CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

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75-02-02.1-01. Definitions.

For the purposes of this chapter:

1. "Agency" means the North Dakota department of human services.

2. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

3. "Blind" has the same meaning as the term has when used by the social security administration in determining blindness for title II or XVI of the Act.

4. "Child" means a person, under twenty-one, or, if blind or disabled, under age eighteen, who is not living independently.

5. "Contiguous" means real property which is not separated by other real property owned by others. Roads and other public rights of way which run through the property, even if owned by others, do not affect the property's contiguity.

6. "County agency" means the county social service board.

7. "Department" means the North Dakota department of human services.

8. "Deprived child" means a child who is deprived of parental support or care because one or both parents are deceased, incapacitated, disabled, aged, or maintains and resides in a separate verified residence for reasons other than employment, education, training, medical care, or uniformed service.

9. "Disabled" has the same meaning as the term has when used by the social security administration in determining disability for title II or XVI of the Act.

10. "Disabled adult child" means a disabled or blind person over the age of twenty-one who became blind or disabled before age twenty-two.

11. "Full calendar month" means the period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

12. "Good-faith effort to sell" means an honest effort to sell in a manner which is reasonably calculated to induce a willing buyer to believe that the property offered for sale is actually for sale at a fair price. A good-faith effort to sell includes, at a minimum, making the offer at a price based on an appraisal, a market analysis by a realtor, or another method which produces an accurate reflection of fair market value or, with respect to a determination of qualified disabled and working individual benefits under section 75-02-02.1-23, sixty-six and two-thirds percent of fair market value, in the following manner:

    a. To any coowner, joint owner, possessor, or occupier of the property, and, if no buyer is thereby secured;

    b. To the regular market for such property, if any regular market exists, or, if no regular market exists;

    c. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered for sale, which advertisement was published successively for two weeks if the newspaper is a weekly publication and for one week if the newspaper is a daily publication, and which includes a plain and accurate description of the property, the selling price, and the name, address, and telephone number of a person who will answer inquiries and receive offers.

13. "Healthy steps" means an insurance program, for children up to age nineteen, administered under North Dakota Century Code chapter 50-29 and title XXI of the Act.

14. "Home" includes, when used in the phrase "the home occupied by the medicaid unit", the land on which the home is located, provided that the acreage [hectarage] does not exceed one hundred sixty contiguous acres [64.75 hectares] if rural or two acres [.81 hectares] if located within the established boundaries of a city.

15. "Home and community-based services" means services, provided under a waiver secured from the United States department of health and human services, which are:

    a. Not otherwise available under medicaid; and

    b. Furnished only to individuals who, but for the provision of such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

16. "Institutionalized individual" means an individual who is an inpatient in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, a psychiatric residential treatment facility, an institution for mental disease, or who receives swing-bed care in a hospital.

17. "Living independently" means, in reference to an individual under the age of twenty-one, a status which arises in any of the following circumstances:

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

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

c. The individual has lived separately and apart from both parents for at least three consecutive full calendar months after the date the individual left a parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. For purposes of this subsection:

(1) Periods when the individual is attending an educational or training facility, receiving care in a specialized facility, or is an institutionalized individual are deemed to be periods when the individual is living with a parent unless the individual first established that the individual was living independently; and

(2) Health insurance coverage and court-ordered child support payments are not "assistance or support".

d. The individual is a former foster care recipient who has established a living arrangement separate and apart from either parent and received no support or assistance from either parent.

e. The individual lives separately and apart from both parents due to incest and receives no support or assistance from either parent.

18. "MAGI-based methodology" means the method of determining eligibility for medicaid that generally follows modified adjusted gross income rules.

19. "Medicaid" means a program implemented pursuant to North Dakota Century Code chapter 50-24.1 and title XIX of the Act [42 U.S.C. 1396 et seq.].

20. "Medicare cost sharing" means the following costs:

a. (1) Medicare part A premiums; and

(2) Medicare part B premiums;

b. Medicare coinsurance;

c. Medicare deductibles; and

d. Twenty percent of the allowed cost for medicare covered services where medicare covers only eighty percent of the allowed costs.

21. "Nursing care services" means nursing care provided in a medical institution, a nursing facility, a swing-bed, the state hospital, or a home and community-based services setting.

22. "Occupied" means, when used in the phrase "the home occupied by the medicaid unit", the home the medicaid unit is living in or, if temporarily absent from, possessed with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement, whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse, disabled adult child, or child under age twenty-one at home, unless a physician has certified that the individual is likely to return home within six months.

23. "Poverty level" means the income official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2).

24. "Property that is essential to earning a livelihood" means property that a member of a medicaid unit owns, and which the medicaid unit is actively engaged in using to earn income, and where the total benefit of such income is derived for the medicaid unit's needs. A member

of a medicaid unit is actively engaged in using the property if a member of the unit contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property.

25. "Property that is not saleable without working an undue hardship" means property which the owner has made a good-faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value, or sixty-six and two-thirds percent of the property's fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-23, and which is continuously for sale. Property may not be included within this definition at any time earlier than the first day of the first month in which a good-faith effort to sell is begun or if a bona fide offer is received by the third month after the month in which the good-faith effort to sell is begun.

26. "Regulation", as used in 42 CFR 431.210, 431.244, and 435.912, includes any written statement of federal or state law or policy, including, but not limited to, federal and state constitutions, statutes, regulations, rules, policy manuals or directives, policy letters or instructions, and relevant controlling decisions of federal or state courts.

27. "Remedial services" means those services, provided in specialized facilities, which produce the maximum reduction of physical or mental disability and restoration of the facilities' residents to the residents' best possible level of functioning.

28. "Residing in the home" refers to individuals who are physically present, individuals who are temporarily absent, or individuals attending educational facilities.

29. "Specialized facility" means a residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility.

30. "State agency" means the North Dakota department of human services.

31. "Student" means an individual who regularly attends and makes satisfactory progress in elementary or secondary school, general educational development classes, college, university, vocational training, including summer vacation periods if the individual intends to return to school in the fall, or a home school program recognized or supervised by the student's state or local school district. A full-time student is a person who attends school on a schedule equal to a full curriculum.

32. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

33. "Temporary assistance for needy families" means a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Act [42 U.S.C. 601 et seq.].

34. "The Act" means the Social Security Act [42 U.S.C. 301 et seq.].

35. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

36. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

37. "Title XIX" means title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; October 1, 1993; July 1, 2003; August 1, 2005; April 1, 2008; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-02. Application and redetermination.

1. **Application.**

   a. All individuals wishing to make application for medicaid must have the opportunity to do so, without delay.

   b. An application is a written request made by an individual desiring assistance under the medicaid program, or by an individual seeking such assistance on behalf of another individual, to a county agency, the department, a disproportionate share hospital, as defined in section 1923(a)(1)(A) of the Act [42 U.S.C. 1396r-4(a)(1)(A)], or a federally qualified health center, as described in section 1905(l)(2)(B) of the Act [42 U.S.C. 1396d(l)(2)(B)].

   c. A prescribed application form must be signed by the applicant or by someone acting responsibly for an incapacitated applicant.

   d. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.

   e. A relative or other interested party may file an application in behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.

   f. The date of application is the date an application, signed by an appropriate individual, is received at a county agency, the department, a disproportionate share hospital, or a federally qualified health center.

2. **Redetermination.** A redetermination must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category, and in any event, no less than annually. A recipient has the same responsibility to furnish information during a redetermination as an applicant has during an application.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; May 1, 2006.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-02.1. Duty to establish eligibility.

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 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.

History: Effective December 1, 1991; amended effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-03. Decision and notice.

1. A decision as to eligibility will be made promptly on applications, within forty-five days, or within ninety days in cases with a disability determination pending, except in unusual circumstances.

2. Following a determination of eligibility or ineligibility, an applicant must be notified of either approval or denial of medicaid.

3. Notice must be sent at the time, and in the manner, required by 42 CFR 431.210 through 431.214.

4. Errors made by public officials and delays caused by the actions of public officials do not create eligibility or additional benefits for an applicant or recipient who is adversely affected.

History: Effective December 1, 1991; amended effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-04. Screening of recipients of certain services.

All applicants or recipients who seek nursing care services in nursing facilities, swing-bed facilities, or intermediate care facilities for individuals with intellectual disabilities, or who seek home and community-based services, must demonstrate a medical necessity for the service sought on or prior to admission to a facility, upon application for medicaid while in a facility, or upon request for home and community-based services. That demonstration must be through the department's established screening process.

History: Effective December 1, 1991; amended effective July 1, 2003; April 1, 2008; October 1, 2010; January 1, 2011; July 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-04.1. Certification of need for children in an institution for mental disease.

1. Children under age twenty-one who seek services in an institution for mental disease must obtain certification of need in order to be eligible for medicaid.

2. For an individual who attains age twenty-one while receiving treatment and continues to receive treatment as an inpatient, eligibility may continue through the month the individual attains the age of twenty-two.

History: Effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-05. Coverage groups.

Within the limits of legislative appropriation, the department may provide medicaid benefits to coverage groups described in the approved medicaid state plan in effect at the time those benefits are sought. These coverage groups do not define eligibility for medicaid benefits. Any person who is within a coverage group must also demonstrate that all other eligibility criteria are met.

1. The categorically needy coverage 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 of deprived children who meet the parent and caretaker relative 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 earned income or because a member of the unit has a reduction in the time-limited earned income disregard;

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. Pregnant women who meet the nonfinancial requirements with modified adjusted gross income at or below the modified adjusted gross income level for pregnant women;

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

j. 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 sixty days beginning on the day of the child's birth and for the remaining days of the month in which the sixtieth day falls;

k. Children up to age nineteen who meet the nonfinancial medicaid requirements with modified adjusted gross income at or below the modified adjusted gross income level for that child's age;

l. Adults between the ages of nineteen and sixty-four, inclusive, who meet the nonfinancial medicaid requirements:

   (1) Who are not eligible under subdivisions e through k above; or

   (2) Who are not eligible for supplemental security income, unless they fail the medically needy asset test; or

   (3) Whose modified adjusted gross income is at or below the established modified adjusted gross income level for this group;

m. Former foster care children through the month they turn twenty-six years of age, who were enrolled in medicaid and were in foster care in this state when they turned eighteen years old, provided they are not eligible under any of the categorically eligible groups other than the group identified in subdivision l.

n. Aged, blind, or disabled individuals who are receiving supplemental security income payments or who appear on the state data exchange as zero payment as a result of supplemental security income'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; and

o. Individuals who meet the more restrictive requirements of the medicaid program and qualify for supplemental security income benefits under section 1619(a) or 1619(b) of the Act [42 U.S.C. 1382h(a) or 1382h(b)].

2. The optional categorically needy coverage group includes:

a. 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; and

b. Uninsured women under age sixty-five, 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 who need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix.

c. Gainfully employed individuals with disabilities age eighteen to sixty-five who meet medically needy nonfinancial criteria, have countable assets within the medically needy asset levels, have income below two hundred twenty-five percent of the poverty level, and are not eligible for medicaid under any other provision except as a qualified medicare beneficiary or a special low-income medicare beneficiary. Coverage under this group ends on the last day of the month before the month in which the individual attains the age of sixty-five.

d. Individuals under age nineteen who are disabled, who meet medically needy nonfinancial criteria, who have income at or below two hundred percent of the poverty level, and who are not eligible for medicaid under any other provision. Coverage under this group ends on the last day of the month in which the individual reaches age nineteen.

3. The medically needy coverage group includes:

a. Individuals under the age of nineteen who qualify for and require medical services on the basis of insufficient income, but who do not qualify under categorically needy or optional categorically needy groups, including foster care children who do not qualify as categorically needy or optional categorically needy;

b. Pregnant women whose pregnancy has been medically verified and who qualify on the basis of financial eligibility;

c. Eligible pregnant women who applied for medicaid during pregnancy, and for whom recipient liability for the month was met no later than on the date each pregnancy ends, 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;

d. 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 sixty days, beginning on the day of the child's birth, and for the remaining days of the month in which the sixtieth day falls;

e. Aged, blind, or disabled individuals who are not in receipt of supplemental security income; and

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

4. The poverty level coverage group includes:

   a. Qualified medicare beneficiaries who are entitled to medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], and have income at or below one hundred percent of the poverty level;

   b. Qualified disabled and working individuals who are individuals entitled to enroll in medicare part A under section 1818a of the Social Security Act [42 U.S.C. 1395i-2(a)], who have income no greater than two hundred percent of the federal poverty level and assets no greater than twice the supplemental security income resource standard, and who are not eligible for medicaid under any other provision;

   c. Special low-income medicare beneficiaries who are entitled to medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], and have income above one hundred percent of the poverty level, but not in excess of one hundred twenty percent of the poverty level; and

   d. Qualifying individuals who are entitled to medicare part A benefits, who meet the medically needy nonfinancial criteria, whose assets do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) [42 U.S.C. 1395w-114(a)(3)], have income above one hundred twenty percent of the poverty level, but not in excess of one hundred thirty-five percent of the poverty level, and are not eligible for medicaid under any other provision.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; January 1, 1994; January 1, 1997; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; April 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-31, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-06. Applicant's choice of aid category.

An individual who could establish eligibility under more than one category may have eligibility determined under the category the individual selects. Except for qualified medicare beneficiaries and special low-income medicare beneficiaries, who may also establish eligibility as aged, blind, or disabled, an individual may establish eligibility under only one category.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-07. Applicant's duty to establish eligibility.

Repealed effective December 1, 1991.

75-02-02.1-08. Medicaid unit.

1. For individuals not subject to MAGI-based methodology, 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 child, 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. 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.

2. For individuals subject to a MAGI-based methodology, a medicaid unit is determined by the individual's tax filing status as well as the individual's relationship to those with whom the individual lives.

   Each individual will have his or her own medicaid unit determined as follows:

   a. If the individual is a tax filer, and is not also claimed as a dependent by someone else, the individual's medicaid unit consists of the individual, the individual's spouse, if living with the individual, and anyone the individual or his or her spouse claims as a dependent, plus a dependent's spouse that lives with them, and any unborn children of a pregnant woman who is included in the unit.

   b. If the individual is claimed as a tax dependent by another, even if the individual files his or her own tax return, and does not meet any of the following exceptions, that individual's medicaid unit 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 of a pregnant woman who is included in the unit:

      (1) The individual is claimed as a dependent by someone other than a spouse, or a natural, adopted, or stepparent;

      (2) The individual is under nineteen years old and is living with both parents but the parents are not filing a joint return; or

      (3) The individual is under nineteen years old and will be claimed as a dependent by a noncustodial parent.

   c. If the individual is not a tax filer, is not expected to be claimed as a dependent by another, or meets one of the conditions set forth in paragraphs 1, 2, or 3 of subdivision b, the individual is subject to the nonfiler rules. A nonfiler individual's medicaid unit is the individual, and, if living with the individual, the individual's spouse; natural, adopted, or stepchildren under nineteen years old; natural, adopted, or stepparents; or natural, adopted, or step-siblings under nineteen years old, plus any of their spouses that live with them, and any unborn children of a pregnant woman who is in the household.

3. Individuals may not be opted out of a medicaid household unit determined under subsection 2.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-08.1. Caretaker relatives.

1. A caretaker relative who is not a child's parent may be eligible for medicaid as a caretaker relative only if:

   a. Age sixteen or older;

   b. Actually living in the same home as the dependent child; and

   c. The dependent child is not only temporarily absent from the home of the child's parent.

2. An individual may be a caretaker relative only if the individual is the dependent child's parent, stepparent, grandparent, brother, sister, stepbrother, stepsister, great-grandparent, aunt, uncle, niece, nephew, great-great-grandparent, great-aunt, great-uncle, first cousin, grandniece, grandnephew, great-great-great-grandparent, great-great-aunt, great-great-uncle, second cousin (a great-aunt's or great-uncle's child), first cousin once removed (an aunt's or uncle's grandchild), great-grandniece, or great-grandnephew, whether by birth or adoption, and whether by whole or half-blood.

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

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

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; July 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-09. Assignment of rights to medical payments and benefits.

1. The applicant and each individual for whom assistance is requested must, as a condition of eligibility, assign rights to payment or benefits from any third party or private insurer and cooperate in obtaining medical payments and benefits. This assignment of rights to payment or benefits is automatic under North Dakota Century Code sections 50-24.1-02 and 50-24.1-02.1. As a condition of eligibility, the applicant or recipient may be required to execute a written assignment whenever appropriate to facilitate establishment of liability of a third party or private insurer.

   a. The department and county agency shall take reasonable measures to obtain, from an applicant or recipient, health coverage information and other necessary information to determine the liability of third parties and private insurers.

   b. For purposes of this subsection:

      (1) "Private insurer" includes any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-related insurance contract and indemnity contracts; any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services covered by the medicaid program; and any organization administering health or casualty insurance plans for professional associations, employer-employee benefit plans, or any similar organization offering these payments or services, including self-insured and self-funded plans.

      (2) "Third party" means any individual, entity, or program that is or may be liable to pay all or a part of the expenditures for services furnished under medicaid, including a parent or other person who owes a duty to provide medical support to or on behalf of a child for whom medicaid benefits are sought.

2. Except as provided in this subsection, each applicant and each individual for whom assistance is requested must, as a condition of eligibility, assign rights to medical support from any absent parent of a deprived child, and cooperate with the department and county agency in obtaining medical support and establishing paternity of a child in the medicaid unit with

respect to whom paternity has not been legally established. This assignment of rights is automatic under North Dakota Century Code sections 50-09-0-6.1 and 50-24.1-02.1. The requirement for the assignment of rights to medical support from absent parents continues through the month in which the child reaches age eighteen.

a. A pregnant woman is not required to cooperate in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock, while pregnant, for sixty days beginning on the date the pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

b. Recipients of transitional or extended medicaid benefits are not required to cooperate in obtaining medical support and establishing paternity.

c. The county agency may waive the requirement to cooperate in obtaining medical support and establishing paternity for good cause if it determines that cooperation is against the best interests of the child. A county agency may determine that cooperation is against the best interests of the child only if:

   (1) The applicant's or recipient's cooperation in establishing paternity or securing medical support is reasonably anticipated to result in:

      (a) Physical harm to the child for whom support is to be sought;

      (b) Emotional harm to the child for whom support is to be sought;

      (c) Physical harm to the parent or caretaker relative with whom the child is living which reduces such person's capacity to care for the child adequately; or

      (d) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately; or

   (2) At least one of the following circumstances exists, and the county agency believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure medical support would be detrimental to the child for whom support would be sought.

      (a) The child for whom support is sought was conceived as a result of incest or forcible rape;

      (b) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

      (c) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep or relinquish the child for adoption, and the discussions have not gone on for more than three months.

d. Physical harm and emotional harm must be of a serious nature in order to justify a waiver of the requirement to cooperate under this subsection.

e. A waiver of the requirement to cooperate under this subsection due to emotional harm may only be based on a demonstration of an emotional impairment that substantially impairs the individual's functioning. In determining a waiver of the requirement to cooperate under this subsection, based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the county agency must consider:

(1) The present emotional state of the individual subject to emotional harm;

(2) The emotional health history of the individual subject to emotional harm;

(3) Intensity and probable duration of the emotional impairment;

(4) The degree of cooperation to be required; and

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

f. A determination to grant a waiver of the requirement to cooperate under this subsection must be reviewed no less frequently than every twelve months to determine if the circumstances which led to the waiver continue to exist.

3. For purposes of this section, "cooperate in obtaining medical support and establishing paternity" and "cooperate in obtaining medical payments and benefits" includes:

a. Appearing at a state or local office designated by the department or county agency to provide information or evidence relevant to the case;

b. Appearing as a witness at a court or other proceeding;

c. Providing credible information, or credibly attesting to lack of information;

d. Paying to the department any support or medical care funds received that are covered by the assignment of rights; and

e. Taking any other reasonable steps to assist in establishing paternity and securing medical support and medical payments and benefits.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-10. Eligibility - Current and retroactive.

1. Current eligibility may be established from the first day of the month in which the application was received. This subsection does not apply to qualified medicare beneficiaries.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the application was received. Eligibility can be established in each of those months for which benefits are sought and if all factors of eligibility are met during each such month. 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 subsection does not apply to qualified medicare beneficiaries.

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

a. An individual is born in the month, in which case the date of birth is the first date of eligibility;

b. An individual who is not receiving medicaid benefits from another state enters the state, in which case the earliest date of eligibility is the date the individual entered the state;

c. An individual who is receiving medicaid benefits from another state enters the state, in which case the later of the date of entry or the day after the last day of eligibility under the other state's medicaid program is the first date of eligibility; and

d. An individual is discharged from a public institution, in which case the date of eligibility is the date of discharge.

4. Eligibility for qualified medicare beneficiaries begins in the month following the month in which the eligibility determination is made.

5. An individual cannot be eligible as a qualifying individual and be eligible under any other medicaid coverage for the same period of time.

6. A child cannot be eligible for medicaid for the same period of time the child is covered under the healthy steps program.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-11. Need.

Need is a factor of eligibility. Need in this sense is not to be confused with the necessity for a particular medical service.

1. Need is established for individuals who are determined to be categorically needy, optionally categorically needy, or poverty level eligible.

2. For a medically needy applicant or recipient, need is established when there is no recipient liability or when the applicant or recipient has incurred current medical expenses for which the applicant or recipient is responsible after any third-party payments, which equal or exceed current recipient liability. If there is no need, there is no eligibility, and the application must be denied or the case must be closed.

History: Effective December 1, 1991; amended effective July 1, 2003; April 1, 2008.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-12. Age and identity.

1. An eligible categorically or medically needy aged applicant or recipient is eligible for medicaid for the entire calendar month in which that individual reaches age sixty-five.

2. An individual who attains age twenty-one while receiving treatment and continues to receive treatment as an inpatient in an institution for mental diseases remains eligible through the month the individual reaches age twenty-two.

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

4. The identity of each applicant must be established and documented.

5. Citizenship status of each applicant must be established and documented.

History: Effective December 1, 1991; amended effective July 1, 2003; June 1, 2004; January 1, 2010; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-12.1. Cost-effective health insurance coverage.

1. For purposes of this section:

   a. "Cost effective" means that medicaid payments for a set of medicaid-covered services are likely to exceed the cost of paying the health plan premium, coinsurance charges, and deductibles for those services.

   b. "Health plan" means any plan under which a third party is obligated by contract to pay for health care provided to an applicant for or recipient of medicaid.

2. Any recipient of medicaid benefits who is enrolled in a cost-effective health plan may have the health plan premium paid by medicaid.

3. Applicants for and recipients of medicaid benefits must provide the information necessary to determine if a health plan is cost effective.

4. Recipients with a health plan the department has determined is cost effective must cooperate with all of the conditions and requirements of the health plan. Applicants and recipients must take any optional coverage provided through the plan when it is cost effective to do so. Failure to cooperate with plan requirements, or to select cost-effective options of the plan, will:

   a. Result in termination of payments for health plan premiums; and

   b. Result in nonpayment for services, by medicaid, which the health plan would pay, or would have paid, had the recipient conformed to the requirements of the health plan.

5. If an applicant for or recipient of medicaid benefits is eligible for enrollment, but is not enrolled in medicare part B, enrollment in any other health plan is not considered cost effective.

6. The department shall determine, using information provided by or at the direction of a medicaid applicant or recipient, guidelines established by the department, and other information at its disposal, whether a health plan is cost effective. The department may make determinations under this subsection on a case-by-case basis, on a plan-by-plan basis, or both.

History: Effective July 1, 1993; amended effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396e

75-02-02.1-13. Social security numbers.

A social security number must be furnished as a condition of eligibility, for each individual for whom medicaid benefits are sought, except for:

1. A newborn child who is eligible during the birth month, for sixty days after the date of birth beginning on the date of birth and for the remaining days of the month in which the sixtieth day falls or, if the newborn is continuously eligible, for the remaining days of the newborn's first eligibility period;

2. Coverage of emergency services provided to illegal aliens; and

3. Individuals who have applied for, but not yet received, social security numbers.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-14. Blindness and disability.

1. 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 shall be reviewed by a review team consisting of technically competent individuals, 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.

2. 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, who shall prepare and submit an eye examination report. The state review team shall review and compare that report with the state's definition of blindness and determine:

   a. Whether the individual meets the definition of blindness; and

   b. Whether and when reexaminations are necessary for periodic redeterminations of eligibility.

3. The state review team must decline to determine blindness or disability for a period of time that such a determination is made for supplemental security income or title II disability benefits by the social security administration, unless the medicaid applicant is applying for workers with disabilities coverage and is not eligible for title II disability due to substantial gainful activity.

4. The 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.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; April 1, 2008.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 CFR Part 435

75-02-02.1-14.1. Eligibility for medically frail medicaid expansion enrollees.

1. A medicaid expansion enrollee interested in applying for a medically frail determination shall complete a self-assessment and return the completed form to the department.

2. If the self-assessment meets a threshold score set by the department, the enrollee shall schedule an appointment with a primary care provider to review and validate the information on the self-assessment. After the enrollee attends a face-to-face appointment with the primary care provider, the enrollee shall ensure that the primary care provider provides documentation to the department that validates the diagnosis or medical condition and that includes a medication list.

3. Upon review of the information provided by the primary care provide, the department shall determine whether the enrollee meets medically frail eligibility requirements.

4. If the medicaid expansion enrollee is approved for eligibility as medically frail, the enrollee may choose coverage through a managed care organization or through the medicaid state plan services.

5. Coverage of an enrollee as medically frail will begin the first of the month following the month in which the determination is made.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04

Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-15. Incapacity of a parent.

1. A child, if otherwise eligible for medicaid benefits, is "deprived of parental support or care" when the child's parent has a physical or mental defect, supported by current competent medical testimony, of such a debilitating nature as to reduce substantially or eliminate the parent's capacity either to earn a livelihood or to discharge the parent's responsibilities as a homemaker and provider of child care for a period of thirty days or more. In making a determination of capacity to earn a livelihood, the department takes into account the limited employment opportunities of disabled parents.

2. The incapacity must be such that it reduces substantially or eliminates employment in the parent's usual occupation. It does not matter whether a parent was employed or fulfilled the role of homemaker prior to the onset of the asserted incapacity. Incapacity is established either when the parent is unable to earn a livelihood or to act as a homemaker. A parent may also establish incapacity by demonstrating that the parent has reached age sixty-five.

3. A determination that a parent is disabled or blind, made by the social security administration, constitutes adequate substantiation of incapacity for purposes of this section.

4. A parent continues to be incapacitated, for purposes of this section, if the incapacity is not reasonably subject to remediation, or if the parent makes reasonable progress towards remediation of the incapacity. For purposes of this section, "reasonable progress towards remediation of the incapacity" means cooperation with medical practitioners who prescribe a course of treatment intended to remediate or limit the effect of the incapacity, including physical therapy, counseling, use of prosthesis, drug therapy and weight loss, cooperation with vocational practitioners, cooperation with vocational and functional capacity evaluations, and reasonable progress in a course of training or education intended to qualify the parent to perform an occupation which, with that training or education, the parent would have the capacity to perform.

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

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

History: Effective December 1, 1991; amended effective December 1, 1991; February 1, 1997; April 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-16. State of residence.

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 eligibility is the date of entry. Residence may not be established for individuals who claim residence in another state.

2. Individuals under age twenty-one.

a. For any individual under age twenty-one who is living independently from the individual's 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.

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 noninstitutionalized individual under age twenty-one, the state of residence is the state in which the child is living with the child's parent or caretaker relative on other than a temporary basis. A child who comes to North Dakota to receive an education, special training, or services in a facility such as the Anne Carlsen facility, a maternity home, or a vocational training center is normally regarded as living temporarily in the state if the intent is to return to the child's home state upon completion of the education or service. A child placed by an out-of-state placement authority, including a court, into the home of relatives or foster parents in North Dakota on other than a permanent basis or for an indefinite period is living in the state for a temporary purpose and remains a legal resident of the state of origin. A resident of North Dakota who leaves the state temporarily to pursue educational goals (including any child participating in job corps) or other specialized services (including a child placed by a North Dakota placement authority, including a court, into the home of out-of-state relatives or foster parents) does not lose residence in the state.

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 the individual's parents and does not have a guardian, the individual is a resident of the state in which the individual is institutionalized.

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. The state of residence, for medicaid purposes, of a migrant or seasonal farm worker is the state in which the individual is employed or seeking employment.

b. Except as provided in subdivision c, the state of residence of an institutionalized individual is the state where the individual is living with the intention to remain there.

c. 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.

4. For purposes of this subsection:

a. "Individual incapable of indicating intent" means one who:

(1) 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;

(2) 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;

(3) Has been found by a court of competent jurisdiction to be legally incompetent; or

(4) 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; and

b. "Institution" means an establishment that furnishes, in single or multiple facilities, food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

5. Notwithstanding any other provision of this section except subsections 6 through 9, individuals placed in out-of-state institutions by a state retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. The application of this subsection ends when a person capable of indicating intent leaves an institution in which the person was placed by this 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.

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 or state adoption assistance 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.

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.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2010; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 CFR Part 435

75-02-02.1-17. Application for other benefits.

1. Applicants and recipients, including spouses and financially responsible parents, must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include veterans' compensation and pensions; old age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation, but do not include needs-based payments.

2. Good cause under this section exists if receipt of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage.

History: Effective December 1, 1991; amended effective July 1, 2003; January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-18. Citizenship and alienage.

1. An applicant or recipient must be a United States citizen or an alien lawfully admitted for permanent residence. Acceptable documents to establish United States citizenship and naturalized citizen status are defined in 42 CFR 435.407.

2. For purposes of qualifying as a United States citizen, the United States includes the fifty states, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for purposes of medicaid.

3. American Indians born in Canada, who may freely enter and reside in the United States, are considered to be lawfully admitted for permanent residence if at least one-half American Indian blood. A spouse or child of such an Indian, or a noncitizen individual whose membership in an Indian tribe or family is created by adoption, may not be considered to be lawfully admitted under this subsection unless the individual is of at least one-half American Indian blood by birth.

4. The following categories of aliens, while lawfully admitted for a temporary or specified period of time, are not eligible for medicaid, except for emergency services, because of the temporary nature of their admission status:

   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 United States;

   d. Crewmen on shore leave;

   e. Treaty traders and investors and their families;

   f. Foreign students;

   g. International organization representatives 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.

5. Except for aliens identified in subsection 4, aliens who are not lawfully admitted for permanent residence in the United States are not eligible for medicaid, except for emergency services.

6. Aliens from the Federated States of Micronesia, the Marshall Islands, or Palau are lawfully admitted as permanent nonimmigrants and are not eligible for medicaid, except for emergency services.

7. Aliens who lawfully entered the United States for permanent residence before August 22, 1996, and who meet all other medicaid criteria may be eligible for medicaid.

8. The following categories of aliens who entered the United States for permanent residence on or after August 22, 1996, and who meet all other medicaid criteria may be eligible for medicaid as qualified aliens:

a. Honorably discharged veterans, aliens on active duty in the United States armed forces, and the spouse or unmarried dependent children of such individuals;

b. Refugees and asylees;

c. Aliens whose deportation was withheld under section 243(h) of the Immigration and Naturalization Act;

d. Cuban and Haitian entrants;

e. Aliens admitted as Amerasian immigrants;

f. Victims of a severe form of trafficking;

g. Iraqi and Afghan aliens and family members who are admitted under section 101(a)(27) of the Immigration and Naturalization Act;

h. For the period paroled, aliens paroled into the United States for at least one year under section 212(d)(5) of the Immigration and Nationality Act;

i. Aliens granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act in effect prior to April 1, 1980;

j. Aliens granted nonimmigrant status under section 101(a)(15)(T) of the Immigration and Nationality Act or who have a pending application that sets forth a prima facie case for eligibility for that nonimmigrant status;

k. Certain battered aliens and their children who have been approved or have a petition pending which sets forth a prima facie case as identified in 8 U.S.C. 1641(c), but only if the department determines there is a substantial connection between the battery and the need for the benefits to be provided; and

l. All other aliens, other than for emergency services, only after five years from the date they entered the United States, and then only if the individual is a lawful permanent resident who has been credited with forty qualifying quarters of social security coverage.

9. An alien who is not eligible for medicaid because of the time limitations or lack of forty qualifying quarters of social security coverage may be eligible to receive emergency services that are not related to an organ transplant procedure if:

a. 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:

(1) Placing health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part;

b. The alien meets all other eligibility requirements for medicaid except the requirements concerning furnishing social security numbers and verification of alien status; and

c. The alien's need for the emergency service continues.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2010; January 1, 2011; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04

Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-19. Inmates of public institutions.

1. An inmate of a public institution is not eligible for medicaid unless the individual is:

   a. Over age sixty-five and a patient in an institution for mental diseases;

   b. Under age twenty-one, is a patient in an institution for mental diseases, and is receiving inpatient psychiatric services consistent with the requirements of 42 CFR 440.160 and 42 CFR part 441, subpart D, or, with respect to a patient who is eligible for medicaid and is receiving services in the institution when the patient reaches age twenty-one, inpatient psychiatric services under 42 CFR 440.160 may continue until age twenty-two; or

   c. Receiving care as an inpatient in one of the following facilities:

      (1) A hospital as defined in 42 CFR 440.140;

      (2) A nursing facility as defined in 42 CFR 440.140 and 42 U.S.C. 1396r(a);

      (3) A psychiatric residential treatment facility as defined in 42 CFR 440.160; or

      (4) An intermediate care facility for the intellectually disabled as defined in 42 CFR 440.140 and 440.150.

2. The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from such an institution.

3. An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age twenty-two and has been receiving inpatient psychiatric services under 42 CFR 440.160 is considered to be a patient in the institution until unconditionally released or, if earlier, the last day of the month in which the patient reaches age twenty-two.

4. For purposes of this section:

   a. "Individual on conditional release" means an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.

   b. "Inmate of a public institution" means a person who has been sentenced, placed, committed, admitted, or otherwise required or allowed to live in the institution, and who has not subsequently been unconditionally released or discharged from the institution. An individual is not considered an inmate if:

      (1) The individual is in a public educational or vocational training institution for purposes of securing education or vocational training;

      (2) The individual is in a public institution for a temporary period pending other arrangements appropriate to the individual's needs;

      (3) The individual has been unconditionally released from the institution; or

      (4) The individual is receiving long-term care services in a public institution.

c. "Institution" means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

d. "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an institution for mental diseases.

e. "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include:

(1) A medical institution as defined in 42 CFR 435.1010;

(2) An intermediate care facility as defined in 42 CFR 440.140 and 440.150;

(3) A publicly operated community residence that serves no more than sixteen residents, as defined in 20 CFR 416.231(b)(6)(i); or

(4) A child care institution as defined in 42 CFR 435.1010 with respect to:

(a) Children for whom foster care maintenance payments are made under title IV-E of the Act; and

(b) Children receiving aid to families with dependent children - foster care under title IV-A of the Act.

f. "Unconditionally released" means released, discharged, or otherwise allowed or required to leave the institution under circumstances such that a return to the institution cannot be required by the operator of the institution.

History: Effective December 1, 1991; amended effective July 1, 2003; July 1, 2012; July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-06; 42 CFR 435.1008; 42 CFR 435.1009

75-02-02.1-19.1. Family coverage group.

1. Parents and caretaker relatives, and their spouses, who meet the medically needy technical requirements and the requirements of this section are eligible under the parent and caretaker relative group.

2. Parents and caretaker relatives eligible under the parent and caretaker relative group must be living with a child who is deprived of a biological or adoptive parent's support or care. The child described in this subsection must be under age eighteen.

3. A family may establish deprivation, for purposes of the parent or caretaker relative group, if the family's countable income is within the parent or caretaker relative group income levels and at least one of the caretaker relatives is:

a. Employed less than one hundred hours per month; or

b. Employed more than one hundred hours in the current month, but was 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.

4. This group shall follow a MAGI-based methodology.

History: Effective January 1, 2003; amended effective September 1, 2003; June 1, 2004; April 1, 2008; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: 50-24.1-37; 42 USC 1396a(e), 42 USC 1396u-1

75-02-02.1-20. Transitional and extended medicaid benefits.

Families that cease to be eligible under the parent and caretaker relative 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 that include at least one individual who was 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 relative's earned income or because a member of the unit has a reduction in the time-limited earned income disregard, may continue to be eligible for transitional medicaid benefits for up to twelve months if:

   a. The family has a child living in the home who meets the family coverage group age requirements; and

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

2. Families that include at least one individual who was eligible under the parent and caretaker relative group in at least three of the six months immediately preceding the month in which the family became ineligible wholly or partly as a result of the collection or increased collection of spousal support continue to be eligible for extended medicaid for four calendar months:

   a. The family has a child living in the home who meets the parent and caretaker relative group age requirements; and

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

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.

4. Children who no longer meet the age requirements under the parent and caretaker relative group are not eligible for transitional or extended medicaid benefits.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

75-02-02.1-21. Continuous eligibility for pregnant women and newborns.

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, while pregnant, for sixty days beginning on the last day of pregnancy, and for the remaining days of the month in which the sixtieth day falls. A child born to a woman who is eligible on the day of the child's birth is eligible and continues to be eligible for medicaid, without regard to the child's income or assets, for sixty days beginning on the day of birth, and for the remaining days of the month in which the sixtieth day falls.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; May 1, 2006.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-22. Medicare savings programs.

1. Qualified medicare beneficiaries are entitled only to medicare cost-sharing benefits described in subsection 19 of section 75-02-02.1-01, beginning in the month following the month in which the eligibility determination is made.

2. Special low-income medicare beneficiaries are entitled only to medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection 19 of section 75-02-02.1-01. Eligibility may be established for as many as three calendar months prior to the month in which the application was received.

3. Qualifying individuals are entitled only to medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection 19 of section 75-02-02.1-01. Eligibility may be established for as many as three calendar months prior to the month in which the application was received unless the individual was in receipt of any other medicaid benefits for the same period. Eligibility shall be established on a first-come, first-served basis to the extent of funding allocated for coverage of this group under section 1933 of the Act [42 U.S.C. 1396u-3].

4. All medically needy technical eligibility factors apply to the medicare savings programs except as identified in this section.

5. No person may be found eligible for the medicare savings programs unless the total value of all nonexcluded assets does not exceed:

   a. For periods of eligibility prior to January 1, 2010:

      (1) Four thousand dollars for a one-person unit; or

      (2) Six thousand dollars for a two-person unit.

   b. For periods of eligibility on or after January 1, 2010, the asset limit described in 42 U.S.C. 1396d(p)(1)(C).

6. Provisions of this chapter governing asset considerations at section 75-02-02.1-25, valuation of assets at section 75-02-02.1-32, excluded assets at section 75-02-02.1-28.1, and forms of asset ownership at section 75-02-02.1-29 apply to eligibility determinations for medicare savings programs except:

   a. Half of a liquid asset held in common with another medicare savings program is presumed available;

   b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining eligibility for the child's parent, except that all liquid assets held in common by the child and the parent are considered available to the parent; and

   c. Assets owned by a spouse who is not residing with an applicant or recipient are not considered available unless the assets are liquid assets held in common.

7. a. Income calculations must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income; section 75-02-02.1-38.2, disregarded income; and section 75-02-02.1-39, income deductions; except:

(1) Married individuals living separate and apart from a spouse are treated as single individuals.

(2) Income disregards in section 75-02-02.1-38.2 are allowed regardless of the individual's living arrangement.

(3) The earned income of any blind or disabled student under age twenty-two is disregarded.

(4) The deductions described in subsections 2, 3, 5, 8, and 9 of section 75-02-02.1-39, income deductions, are not allowed.

(5) The deductions described in subsection 10 and subdivision e of subsection 11 of section 75-02-02.1-39, income deductions, are allowed regardless of the individual's living arrangement.

(6) Annual title II cost of living allowances effective in January shall be disregarded when determining eligibility for medicare savings programs for January, February, and March.

b. A qualified medicare beneficiary is eligible if countable income is equal to or less than one hundred percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

c. A special low-income medicare beneficiary is eligible if countable income is more than one hundred percent but equal to or less than one hundred twenty percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

d. A qualifying individual is income eligible if countable income is more than one hundred twenty percent, but equal to or less than one hundred thirty-five percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; January 1, 2010.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-23. Eligibility of qualified disabled and working individuals.

1. Qualified disabled and working individuals are entitled only to medicare cost-sharing benefits described in paragraph 1 of subdivision a of subsection 19 of section 75-02-02.1-01.

2. No person may be found to be a qualified disabled and working individual unless the total value of all assets not described in subsection 4 does not exceed:

   a. Four thousand dollars for a one-person unit; or

   b. Six thousand dollars for a two-person unit.

3. Provisions of this chapter governing asset considerations at section 75-02-02.1-25, valuation of assets at section 75-02-02.1-32, excluded assets at section 75-02-02.1-28.1, and forms of asset ownership at section 75-02-02.1-29 apply to qualified disabled and working individual eligibility determinations except:

   a. Half of a liquid asset held in common with another qualified disabled and working individual is presumed available;

b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining eligibility for the child's parent except that all liquid assets held in common by the child and the parent are considered available to the parent; and

c. Assets owned by a spouse who is not residing with an applicant for or recipient are not considered available unless they are liquid assets held in common.

4. a. Income methodologies used in the supplemental security income program shall be used in determining income eligibility.

b. Annual title II cost of living allowances effective in January shall be disregarded when determining qualified disabled and working individual eligibility for January, February, and March.

c. A qualified disabled and working individual is eligible if countable income is equal to or less than two hundred percent of the poverty level applicable to a family of the size involved, and if the individual meets all of the requirements described in this section; but is otherwise ineligible for medicaid.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-24. Spousal impoverishment prevention.

1. For purposes of this section:

a. "Community spouse" means the spouse of an institutionalized spouse or the spouse of a home and community-based services spouse.

b. "Family member" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized spouse, home and community-based services spouse, or community spouse who are residing with the community spouse. For purposes of applying this definition, a family member is dependent only if that family member is, and may properly be, claimed as a dependent on the federal income tax return filed by the institutionalized spouse or home and community-based services spouse, or the community spouse, or filed jointly by both.

c. "Home and community-based services spouse" means an individual who:

(1) Requires care of the type provided in a nursing facility, but chooses to receive home and community-based services in the community; and

(2) Is married to a spouse who resides in the community at least one day of each month.

d. "Institutionalized spouse" means an individual who:

(1) Requires care in a medical institution, a nursing facility, a swing bed, or the state hospital and, at the beginning of the individual's institutionalization, was likely to be in the facility for at least thirty consecutive days even though the individual does not actually remain in the facility for thirty consecutive days; and

(2) Is married to a spouse who resides in the community at least one day of each month.

e. "Monthly maintenance needs allowance" means for a community spouse, the greater of the amount authorized by the legislative assembly per month or the minimum amount

permitted under section 1924(d)(3) of the Act [42 U.S.C. 1396r-5(d)(3)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

2. a. At the request of an institutionalized spouse, a home and community-based services spouse, or a community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse, or the beginning of the first continuous period of receipt of home and community-based services by a home and community-based services spouse, and upon receipt of relevant documentation of assets, the total value described in subdivision b shall be assessed and documented.

   b. There shall be computed, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse, or as of the beginning of the first continuous period of receipt of home and community-based services by a home and community-based services spouse:

      (1) The total value of the countable assets to the extent either the institutionalized spouse or the community spouse, or the home and community-based services spouse and the community spouse, has an ownership interest; and

      (2) A spousal share, which is equal to one-half of all countable assets, but not less than the minimum amount permitted under section 1924(f)(2)(A)(i) of the Act [42 U.S.C. 1396r-5(f)(2)(A)(i)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)], and not more than the maximum amount permitted under section 1924(f)(2)(A)(ii)(II) of the Act [42 U.S.C. 1396r-5(f)(2)(A)(ii)(II)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

   c. In determining the assets of the institutionalized spouse at the time of application, all countable assets held by the institutionalized spouse, the community spouse, or both, must be considered available to the institutionalized spouse to the extent they exceed the community spouse countable asset allowance.

   d. In determining the assets of the home and community-based services spouse at the time of application, all countable assets held by the home and community-based services spouse, the community spouse, or both, must be considered available to the home and community-based services spouse to the extent they exceed the community spouse asset allowance.

   e. During the continuous period in which the spouse is in an institution or receiving home and community-based services, and after the month in which an institutionalized spouse or a home and community-based services spouse is determined to be eligible for benefits under this chapter, no countable assets of the community spouse may be deemed available to the institutionalized spouse or home and community-based services spouse. Assets owned by the community spouse are not considered available to the institutionalized spouse or home and community-based services spouse during this continuous period of eligibility. A transfer of assets or income by the community spouse for less than fair market value is governed by section 75-02-02.1-33.1 and shall be considered in determining continuing eligibility of the institutionalized spouse or home and community-based services spouse.

   f. The institutionalized spouse or home and community-based services spouse is not ineligible by reason of assets determined under subdivision c or d to be available for the cost of care if:

      (1) The institutionalized spouse or the home and community-based services spouse has assigned to the state any rights to support from the community spouse; or

(2) It is determined that a denial of eligibility would work an undue hardship because the presumption described in subsection 3 of section 75-02-02.1-25 has been rebutted.

g. An institutionalized spouse or home and community-based services spouse is allowed the medically needy asset limit of three thousand dollars.

h. An institutionalized spouse or a home and community-based services spouse is asset eligible if the total value of all countable assets owned by both spouses is less than the total of the community spouse countable asset allowance and the institutionalized spouse asset limit or home and community-based services asset limit, as applicable. The assets may be owned by either spouse provided that the requirements of subdivision i are complied with.

i. An institutionalized spouse or a home and community-based services spouse may transfer an amount equal to the community spouse countable asset allowance, but only to the extent the assets of the institutionalized spouse or home and community-based services spouse are transferred to, or for the sole benefit of, the community spouse. Such transfers, when made by an individual who has otherwise qualified for medicaid benefits, must be completed before the next regularly scheduled redetermination of eligibility. During this period, such assets are not counted as available to the institutionalized spouse even though the assets are not yet transferred.

(1) When an eligible institutionalized spouse or home and community-based services spouse exceeds the asset limits due to an increase in the value of assets or the receipt of assets not previously owned, the institutionalized spouse or home and community-based services spouse may transfer additional assets to the community spouse equal to no more than the current community spouse countable asset allowance less the total value of assets owned by the community spouse, previously transferred to, or for the sole benefit of, the community spouse under this subdivision.

(2) If a transfer made under this subdivision causes the total value of all assets owned by the community spouse immediately prior to the transfer, plus the value of all assets transferred at any time under this subdivision, to equal or exceed the current community spouse asset allowance, no further transfer may be made under paragraph 1.

(3) If a court has entered an order against an institutionalized spouse for the support of a community spouse, assets required by such order to be transferred, by the institutionalized spouse to the community spouse, may not be counted as available to the institutionalized spouse even though the assets are not yet transferred.

3. A community spouse may retain or receive assets, which do not exceed the community spouse countable asset allowance, for purposes of determining the medicaid eligibility of the institutionalized spouse. The community spouse countable asset allowance means the spousal share determined under paragraph 2 of subdivision b of subsection 2, as adjusted pursuant to section 1924(g) of the Act [Pub. L. 105-33; 111 Stat. 549; 42 U.S.C. 1396r-5(g)] plus:

a. Any additional amount transferred under a court order in the manner and for the purpose described in paragraph 4 of subdivision i of subsection 2; or

b. Any additional amount established through a fair hearing conducted under subsection 6.

4. Countable assets include all assets that are not specifically excluded. The provisions of section 75-02-02.1-28.1 governing asset exclusions apply to this section.

5. Income calculations must consider income in the manner provided for in section 75-02-02.1-34, income considerations, section 75-02-02.1-37, unearned income, section 75-02-02.1-38, earned income, section 75-02-02.1-38.1, posteligibility treatment of income, section 75-02-02.1-38.2, disregarded income, section 75-02-02.1-39, income deductions, and section 75-02-02.1-40, income levels, except:

   a. No income of the community spouse may be deemed available to an institutionalized spouse during any month in which an institutionalized spouse is in the institution, or to a home and community-based services spouse during any month in which that spouse receives home and community-based services; and

   b. No institutionalized spouse may be income eligible for medicaid in any month in which that spouse's income, after all income disregards and deductions other than the deduction of amounts provided to a spouse or family member, exceed an amount equal to that individual's current monthly medical expenses, not covered by a third party, plus the medically needy income level for one.

6. The provisions of this section describing the treatment of income and assets for the community spouse do not describe that treatment for the purposes of determining medicaid eligibility for the community spouse or for children of the community spouse.

7. a. Notice must be provided of the amount of the community spouse income allowance, of the amount of any family allowances, of the method of computing the amount of the community spouse countable asset allowance, and of the right to a fair hearing respecting ownership or availability of income and assets, and the determination of the community spouse monthly income or countable asset allowance. The notice must be provided, upon a determination of medicaid eligibility of an institutionalized spouse, to both spouses, and upon a subsequent request by either spouse or a representative acting on behalf of either spouse, to the spouse making the request.

   b. A community spouse, or an institutionalized spouse or a home and community-based services spouse, is entitled to a fair hearing under chapter 75-01-03 if application for medicaid has been made on behalf of the institutionalized spouse or home and community-based services spouse and either spouse is dissatisfied with a determination of:

      (1) The community spouse monthly income allowance;

      (2) The amount of monthly income otherwise available to the community spouse as determined in calculating the community spouse monthly income allowance;

      (3) The computation of the spousal share of countable assets;

      (4) The attribution of countable assets; or

      (5) The determination of the community spouse countable asset allowance.

   c. Any hearing respecting the determination of the community spouse countable asset allowance must be held within thirty days of the request for the hearing.

   d. If either spouse establishes that the community spouse needs income, above the level provided by the monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs

allowance for that spouse must be increased to an amount adequate to provide necessary additional income.

e. (1) If either spouse establishes that the assets included within the community spouse countable asset allowance generate an amount of income inadequate to raise the community spouse's income to the monthly maintenance needs allowance, to the extent that total assets permit, the community spouse countable asset allowance for that spouse must be increased to an amount adequate to provide such a monthly maintenance needs allowance. For purposes of calculations made under this subdivision, all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, must be treated as having been made available before an additional amount of assets may be allocated to the community spouse under this subdivision.

(2) To establish a need for an increased asset allowance under this subdivision, the applicant, recipient, or the community spouse must provide verification of all income and assets of the community spouse.

(3) The amount of assets adequate to provide a monthly maintenance needs allowance for the community spouse must be based on the cost of a single premium lifetime annuity selected by the department that provides monthly payments equal to the difference between the monthly maintenance needs allowance and other income of both spouses not generated by either spouse's countable assets.

(4) The monthly maintenance needs allowance amount upon which calculations under this subdivision are made must be the amount in effect upon filing of the appeal.

(5) The estimate of the cost of an annuity described in paragraph 3 must be substituted for the amount of assets attributed to the community spouse if the amount of assets previously determined is less than the estimate. If the amount of assets attributed to the community spouse prior to the hearing is greater than the estimate of the cost of an annuity described in paragraph 3, the attribution of assets to the community spouse made prior to the hearing must be affirmed.

(6) No applicant, recipient, or community spouse is required to purchase an annuity as a condition of the applicant or recipient's eligibility for medicaid benefits.

8. Any transfer of an asset or income is a disqualifying transfer under section 75-02-02.1-33.1 or 75-02-02.1-33.2, whether made by a community spouse, a home and community-based services spouse, or an institutionalized spouse, unless specifically authorized by this section. The income that may be received by or deemed provided to an ineligible community spouse, and the asset amounts that an ineligible community spouse may retain, are intended to allow that community spouse to avoid impoverishment. They are not intended to allow the community spouse to make transfers of assets or income, for less than adequate consideration, which would disqualify the institutionalized spouse or home and community-based services spouse, if made by the institutionalized spouse or home and community-based services spouse.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; October 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2011; April 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396r-5

75-02-02.1-24.1. Breast and cervical cancer early detection program.

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;

2. Have been screened for breast and cervical cancer through women's way 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. Meet the requirements of section 75-02-02.1-16, relating to residence, section 75-02-02.1-18, relating to citizenship, and section 75-02-02.1-19, relating to inmates of public institutions; and

4. Become eligible on the first day of the later of the month of diagnosis or the first month of retroactive eligibility, as provided in section 75-02-02.1-10, and continue to be eligible until they no longer require treatment for breast or cervical cancer or no longer meet the requirements of this subsection.

History: Effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-17

75-02-02.1-24.2. Eligibility for workers with disabilities.

1. An individual shall be enrolled as a member of the workers with disabilities coverage if that individual:

   a. Is gainfully employed;

   b. Is at least sixteen, but less than sixty-five, years of age;

   c. Is disabled as determined by the social security administration or the state review team;

   d. Meets the requirements of this section; and

   e. Is not in receipt of any other medicaid benefits under this chapter other than coverage as a qualified medicare beneficiary or a special low-income medicare beneficiary.

2. An individual may be regarded as gainfully employed only if, taking all factors into consideration, the individual shows that the activity asserted as employment:

   a. Produces a product or service that someone would ordinarily be employed to produce and for which payment is received;

   b. Reflects a relationship of employer and employee or producer and customer;

   c. Requires the individual's physical effort for completion of job tasks, or, if the individual has the skills and knowledge to direct the activity of others, reflects the outcome of that direction; and

   d. The employment setting is not primarily an evaluative or experiential activity.

3. Asset considerations provided under section 75-02-02.1-25, asset limits provided under section 75-02-02.1-26, and excluded assets provided under section 75-02-02.1-28.1 are applicable to the workers with disabilities coverage except that each individual enrolled as a member of the workers with disabilities coverage group is allowed an additional ten thousand dollars in assets.

4. Except for Indians who are exempt from cost-sharing under federal law, an individual who has not paid a one-time enrollment fee of one hundred dollars may not be enrolled.

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

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

7. A monthly premium is due on the tenth day of each month for which coverage is sought and shall be equal to five percent of the individual's gross countable income. This requirement does not apply to Indians who are exempt from cost-sharing under federal law.

8. No individual may be found eligible under this section if the individual and the individual's family have total net income equaling or exceeding two hundred twenty-five percent of the poverty level.

9. This section becomes effective on the effective date of approved amendments to the medicaid state plan sufficient to secure federal financial participation in the cost of services provided to individuals found eligible under this section, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

History: Effective June 1, 2004; amended effective August 1, 2005; April 1, 2008; January 1, 2011; April 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02.7, 50-24.1-18.1

75-02-02.1-24.3. Eligibility for children with disabilities.

1. A child must be enrolled as a member of the children with disabilities coverage if that child:

   a. Is under age nineteen, including the month the child turns age nineteen;

   b. Is disabled;

   c. Meets the requirements of this section; and

   d. Is not in receipt of any other medicaid benefits under this chapter.

2. As a condition of eligibility, a child must be enrolled in a health insurance policy if:

   a. The child's family has an employer-based health insurance plan available to them; and

   b. The employer pays at least fifty percent of the premium.

3. A monthly premium is due on the tenth day of each month for which coverage is sought and is equal to five percent of the family's gross countable income. This premium may be offset by any other health insurance premium the family pays for a health insurance plan that provides coverage for the individual claiming eligibility under this section. This subsection does not apply to Indians who are exempt from cost-sharing under federal law.

4. If the premium established for an individual's coverage under this section is not paid for three months, the individual will be disenrolled and may not be reenrolled without first reestablishing eligibility under this section and paying all outstanding premiums. Any month in which no payment is due may not be counted as a month in which the individual's premium failed to be paid.

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

6. No individual may be found eligible under this section if the individual and the individual's family have total net income in excess of two hundred percent of the poverty level.

7. This section becomes effective March 1, 2008, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

8. For purposes of this section, "family" means any member of the medicaid unit who is a spouse, parent, financially responsible caretaker relative, sibling, or child of the individual requesting benefits under this section.

History: Effective April 1, 2008; amended effective January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-31

75-02-02.1-24.4. Hospital presumptive eligibility.

1. For purposes of this section, "qualified hospital" means a hospital or hospital-owned physician practice or clinic that:

   a. Is a medicaid provider;

   b. Notifies the department of its election to make presumptive eligibility determinations; and

   c. Has been approved by the department to make presumptive eligibility determinations under this section.

2. The department may provide medicaid benefits during a period of presumptive eligibility, prior to a determination of medicaid eligibility, to the following individuals:

   a. Children through the month they turn nineteen years of age;

   b. Former foster care children through the month they turn twenty-six years of age, who were enrolled in medicaid and were in foster care in this state when they turned eighteen years old;

   c. Parents and caretaker relatives of children through the month the children turn nineteen years of age;

   d. Pregnant women; and

   e. Medicaid expansion group ages nineteen through sixty-four, from the month following the month they turn nineteen years of age through the month prior to the month they turn sixty-five years of age.

3. An applicant shall apply for presumptive eligibility coverage at a qualified hospital. Applicants do not need to be hospitalized. Presumptive eligibility determinations may be made only by qualified hospital employees who are trained and certified to determine presumptive eligibility.

4. The application for presumptive eligibility must be signed by the applicant, an authorized representative, or if the applicant is incompetent or incapacitated and has not designated an authorized representative, someone acting responsibly for the applicant.

5. The presumptive eligibility determination is based on the information reported by the applicant and verification is not required. The applicant shall provide all information the qualified hospital needs to determine presumptive eligibility.

6. Applicants shall attest to each of the following for each household member requesting presumptive eligibility:

    a. United States citizen, United States national, or eligible immigrant status;

    b. North Dakota residency;

    c. Gross income amount;

    d. Whether or not the applicant is currently enrolled in medicaid; and

    e. That the applicant does not have any other health insurance coverage that meets minimum essential coverage, as defined in section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, and implementing regulations.

7. MAGI-based methodology must be used to determine presumptive eligibility.

8. The presumptive eligibility period begins on the day the presumptive eligibility determination is made and ends the earlier of:

    a. If a medicaid application has been submitted, the day on which a decision is made on that application; or

    b. If a medicaid application has not been submitted, the last day of the month following the month the presumptive eligibility determination was made.

9. Individuals, excluding pregnant women, are eligible for one period of presumptive eligibility per calendar year. Pregnant women are eligible for presumptive eligibility coverage once per pregnancy.

10. Presumptive eligibility coverage does not include the three-month prior period.

11. An individual may not appeal presumptive eligibility determinations.

12. Qualified hospitals shall:

    a. Make presumptive eligibility determinations for applicants without medicaid or other health care coverage;

    b. Assure timely access to care while the presumptive eligibility determination is being made;

    c. Ensure all employees assisting in and completing presumptive eligibility determinations follow department regulations and policies for presumptive eligibility determinations;

    d. Provide the applicant with notice of the presumptive eligibility determination;

e. Inform applicants at the time of the presumptive eligibility determination that applicants must submit an application for medicaid to obtain medicaid coverage beyond the presumptive eligibility period;

f. Assist applicants in completing and submitting an application for medicaid and children's health insurance program or subsidized insurance through the federally facilitated marketplace;

g. Meet the performance standards as set forth in subsection 13;

h. Ensure all employees assisting in and completing presumptive eligibility applications and determinations attend all presumptive eligibility policy training provided by the department and stay current with changes, including the following:

(1) Participate in all inperson, telephone conference, webinar, and computer-based presumptive eligibility training sessions; and

(2) Read all information provided regarding updates and changes to presumptive eligibility policies and regulations; and

i. Provide verification to the department upon request that all employees assisting in and completing presumptive eligibility applications and determinations have completed the training set forth in subdivision h.

13. Qualified hospitals shall meet the following performance standards:

a. Ninety-five percent of applicants are not enrolled in medicaid at the time the presumptive eligibility determination is made;

b. Ninety percent of applicants determined presumptively eligible by the qualified hospital submit a medicaid application during the presumptive eligibility period; and

c. Eighty-five percent of applicants that are determined presumptively eligible and submit a medicaid application during the presumptive eligibility period are determined eligible for medicaid.

14. Qualified hospitals that do not meet the performance standards set forth in subsection 13 for three consecutive months are required to participate in additional training or other reasonable corrective action measures, or both, provided by the department. If the qualified hospital continues to fail to meet the performance standards for an additional two consecutive months after the training or other corrective action measures, the department will disqualify the qualified hospital.

History: Effective July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 U.S.C. 1396a(e)

75-02-02.1-25. Asset considerations.

Except as otherwise provided in this chapter, this section applies to all aged, blind, and disabled applicants and recipients of medicaid.

1. All actually available assets must be considered in establishing eligibility for medicaid. Assets are actually available when 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

asset available, or to cause the asset to be made available. This subsection does not supersede other provisions of this chapter which describe or require specific treatment of assets, or which describe specific circumstances which require a particular treatment of assets.

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

3. It is presumed that all spousal assets are actually available. In order to rebut this presumption, the applicant or recipient must demonstrate that the spousal assets are unavailable despite reasonable and diligent efforts to access such assets. No applicant or recipient who has a statutory or common-law cause of action for support out of the assets of a spouse, but who has failed to diligently pursue that cause of action, may rebut the presumption. Any applicant or recipient who documents any of the following circumstances will have rebutted the presumption without further proof:

   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 any of the United States;

   c. The applicant or recipient has been subject to marital separation, with or without court order, and the parties have not separated for the purpose of securing medicaid benefits; or

   d. In cases where section 75-02-02.1-24 applies, the assets are those properly treated as belonging to the community spouse.

4. All parental assets are considered actually available to a disabled child under age eighteen unless the child is living:

   a. Independently; or

   b. With a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing medicaid benefits, in which case only the assets of the parent with whom the child is living are considered available.

5. When considering the availability of assets from an estate, assets received from the estate of a spouse, or a parent who was providing support, are available as of the date of the death of the person who was providing such support. Assets received from the estate of any other person are available at the earlier of:

   a. The day on which the assets are received from the estate; or

   b. Six months after the person's death.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; May 1, 2006; April 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-26. Asset limits.

In all instances, including determinations of equity, property must be realistically evaluated in accord with current fair market value. No one subject to an asset limit may be found eligible for medicaid unless the combined equity value of the medicaid unit's assets of whatever nature, not excluded pursuant to section 75-02-02.1-28 or section 75-02-02.1-28.1, do not exceed:

1. For individuals who seek benefits as members of the categorically needy or medically needy aged, blind, and disabled groups:

   a. Three thousand dollars for a one-person unit;

   b. Six thousand dollars for a two-person unit; and

   c. An additional amount of twenty-five dollars for each member of the unit in excess of two;

2. For individuals who seek benefits as qualified medicare beneficiaries, qualifying individuals, or special low-income medicare beneficiaries pursuant to section 75-02-02.1-22, the asset limits provided in that section; or

3. For individuals who seek benefits as qualified disabled and working individuals pursuant to section 75-02-02.1-23, the asset limits provided in that section.

History: Effective December 1, 1991; amended effective July 1, 1993; July 1, 2003; April 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-27. Exempt assets.

Repealed effective April 1, 2012.

75-02-02.1-28. Excluded assets.

Except as provided in section 75-02-02.1-28.1, the following types of assets will be excluded in determining if the available assets of an applicant or recipient exceed asset limits:

1. The home occupied by the medicaid unit, including trailer homes being used as living quarters.

2. Personal effects, wearing apparel, household goods, and furniture.

3. One motor vehicle if the primary use of the vehicle is to serve the needs of members of the medicaid unit.

4. Indian trust or restricted lands and the proceeds from the sale thereof, so long as those proceeds are impressed with the original trust.

5. Indian per capita funds and judgment funds awarded by either the Indian claims commission or the court of claims after October 19, 1973, interest and investment income accrued on such Indian per capita or judgment funds while held in trust, and purchases made using interest or investment income accrued on such funds while held in trust. The funds must be identifiable and distinguishable from other funds. Commingling of per capita funds, judgment funds, and interest and investment income earned on those funds, with other funds, results in loss of the exemption.

6. a. In determining the eligibility of an individual with respect to skilled nursing services, swing-bed, or home and community-based benefits, the individual will be ineligible for

those medicaid benefits if the individual's equity interest in the individual's home exceeds five hundred thousand dollars.

b. The dollar amount specified in this subsection will be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers, all items, United States city average, rounded to the nearest one thousand dollars.

c. This subsection does not apply to an individual whose spouse, or child who is under age twenty-one or is blind or disabled, lawfully resides in the individual's home.

d. This subsection may not be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

e. This subsection applies only to individuals who made application for medicaid with respect to skilled nursing facility services, swing-bed, or home and community-based benefits on or after January 1, 2006.

7. a. Notwithstanding any other provision to the contrary, the assets of an individual must be disregarded when determining medicaid eligibility in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that:

(1) Covers an insured who was a resident of North Dakota when coverage first became effective under the policy;

(2) Is a qualified long-term care insurance policy, as defined in section 7702B(b) of the Internal Revenue Code of 1986, issued not earlier than the effective date of the state plan amendment described in subdivision b;

(3) The agency determines meets the requirements of the long-term care insurance model regulations and the long-term care insurance model act promulgated by the national association of insurance commissioners as adopted as of October 2000, or the state insurance commissioner certifies that the policy meets such requirements; and

(4) Is sold to an individual who:

(a) Has not attained age sixty-one as of the date of purchase, if the policy provides compound annual inflation protection;

(b) Has attained age sixty-one but has not attained age seventy-six as of the date of purchase, if the policy provides some level of inflation protection; or

(c) Has attained age seventy-six as of the date of purchase.

b. This subsection applies only to individuals who have purchased a long-term care insurance policy described in this subsection with an issue date on or after the date specified in an approved medicaid state plan amendment that provides for the disregard of assets:

(1) To the extent that payments are made under such a long-term care insurance policy; or

(2) Because an individual has received or is entitled to receive benefits under such a long-term care insurance policy.

8. Property that is essential to earning a livelihood.

a. Property may be excluded as essential to earning a livelihood only during months in which a member of the medicaid unit is actively engaged in using the property to earn a livelihood, or during months when the medicaid unit is not actively engaged in using the property to earn a livelihood, if the medicaid unit shows that the property has been in such use and there is a reasonable expectation that the use will resume:

(1) Within twelve months of the last use; or

(2) If the nonuse is due to the disabling condition of a member of the medicaid unit, within twenty-four months of the last use.

b. Property consisting of an ownership interest in a business entity that employs anyone whose assets are used to determine eligibility may be excluded as property essential to earning a livelihood if:

(1) The individual's employment is contingent upon ownership of the property; or

(2) There is no ready market for the property.

c. A ready market for property consisting of an ownership interest in a business entity exists if the interest may be publicly traded. A ready market does not exist if there are unreasonable limitations on the sale of the interest, such as a requirement that the interest be sold at a price substantially below its actual value or a requirement that effectively precludes competition among potential buyers.

d. Property currently enrolled in the conservation reserve program is considered to be property essential to earning a livelihood.

e. Property from which a medicaid unit is receiving only rental or lease income is not essential to earning a livelihood.

f. Liquid assets, to the extent reasonably necessary for the operation of a trade or business, are considered to be property essential to earning a livelihood. Liquid assets may not otherwise be treated as essential to earning a livelihood.

9. Property which is not saleable without working an undue hardship. Such property may be excluded no earlier than the first day of the month in which good-faith attempts to sell are begun, and continues to be excluded only for so long as the asset continues to be for sale and until a bona fide offer for at least seventy-five percent of the property's fair market value is made. Good-faith efforts to sell must be repeated at least annually in order for the property to continue to be excluded.

a. Persons seeking to establish retroactive eligibility must demonstrate that good-faith efforts to sell were begun and continued in each of the months for which retroactive eligibility is sought. Information concerning attempts to sell, which demonstrate that an asset is not saleable without working an undue hardship, are relevant to establishing eligibility in the month in which the good-faith efforts to sell are begun, but are not relevant to months prior to that month and do not relate back to prior months.

(1) A good-faith effort to sell real property or a mobile home must be made for at least three calendar months in which no bona fide offer for at least seventy-five percent of the property's fair market value is received before the property can be shown to be not saleable without working an undue hardship. The three calendar months must include a good-faith effort to sell through the regular market for three calendar months.

(2) A good-faith effort to sell property other than real property, a mobile home, or an annuity must be made for at least thirty days in which no bona fide offer for at least seventy-five percent of the property's fair market value is received before the property can be shown to be not saleable without working an undue hardship.

b. Property may not be shown to be not saleable without working an undue hardship if the owner of the property fails to take action to collect amounts due and unpaid with respect to the property or otherwise fails to assure the receipt of regular and timely payments due with respect to the property.

10. a. Any pre-need burial contracts, prepayments, or deposits up to the amount set by the department in accordance with state law and the medicaid state plan, which are designated by an applicant or recipient for the burial of the applicant or recipient. Earnings accrued on the total amount of the designated burial fund are excluded.

(1) The burial fund must be identifiable and may not be commingled with other funds. Checking accounts are considered to be commingled.

(2) The value of an irrevocable burial arrangement shall be considered toward the burial exclusion. The irrevocable amount may not exceed the amount of the burial asset exclusion at the time of the contract is entered, plus the portion of the three thousand dollar asset limitation the purchaser designates for funeral expenses.

(3) The prepayments on a whole life insurance policy or annuity are the lesser of the face value or the premiums that have been paid.

(4) Any fund, insurance, or other property given to another person or entity in contemplation that its value will be used to meet the burial needs of the applicant or recipient shall be considered part of the burial fund. If an applicant or recipient's burial is funded by an insurance policy, the amount considered set aside for the burial is the lesser of the cost basis or the face value of the insurance policy.

(5) At the time of application, the value of a designated burial fund shall be determined by identifying the value of the prepayments which are subject to the burial exclusion and asset limit amounts.

(6) Designated burial funds which have been decreased prior to application for medicaid shall be considered redesignated as the date of last withdrawal. The balance at that point shall be considered the prepayment amount and earnings from that date forward shall be disregarded.

(7) Reductions made in a designated burial fund after eligibility is established must first reduce the amount of earnings.

(8) An applicant shall be determined eligible for the three-month prior period when a burial fund is established at the time of application if the value of all assets are within the medicaid burial fund exclusion and asset limit amounts for each of the three prior months. Future earnings on the newly established burial fund must be excluded.

b. A burial plot for each family member.

11. Home replacement funds, derived from the sale of an excluded home, and if intended for the purchase of another excluded home, until the last day of the third month following the month in which the proceeds from the sale are received. This asset must be identifiable and not commingled with other assets.

12. Unspent assistance, and interest earned on unspent assistance, received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, and comparable disaster assistance received from a state or local government, or from a disaster assistance organization. This asset must be identifiable and not commingled with other assets.

13. Payments, interest earned on the payments, and in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets are excluded for nine months, and may be excluded for an additional twenty-one months, if circumstances beyond the person's control prevent the repair or replacement of the lost, damaged, or stolen assets, and keep the person from contracting for such repair or replacement. This asset must be identifiable and not commingled with other assets.

14. For nine months, beginning after the month of receipt, unspent assistance received from a fund established by a state to aid victims of crime, to the extent that the applicant or recipient demonstrates that such amount was paid in compensation for expenses incurred or losses suffered as a result of a crime. This asset must be identifiable and not commingled with other assets.

15. Payments from a fund established by a state as compensation for expenses incurred or losses suffered as a result of a crime. This asset must be identifiable and not commingled with other assets.

16. Payments made pursuant to the Confederate Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, [Pub. L. 103-436; 108 Stat. 4577 et seq.]. This asset must be identifiable and not commingled with other assets.

17. Stock in regional or village corporations held by natives of Alaska issued pursuant to section 7 of the Alaska Native Claims Settlement Act, [Pub. L. 92-203; 42 U.S.C. 1606].

18. For nine months beginning after the month of receipt, any educational scholarship, grant, or award and any fellowship or gift, or portion of a gift, used to pay the cost of tuition and fees at any educational institution. This asset must be identifiable and not commingled with other assets.

19. For nine months beginning after the month of receipt, any income tax refund, any earned income tax credit refund, or any advance payments of earned income tax credit. This asset must be identifiable and not commingled with other assets.

20. Assets set aside, by a blind or disabled, but not an aged, supplemental security income recipient, as a part of a plan to achieve self-support which has been approved by the social security administration.

21. The value of a life estate.

22. Allowances paid to children of Vietnam veterans who are born with spina bifida. This asset must be identifiable and not commingled with other assets.

23. The value of mineral acres.

24. Funds, including interest accruing, maintained in an individual development account established under title IV of the Assets for Independence Act, as amended [Pub. L. 105-285; 42 U.S.C. 604, note].

25. Property connected to the political relationship between Indian tribes and the federal government which consists of:

a. Any Indian trust or restricted land, or any other property under the supervision of the secretary of the interior located on a federally recognized Indian reservation, including any federally recognized Indian tribe's pueblo or colony, and including Indian allotments on or near a reservation as designated and approved by the bureau of Indian affairs of the department of interior.

b. Property located within the most recent boundaries of a prior federal reservation, including former reservations in Oklahoma and Alaska native regions established by the Alaska Native Claims Settlement Act.

c. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

d. Property with unique Indian significance such as ownership interests in or usage rights to items not covered by subdivisions a through c that have unique religious, spiritual, traditional, or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

26. Funds held in retirement plans that are considered qualified retirement plans in the Internal Revenue Code [26 U.S.C.].

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; August 1, 2005; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

75-02-02.1-28.1. Excluded assets for medicare savings programs, qualified disabled and working individuals, and spousal impoverishment prevention.

1. An asset may be excluded for purposes of medicare savings programs, qualified disabled and working individuals, and spousal impoverishment prevention only if this section provides for the exclusion. An asset may be excluded under this section only if the asset is identified.

2. The assets described in subsections 2 through 5 and subsections 8, 9, and 11 through 26 of section 75-02-02.1-28 are excluded.

3. A residence occupied by the individual, the individual's spouse, or the individual's dependent relative is excluded for medicare savings programs and qualified disabled and working individuals. A residence occupied by the community spouse is excluded for spousal impoverishment prevention cases. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. The residence remains excluded during temporary absence of the individual from the residence so long as the individual intends to return. Renting or leasing part of the residence to a third party does not affect this definition. For purposes of this subsection:

   a. "Dependent" means an individual who relies on another for medical, financial, and other forms of support, provided that an individual is financially dependent only when another individual may lawfully claim the financially dependent individual as a dependent for federal income tax purposes;

   b. "Relative" means the parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, or first cousin, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse; and

c. "Residence" includes all contiguous lands, including mineral interests, upon which it is located.

4. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds, held for the individual and for the individual's spouse, are excluded from the date of application. Burial funds may consist of revocable burial accounts, revocable burial trusts, other revocable burial arrangements including the value of installment sales contracts for burial spaces, cash, financial accounts such as savings or checking accounts, or other financial instruments with definite cash value, such as stocks, bonds, or certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with non-burial-related assets, and must be identified as a burial fund by title of account or a signed statement. Life or burial insurance designated under subsection 10 must be considered at face value toward meeting the burial fund exclusion. Cash surrender value of an individual's life insurance not excluded under subsection 10 may be applied toward the burial fund exclusion.

5. A burial space or agreement which represents the purchase of a burial space, paid for in full, for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion set forth in subsection 4. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this subsection:

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

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

6. At the option of the individual, and in lieu of, but not in addition to, the burial fund described in subsection 4 and the burial space described in subsection 5, the medicaid burial described in subsection 3 of section 75-02-02.1-28 may be excluded. This optional exclusion is not available to qualified disabled and working individuals or to community spouses.

7. Property essential to self-support is excluded.

   a. Up to six thousand dollars of the equity value of nonbusiness, income-producing property, which produces annual net income at least equal to six percent of the excluded amount, may be excluded. Two or more properties may be excluded if each property produces at least a six percent annual net return, but no more than a total of six thousand dollars of the combined equity value of the properties may be excluded. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars. Equity in such property is a countable asset if it produces an annual net income of less than six percent of equity.

   b. Up to six thousand dollars of the equity value of nonbusiness property used to produce goods and services essential to daily activities is excluded. Such nonbusiness property is used to produce goods and services essential to daily activities when, for instance, it is used to grow produce or livestock solely for consumption in the individual's household. Equity in such property is a countable asset to the extent that equity exceeds six thousand dollars.

c. To be excluded, property essential for self-support must be in current use, or, if not in current use, must have been in such use, and there must be a reasonable expectation that the use will resume, and, with respect to property described in subdivision a, the annual return test must be met:

(1) Within twelve months of the last use;

(2) If the nonuse is due to the disabling condition of the applicant or recipient, or, with respect to spousal impoverishment prevent cases, the community spouse, within twenty-four months of the last use; or

(3) With respect to property described in subdivision a, if the property produces less than a six percent return for reasons beyond the control of the applicant or recipient, and there is a reasonable expectation that the property shall again produce a six percent return within twenty-four months of the tax year in which the return dropped below six percent.

d. Liquid assets are not property essential to self-support.

8. Lump sum payments of title II or supplemental security income benefits are excluded for nine consecutive months following the month of receipt.

9. Real property, the sale of which would cause undue hardship to a co-owner, is excluded for so long as the co-owner uses the property as a principal residence, would have to move if the property were sold, and has no other readily available housing. This exclusion is not available in spousal impoverishment cases.

10. Life or burial insurance that generates a cash surrender value is excluded if the face value of all such life and burial insurance policies on the life of that individual total one thousand five hundred dollars or less. This exclusion is not available for applicants or recipients who select the medicaid burial described in subsection 10 of section 75-02-02.1-28.

11. The value of assistance is excluded if paid with respect to a dwelling unit occupied by the applicant or recipient, or by the applicant's or recipient's spouse, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965 [12 U.S.C. 1701s], title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

12. Relocation assistance is excluded if provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.], which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636]. Relocation assistance provided by a state or local government that is comparable to the described federal relocation assistance is excluded, but only for nine months following the month of receipt.

13. Agent orange payments are excluded.

14. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [50 U.S.C. App. 1989 et seq.] are excluded.

15. German reparations payments to survivors of the holocaust, and reparations payments made under sections 500 through 506 of the Austrian General Social Insurance Act are excluded.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; April 1, 2012.

General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

75-02-02.1-29. Forms of asset ownership.

1. Ownership of real or personal property or liquid assets can take various forms. The first basic consideration is the distinction between real and personal property. Real property relates to land and those things, such as houses, barns, and office buildings, which are more or less permanently attached to it. Personal property describes all other things which are subject to individual rights. Personal property includes liquid assets, but liquid assets are distinguished from other personal property because liquid assets have a market at a price that may not ordinarily be negotiated between buyer and seller. Liquid assets include cash, accounts, publicly traded stocks, bonds, and other securities, and commodities for which there is an established market.

2. Since the various types of property ownership may affect the valuation of the applicant's or recipient's assets, it is important to carefully record information relating to such property.

   a. "Fee" or "fee simple" ownership is a term applied to real property in which the "owner" has the sole ownership interest. A fee simple interest will, in theory, last as long as the land. Even though one owner dies, that owner has the power to sell or to "will" the property. The resulting series of owners each has a fee simple. A fee simple ownership interest is not changed when the property is mortgaged. The mortgage merely secures the owner's promise to repay a debt. If the debt is not paid, the owner may be obliged to forfeit the property. Fee simple ownership may be individual or may be shared.

   b. Shared ownership means that the ownership interest in the property is vested in more than one person. Shared ownership may be by "joint tenancy" or by "tenancy in common". Shared ownership occurs both with real property and with valuable personal property, such as accounts, motor vehicles, and mobile homes.

      (1) In joint tenancy, each of two or more joint tenants has an equal interest in the whole property. On the death of one of two joint tenants, the survivor becomes the sole owner. On the death of one of three or more joint tenants, the survivors remain joint tenants in the entire interest. Any joint tenant, acting independently, may convert the joint tenancy to a tenancy in common by selling that person's interest.

      (2) In tenancy in common, two or more persons have an undivided fractional interest in the whole property. There is no "right of survivorship" in a tenancy in common. On the death of one of the tenants in a tenancy in common, the surviving tenants gain nothing, and the estate of the deceased tenant thereafter owns the deceased tenant's share.

   c. Life estates and remainder interests.

      (1) Real property interests may be divided in terms of the time when the owner of the interest is entitled to possession of the property. The owner of a life estate, or life tenant, is entitled to possession of the real property for a period measured by the lifetime of a specific person or persons. A life tenant has the right to use the property and is entitled to any rents or profits from the property. A life tenant may sell the life estate, but such a sale does not change the identity of the person or persons whose lifetimes measure the duration of the life estate. A life estate may be referred to as a "life lease".

      (2) When a life estate is created, a right to possess the property, after the death of the life tenant, must also be created. That right is called a "remainder interest", and the

owner of that right is called a "remainderman". Upon the death of the life tenant, the remainderman owns the property. The remainderman is not entitled to possess or use the property until the death of the life tenant. The remainderman does have the right to sell the remainder interest.

(3) A life estate may be created in which the right to possess the property returns, upon the death of the life tenant, to the person or entity that created the life estate. The right to have possession of property returned after the end of a life estate is properly called a "reversion", but is treated as a remainder interest for purposes of valuation.

3. The effect of an interest in property, and not what that interest is called, governs the rules to be applied in its treatment for medicaid purposes.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-30. Contractual rights to receive money payments.

1. An applicant or recipient may own contractual rights to receive money payments. Such contractual rights are available assets subject to the asset limits. If the applicant or recipient has sold property and received in return a promise of payments of money at a later date, usually to be made periodically, and an attendant promise to return the property if the payments are not made, the arrangement is usually called a "contract for deed". The essential feature of such a contract is the right to receive future payments, usually coupled with a right to get the property back if the payments are not made. Contractual rights to receive money payments also arise out of other types of transactions. The valuable contract document may be called a promissory note, accounts receivable, annuity, mortgage, or by some other name.

2. There is a presumption that the holder's interest in contractual rights to receive money payments is saleable without working an undue hardship. This presumption may be rebutted by evidence demonstrating that the contractual rights are not saleable without working an undue hardship.

History: Effective December 1, 1991; amended effective July 1, 2003.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-30.1. Annuities.

Repealed pursuant to North Dakota Century Code section 28-32-18.1, effective July 16, 2003.

75-02-02.1-31. Trusts.

1. A trust is an arrangement whereby a person known as the "grantor" or "trustor" gives assets to another person known as the "trustee" with instructions to use the assets for the benefit of a third person known as the "beneficiary". The assets placed in trust are called the "principal" or "corpus". The positions of grantor, trustee, and beneficiary occur in all trusts, but it is not uncommon for a single trust to involve more than one grantor, trustee, or beneficiary. It is also not uncommon for a grantor to establish a trust where the grantor is also a beneficiary or where the trustee is also a beneficiary. "Trusts" includes escrow accounts, investment accounts, conservatorship accounts, and any other legal instruments, devices, or arrangements, whether or not written, managed by an individual or entity with fiduciary obligations. A trust may have an effect on eligibility whether the applicant is a grantor, trustee, or beneficiary.

2. Review of a trust as a part of an eligibility determination includes efforts to ascertain the intent of the grantor. The grantor has no authority or power to determine eligibility or to require a particular outcome in an eligibility determination, and a grantor's efforts to do so may be disregarded.

3. Trusts may be categorized in many ways, but the revocability of a trust is a fundamental characteristic. A revocable trust is a trust that the grantor, or someone acting at the request, direction, or influence of the grantor, has the power to revoke, remove from, or otherwise end the trust. An irrevocable trust is a trust that may not be revoked in any way by the grantor or anyone acting at the request, direction, or influence of the grantor. The determination of trust revocability is not based solely on trust terms stating the trust is irrevocable. A trust is treated as revocable, regardless of its terms, if:

   a. The trust reserves a power to amend to the grantor, or grants a power to amend to some other person, unless the power to amend is limited to authority to terminate the trust for impossibility of administration, and the trust also provides for distribution of the trust assets to the primary beneficiary, free of trust;

   b. The grantor and the beneficiaries consent to the revocation;

   c. The grantor is also the sole beneficiary of the trust;

   d. The grantor of a trust and all trust beneficiaries are part of a medicaid unit;

   e. The grantor is a parent, and beneficiaries of the trust include only the grantor, the grantor's spouse, or the grantor's minor children;

   f. The trust has been amended subsequent to its establishment, unless the trust was amended under North Dakota Century Code section 59-12-11;

   g. The trust provides for termination and disbursement to the grantor upon conditions relating to the grantor during the grantor's lifetime; or

   h. The trust provides for revocation or amendment only upon order of a court.

4. In the case of a revocable trust:

   a. The corpus of the trust shall be considered assets available to the grantor;

   b. Payments from the trust to or for the benefit of grantor, the grantor's spouse, or the grantor's dependent child shall be considered income of the grantor;

   c. Any other payments from the trust shall be considered income or assets disposed of by the grantor for purposes of section 75-02-02.1-33.1 or 75-02-02.1-33.2.

5. Once distributed or paid, a distribution or payment from a trust is not a trust asset, but is an asset of, or income to, the distributee or payee.

6. a. For purposes of this subsection:

      (1) "Medicaid-qualifying trust" means a trust established, other than by will, by an individual or the individual's spouse, under which the individual may be the beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

      (2) "A trust established by an individual or the individual's spouse" includes trusts created or approved by courts or by the individual or the individual's spouse where

the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse against any third party.

b. The amount from an irrevocable medicaid-qualifying trust deemed available to the grantor or the grantor's spouse is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of this subdivision, "grantor" means the individual referred to in paragraph 1 of subdivision a.

c. This subsection applies:

(1) Even though the medicaid-qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medicaid; and

(2) Whether or not the discretion described in paragraph 1 of subdivision a is actually exercised.

7. a. For purposes of this subsection, "support trust" means a trust which has, as a purpose, the provision of support or care to a beneficiary. The purpose of a support trust is indicated by language such as "to provide for the care, support, and maintenance of . . ."; "to provide as necessary for the support of . . ."; or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort, and general welfare". No particular language is necessary, but words such as "care", "maintenance", "medical needs", or "support" are usually present. The term includes trusts which may also be called "discretionary support trusts", so long as support is a trust purpose and the trustee's discretion is not unfettered. This subsection applies without regard to:

(1) Whether or not the support trust is irrevocable or is established for purposes other than to enable a beneficiary to qualify for medicaid or any other benefit program where availability of benefits requires the establishment of financial need; or

(2) Whether or not the discretion is actually exercised.

b. Except as provided in subdivisions c and d, the amount from a support trust deemed available to the beneficiary, the beneficiary's spouse, and the beneficiary's children is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the beneficiary.

c. A beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise any discretion with respect to that distribution, may show that the amounts deemed available under subdivision b are not actually available by:

(1) Commencing proceedings against the trustee or trustees in a court of competent jurisdiction;

(2) Diligently and in good faith asserted in the proceeding that the trustee or trustees is required to provide support out of the trust; and

(3) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount determined under subdivision b.

d. If the beneficiary makes the showing described in subdivision c, the amount deemed available from the trust is the amount determined by the court.

e. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing under subdivision c, to make the department, the state of North Dakota, or a county agency a party to the proceeding, or to show to the court that medicaid benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required under subdivision c.

8. a. For purposes of this subsection, "other trust" means any trust for which treatment is not otherwise described in this section or section 75-02-02.1-31.1.

   b. The amount from an "other trust" deemed available to a beneficiary of that trust is the greater of the amount which must be distributed to that beneficiary under the terms of the trust, whether or not that amount is actually distributed, and the amount which is actually distributed.

9. An applicant or recipient who is a trustee has the legal ownership of trust property and the legal powers to distribute income or trust assets which are described in the trust. However, those powers may be exercised only on behalf of trust beneficiaries. If the trustee or other members of the medicaid unit are not also beneficiaries or grantors to whom trust income or assets are treated as available, trust assets are not available to the trustee.

10. Trusts may provide that trust benefits are intended only for a beneficiary's "special needs", and require the trustee to take into consideration the availability of public benefits and resources, including medicaid. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including medicaid benefits. Some trusts may contain terms which attempt to declare or make the determination of the availability of trusts assets for medicaid purposes. If a trust contains such terms, the amount available to the medicaid applicant or recipient is the amount provided in this section, assuming, for the purposes of making that determination, that the applicant or recipient is ineligible for medicaid.

11. A trust is established, with respect to any asset that is a part of the trust corpus, on the date that asset is made subject to the trust by an effective transfer to the trustee.

12. This section applies to any trust to which section 75-02-02.1-31.1 does not apply. Subsections 1, 2, and 3 apply to trusts described in section 75-02-02.1-31.1.

History: Effective December 1, 1991; amended effective December 1, 1991; October 1, 1993; July 1, 2003; April 1, 2008; April 1, 2010.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396a(k)

75-02-02.1-31.1. Trusts established by applicants, recipients, or their spouses after August 10, 1993.

1. For purposes of determining an individual's eligibility under this chapter, subject to subsection 4, this section applies to a trust established by the individual after August 10, 1993. Subsections 1, 2, and 3 of section 75-02-02.1-31 apply to this section.

2. a. For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used, by someone with lawful authority over those assets, to form all or part of the corpus of the trust and if any of the following individuals established that trust other than by will:

   (1) The individual;

   (2) The individual's spouse;

(3) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(4) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

b. In the case of a trust the corpus of which includes assets of an individual, as determined under subdivision a, and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

c. Subject to subsection 4, this section shall apply without regard to:

(1) The purposes for which a trust is established;

(2) Whether the trustees have or exercise any discretion under the trust;

(3) Any restrictions on when or whether distributions may be made from the trust; or

(4) Any restrictions on the use of distributions from the trust.

3. a. In the case of a revocable trust:

(1) The corpus of the trust shall be considered assets available to the individual;

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual; and

(3) Any other payments from the trust shall be considered income or assets disposed of by the individual for purposes of section 75-02-02.1-33.1 or 75-02-02.1-33.2.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered available to the individual, and payments from that portion of the corpus or income:

(a) To or for the benefit of the individual, shall be considered income of the individual; and

(b) For any other purpose, shall be considered a transfer of income or assets by the individual subject to section 75-02-02.1-33.1; and

(2) Any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the individual was foreclosed, to be income or assets disposed by the individual for purposes of section 75-02-02.1-33.1 or 75-02-02.1-33.2, and the value of the trust shall be determined for purposes of section 75-02-02.1-33.1 or 75-02-02.1-33.2 by including the amount of any payments made from such portion of the trust after such date.

4. This section shall not apply to:

a. A trust containing the assets of an individual under age sixty-five who is disabled and which is established for the benefit of such individual by a parent, grandparent, legal

guardian of the individual, or a court, to the extent the person establishing the trust has lawful authority over the individual's assets, and if, under the terms of the trust, the department will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medicaid benefits paid under North Dakota Century Code chapter 50-24.1 on behalf of the individual; or

b. A trust containing the assets of a disabled individual that meets the following conditions:

(1) The trust is established and managed by a qualified nonprofit association that acts as trustee;

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts;

(3) Accounts in the trust are established solely for the benefit of a disabled individual by the parent, grandparent, or legal guardian of the individual, by the individual, or by a court; and

(4) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the department from such remaining amounts in the account an amount equal to the total amount of medicaid benefits paid under North Dakota Century Code chapter 50-24.1 on behalf of the beneficiary.

5. The department may waive application of this section as creating an undue hardship if the individual establishes that some other person, not currently receiving medicaid, supplemental nutrition assistance program benefits, temporary assistance for needy families benefits, or low-income home energy assistance program benefits, would become eligible for such benefits because of and upon application of this section, and that the cost of those benefits, provided to that other person, exceeds the cost of medicaid benefits available to the individual if application is waived.

6. For purposes of this section "income" and "assets" include all income and assets of the individual and of the individual's spouse, including any income or assets that the individual or the individual's spouse is entitled to, but does not receive because of action:

a. By the individual or the individual's spouse;

b. By a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

c. By any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

7. A trust is established, with respect to any asset that is a part of the trust corpus, on the date that asset is made subject to the trust by an effective transfer to the trustee.

8. A nonprofit association is qualified to establish and manage a trust described in subdivision b of subsection 4 only if the nonprofit corporation:

a. Is organized and operated exclusively for other than profit-making purposes and distributes no part of the corporation's income to its members;

b. Is qualified to receive charitable donations for which a taxpayer may lawfully claim a deduction under the provisions of section 501(c)(3) of the Internal Revenue Code [26 U.S.C. 501(c)(3)];

c. Has a governing board that includes no more than twenty percent membership related to any one disabled individual with an account maintained in the trust:

(1) As a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, nephew, great-great-grandparent, great-great-grandchild, great-aunt, great-uncle, first cousin, grandniece, or grandnephew, whether by birth or adoption, and whether by whole or half-blood, of the disabled individual or the disabled individual's current or former spouse; or

(2) As agent or fiduciary of any kind except with respect to the trust established and managed by the nonprofit association.

d. Has no employee or agent whose compensation is in any way related to or conditioned upon the amount or nature of funds retained by the trust from the account of any deceased beneficiary;

e. Complies with the provisions of North Dakota Century Code section 10-33-12, whether or not incorporated or doing business in North Dakota; and

f. Retains funds from a deceased beneficiary's account only if:

(1) The retained funds are to compensate the trust for services rendered;

(2) The account is that of a beneficiary who was a disabled individual who did not receive benefits under this chapter; or

(3) The account does not contain the assets of a disabled individual.

History: Effective October 1, 1993; amended effective July 1, 2003; April 1, 2008; January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(d)

75-02-02.1-32. Valuation of assets.

It is not always possible to determine the value of assets with absolute certainty, but it is necessary to determine a value in order to determine eligibility. The valuation must be based on reasonably reliable information. It is the responsibility of the applicant or recipient, or the persons acting on behalf of the applicant or recipient, to furnish reasonably reliable information. Because an applicant or recipient may not be knowledgeable of asset values, and particularly because that person may have a strong interest in the establishment of a particular value, whether or not that value is accurate, some verification of value must be obtained. If a valuation from a source offered by an applicant or recipient is greatly different from generally available or published sources, the applicant or recipient must provide a convincing explanation for the differences particularly if the applicant or recipient may be able to influence the person providing the valuation. If reasonably reliable information concerning the value of assets is not made available, eligibility may not be determined. Useful sources of verification include:

1. With respect to liquid assets: reliable account records.

2. With respect to personal property other than liquid assets:

a. Publicly traded stocks, bonds, and securities: stockbrokers.

b. Autos, trucks, mobile homes, boats, farm equipment, or any other property listed in published valuation guides accepted in the trade: the valuation guide.

c. With respect to harvested grains or produce: grain buyers, grain elevator operators, produce buyers; and, for crops grown on contract: the contract.

d. With respect to stock in corporations not publicly traded: appraisers, accountants.

e. With respect to other personal property: dealers and buyers of that property.

f. With respect to a life insurance policy: the life insurance company.

3. Real property.

a. With respect to mineral interests:

(1) If determining current value, the best offer received following a good-faith effort to sell the mineral interests. A good-faith effort to sell means offering the mineral interests to at least three companies purchasing mineral rights in the area, or by offering for bids through public advertisement.

(2) If determining a past value for mineral rights previously sold or transferred:

(a) If producing, the value is an amount equal to any lease income received after the transfer plus three times the annual royalty income based on actual royalty income from the sixty months following the transfer, or if sixty months have not yet passed, based on actual royalty income in the months that have already passed plus an estimate for the remainder of the sixty-month period.

(b) If not producing, but the mineral rights are leased, the value is an amount equal to two times the total lease amount; or

(c) If not leased, the value is an amount equal to the greater of two times the estimated lease amount or the potential sale value of the mineral rights, as determined by a geologist, mineral broker, or mineral appraiser.

(3) In determining current or past value, an applicant, recipient, or the department may provide persuasive evidence establishing a value different from the value established using the process described in this subdivision.

b. With respect to agricultural lands: appraisers, real estate agents dealing in the area, loan officers in local agricultural lending institutions, and other persons known to be knowledgeable of land sales in the area in which the lands are located, but not the "true and full" value from tax records.

c. With respect to real property other than mineral interests and agricultural lands: market value or "true and full" value from tax records, whichever represents a reasonable approximation of fair market value; real estate agents dealing in the area; and loan officers in local lending institutions.

4. Divided or partial interests. Divided or partial interests include assets held by the applicant or recipients; jointly or in common with persons who are not in the medicaid unit; assets where the applicant or recipient or other persons within the medicaid unit own only a partial share of what is usually regarded as the entire asset; and interests where the applicant or recipient owns only a life estate or remainder interest in the asset.

a. Liquid assets. The value of a partial or shared interest in a liquid asset is equal to the total value of that asset.

b. Personal property other than liquid assets and real property other than life estates and remainder interests. The value of a partial or shared interest is a proportionate share of the total value of the asset equal to the proportionate share of the asset owned by the applicant or recipient.

c. Life estates and remainder interests.

(1) The life estate and remainder interest tables must be used to determine the value of a life estate or remainder interest. In order to use the table, it is necessary to first know the age of the life tenant or, if there are more than one life tenants, the age of the youngest life tenant; and the fair market value of the property which is subject to the life estate or remainder interest. The value of a life estate is found by selecting the appropriate age in the table and multiplying the corresponding life estate decimal fraction times the fair market value of the property. The value of a remainder interest is found by selecting the appropriate age of the life tenant in the table and multiplying the corresponding remainder interest decimal fraction times the fair market value of the property.

Life Estate and Remainder Interest Table

Age	Life Estate	Remainder Interest
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755

22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031

53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358

84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(2) The life estate and remainder interest tables are based on the anticipated lifetimes of individuals of a given age according to statistical tables of probability. If the life tenant suffers from a condition likely to cause death at an unusually early age, the value of the life estate decreases and the value of the remainder interest increases. An individual who requires long-term care, who suffers from a condition that is anticipated to require long-term care within twelve months, or who has been diagnosed with a disease or condition likely to reduce the individual's life expectancy is presumed to suffer from a condition likely to cause death at an

unusually early age, and may not rely upon statistical tables of probability applicable to the general population to establish the value of a life estate or remainder interest. If an individual is presumed to suffer from a condition likely to cause death at an unusually early age, an applicant or recipient whose eligibility depends upon establishing the value of a life estate or remainder interest must provide a reliable medical statement that estimates the remaining duration of life in years. The estimated remaining duration of life may be used, in conjunction with a life expectancy table, to determine the comparable age for application of the life estate and remainder interest table.

5. Contractual rights to receive money payments:

   a. Except during any disqualifying transfer penalty period as established by subdivision d, the value of contractual rights to receive money payments in which payments are current is an amount equal to the total of all outstanding payments of principal required to be made by the contract unless evidence is furnished that establishes a lower value.

   b. Except during any disqualifying transfer penalty period as established by subdivision d, the value of contractual rights to receive money payments in which payments are not current is the current fair market value of the property subject to the contract.

   c. Except during any disqualifying transfer penalty period as established by subdivision d, if upon execution the total of all principal payments required under the terms of the contract is less than the fair market value of the property sold, the difference is a disqualifying transfer governed by section 75-02-02.1-33.1 or 75-02-02.1-33.2, and the value of the contract is determined under subdivision a or b.

   d. A contractual right to receive money payments that consists of a promissory note, loan, or mortgage is a disqualifying transfer governed by section 75-02-02.1-33.2 of an amount equal to the outstanding balance due as of the date the lender or purchaser, or the lender's or purchaser's spouse, first applies for medicaid to secure nursing care services, as defined in section 75-02-02.1-33.2, if:

      (1) Any payment on the contract is due after the end of the contract payee's life expectancy as established in accordance with actuarial publications of the office of the chief actuary of the social security administration;

      (2) The contract provides for other than equal payments or for any balloon or deferred payment; or

      (3) The contract provides for any payment otherwise due to be diminished after the contract payee's death.

   e. The value of a secured contractual right to receive money payments that consists of a promissory note, loan, or mortgage not described in subdivision d shall be determined under subdivision a or b. For an unsecured note, loan, or mortgage, the value is the outstanding payments of principal and overdue interest unless evidence is furnished that establishes a lower value.

6. Contract values.

   a. The value of a contract under which payments are made to an applicant or a recipient and in which payments are current is equal to the total of all outstanding payments of principal required to be made by the contract, unless evidence is furnished that establishes a lower value.

b. The value of a contract under which payments are made to an applicant or a recipient and in which payments are not current is an amount equal to the current fair market value of the property subject to the contract. If the contract is not secured by property, the value of the contract is the total of all outstanding payments of principal and past-due interest required to be made under the contract.

c. If the contractual right to receive money payments is not collectible and is not secured, the debt has no collectible value and is not a countable asset. An applicant or recipient can establish that a note has no collectable value if:

(1) The debtor is judgement proof which means a money judgement has been secured, an execution has been served upon the debtor which has been returned as wholly unsatisfied, and the debtor's affidavit and claim for exemptions exempt all of the debtor's property; or

(2) The applicant or recipient verifies the debt is uncollectible due to a statute of limitations which may be shown, among other ways, by an attorney's letter identifying the applicable statute and the facts that make the debt uncollectible under that statute of limitations.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-33. Disqualifying transfers made on or before August 10, 1993.

Repealed effective February 1, 1996.

75-02-02.1-33.1. Disqualifying transfers made before February 8, 2006.

1. a. Except as provided in subsections 2 and 10, an individual is ineligible for nursing care services, swing-bed services, or home and community-based services if the individual or the spouse of the individual disposes of assets or income for less than fair market value on or after the look-back date specified in subdivision b.

b. The look-back date specified in this subdivision is a date that is the number of months specified in paragraph 1 or 2 before the first date on which the individual is both receiving nursing care services and has applied for benefits under this chapter, without regard to the action taken on the application.

(1) Except as provided in paragraph 2, the number of months is thirty-six months.

(2) The number of months is sixty months:

(a) In the case of payments from a revocable trust that are treated as income or assets disposed of by an individual pursuant to subdivision c of subsection 4 of section 75-02-02.1-31 or paragraph 3 of subdivision a of subsection 3 of section 75-02-02.1-31.1;

(b) In the case of payments from an irrevocable trust that are treated as income or assets disposed of by an individual pursuant to subparagraph b of paragraph 1 of subdivision b of subsection 3 of section 75-02-02.1-31.1; and

(c) In the case of payments to an irrevocable trust that are treated as income or assets disposed of by an individual pursuant to paragraph 2 of subdivision b of subsection 3 of section 75-02-02.1-31.1.

c. The period of ineligibility begins the first day of the month in which income or assets have been transferred for less than fair market value, or if that day is within any other period of ineligibility under this section, the first day thereafter that is not in such a period of ineligibility.

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

2. An individual may not be ineligible for medicaid by reason of subsection 1 to the extent that:

a. The assets transferred were a home, and title to the home was transferred to:

(1) The individual's spouse;

(2) The individual's son or daughter who is under age twenty-one, blind, or disabled;

(3) The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual became an institutionalized individual; or

(4) The individual's son or daughter, other than a child described in paragraph 2, who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services;

b. The income or assets:

(1) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(2) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(3) Were transferred to, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or

(4) Were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled;

c. The individual makes a satisfactory showing that:

(1) The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

(2) The income or assets were transferred exclusively for a purpose other than to qualify for medicaid; or

(3) For periods after the return, all income or assets transferred for less than fair market value have been returned to the individual; or

d. The asset transferred was an asset excluded for medicaid purposes other than:

(1) The home or residence of the individual or the individual's spouse;

(2) Property which is not saleable without working an undue hardship;

(3) Excluded home replacement funds;

(4) Excluded payments, excluded interest on those payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;

(5) Life estate interests;

(6) Mineral interests;

(7) An asset received from a decedent's estate during any period it is considered to be unavailable under subsection 5 of section 75-02-02.1-25; or

(8) An annuity.

3. An individual shall not be ineligible for medicaid by reason of subsection 1 to the extent the individual makes a satisfactory showing that an undue hardship exists.

a. An undue hardship exists only if the total cumulative uncompensated value of all income and assets transferred for less than fair market value by the individual or the individual's spouse is less than the total of all unpaid nursing care bills for services:

(1) Provided after the last such transfer was made which are not subject to payment by any third party; and

(2) Incurred when the individual and the individual's spouse had no assets in excess of the appropriate asset levels.

b. If the individual shows that an undue hardship exists, the individual shall be subject to an alternative period of ineligibility that begins on the first day of the month in which the individual and the individual's spouse had no excess assets and continues for the number of months determined by dividing the total cumulative uncompensated value of all such transfers by the average monthly unpaid charges incurred by the individual for nursing care services provided after the beginning of the alternative period of ineligibility.

4. There is a presumption that a transfer for less than fair market value was made for purposes that include the purpose of qualifying for medicaid:

a. In any case in which the individual's assets (and the assets of the individual's spouse) remaining after the transfer produce income which, when added to other income available to the individual (and to the individual's spouse) totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual (and by the individual's spouse) in the month of transfer and in the thirty-five months (or fifty-nine months in the case of a transfer from a revocable or irrevocable trust that is treated as assets or income disposed of by the individual (or the individual's spouse) or in the case of payments to an irrevocable trust that are treated as assets or income disposed of by the individual (or the individual's spouse)) following the month of transfer;

b. In any case in which an inquiry about medicaid benefits was made, by or on behalf of the individual to any person, before the date of the transfer;

c. In any case in which the individual or the individual's spouse was an applicant for or recipient of medicaid before the date of transfer;

d. In any case in which a transfer is made by or on behalf of the individual or the individual's spouse, if the value of the transferred income or asset, when added to the value of the individual's other countable assets, would exceed the asset limits at section 75-02-02.1-26; or

e. In any case in which the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the individual's relative, or to the guardian, conservator, or attorney-in-fact or to any parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew, whether by birth, adoption, and whether by whole or half-blood, of the guardian, conservator, or attorney-in-fact or the spouse or former spouse of the guardian, conservator, or attorney-in-fact.

5. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for medicaid must show that a desire to receive medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subsection 4. The fact, if it is a fact, that the individual would be eligible for the medicaid coverage for nursing care services, had the individual or the individual's spouse not transferred income or assets for less than fair market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for medicaid.

6. If a transfer results in a period of ineligibility under this section for an individual receiving nursing care services, and the transfer was made on or after the look-back date of the individual's spouse, and if the individual's spouse is otherwise eligible for medicaid and requires nursing care services, the remaining period of ineligibility shall be apportioned equally between the spouses. If one such spouse dies or stops receiving nursing care services, any months remaining in that spouse's apportioned period of ineligibility must be assigned or reassigned to the spouse who continues to receive nursing care services.

7. No income or asset transferred to a parent, stepparent, child, stepchild, grandparent, grandchild, brother, sister, stepsister, stepbrother, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew of the individual or the individual's spouse, purportedly for services or assistance furnished by the transferee to the individual or the individual's spouse, may be treated as consideration for the services or assistance furnished unless:

   a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance;

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

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

   d. The parties' course of dealing included paying compensation upon rendering services or assistance, or within thirty days thereafter.

8. A transfer is complete when the individual or the individual's spouse making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

9. For purposes of this section:

a. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future, but does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals must begin by age seventy and one-half.

b. "Average monthly cost of nursing facility care" means the cost determined by the department under section 1917(c)(1)(E)(i)(II) of the Act [42 U.S.C. 1396p(c)(1)(E)(i)(II)].

c. "Fair market value" means:

(1) In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of apparent fair market value;

(2) In the case of real or personal property that is subject to reasonable dispute concerning its value:

(a) If conveyed in an arm's-length transaction to someone not in a confidential relationship with the individual or anyone acting on the individual's behalf, seventy-five percent of estimated fair market value; or

(b) If conveyed to someone in a confidential relationship with the individual or anyone acting on the individual's behalf, one hundred percent of estimated fair market value; and

(3) In the case of income, one hundred percent of apparent fair market value.

d. "Major medical policy" includes any policy, certificate, or subscriber contract issued on a group or individual basis by any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization, which provides a plan of health insurance or health benefit coverage including medical, hospital, and surgical care, approved for issuance by the insurance regulatory body in the state of issuance, but does not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance.

e. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1965, as amended [42 U.S.C. 1395, et seq.; Pub. L. 92-603; 86 Stat. 1370].

f. "Medicare supplement policy offering plan F benefits" means a policy, group, or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the Social Security Act [42 U.S.C. 1395, et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the Social Security Act that:

(1) Is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare;

(2) Is not a policy or contract of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization;

(3) Is approved for issuance by the insurance regulatory body in the state of issuance; and

(4) Includes:

(a) Hospitalization benefits consisting of medicare part A coinsurance plus coverage for three hundred sixty-five additional days after medicare benefits end;

(b) Medical expense benefits consisting of medicare part B coinsurance;

(c) Blood provision consisting of the first three pints of blood each year;

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;

(f) Medicare part B deductible coverage;

(g) Medicare part B excess benefits at one hundred percent coverage; and

(h) Foreign travel emergency coverage.

g. "Relative" means a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, nephew, great-great-grandparent, great-great-grandchild, great-aunt, great-uncle, first cousin, grandniece, or grandnephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse.

h. "Someone in a confidential relationship" includes an individual's attorney-in-fact, guardian, conservator, legal custodian, caretaker, trustee, attorney, accountant, or agent, and may include a relative or other person with a close and trusted relationship to the individual.

i. "Uncompensated value" means the difference between fair market value and the value of any consideration received.

10. The provisions of this section do not apply in determining eligibility for medicare savings programs.

11. An individual disposes of assets or income when the individual, or anyone on behalf of the individual or at the request of the individual, acts or fails to act in a manner that effects a transfer, conveyance, assignment, renunciation, or disclaimer of any asset or income in which the individual had or was entitled to claim an interest of any kind.

12. An individual who disposes of assets or income to someone in a confidential relationship is presumed to have transferred the assets or income to an implied trust in which the individual is the beneficiary and which is subject to treatment under section 75-02-02.1-31.1. The presumption may be rebutted only if the individual shows:

a. The compensation actually received by the individual for the assets or income disposed of was equal to at least one hundred percent of fair market value, in which case this section has no application; or

b. The individual, having capacity to contract, disposed of the assets or income with full knowledge of the motives of the transferee and all other facts concerning the transaction which might affect the individual's own decision and without the use of any influence on the part of the transferee, in which case the transaction is governed by this section.

13. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home care and long-term care coverage, purchased on or before July 31, 2003, with a daily benefit at least equal to 1.25 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

    a. For each such month during which the individual is not eligible for medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

    b. For each such month during which the individual is eligible for medicare benefits, the individual has in force a medicare supplement policy offering plan F benefits, or their equivalent.

14. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, with a daily benefit at least equal to 1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

    a. For each month during which the individual is not eligible for medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

    b. For each such month during which the individual is eligible for medicare benefits, the individual has in force a medicare supplement policy offering plan F benefits, or their equivalent.

15. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid, if the asset was used to acquire an annuity, only if:

    a. The annuity is irrevocable and cannot be assigned to another person;

    b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;

    c. The annuity provides substantially equal monthly payments such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;

    d. The annuity will return the full principal and interest within the purchaser's life expectancy as determined by the department; and

e. The monthly payments from the annuity, unless specifically ordered otherwise by a court of competent jurisdiction, do not exceed the maximum monthly maintenance needs allowance provided under subsection 1 of section 75-02-02.1-24.

16. This section applies to transfers of income or assets made before February 8, 2006.

History: Effective October 1, 1993; amended effective December 1, 1996; July 1, 2003; June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; April 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

75-02-02.1-33.2. Disqualifying transfers made on or after February 8, 2006.

1. This section applies to transfers of income or assets made on or after February 8, 2006.

2. Except as provided in subsections 7 and 16, an individual is ineligible for skilled nursing care, swing-bed, or home and community-based benefits if the individual or the individual's spouse disposes of assets or income for less than fair market value on or after the look-back date. The look-back date is a date that is sixty months before the first date on which the individual is both receiving skilled nursing care, swing-bed, or home and community-based services and has applied for benefits under this chapter, without regard to the action taken on the application.

3. An applicant, recipient, or anyone acting on behalf of an applicant or recipient, has a duty to disclose any transfer of any asset or income made by or on behalf of the applicant or recipient, or the spouse of the applicant or recipient, for less than full fair market value:

   a. When making an application;

   b. When completing a redetermination; and

   c. If made after eligibility has been established, by the end of the month in which the transfer was made.

4. The date that a period of ineligibility begins is the latest of:

   a. The first day of the month in which the income or assets were transferred for less than fair market value;

   b. The first day on which the individual is receiving nursing care services and would otherwise have been receiving benefits for institutional care but for the penalty; or

   c. The first day thereafter which is not in a period of ineligibility.

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

   b. A fractional period of ineligibility may not be rounded down or otherwise disregarded with respect to any disposal of assets or income for less than fair market value.

   c. Notwithstanding any contrary provisions of this section, in the case of an individual or an individual's spouse who makes multiple fractional transfers of assets or income in more than one month for less than fair market value on or after the look-back date established under subsection 2, the period of ineligibility applicable to such individual must be determined by treating the total, cumulative uncompensated value of all assets or income

transferred during all months on or after the look-back date as one transfer and one penalty period must be imposed beginning on the earliest date applicable to any of the transfers.

6. For purposes of this section, "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

7. An individual may not be ineligible for medicaid by reason of subsection 2 to the extent that:

   a. The assets transferred were a home, and title to the home was transferred to:

      (1) The individual's spouse;

      (2) The individual's son or daughter who is under age twenty-one, blind, or disabled;

      (3) The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual became an institutionalized individual; or

      (4) The individual's son or daughter, other than a child described in paragraph 2, who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services;

   b. The income or assets:

      (1) Were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

      (2) Were transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

      (3) Were transferred to, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or

      (4) Were transferred to a trust established solely for the benefit of an individual less than sixty-five years of age who is disabled;

   c. The individual makes a satisfactory showing that:

      (1) The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

      (2) The income or assets were transferred exclusively for a purpose other than to qualify for medicaid; or

      (3) For periods after the return, all income or assets transferred for less than fair market value have been returned to the individual; or

   d. The asset transferred was an asset excluded for medicaid purposes other than:

      (1) The home or residence of the individual or the individual's spouse;

      (2) Property that is not saleable without working an undue hardship;

      (3) Excluded home replacement funds;

(4) Excluded payments, excluded interest on those payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;

(5) Life estate interests;

(6) Mineral interests;

(7) An asset received from a decedent's estate during any period it is considered to be unavailable under subsection 5 of section 75-02-02.1-25; or

(8) An annuity.

8. a. An individual shall not be ineligible for medicaid by reason of subsection 2 to the extent the individual makes a satisfactory showing that an undue hardship exists for the individual. Upon imposition of a period of ineligibility because of a transfer of assets or income for less than fair market value, the department shall notify the applicant or recipient of the right to request an undue hardship exception. An individual may apply for an exception to the transfer of asset penalty if the individual claims that the ineligibility period will cause an undue hardship to the individual. A request for a determination of undue hardship must be made within ninety days after the circumstances upon which the claim of undue hardship is made were known or should have been known to the affected individual or the person acting on behalf of that individual if incompetent. The individual must provide to the department sufficient documentation to support the claim of undue hardship. The department shall determine whether a hardship exists upon receipt of all necessary documentation submitted in support of a request for a hardship exception. An undue hardship exists only if the individual shows that all of the following conditions are met:

(1) Application of the period of ineligibility would deprive the individual of food, clothing, shelter, or other necessities of life or would deprive the individual of medical care such that the individual's health or life would be endangered;

(2) The individual who transferred the assets or income, or on whose behalf the assets or income were transferred, has exhausted all lawful means to recover the assets or income or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer;

(3) A person who would otherwise provide care would have no cause of action, or has exhausted all causes of action, against the transferee of the assets or income of the individual or the individual's spouse under North Dakota Century Code chapter 13-02.1, the Uniform Fraudulent Transfers Act, or any substantially similar law of another jurisdiction; and

(4) The individual's remaining available assets and the remaining assets of the individual's spouse are less than the asset limit in subsection 1 of section 75-02-02.1-26 counting the value of all assets except:

(a) A home, exempt under section 75-02-02.1-28, but not if the individual or the individual's spouse has equity in the home in excess of twenty-five percent of the amount established in the approved state plan for medical assistance which is allowed as the maximum home equity interest for nursing facility services or other long-term care services;

(b) Household and personal effects;

(c) One motor vehicle if the primary use is for transportation of the individual, or the individual's spouse or minor, blind, or disabled child who occupies the home; and

(d) Funds for burial up to the amount excluded in subsection 10 of section 75-02-02.1-28 for the individual and the individual's spouse.

b. Upon the showing required by this subsection, the department shall state the date upon which an undue hardship begins and, if applicable, when it ends.

c. The agency shall terminate the undue hardship exception, if not earlier, at the time an individual, the spouse of the individual, or anyone with authority to act on behalf of the individual, makes any uncompensated transfer of income or assets after the undue hardship exception is granted. The agency shall deny any further requests for an undue hardship exception due to either the disqualification based on the transfer upon which the initial undue hardship determination was based, or a disqualification based on any subsequent transfer.

9. If a request for an undue hardship waiver is denied, the applicant or recipient may request a fair hearing in accordance with the provisions of chapter 75-01-03.

10. There is a presumption that a transfer for less than fair market value was made for purposes that include the purpose of qualifying for medicaid:

a. In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer produce income which, when added to other income available to the individual and to the individual's spouse, total an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual and by the individual's spouse in the month of transfer and in the fifty-nine months following the month of transfer;

b. In any case in which an inquiry about medicaid benefits was made, by or on behalf of the individual to any person, before the date of the transfer;

c. In any case in which the individual or the individual's spouse was an applicant for or recipient of medicaid before the date of transfer;

d. In any case in which a transfer is made by or on behalf of the individual or the individual's spouse, if the value of the transferred income or asset, when added to the value of the individual's other countable assets, would exceed the asset limits in section 75-02-02.1-26; or

e. In any case in which the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney in fact, to a relative of the individual or the individual's spouse, or to the guardian, conservator, or attorney in fact or to any parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew, whether by birth, adoption, and whether by whole or half-blood, of the guardian, conservator, or attorney in fact or the spouse or former spouse of the guardian, conservator, or attorney in fact.

11. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for medicaid must show that a desire to receive medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subsection 10. The fact, if it is a fact, that the individual would be eligible for the medicaid coverage for nursing care services, had the individual or the individual's spouse not

transferred income or assets for less than fair market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for medicaid.

12. If a transfer results in a period of ineligibility under this section for an individual receiving nursing care services, and if the individual's spouse is otherwise eligible for medicaid and requires nursing care services, the remaining period of ineligibility shall be apportioned equally between the spouses. If one such spouse dies or stops receiving nursing care services, any months remaining in that spouse's apportioned period of ineligibility must be assigned or reassigned to the spouse who continues to receive nursing care services.

13. No income or asset transferred to a parent, stepparent, child, stepchild, grandparent, grandchild, brother, sister, stepsister, stepbrother, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew of the individual or the individual's spouse, purportedly for services or assistance furnished by the transferee to the individual or the individual's spouse, may be treated as consideration for the services or assistance furnished unless:

    a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance;

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

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

    d. The parties' course of dealing included paying compensation upon rendering services or assistance, or within thirty days thereafter.

14. A transfer is complete when the individual or the individual's spouse making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

15. For purposes of this section:

    a. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future, but does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals must begin by age seventy and one-half.

    b. "Average monthly cost of nursing facility care" means the cost determined by the department under section 1917(c)(1)(E)(i)(II) of the Act [42 U.S.C. 1396p(c)(1)(E)(i)(II)].

    c. "Fair market value" means:

        (1) In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of apparent fair market value;

        (2) In the case of real or personal property that is subject to reasonable dispute concerning its value:

            (a) If conveyed in an arm's-length transaction to someone not in a confidential relationship with the individual or anyone acting on the individual's behalf, seventy-five percent of estimated fair market value; or

(b) If conveyed to someone in a confidential relationship with the individual or anyone acting on the individual's behalf, one hundred percent of estimated fair market value; and

(3) In the case of income, one hundred percent of apparent fair market value.

d. "Major medical policy" includes any policy, certificate, or subscriber contract issued on a group or individual basis by any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization, which provides a plan of health insurance or health benefit coverage, including medical, hospital, and surgical care, approved for issuance by the insurance regulatory body in the state of issuance, but does not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance or automobile medical payment insurance, or a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance.

e. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1965, as amended [42 U.S.C. 1395 et seq; Pub. L. 92-603; 86 Stat. 1370].

f. "Medicare supplement policy offering plan F benefits" means a policy, group, or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization or preferred provider organization, other than a policy issued pursuant to a contract under section 1876 or 1833 of the Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the Social Security Act that:

(1) Is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare;

(2) Is not a policy or contract of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization;

(3) Is approved for issuance by the insurance regulatory body in the state of issuance; and

(4) Includes:

(a) Hospitalization benefits consisting of medicare part A coinsurance plus coverage for three hundred sixty-five additional days after medicare benefits end;

(b) Medical expense benefits consisting of medicare part B coinsurance;

(c) Blood provision consisting of the first three pints of blood each year;

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;

(f) Medicare part B deductible coverage;

(g) Medicare part B excess benefits at one hundred percent coverage; and

(h) Foreign travel emergency coverage.

g. "Relative" means a parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, great-grandparent, great-grandchild, aunt, uncle, niece, nephew, great-great-grandparent, great-great-grandchild, great-aunt, great-uncle, first cousin, grandniece, or grandnephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse.

h. "Someone in a confidential relationship" includes an individual's attorney in fact, guardian, conservator, legal custodian, caretaker, trustee, attorney, accountant, or agent, and may include a relative or other person with a close and trusted relationship to the individual.

i. "Uncompensated value" means the difference between fair market value and the value of any consideration received.

16. The provisions of this section do not apply in determining eligibility for medicare savings programs.

17. An individual disposes of assets or income when the individual, or anyone on behalf of the individual or at the request of the individual, acts or fails to act in a manner that effects a transfer, conveyance, assignment, renunciation, or disclaimer of any asset or income in which the individual had or was entitled to claim an interest of any kind.

18. An individual who disposes of assets or income to someone in a confidential relationship is presumed to have transferred the assets or income to an implied trust in which the individual is the beneficiary and which is subject to treatment under section 75-02-02.1-31.1. The presumption may be rebutted only if the individual shows:

    a. The compensation actually received by the individual for the assets or income disposed of was equal to at least one hundred percent of fair market value, in which case this section has no application; or

    b. The individual is competent and disposed of the assets or income, or directed the disposal if made by someone in a confidential relationship, with full knowledge of the motives of the transferee and all other facts concerning the transaction which might affect the individual's own decision and without the use of any influence on the part of the transferee, in which case the transaction is governed by this section.

19. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home care and long-term care coverage, purchased on or before July 31, 2003, with a daily benefit at least equal to 1.25 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

    a. For each such month during which the individual is not eligible for medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

    b. For each such month during which the individual is eligible for medicare benefits, the individual has in force a medicare supplement policy offering plan F benefits, or their equivalent.

20. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, and before January 1, 2007, with a daily benefit at least equal to 1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

    a. For each month during which the individual is not eligible for medicare benefits, the individual has in force a major medical policy that provides a lifetime maximum benefit of one million dollars or more, an annual aggregate deductible of five thousand dollars or less, and an out-of-pocket maximum annual expenditure per qualifying individual of five thousand dollars or less; and

    b. For each such month during which the individual is eligible for medicare benefits, the individual has in force a medicare supplement policy offering plan F benefits, or their equivalent.

21. With respect to an annuity transaction which includes the purchase of, selection of an irrevocable payment option, addition of principal to, elective withdrawal from, request to change distribution from, or any other transaction that changes the course of payments from an annuity which occurs on or after February 8, 2006, an individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid, if the asset was used to acquire an annuity, only if:

    a. The owner of the annuity provides documentation satisfactory to the department that names the department as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant or the department is named in the second position after the community spouse or minor or disabled child, and that establishes that any attempt by such spouse or a representative of such child to dispose of any such remainder shall cause the department to become the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant;

    b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;

    c. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;

    d. The annuity provides substantially equal monthly payments of principal and interest that vary by five percent or less from the total annual payment of the previous year, and does not have a balloon or deferred payment of principal or interest;

    e. The annuity will return the full principal and interest within the purchaser's life expectancy as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration; and

    f. All annuities owned by the purchaser produce total monthly gross income that:

        (1) Does not exceed the minimum monthly maintenance needs allowance for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5; and

        (2) When combined with the purchaser's other monthly income at the time the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse applies for benefits under this chapter, does not exceed one hundred fifty percent of the

minimum monthly maintenance needs allowance allowed for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5.

History: Effective April 1, 2008; amended effective January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

75-02-02.1-34. Income considerations.

1. All income that is actually available shall 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. Income shall be reasonably evaluated. This subsection does not supersede other provisions of this chapter which describe or require specific treatment of income, or which describe specific circumstances which require a particular treatment of income.

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 a child 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 to the applicant or recipient, even if that income is not actually contributed. Biological and adoptive parents, and stepparents, are treated as parents.

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 any 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 that person's spouse to render the applicant or family member eligible for medicaid.

4. All parental income is considered actually available to a child under age twenty-one unless the child is:

   a. Disabled and at least age eighteen;

   b. Living independently;

   c. 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; or

   d. Filing an income tax return and the parents are not claiming the child as a tax dependent.

5. Income may be received weekly, biweekly, monthly, intermittently, or annually. However income is received, a monthly income amount must be computed.

6. 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 toward the recipient's medical costs. These payments include health or long-term care insurance payments, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and veterans administration homebound benefits intended for medical expenses.

a. 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.

b. Except for individuals subject to a MAGI-based methodology, veterans 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;

c. Except for individuals subject to a MAGI-based methodology, veterans 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; and

d. Except for individuals subject to a MAGI-based methodology, veterans 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 expenses incurred in those months. This does not apply to homebound benefits which are not intended for medical expenses.

7. a. In determining ownership of income from a document, income must be considered available to each individual as provided in the document, or, in the absence of a specific provision in the document:

(1) If payment of income is made solely to one individual, the income shall be considered available only to that individual; and

(2) If payment of income is made to more than one individual, the income shall be considered available to each individual in proportion to the individual's interest.

b. In the case of income available to a couple in which there is no document establishing ownership, one-half of the income shall be considered to be available to each spouse.

c. Except in the case of income from a trust, the rules for determining ownership of income are superseded to the extent that the applicant or recipient can establish that the ownership interests are otherwise than as provided in those rules.

8. Except for individuals not subject to a MAGI-based methodology, countable income from a business entity that employs anyone whose income is used to determine eligibility is:

a. If the applicant or recipient and other members of the medicaid unit, in combination, own a controlling interest in the business entity, an amount determined as for a self-employed individual or family under section 75-02-02.1-38;

b. If the applicant or recipient and other members of the medicaid unit, in combination, own less than a controlling interest, but more than a nominal interest, in the business entity, an amount determined by:

(1) Subtracting any cost of goods for resale, repair, or replacement, and any wages, salaries, or guarantees (but not draws) paid to all owners of interests in the business entity who are actively engaged in the business to establish the business entity's adjusted gross income, from the business entity's gross income;

(2) Establishing the applicant or recipient's share of the business entity's adjusted gross income, based on the medicaid unit's proportionate share of ownership of the business entity;

(3) Adding any wages, salary, or guarantee paid to the applicant's or recipient's share of the business entity's adjusted gross income; and

(4) Applying the disregards appropriate to the type of business as described in section 75-02-02.1-38; 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.

9. For an individual subject to a MAGI-based methodology, the individual's share of the net income plus any gross wages paid from the entity is countable income from the entity.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; June 1, 2004; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-34.1. MAGI-based methodology.

Effective for the benefit month of January 2014, the following MAGI-based methodology will be used in determining income eligibility for medicaid.

1. Income is based on household composition.

2. Monthly income is used prospectively for new applications; annualized income is used for ongoing cases.

3. Current, point in time income is used; however, reasonable expected changes in income must be included.

4. A tax dependent child's income does not count in a taxpayer parent's or caretaker relative'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 relative 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 relative is not in the child's medicaid household, the child's income counts in the child's household.

   c. If the child is not required to file a tax return, however, files a return to get a refund of taxes withheld, the child's income is not counted.

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

5. If eligibility is determined by using an individual's federal tax return, modified adjusted gross income is as stated in the federal tax return:

   a. Plus:

(1) Any foreign earned income excluded from taxes.

(2) Tax-exempt interest.

(3) Tax-exempt social security income.

b. Less:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses if included in taxable income.

(2) Certain distributions, payments, and student financial assistance for American Indians and Alaska Natives if included in taxable income.

6. When available, the department shall use the most current information to reflect the income elements identified in subsection 5, regardless of whether they were the amounts used for the tax return.

7. If eligibility is determined without using an individual's federal tax return, the department shall determine modified adjusted gross income using internal revenue service rules combined with medicaid and children's health insurance program rules as follows:

a. Add:

(1) Gross wages less pretax deductions;

(2) Gross interest income;

(3) Gross dividend income;

(4) Taxable refunds of state or local income taxes (counted only in the month received);

(5) Gross alimony received;

(6) Net business income or loss from self-employment;

(7) Capital gains or losses, if expected to recur;

(8) Taxable amount of individual retirement account distributions;

(9) Taxable amount of pensions and annuities;

(10) Net rents, royalties, and partnership, S corporation, or trust income;

(11) Net farm income or loss;

(12) Gross unemployment compensation;

(13) Gross social security income;

(14) Gross foreign earned income; and

(15) Other income determined to be reportable by the internal revenue service.

b. Subtract from that sum:

(1) Educator expenses;

(2) Business expenses of reservist, performing artist, and fee-basis government official;

(3) Health savings account deduction;

(4) Moving expenses;

(5) Deductible portion of self-employment tax;

(6) Contributions to self-employed SEP, SIMPLE, and qualified plans;

(7) Self-employed health insurance deduction;

(8) Penalty on early withdrawal of savings;

(9) Alimony paid;

(10) Contributions to an individual retirement account;

(11) Student loan interest deduction;

(12) Tuition and fees;

(13) Domestic production activities deduction;

(14) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(15) Certain distributions, payments, and student financial assistance for American Indians and Alaska Natives.

8. The following income types are not reported on internal revenue service form 1040 and are not countable income under a MAGI-based methodology:

   a. Child support income;

   b. Veterans' benefits (aid and attendance, homebound benefits, and reimbursements for unusual medical expenses);

   c. Supplemental security income;

   d. Temporary assistance for needy families benefits;

   e. Proceeds from life insurance, accident insurance, or health insurance;

   f. Gifts and loans;

   g. Inheritances; and

   h. Workers' compensation payments.

9. Instead of itemized disregards and deductions, the department may apply a standard disregard equal to five percent of the federal poverty level as part of the MAGI-based methodology.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-34.2. Income conversion for individuals subject to a MAGI-based methodology.

1. For purposes of this section, "biweekly" means every two weeks.

2. Income received either weekly or biweekly must be converted to monthly income in determining the household's countable income under MAGI-based methodology. Income must be received each week for those paid weekly, or every other week for those paid biweekly, for income to be converted.

3. Income conversion is not done for the three month prior period. Actual income received in those months is counted in determining eligibility.

History: Effective July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 U.S.C. 1396a(e)

75-02-02.1-34.3. Reasonable compatibility of income for individuals subject to a MAGI-based methodology.

1. For purposes of this section, "reasonable compatibility" refers to an allowable difference or discrepancy between the income reported by an applicant or recipient and the income reported by an electronic data source.

2. The department may request additional information or documentation from an applicant or recipient only if verification cannot be obtained from an electronic data source or information obtained from the electronic data source is not reasonably compatible with information provided by the applicant or recipient.

3. The most recent verification of income from an electronic data source is reasonably compatible if it results in the same eligibility outcome as information reported by the applicant or recipient.

4. Any income verification information requested and received by the department as a result of the application or review of other economic assistance programs must be used to determine eligibility for medicaid and children's health insurance program and reasonable compatibility does not need to be determined.

5. If an applicant or recipient has multiple types of income and income from different sources, each type of income and each source of income must be compared for reasonable compatibility, and the highest amount from each type and source must be used to determine eligibility.

6. When income verification is received quarterly, the income must be converted to a monthly amount to determine reasonable compatibility.

7. For purposes of determining reasonable compatibility for earned income, other than self-employment, and unearned income:

   a. When both the electronic data source and the applicant or recipient report total countable income that is below the budget unit income level, the two data sources are considered to be reasonably compatible and further verification may not be requested. The higher of the two amounts will be used to determine eligibility.

   b. When both the electronic data source and the applicant or recipient report total countable income that is above the budget unit income level, the two data sources are considered to be reasonably compatible and further verification may not be requested.

   c. When verification from the electronic data source is above the budget unit income level, but the information reported by the applicant or recipient is less than the budget unit income level, or when verification from the electronic data source is below the budget unit income level but the information reported by the applicant or recipient is higher than

the budget unit income level, the two data sources are not reasonably compatible and further verification is required to determine eligibility.

d. When the electronic data source does not provide verification of income from the same source and type as the applicant or recipient reported, the two data sources are not reasonably compatible and further verification is required in order to determine eligibility.

8. Reasonable compatibility is not determined for self-employment income.

History: Effective July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 U.S.C. 1396a(e)

75-02-02.1-35. Budgeting.

Repealed effective December 1, 1991.

75-02-02.1-36. Disregarded income.

Repealed effective July 1, 2003.

75-02-02.1-37. Unearned income.

Unearned income is income that is not earned income. Unearned income received in a fixed amount each month shall be applied in the month in which it is normally received. The following income rules apply to individuals not subject to a MAGI-based methodology:

1. Recurring unearned lump sum payments received after application for medicaid shall be prorated over the number of months the payment is intended to cover. When a payment is received and prorated in an ongoing case, or after a period of medicaid eligibility or eligibility for the children's health insurance program as provided in chapter 75-02-02.2, and the case is closed and then reopened during the prorated period, or within the following proration period, the lump sum payment proration must continue. All other recurring unearned lump sum payments received before application for medicaid or for the children's health insurance program as provided in chapter 75-02-02.2 are considered income in the month received and are not prorated.

2. All nonrecurring unearned lump sum payments, except health or long-term care insurance payments, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and veterans administration homebound benefits intended for medical expenses shall be considered as income in the month received and assets thereafter.

3. One-twelfth of annual conservation reserve program payments, less expenses, such as seeding and spraying, necessary to maintain the conservation reserve program land in accordance with that program's requirements, is unearned income in each month.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; June 1, 2004; August 1, 2005; January 1, 2011; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-37.1. Unearned income for individuals subject to a MAGI-based methodology.

Unearned income is income that is not earned income. Unearned income received in a fixed amount each month shall be applied in the month in which it is normally received. Effective January 1, 2014, individuals subject to a MAGI-based methodology will have income treated as follows:

1. Recurring unearned lump sum payments received after application for medicaid shall be prorated over the number of months the payment is intended to cover. When a payment is received and prorated in an ongoing case, or after a period of medicaid eligibility or eligibility for the children's health insurance program as provided in chapter 75-02-02.2, and the case is closed and then reopened during the prorated period, or within the following proration period, the lump sum payment proration must continue. All other recurring unearned lump sum payments received before application for medicaid or for the children's health insurance program as provided in chapter 75-02-02.2 are considered income in the month received and are not prorated.

2. All nonrecurring unearned lump sum payments, except health or long-term care insurance payments, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and veterans administration homebound benefits intended for medical expenses shall be considered as income in the month received and assets thereafter.

3. Net taxable conservation reserve program (CRP) income is considered income and prorated over the year.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-38. Earned income.

Earned income is income that is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. Income is "earned" only if the individual or family contributes an appreciable amount of personal involvement and effort. Earned income shall be applied in the month in which it is normally received. The following income rules apply to individuals not subject to a MAGI-based methodology:

1. If earnings from more than one month are received in a single payment, the payment must be divided by the number of months in which the income was earned, and the resulting monthly amounts shall be attributed to each of the months with respect to which the earnings were received.

2. If a self-employed individual's business does not require the purchase of goods for sale or resale, net income from self-employment is seventy-five percent of gross earnings from self-employment.

3. If a self-employed individual's business requires the purchase of goods for sale or resale, net income from self-employment is seventy-five percent of the result determined by subtracting cost of goods purchased from gross receipts.

4. If a self-employed individual's business furnishes room and board, net income from self-employment is monthly gross receipts less one hundred dollars per room and board client.

5. If a self-employed individual is in a service business that requires the purchase of goods or parts for repair or replacement, net income from self-employment is twenty-five percent of the result determined by subtracting cost of goods or parts purchased from gross earnings from self-employment.

6. If a self-employed individual receives income other than monthly, and the most recently available federal income tax return accurately predicts income, net income from self-employment is twenty-five percent of gross annual income, plus any net gain resulting from the sale of capital items, plus ordinary gains or minus ordinary losses, divided by twelve. If the most recent available federal income tax return does not accurately predict income because the business has been recently established, because the business has been terminated or subject to a severe change, such as a decrease or increase in the size of the operation, or an uninsured loss, net income from self-employment is an amount determined by the county agency to represent the best estimate of monthly net income from self-employment. A self-employed individual may be required to provide, on a monthly basis, the best information available on income and cost of goods. Income statements, when available, shall be used as a basis for computation. If the business is farming, or any other seasonal business, the annual net income, divided by twelve, is the monthly net income.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-38.1. Post-eligibility treatment of income.

Except in determining eligibility for workers with disabilities or children with disabilities, this section prescribes specific financial requirements for determining the treatment of income and application of income to the cost of care for an individual screened as requiring nursing care services who resides in a nursing facility, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, or an intermediate care facility for individuals with intellectual disabilities, or who receives swing-bed care in a hospital.

1. The following types of income may be disregarded in determining medicaid eligibility:

   a. Occasional small gifts;

   b. For so long as 38 U.S.C. 5503 remains effective, ninety dollars of veterans administration improved pensions paid to a veteran, or a surviving spouse of a veteran, who has neither spouse nor child, and who resides in a medicaid-approved nursing facility;

   c. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [50 U.S.C. App. 1989 et seq.];

   d. Agent orange payments;

   e. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

   f. Netherlands reparation payments based on Nazi, but not Japanese, persecution during World War II [Pub. L. 103-286; 42 U.S.C. 1437a, note];

   g. Radiation Exposure Compensation Act [Pub. L. 101-426; 42 U.S.C. 2210, note];

   h. Interest or dividend income from liquid assets; and

   i. From annual countable gross rental income, an amount equal to real estate taxes for rental property that the recipient is responsible for paying on that property.

2. The mandatory payroll deductions under the Federal Insurance Contributions Act [26 U.S.C. 3101 et seq.] and medicare are allowed from earned income.

3. In establishing the application of income to the cost of care, the following deductions are allowed in the following order:

   a. The nursing care income level;

   b. Amounts provided to a spouse or family member for maintenance needs;

   c. The cost of premiums for health insurance in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage;

   d. The cost of premiums for long-term care insurance carried by an individual or the individual's spouse in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage;

   e. Medical expenses for necessary medical or remedial care that are each:

      (1) Documented in a manner which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider;

      (2) Incurred in the month for which eligibility is being determined, or was incurred in a prior month but was actually paid in the month for which eligibility is being determined and was not previously allowed as a deduction or offset of recipient liability, and was not applied previously to recipient liability;

      (3) Provided by a medical practitioner licensed to furnish the care;

      (4) Not subject to payment by any third party, including medicaid and medicare;

      (5) Not incurred for nursing facility services, swing-bed services, or home and community-based services during a period of ineligibility because of a disqualifying transfer; and

      (6) Claimed; and

   f. The cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

4. For purposes of this section, "premiums for health insurance" include any payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:

   a. Limited to disability or income protection coverage;

   b. Automobile medical payment coverage;

   c. Supplemental to liability insurance;

   d. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or

   e. Credit accident and health insurance.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; July 1, 2012.

General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-38.2. Disregarded income.

This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs, but does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, an intermediate care facility for individuals with intellectual disabilities, or receiving swing-bed care in a hospital. The following types of income shall be disregarded in determining medicaid eligibility for individuals not subject to a MAGI-based methodology:

1. Money payments made by the department in connection with foster care, subsidized guardianship, or the subsidized adoption program;

2. Occasional small gifts;

3. County general assistance that may be issued on an intermittent basis to cover emergency-type situations;

4. Income received as a housing allowance by a program sponsored by the United States department of housing and urban development or rent supplements or utility payments provided through a housing assistance program;

5. Income of an individual living in the parental home if the individual is not included in the medicaid unit;

6. Educational loans, scholarships, grants, awards, workers compensation, vocational rehabilitation payments, and work study received by a student, or any fellowship or gift, or portion of a gift, used to pay the cost of tuition and fees at any educational institution;

7. In-kind income except in-kind income received in lieu of wages;

8. Per capita judgment funds paid to members of the Blackfeet Tribe and the Gross Ventre Tribe under Pub. L. 92-254, to any tribe to pay a judgment of the Indian claims commission or the court of claims under Pub. L. 93-134, or to the Turtle Mountain Band of Chippewa Indians, the Chippewa Cree Tribe of Rocky Boy's Reservation, the Minnesota Chippewa Tribe, or the Little Shell Tribe of Chippewa Indians of Montana under Pub. L. 97-403;

9. Compensation received by volunteers participating in the action program as stipulated in the Domestic Volunteer Service Act of 1973 [Pub. L. 93-113; 42 U.S.C. 4950 et seq.], including foster grandparents, older American community service program, retired senior volunteer program, service corps of retired executives, volunteers in service to America, and university year for action;

10. Benefits received through the low income home energy assistance program;

11. Training funds received from vocational rehabilitation;

12. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the job opportunity and basic skills program;

13. Income tax refunds and earned income credits;

14. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act [29 U.S.C. 2801 et seq.], and through the job opportunities and basic skills program;

15. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by section 6 of Pub. L. 94-114 [25 U.S.C. 459e];

16. Income earned by a child who is a full-time student or a part-time student who is not employed one hundred hours or more per month;

17. Payments from the family subsidy program;

18. The first fifty dollars per month of current child support, received on behalf of children in the medicaid unit, from each budget unit that is budgeted with a separate income level;

19. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 [Pub. L. 91-646, 42 U.S.C. 4621 et seq.];

20. Payments made tax exempt as a result of section 21 of the Alaska Native Claims Settlement Act [Pub. L. 92-203];

21. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383; 50 U.S.C. App. 1989 et seq.];

22. Agent orange payments;

23. A loan from any source that is subject to a written agreement requiring repayment by the recipient;

24. The medicare part B premium refunded by the social security administration;

25. Payments from a fund established by a state as compensation for expenses incurred or losses suffered as a result of a crime;

26. Temporary assistance for needy families benefit and support service payments;

27. Lump sum supplemental security income benefits in the month in which the benefit is received;

28. German reparation payments made to survivors of the holocaust and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

29. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288; 42 U.S.C. 5121 et seq.], or some other federal statute, because of a presidentially declared major disaster, and interest earned on that assistance;

30. Refugee cash assistance or grant payments;

31. Payments from the child and adult food program for meals and snacks to licensed families who provide day care in their home;

32. Extra checks consisting only of the third regular payroll check or unemployment benefit payment received in a month by an individual who is paid biweekly, and the fifth regular payroll check received in a month by an individual who is paid weekly;

33. All income, allowances, and bonuses received as a result of participation in the job corps program;

34. Payments received for the repair or replacement of lost, damaged, or stolen assets;

35. Homestead tax credit;

36. Training stipends provided to victims of domestic violence by private, charitable organizations for attending their educational programs;

37. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects, under 38 U.S.C. 1805 or 38 U.S.C. 1815;

38. Netherlands reparation payments based on Nazi, but not Japanese, persecution during World War II [Pub. L. 103-286; 42 U.S.C. 1437a, note];

39. Radiation Exposure Compensation Act [Pub. L. 101-426; 42 U.S.C. 2210, note];

40. Interest or dividend income from liquid assets;

41. Additional pay received by military personnel as a result of deployment to a combat zone; and

42. All wages paid by the census bureau for temporary employment related to census activities.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-38.3. Disregarded income for certain individuals subject to a MAGI-based methodology.

This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs, but does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, an intermediate care facility for individuals with intellectual disabilities, or receiving swing-bed care in a hospital. Effective January 1, 2014, the above-identified individuals subject to a MAGI-based methodology are allowed the following income disregards:

1. Nontaxable income other than:

    a. Nontaxable foreign earned income;

    b. Nontaxable interest; and

    c. The nontaxable portion of social security benefits.

2. Supplemental security income.

3. Veterans administration benefits other than retirement pensions.

4. Child support income.

5. Temporary assistance for needy families benefits.

6. Workers' compensation benefits.

7. Proceeds from life insurance, accident insurance, or health insurance.

8. Federal tax credits and federal tax refunds.

9. Gifts and loans

10. Inheritances.

11. Adjustments from gross income that are used in determining adjusted gross income for income tax purposes must be allowed.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-38.4. Earned income for individuals subject to a MAGI-based methodology.

Earned income is income that is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. Income is "earned" only if the individual or family contributes an appreciable amount of personal involvement and effort. Earned income shall be applied in the month in which it is normally received. Effective January 1, 2014, individuals subject to a MAGI-based methodology will have income treated as follows:

1. If earnings from more than one month are received in a single payment, the payment must be divided by the number of months in which the income was earned, and the resulting monthly amounts shall be attributed to each of the months with respect to which the earnings were received.

2. Net earnings or losses from self-employment as considered for income tax purposes are counted for modified adjusted gross income households.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-39. Income deductions.

This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs, but does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, an intermediate care facility for individuals with intellectual disabilities, or receiving swing-bed care in a hospital. No deduction not described in subsections 1 through 14 may be allowed in determining medicaid eligibility. For individuals not subject to a MAGI-based methodology, the following deductions apply:

1. Except in determining eligibility for the medicare savings programs, the cost of premiums for health insurance may be deducted from income in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage. In determining eligibility for the workers with disabilities coverage, the workers with disabilities enrollment fee and premiums are not deducted. In determining eligibility for the children with disabilities coverage, the children with disabilities premiums are not deducted. For purposes of this subsection, "premiums for health insurance" include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:

    a. Limited to disability or income protection coverage;

    b. Automobile medical payment coverage;

    c. Supplemental to liability insurance;

    d. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or

e. Credit accident and health insurance.

2. Except in determining eligibility for the medicare savings programs, medical expenses for necessary medical or remedial care may be deducted only if each is:

   a. Documented in a manner which describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider;

   b. Incurred by a member of a medicaid unit in the month for which eligibility is being determined, or was incurred in a prior month but was actually paid in the month for which eligibility is being determined and was not previously allowed as a deduction or offset of recipient liability, and was not previously applied to recipient liability;

   c. Provided by a medical practitioner licensed to furnish the care;

   d. Not subject to payment by any third party, including medicaid and medicare;

   e. Not incurred for nursing facility services, swing-bed services, or home and community-based services during a period of ineligibility determined under section 75-02-02.1-33.1; and

   f. Claimed.

3. Reasonable expenses such as food and veterinarian expenses necessary to maintain a service animal that is trained to detect seizures for a member of the medicaid unit.

4. Except for a support payment withheld from an extra check that is disregarded, nonvoluntary child and spousal support payments may be deducted if actually paid by a member of the medicaid unit.

5. The cost of premiums for long-term care insurance carried by an individual or the individual's spouse may be deducted from income in the month the premium is paid or prorated and deducted from income the months for which the premium affords coverage. No premium deduction may be made in determining eligibility for the medicare savings programs.

6. Reasonable child care expenses, not otherwise reimbursed, may be deducted to the extent necessary to permit a caretaker or a spouse to work or participate in training. Reasonable child care expenses do not include payments to parents to care for their own children.

7. With respect to each individual in the medicaid unit who is employed or in training, but who is not aged, blind, or disabled, thirty dollars may be deducted as a work or training allowance, but only if the individual's income is counted in the eligibility determination.

8. Except in determining eligibility for the medicare savings programs, transportation expenses may be deducted if necessary to secure medical care provided for a member of the medicaid unit.

9. Except in determining eligibility for the medicare savings programs, the cost of remedial care for an individual residing in a specialized facility, limited to the difference between the recipient's cost of care at the facility and the regular medically needy income level, may be deducted.

10. A disregard of twenty dollars per month is deducted from any income, except income based on need, such as supplemental security income and need-based veterans' pensions. This deduction applies to all aged, blind, and disabled applicants or recipients, provided that:

    a. When more than one aged, blind, or disabled person lives together, no more than a total of twenty dollars may be deducted;

b. When both earned and unearned income is available, this deduction must be made from unearned income; and

c. When only earned income is available, this deduction must be made before deduction of sixty-five dollars plus one-half of the remaining monthly gross income made under subdivision b of subsection 13.

11. Reasonable adult dependent care expenses for an incapacitated or disabled adult member of the medicaid unit may be deducted to the extent necessary to permit a caretaker or a spouse to work or participate in training.

12. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.

13. The deductions described in this subsection may be allowed only on earned income.

    a. For all individuals except aged, blind, or disabled applicants or recipients, deduct:

        (1) Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;

        (2) Mandatory retirement plan deductions;

        (3) Union dues actually paid; and

        (4) Expenses of a nondisabled blind person, reasonably attributable to earning income.

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

14. A deduction may be made for the cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-39.1 Income deductions for individuals subject to a MAGI-based methodology.

This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs. This section does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, an intermediate care facility for individuals with intellectual disabilities, or receiving swing-bed care in a hospital. Effective January 1, 2014. individuals subject to a MAGI-based methodology are allowed a standard deduction of five percent of the one hundred percent of poverty level applicable to the size of the individual's medicaid unit.

History: Effective January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-40. Income levels.

1. Levels of income for maintenance shall be used as a basis for establishing financial eligibility for medicaid. The income levels applicable to individuals and units are:

   a. Categorically needy income levels.

      (1) Family coverage income levels established in the medicaid state plan are applied to the family coverage group. The family size is increased for each unborn child when determining the appropriate family size.

      (2) Except for individuals subject to the nursing care income level, the income level for categorically needy aged, blind, or disabled recipients is that which establishes supplemental security income eligibility.

   b. Medically needy income levels.

      (1) Medically needy income levels established in the medicaid state plan are applied when a medicaid individual or unit resides in the individual's or the unit's own home or in a specialized facility, and when a medicaid individual has been screened as requiring nursing care, but elects to receive home and community-based services. The family size is increased for each unborn child when determining the appropriate family size.

      (2) The nursing care income levels established in the medicaid state plan are applied to residents receiving care in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, or receiving swing-bed care in a hospital.

      (3) The community spouse income level for a medicaid eligible community spouse is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the greater of two thousand two hundred sixty-seven dollars per month or the minimum amount permitted under section 1924(d)(3)(c) of the Act [42 U.S.C. 1396r-5(d)(3)(C)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

      (4) The income level for each ineligible family member in a spousal impoverishment prevention case is equal to one-third of an amount determined in accordance with section 1924(d)(3)(A)(i) of the Act [42 U.S.C. 1396r-5(d)(3)(A)(i)], less the monthly income of that family member. For purposes of this paragraph, "family member" has the meaning given in subsection 1 of section 75-02-02.1-24.

   c. Poverty income level.

      (1) The income level for pregnant women and children under age six is equal to one hundred forty-seven percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

      (2) Qualified medicare beneficiaries. The income level for qualified medicare beneficiaries is equal to one hundred percent of the poverty level applicable to the family of the size involved. The income level applies regardless of living arrangement.

      (3) The income level for children aged six to nineteen and adults aged nineteen to sixty-five is equal to one hundred thirty-three percent of the poverty level applicable

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

(4) The income level for transitional medicaid benefits is equal to one hundred and eighty-five percent of the poverty level applicable to a family of the size involved. The family size is increased for each unborn child when determining the appropriate family size.

(5) The income level for qualified working and disabled individuals is equal to two hundred percent of the poverty level applicable to the family of the size involved. The income level applies regardless of living arrangement.

(6) The income level for specified low-income medicare beneficiaries is equal to one hundred twenty percent, of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(7) The income level for qualified individuals is equal to one hundred thirty-five percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(8) The income level for workers with disabilities is two hundred twenty-five percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

(9) The income level for children with disabilities is two hundred percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

2. Determining the appropriate income level in special circumstances.

a. During a month in which an individual enters a specialized facility or leaves a specialized facility to return home, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate income level. An individual residing in a specialized facility shall be allowed the appropriate medically needy, workers with disabilities, or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

b. During a month in which an individual with eligible family members in the home enters or leaves a nursing facility to return home, or elects to receive home and community-based services or terminates that election, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate medically needy, workers with disabilities, or children with disabilities income level. An individual in a nursing facility shall be allowed sixty-five dollars to meet maintenance needs during all full calendar months in which the individual resides in the nursing facility. A recipient of home and community-based services shall be allowed the medically needy income level for one during all full calendar months in which the individual receives home and community-based services. In determining eligibility for workers with disabilities or children with disabilities coverage, individuals in a nursing facility, or in receipt of home and community-based services, will be allowed the appropriate workers with disabilities or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

c. For an institutionalized spouse with an ineligible community spouse, the sixty-five dollar income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse and any other family members

remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

d. For a spouse electing to receive home and community based services, who has an ineligible community spouse, the medically needy income level for one is effective in the month the home and community-based services begin, during full calendar months, and in the month the home and community-based services are terminated. The ineligible community spouse and any other family members remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

e. 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 may have only the nursing care income level beginning in the month following the month of the status change. An individual may receive the medically needy income level for only one six-month period per stay in a nursing facility. If an individual is discharged, then readmitted to a 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.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; January 1, 2011; July 1, 2012; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37

75-02-02.1-41. Deeming of income.

Excess income is the amount of net income remaining after allowing the appropriate disregards, deductions, and medicaid income level.

1. Twenty-five percent of the excess income of an ineligible medicaid unit shall be deemed available during any full calendar month an eligible member of the medicaid unit receives services in a specialized facility.

2. No income may be deemed to a supplemental security income recipient in a specialized facility or receiving home and community-based services as such a recipient's maintenance needs are met by the supplemental security income grant.

3. If subdivision a or b applies, the excess income of an individual in nursing care, an intermediate care facility for individuals with intellectual disabilities, the state hospital, or the Anne Carlsen facility, receiving swing bed care in a hospital or receiving home and community-based services may be deemed to the individual's legal dependents to bring their income up to the appropriate medically needy income level.

   a. The legal dependents who are also eligible for medicaid do not receive a temporary assistance for needy families payment or supplemental security income. In these circumstances, income may be deemed only to the extent it raises the legal dependents' income to the appropriate medically needy income level.

   b. The legal dependents are ineligible for medicaid or choose not to be covered by medicaid. In these circumstances, income may be deemed only to the extent it raises the legal dependents' net income to the appropriate community spouse or family member income level.

(1) Income of the institutionalized or home and community-based spouse may be deemed to an ineligible community spouse only to the extent that income is made available to the community spouse.

(2) Excess income shall be deemed to family members in spousal impoverishment cases, up to the family members' income level.

4. The excess income of a spouse or parent may not be deemed to a recipient to meet medical expenses during any full calendar month in which the recipient receives nursing care services in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, an institution for mental disease, or a psychiatric residential treatment facility, receives swing-bed care in a hospital, or receives home and community-based services. Income of any eligible spouse or parent shall be deemed to an individual who is ineligible for supplemental security income, up to the appropriate income level.

5. For purposes of determining eligibility for workers with disabilities or children with disabilities coverage, income of a spouse or parent may be deemed to a nonsupplemental security income spouse or child, who is in the medicaid unit, but who is not residing with the applicant or recipient, to bring their income up to the appropriate workers with disabilities or children with disabilities income level.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2011; July 1, 2012.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-41.1. Recipient liability.

Recipient liability is the amount of monthly net income remaining after all appropriate deductions, disregards, and medicaid income levels have been allowed. All such income must be considered to be available for the payment of medical services provided to the eligible individual or family.

1. The following deductions apply to individuals not subject to a MAGI-based methodology:

   a. Up to fifteen dollars per month of expenses for necessary medical or remedial care, incurred by a member of the medicaid unit or spouse or child for whom that member is legally responsible, in a month prior to the month for which eligibility is being determined, may be subtracted from recipient liability other than recipient liability created as a result of medical care payments, to determine remaining recipient liability, provided that:

      (1) The expense was incurred in any month during which the individual who received the medical or remedial care was not a medicaid recipient or the expense was incurred in a month the individual was a medicaid recipient, but for a medical or remedial service not covered by medicaid;

      (2) The expense was not previously applied in determining eligibility for, or the amount of, medicaid benefits for any medicaid recipient;

      (3) The medical or remedial care was provided by a medical practitioner licensed to furnish the care;

      (4) The expense is not subject to payment by any third party, including medicaid and medicare;

      (5) The expense was not incurred for swing-bed services provided in a hospital, nursing facility services, or home and community-based services during a period of ineligibility determined under section 75-02-02.1-33.1;

(6) Each expense claimed for subtraction is documented by the applicant or recipient in a manner which describes the service, the date of the service, the amount of the cost incurred, the amount of the cost remaining unpaid, the amount of the cost previously applied in determining medicaid benefits for any medicaid recipient, and the name of the service provider; and

(7) The medicaid unit is still obligated to pay the provider of the medical or remedial service.

b. The medicaid unit must apply the remaining recipient liability to expenses of necessary medical care incurred by a member of the medicaid unit in the month for which eligibility is being determined. The medicaid unit is eligible for medicaid benefits to the extent the expenses of necessary medical care incurred in the month for which eligibility is being determined exceed remaining recipient liability in that month.

2. Effective January 1, 2014, individuals subject to a MAGI-based methodology are allowed a standard deduction of five percent of the one hundred percent of poverty level applicable to the size of the household.

History: Effective December 1, 1991; amended effective January 1, 2003; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 USC 1396a(e)

75-02-02.1-41.2. Budgeting.

1. **Definitions.** For purposes of this section:

a. "Base month" means the calendar month prior to the processing month.

b. "Benefit month" means the calendar month for which eligibility and recipient liability is being computed.

c. "Best estimate" means an income, expense, or circumstance prediction based on past amounts of income and expenses and known factual information concerning future circumstances which affect eligibility, expenses to be incurred; or income to be received in the benefit month. Factual information concerning future circumstances must be based on information by which the applicant or recipient demonstrates known changes or highly probable changes to the income, expenses, or circumstances which offset eligibility, from the base month to the benefit month.

d. "Processing month" means the month between the base month and the benefit month.

e. "Prospective budgeting" means computation of a household's eligibility and recipient liability based on the best estimate of income, expenses, and circumstances for a benefit month.

2. **Computing recipient liability for previous month.** Compute the amount of recipient liability by use of actual verified information, rather than best estimate, in each of the previous months for which eligibility is sought.

3. **Computing recipient liability for the current month and next month at time of approval of the application.** Compute the amount of the recipient liability prospectively for the current month and the next month. The income received or best estimate of income to be received during the current month must be used to compute the recipient liability for the current month. The best estimates of income to be received during the next month must be used to compute the recipient liability for the next month.

4. **Computing recipient liability for ongoing cases.**

   a. For cases with fluctuating income, compute the recipient liability using verified income, expenses, and circumstances which existed during the base month, unless factual information concerning future circumstances is available. Recipients must report their income, expenses, and other circumstances on a monthly basis to determine continued eligibility.

   b. For cases with stable income, compute the recipient liability using the best estimate of income, expenses, and circumstances. Recipients with stable income must report changes in income, expenses, and other circumstances within ten days of the day the recipients became aware of the change. A determination of continued eligibility, after a change is reported and demonstrated, is based on a revised best estimate which takes the changes into consideration.

5. **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 unless the individual would have been eligible under the adult group. Recipient liability will be based on the unit's actual income and circumstances when adding each individual for retroactive periods. Recipient liability 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, unless the individual would have been eligible under the adult group.

6. **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.

History: Effective December 1, 1991; amended effective May 1, 2006; January 1, 2014.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37

75-02-02.1-42. Eligibility under 1972 state plan.

No individual may be determined to be ineligible for medicaid for any month if, had the approved state plan for medical assistance in effect on January 1, 1972, been in effect in such month, that individual would be eligible. The following income and resource standards were a part of the approved state plan in effect on January 1, 1972, and may not be exceeded by any individual who claims eligibility under this section:

1. The income level for a family of one is one hundred fifty dollars per month. The income level for a family of two is two hundred dollars per month. The income level for a family of three is two hundred fifty dollars per month. The income level for a family of four is three hundred dollars per month. The income level for a family of five is three hundred forty-two dollars per month. The income level for a family of six is three hundred eighty-four dollars per month. The income level for a family of seven is four hundred twenty-five dollars per month. An additional thirty-four dollars per month will be added for each family member beyond seven to establish the income level for families with more than seven members. The income level for a person residing in a long-term care facility is eight dollars per month.

2. The home occupied by the medicaid unit will be exempted in determining medicaid eligibility.

3. Real property other than the home may not exceed an equity of two thousand five hundred dollars, except that real property which is essential to earning a livelihood shall be exempt from the limitation, if the liquidation of such assets would cause undue hardship. Liquidation of income-producing real property, which would result in reducing annual income below the established income levels, would be considered undue hardship. If undue hardship is not a consideration, equity in excess of the two thousand five hundred dollars would be considered available for meeting medical costs, providing the property is saleable. The person would have the option of liquidating the excess property or borrowing funds on it.

4. For the purposes of subsections 5, 6, and 7, personal property includes cash, savings, redeemable stocks and bonds, vehicles, machinery, or livestock, but does not include personal effects, wearing apparel, household goods, furniture, or trailer homes being used for living quarters. Cash surrender value of life insurance policies will be considered personal property, but will not be considered cash.

5. Personal property may not exceed an equity of two thousand five hundred dollars except that such property which is essential to the earning of a livelihood shall be exempt from the limitation if the liquidation of such excess assets would cause undue hardship. Liquidation of income-producing personal property which would result in reducing annual income below the established income levels would be considered undue hardship. If undue hardship is not found to be a consideration, equity in excess of the two thousand five hundred dollars would be considered available for meeting medical costs providing the property is saleable. The person would have the option of liquidating the excess property or borrowing funds on it.

6. In all instances, real and personal property must be realistically evaluated in accord with current market value and, in considering net equity, any possible costs which may be associated with liquidation of the excess property must be taken into account.

7. With respect to cash, savings, redeemable stocks and bonds, and other liquid assets, the following levels will be applicable to families of various sizes:

   a. Three hundred fifty dollars for one person;

   b. Seven hundred dollars for two persons;

   c. Fifty dollars for each family member through ten; and

   d. Twenty-five dollars for each additional family member. These amounts will not be considered as being available for medical expenses.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-43. Payment for services by attorney-in-fact.

1. For purposes of determining an individual's eligibility under this chapter, if payment is made by the individual to the individual's attorney-in-fact for services or assistance furnished to the individual by the attorney-in-fact, the department may not treat the services or assistance furnished as consideration for the transferred income or asset unless:

   a. (1) The payment is made pursuant to a valid written contract entered between the individual and the attorney-in-fact prior to the attorney-in-fact rendering the services;

      (2) The contract was executed by the individual or the individual's fiduciary who is not the provider or services or assistance under the contract;

(3) Compensation is reasonable and consistent with rates paid in the open market for the services actually provided; and

(4) The services are necessary and reasonable; or

b. The prior course of dealing between the individual and the attorney-in-fact included the individual paying compensation to the attorney-in-fact upon the attorney-in-fact's rendering of services or assistance to the individual, or within thirty days thereafter.

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

History: Effective April 1, 2014.
General Authority: NDCC 50-06-16
Law Implemented: NDCC 50-24.1-02