CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

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SECTION 1: Subsection 3 of 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 who is within a coverage group must also demonstrate that all other eligibility criteria are met.

3. The medically needy coverage group includes:

   a. Individuals under the age of ~~nineteen~~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.

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.
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 2: Section 75-02-02.1-14.1 is amended as follows:

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

1. For the purpose of this section, "medically frail" means an individual who is eligible for or enrolled with medicaid expansion and has been deemed to meet the status of medically frail which upon a review and determination may include an individual with any of the following: serious

or complex medical conditions; disabling mental disorders; chronic substance use disorders; or physical, intellectual, or developmental disability that significantly impairs one's ability to perform one or more activities of daily living.

2. 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~~In any instance in which a determination is to be made as to whether any individual is medically frail, documentation that validates the diagnosis or medical condition along with any other supporting documentation must be submitted to the department. The self-assessment form and documentation submitted shall be reviewed by a medical professional with professional training and pertinent experience, and who shall determine if the applicant 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~~may begin no earlier than the first of the month ~~following the month~~ in which the ~~determination is made~~self-assessment was received by the department.

History: Effective January 1, 2014; amended effective April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37; 42 CFR 440.315(f)

SECTION 3: Section 75-02-02.1-17 is amended as follows:

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:~~

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

   b. An employed or self-employed individual has not met their full retirement age and chooses not to apply for social security early retirement or widows benefits; or

   c. An employed individual whose retirement benefits are through their current employer and the individual is not allowed to access them while employed.

History: Effective December 1, 1991; amended effective July 1, 2003; January 1, 2011; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 4: Section 75-02-02.1-20 is amended as follows:

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~~parent and caretaker relative 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~~children's coverage group age requirements; ~~and~~

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

   c. At least one member of the family remains employed or shows good cause for not being employed; 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 if:

   a. The family has a child living in the home who meets ~~the parent and caretaker relative~~children's coverage 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; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

SECTION 5: Section 75-02-02.1-28 is amended as follows:

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, 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.].

27. A charitable gift annuity that is irrevocable and cannot be assigned to another person.

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.
General Authority: NDCC 50-06-16, 50-24.1-04

Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

SECTION 6: Subsection 2 of section 75-02-02.1-28.1 is amended as follows:

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

2. The assets described in subsections 2 through 5 and subsections 8, 9, and 11 through ~~26~~27 of section 75-02-02.1-28 are excluded.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; April 1, 2012; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

SECTION 7: Subsection 4 of section 75-02-02.1-31.1 is amended as follows:

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

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 the individual, 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.

History: Effective October 1, 1993; amended effective July 1, 2003; April 1, 2008; January 1, 2011; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(d)

SECTION 8: Subsection 6 of section 75-02-02.1-32 is amended as follows:

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:

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 as determined by the department; 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; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 9: Section 75-02-02.1-33.1 is amended as follows:

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.

e. Any portion of the transferred asset or income returned prior to the imposition of the period of ineligibility will reduce the total amount of the disqualifying transfer.

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; or

(9) A motor vehicle.

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 or in absence of a valid written contract, evidence is provided the services were required and provided;

   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~~, seventy-five percent of the 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; 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.~~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 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.~~14. 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, no less frequently than annually, 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, if purchased before August 1, 2005, 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~~annuity, if purchased after July 31, 2005, and before February 8, 2006, will return the full principal and has a guaranteed period that is equal to at least eighty-five percent of the purchaser's life expectancy as determined by the life expectancy tables used by the department and, if the applicant is age fifty-five or older, the department is irrevocably named as the primary beneficiary following the death of the applicant and the applicant's spouse, not to exceed the amount of medical assistance benefits paid on behalf of the applicant after age fifty-five.

~~16.~~15. 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; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

SECTION 10: Section 75-02-02.1-33.2 is amended as follows:

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.

d. Any portion of the transferred asset or income returned prior to the imposition of the period of ineligibility will reduce the total amount of the disqualifying transfer.

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; or

(9) A motor vehicle.

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~~reasonable means to recover the assets or income or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer; and

(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, or if applicable, the minimum allowed under section 75-02-02.1-24, 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 or in absence of a valid written contract, evidence is provided the services were required and provided;

    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~~, seventy-five percent of the 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.~~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 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.~~20. 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, no less frequently than annually, 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; and

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; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

SECTION 11: Section 75-02-02.1-41.2 is amended as follows:

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.

7. **Budgeting procedures when determining overpayments.** When a household fails to report a change that results in a decrease in coverage, the maximum amount of the overpayment is:

   a. The difference between the correct amount of recipient liability and the actual recipient liability paid by the medicaid household;

b. The amount paid in error for all months the individual should not have been eligible under a fee for service benefit plan; or

c. The amount paid for a premium under a managed care benefit plan.

History: Effective December 1, 1991; amended effective May 1, 2006; January 1, 2014; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37