CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

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SECTION 1: Section 75-02-02.1-01 is amended as follows:

75-02-02.1-01. Definitions.

For the purposes of this chapter:

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

2. "Applicant" means an individual seeking health care coverage benefits.

3. "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.~~4. "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.~~5. "Child" means ~~a person~~an individual, under twenty-one, or, if blind or disabled, under age eighteen, who is not living independently.

6. "Children's health insurance program" means the North Dakota children's health insurance program implemented pursuant to North Dakota Century Code chapter 50-29 and 42 U.S.C. 1397aa et seq. to furnish health assistance to low-income children funded through title XXI of the Social Security Act [42U.S.C. 1397aa et seq.].

~~5.~~7. "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.~~8. "County agency" means the ~~county social service board~~human service zone.

9. "Creditable health insurance coverage" means a health benefit plan which includes coverage for hospital, medical, or major medical. The following are not considered creditable health insurance coverage:

a. Coverage only for accident or disability income insurance;

b. Coverage issued as a supplement to automobile liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workforce safety insurance or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for onsite medical clinics;

h. Other similar insurance coverage specified in federal regulations

under which benefits for medical care are secondary or incidental to other insurance;

i. Coverage for dental or vision;

j. Coverage for long-term care, nursing home care, home health care, or community-based care;

k. Coverage only for specified disease or illness;

l. Hospital indemnity or other fixed indemnity insurance; and

m. Coverage provided through Indian health services.

~~7.~~10. "Department" means the North Dakota department of human services.

~~8.~~11. "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.~~12. "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.~~13. "Disabled adult child" means a disabled or blind ~~person~~individual over the age of twenty-one who became blind or disabled before age twenty-two.

~~11.~~14. "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.~~15. "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.~~16. "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.~~17. "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.~~18. "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.~~19. "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.

20. "Long-term care" means the services received by an individual when the individual is screened or certified as requiring long-term care services.

~~18.~~21. "MAGI-based methodology" means the method of determining eligibility for Medicaid that generally follows modified adjusted gross income rules.

~~19.~~22. "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.~~23. "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.~~24. "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.~~25. "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.~~26. "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.~~27. "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.~~28. "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.

29. "Recipient" means an individual approved as eligible for health care coverage.

~~26.~~30. "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.~~31. "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.~~32. "Residing in the home" refers to individuals who are physically present, individuals who are temporarily absent, or individuals attending educational facilities.

~~29.~~33. "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.~~34. "State agency" means the North Dakota department of human services.

~~31.~~35. "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~~an individual who attends school on a schedule equal to a full curriculum.

~~32.~~36. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~33.~~37. "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.~~38. "The Act" means the Social Security Act [42 U.S.C. 301 et seq.].

~~35.~~39. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

~~36.~~40. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

~~37.~~41. "Title XIX" means title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

42. "Title XXI" means title XXI of the Social Security Act [42 U.S.C. 1397aa 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; January 1, 2020.
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)

SECTION 2: Section 75-02-02.1-02.1 is amended as follows:

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; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01.

SECTION 3: Subsection 2 of section 75-02-02.1-03 is amended as follows:

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

History: Effective December 1, 1991; amended effective July 1, 2003; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 4: Section 75-02-02.1-05 is amended as follows:

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~~individual 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~~individuals under age sixty-five, who are not otherwise eligible for Medicaid, who have been screened for breast ~~and~~or 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~~.~~; and

d. Individuals under age nineteen who are disabled, who meet medically needy nonfinancial criteria, who have income at or below two hundred fifty 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 twenty-one 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.

5. Children's health insurance program includes individuals under age nineteen, and who have income at or below one hundred seventy percent of the poverty level. Coverage under this group ends on the last day of the month in which the individual reaches age nineteen.

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; April 1, 2018; January 1, 2020.
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)

SECTION 5: Section 75-02-02.1-08 is amended as follows:

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.

4. To determine medically needy eligibility for pregnant women, children aged to nineteen, or parent or caretaker relatives; income budgeting will be based on non-MAGI income methodology with the exclusion of assets.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2014; January 1, 2020.
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)

SECTION 6: Section 75-02-02.1-10 is amended as follows:

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~~children's health insurance program.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 7: Subsection 6 of section 75-02-02.1-24.3 is amended as follows:

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 fifty percent of the poverty level.

History: Effective April 1, 2008; amended effective January 1, 2011; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-31

SECTION 8: Subsection 10 of section 75-02-02.1-28 is amended as follows:

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~~irrevocable.

(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~~must be irrevocable.

(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.

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; April 1, 2018; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

SECTION 9: Subsection 1 of section 75-02-02.1-40 is amended as follows:

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) The income level for pregnant women is equal to one hundred sixty-two 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.

(3) 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)~~(4) 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)~~(5) 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)~~(6) 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)~~(7) 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)~~(8) 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)~~(9) 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)~~(10) The income level for children with disabilities is two hundred fifty percent of the poverty level applicable to a family of the size involved. The income level applies regardless of living arrangement.

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; January 1, 2020.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37

SECTION 10: Section 75-02-02.1-41.1 is amended as follows:

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 all individuals ~~not subject to a MAGI-~~

~~based methodology~~:

~~a.~~1. 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)~~a. 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)~~b. The expense was not previously applied in determining eligibility for, or the amount of, Medicaid benefits for any Medicaid recipient;

~~(3)~~c. The medical or remedial care was provided by a medical practitioner licensed to furnish the care;

~~(4)~~d. The expense is not subject to payment by any third party, including Medicaid and Medicare;

~~(5)~~e. 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)~~f. 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)~~g. The Medicaid unit is still obligated to pay the provider of the medical or remedial service.

~~b.~~2. 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; January 1, 2020.
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)

SECTION 11: Section 75-02-02.1-44 is created as follows:

75-02-02.1-44. Children's health insurance program.

1. **Eligibility criteria.**

   a. Children ages birth through eighteen years of age are eligible for plan coverage provided all other eligibility criteria are met. Coverage for children who are eighteen years of age will continue through the last day of the month in which the child turns nineteen years of age.

   b. A child who has current creditable health insurance coverage or has coverage, which is available at no cost, as defined in section 2701(c) of the Public Health Service Act [42 U.S.C. 300gg(c)] is not eligible for plan coverage.

   c. If the department estimates that available funds are insufficient to allow plan coverage for additional applicants, the department may take any action appropriate to avoid commitment of funds in excess of available funds including denying applications and establishing waiting lists not forbidden by title XXI of the Social Security Act [42 U.S.C. section 1397aa et seq.] or regulations adopted thereunder. If federal children's health insurance program funding decreases, the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

2. **Asset considerations.** Assets may not be considered in determining eligibility for plan coverage.

3. **Children's health insurance program unit.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014. A plan unit may consist of one individual, a married couple, or a family with children under twenty-one years of age, or if disabled, under age eighteen, whose income is considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

A parent or other caretaker of children under twenty-one years of age may select the children who will be included in the plan unit. Anyone who is included in the unit for any month is subject to all plan requirements which may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

4. **Income considerations.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014.

a. All income that is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible relative when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available; 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.

b. It is presumed that all parental income is actually available to a child under twenty-one years of age. This presumption may be rebutted by a showing that the child is:

(1) Living independently; or

(2) 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 plan coverage.

c. As a condition of eligibility, an applicant, recipient, and financially responsible relative 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.

(1) 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. Good cause must be documented in the case file.

(2) Application for needs-based payments such as social security supplemental security income benefits or temporary aid to needy families benefits cannot be imposed as a condition of eligibility.

d. The financial responsibility of any individual for any other member of the plan unit will be limited to the responsibility of spouse for spouse and parents for children under age twenty-one or under age eighteen if the child is disabled. Such responsibility is imposed as a condition of plan eligibility. Except as otherwise provided in this subsection, the income of the spouse and parents is considered available even if that income is not actually contributed. Natural and adoptive parents, but not stepparents, are treated as parents.

e. Income may be received weekly, biweekly, monthly, intermittently, or annually. A monthly income amount must be computed by the department or county agency regardless of how often income is received.

f. The following types of income must be disregarded in determining eligibility for plan coverage:

(1) Supplemental security income benefits provided by the social security administration.

(2) Income disregards in section 75-02-02.1-38.2.

g. (1) 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:

(a) Income shall be considered available only to the individual if payment of the income was made solely to that individual; and

(b) Income shall be considered available to each individual in proportion to the individual's interest if payment of income is made to more than one individual.

(2) One-half of income shall be considered available to each spouse in the case of income available to a married couple in which there is no document establishing ownership otherwise.

(3) 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 subdivision f of subsection 4.

h. To determine the appropriate income level for a plan unit:

(1) The size of the household is increased by one for each unborn child of a household member;

(2) A child who is away at school is not treated as living independently, but is allowed a separate income level for one in addition to the income level applicable for the family unit remaining at home;

(3) A child who is living outside of the parental home but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level. This does not apply to situations in which an individual simply decides to live separately;

(4) An individual in a specialized facility is allowed a separate income level for one during all full calendar months in which the individual resides in the facility;

(5) An individual in a nursing facility is allowed a separate income level for one; and

(6) A recipient of home and community-based services is allowed a separate income level for one.

i. For a child to be eligible for plan coverage, the income remaining after allowing the appropriate disregards and deductions must be equal to or below the income level set by the department in accordance with state law and federal authorization and must be based on the size of the household. If federal children's health insurance program funding decreases, the department may decrease the income eligibility limit to accommodate the decrease in federal funding.

5. **Income deductions.** This subsection applies to applications and reviews received and processed for those requesting benefits prior to January 1, 2014. The following deductions must be subtracted from monthly income to determine adjusted gross income:

a. For household members with countable earned income:

(1) Actual mandatory payroll deductions, including federal, state, or social security taxes or ninety dollars per month, whichever is greater;

(2) Mandatory retirement plan deductions;

(3) Union dues actually paid; and

(4) Expenses of a nondisabled blind individual, reasonably attributable to earning income;

b. Reasonable child care expenses, not otherwise reimbursed by third parties if necessary to engage in employment or training. Reasonable child care expenses do not include payments to parents to care for their own children;

c. Except for a support payment withheld from an extra check that is disregarded, nonvoluntary child and spousal support payments if actually paid by a parent on behalf of an individual who is not a member of the household;

d. With respect to each individual in the unit who is employed or in training, thirty dollars as a work or training allowance, but only if the individual's income is counted in the eligibility determination;

e. The cost of premiums for health insurance may be deducted from income in the month the premium is paid or may be prorated and deducted from income in the months for which the premium affords coverage. This deduction applies primarily for premiums paid for health insurance coverage of members in the unit who are not eligible for this plan coverage. For eligible members, this deduction may be allowed if the health insurance coverage is not creditable coverage for hospital, medical, or major medical coverage; and

f. The cost of medical expenses for necessary medical or remedial care for members of the unit who are not eligible for this plan coverage.

History: Effective January 1, 2020.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-24.1-37, 50-29; 42 USC 1397aa et seq.

SECTION 12: Chapter 75-02-02.2 is repealed as follows:

CHAPTER 75-02-02.2
CHILDREN'S HEALTH INSURANCE PROGRAM

[Repealed effective January 1, 2020]

~~Section~~
~~75-02-02.2-01 Definitions~~
~~75-02-02.2-02 Application, Redetermination, and Eligibility Periods~~
~~75-02-02.2-03 Duty to Establish Eligibility~~
~~75-02-02.2-04 Decision, Notice, and Appeal~~
~~75-02-02.2-05 Notice of Potential Medicaid Eligibility - Choice of Program [Repealed]~~
~~75-02-02.2-06 Renewal of Eligibility [Repealed]~~
~~75-02-02.2-06.1 Children's Health Insurance Program Unit~~
~~75-02-02.2-06.2 Children's Health Insurance Program MAGI-Based Methodology Household Unit~~
~~75-02-02.2-07 Duty to Report Changes in Household~~
~~75-02-02.2-08 Termination of Coverage by Recipient~~
~~75-02-02.2-09 Residence and Citizenship Requirements~~
~~75-02-02.2-10 Eligibility Criteria~~
~~75-02-02.2-11 Asset Considerations~~
~~75-02-02.2-12 Income Considerations~~
~~75-02-02.2-12.1 Income Considerations Under a MAGI-Based Methodology~~
~~75-02-02.2-12.2 MAGI-Based Methodology~~
~~75-02-02.2-13 Determining Household Income~~
~~75-02-02.2-13.1 Income Deductions~~
~~75-02-02.2-13.2 Budgeting~~
~~75-02-02.2-13.3 Reasonable Compatibility of Income for Individuals Subject to a MAGI-Based Methodology~~
~~75-02-02.2-14 Eligibility Period~~
~~75-02-02.2-15 Covered Services~~