicaid recipient has had a non-pay SSI reason due to income and asset levels for one year. **Note:** If the individual is non-pay due to income levels AND is 1619(b) eligible, the individual is still disabled and no evaluation by the State Review Team is required.

f. The applicant is not eligible for SSA disability due to not having met the work quarter requirements. This is also known as 'active uninsured'.

g. The applicant is applying for Workers with Disabilities coverage and is not eligible for SSA disability due to substantial gainful activity.

h. The applicant is within 6 months of reaching full retirement age so SSA may not make a disability determination.

i. The applicant is requesting assistance under the Children with Disabilities coverage and has not been determined disabled by SSA.

j. The applicant has been found disabled by the Veterans' Administration (VA), Workforce Safety and Insurance (WSI), or the Railroad Retirement Board (RRB), but Social Security has not made a decision. **Note:** Disability

decisions made by VA, WSI, or RRB do not guarantee a disability determination by the State Review Team.

8. An SFN 451 must be completed and sent to the State Review Team when an individual has applied for or is requesting Medicaid based on a disability and they also have a pending disability application through the SSA. When the SRT receives the completed SFN 451, the SRT will contact the person and request copies of their medical records.

9. There are times when an individual has to be referred to the SRT for a disability determination but they do not have a pending disability application through the SSA or the SSA will not make a disability determination.

    a. If an individual is applying for Incapacity or Emergency Services, they won't be applying for disability. If they are applying for or requesting disability-based Medicaid, CWD, or WWD, the SSA may not make a disability determination based on one of the reasons listed above in #7. If the individual does not have a pending disability application through the SSA, the SFN 451 and SFN 228 must still be sent to the SRT but the zone agency must contact the individual and request the medical records. The individual can send the medical records directly to the SRT or to the zone agency who will forward the records to the SRT.

10. The SRT will make a disability determination within the 90 day period that starts on the date the individual applies for or requests Medicaid and a referral to the SRT is required.

11. The State Review Team cannot make an independent disability determination if the SSA has made a decision. If the SRT makes a determination while the SSA disability application is pending and the SSA later makes a different determination, Medicaid must follow the SSA decision.

12. Any medical bills incurred by an applicant upon request of the State Review Team to obtain medical information to determine eligibility will be paid through Medicaid. If the applicant is determined to be ineligible for Medicaid, the medical bills will be paid through administrative costs.

13. If an individual's Medicaid application is denied or their Medicaid case is closed due to an SSI or SSA denial or termination and they appeal the SSA denial and win the appeal, the denied Medicaid application or case closure can be reversed if the person notifies the zone agency within 6 months of the date on the notice sent to them by the SSA that they won the appeal.

5. Income Deductions 510-05-85-35

5. Except in determining eligibility for the Medicare Savings Programs, the cost of remedial care for an individual residing in a specialized facility is limited to the difference between the recipient's cost of care at the facility (e.g. remedial rate in a basic care facility) and the regular medically needy income level may be deducted.

6. Income Levels 510-05-85-40

2. Medically needy income levels.

b. Nursing care income level. The nursing care income level is ~~$115~~ $118 per month and must be applied to residents receiving psychiatric or nursing care services in nursing facilities, the state hospital, Prairie Saint John's, 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),is ~~$150~~ $153 effective July 1,~~2025~~ 2026

d. Community spouse income level. The income level for a community spouse who is eligible for Medicaid is subject to the categorically needy, medically needy, or poverty level income levels. The level for an ineligible community spouse is ~~$2644~~ $2705, or a higher amount if ordered by a court or hearing officer.

e. Family member income level. The income level for each ineligible family member in a spousal impoverishment case is $~~881~~ 902 effective July ~~2025~~ 2026 ~~($822 effective July 2023, $852 effective July 2024)~~ ($881 effective July 2025, $852 effective July 2024).

6. State LTC Subsidy Program 510-05-95-45

a. The subsidy payment is the difference between the $30 SSI payment level and $100, less any other income available to the recipient. The maximum subsidy cannot exceed ~~$70~~ $88 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 ~~$70~~ $88, even if the amount actually paid is less than that amount.