CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

Section	
75-02-02.1-01	Definitions
75-02-02.1-02	Application and Redetermination
75-02-02.1-02.1	Duty to Establish Eligibility
75-02-02.1-03	Decision and Notice
75-02-02.1-04	Screening of Recipients of Certain Services
75-02-02.1-04.1	Certification of Need for Children in an Institution for Mental Disease
75-02-02.1-05	Coverage Groups
75-02-02.1-06	Applicant's Choice of Aid Category
75-02-02.1-07	Applicant's Duty to Establish Eligibility [Repealed]
75-02-02.1-08	Medicaid Unit
75-02-02.1-08.1	Caretaker Relatives
75-02-02.1-09	Assignment of Rights to Medical Payments and Benefits
75-02-02.1-10	Eligibility - Current and Retroactive
75-02-02.1-11	Need
75-02-02.1-12	Age and Identity
75-02-02.1-12.1	Cost-Effective Health Insurance Coverage
75-02-02.1-13	Social Security Numbers
75-02-02.1-14	Blindness and Disability
75-02-02.1-14.1	Eligibility for Medically Frail Medicaid Expansion Enrollees
75-02-02.1-15	Incapacity of a Parent
75-02-02.1-16	State of Residence
75-02-02.1-17	Application for Other Benefits
75-02-02.1-18	Citizenship and Alienage
75-02-02.1-19	Inmates of Public Institutions
75-02-02.1-19.1	Family Coverage Group
75-02-02.1-20	Transitional and Extended Medicaid Benefits
75-02-02.1-21	Continuous Eligibility for Pregnant Women and Newborns
75-02-02.1-22	Medicare Savings Programs
75-02-02.1-23	Eligibility of Qualified Disabled and Working Individuals
75-02-02.1-24	Spousal Impoverishment Prevention
75-02-02.1-24.1	Breast and Cervical Cancer Early Detection Program
75-02-02.1-24.2	Eligibility for Workers With Disabilities
75-02-02.1-24.3	Eligibility for Children With Disabilities
75-02-02.1-24.4	Hospital Presumptive Eligibility
75-02-02.1-25	Asset Considerations
75-02-02.1-26	Asset Limits
75-02-02.1-27	Exempt Assets [Repealed]
75-02-02.1-28	Excluded Assets
75-02-02.1-28.1	Excluded Assets for Medicare Savings Programs, Qualified Disabled and Working Individuals, and Spousal Impoverishment Prevention
75-02-02.1-29	Forms of Asset Ownership

75-02-02.1-30 Contractual Rights to Receive Money Payments
75-02-02.1-30.1 Annuities [Repealed]
75-02-02.1-31 Trusts
75-02-02.1-31.1 Trusts Established by Applicants, Recipients, or Their Spouses After August 10, 1993
75-02-02.1-32 Valuation of Assets
75-02-02.1-33 Disqualifying Transfers Made on or Before August 10, 1993 [Repealed]
75-02-02.1-33.1 Disqualifying Transfers Made Before February 8, 2006 [Repealed]
75-02-02.1-33.2 Disqualifying Transfers Made on or After February 8, 2006
75-02-02.1-34 Income Considerations
75-02-02.1-34.1 MAGI-Based Methodology
75-02-02.1-34.2 Income Conversion for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-34. Reasonable Compatibility of Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-35 Budgeting [Repealed]
75-02-02.1-36 Disregarded Income [Repealed]
75-02-02.1-37 Unearned Income
75-02-02.1-37.1 Unearned Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-38 Earned Income
75-02-02.1-38.1 Post-Eligibility Treatment of Income
75-02-02.1-38.2 Disregarded Income
75-02-02.1-38.3 Disregarded Income for Certain Individuals Subject to a MAGI-Based Methodology
75-02-02.1-38.4 Earned Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-39 Income Deductions
75-02-02.1-39.1 Income Deductions for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-40 Income Levels
75-02-02.1-41 Deeming of Income
75-02-02.1-41.1 Recipient Liability
75-02-02.1-41.2 Budgeting
75-02-02.1-42 Eligibility Under 1972 State Plan
75-02-02.1-43 Payment for Services by Attorney-in-Fact
75-02-02.1-44 Children's Health Insurance Program

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 health and 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.

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.

5. "Child" means 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 [42 U.S.C. 1397aa et seq.].

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.

8. "County agency" means the 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 and 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~~service.

10. "Department" means the North Dakota department of health and human services.

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.

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.

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

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.

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.

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.

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.

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.

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.

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

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.].

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.

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.

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.

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).

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.

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.

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.

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.

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

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.

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

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

~~36.~~35. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~37.~~36. "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.].

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

~~39.~~38. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

~~40.~~39. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

~~41.~~40. "Title XIX" means title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

~~42.~~41. "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; January 1, 2024.
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 75-02-02.1-05 is amended as follows:

75-02-02.1-05. Coverage groups.

Within the limits of legislative appropriation, the department may provide 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 benefits. Any 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 twelve months beginning on the last day of the pregnancy, and through the end of the month in which the twelve-month period ends;

j. Children born to the 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 twelve months beginning on the day of the child's birth and through the end of the month in which the twelve-month period ends;

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 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;

b. Uninsured individuals under age sixty-five, who are not otherwise eligible for Medicaid, who have been screened for breast 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 twelve months beginning on the last day of pregnancy and through the end of the month in which the twelve-month period ends;

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 twelve months beginning on the day of the child's birth, and through the end of the month in which the twelve-month period ends;

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.; and

e. Individuals eligible for the Medicare part B immunosuppressive drug benefit are entitled to coverage for the Medicare part B immunosuppressive drug benefit only. To be eligible, the individual is required to have Medicare coverage under Medicare end stage renal disease and this benefit ends thirty-six months after a successful transplant.

5. Children's health insurance program includes individuals under age nineteen, and who have income at or below onetwo hundred seventyten 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; January 1, 2023; January 1, 2024.
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 3. 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~~entering the state~~, in which case the earliest date of eligibility~~ is eligible for Medicaid as of the date the individual entered the state; and

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 individual is determined eligible.

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 children's health insurance program.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2020; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 4. Section 75-02-02.1-16 is amended as follows:

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

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

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

2. Individuals under age twenty-one.

a. For any individual under age twenty-one who is living independently from the individual's parents or who is married and capable of indicating intent, the state of residence is the state where the individual is living with the intention to remain there.

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

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

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

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

3. Individuals age twenty-one and over:

   a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there or is entering the state with a job commitment or seeking employment. The state of residence, for Medicaid purposes, of a migrant or seasonal farm worker is the state in which the individual is employed or seeking employment.

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

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

4. For purposes of this subsection:

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

      (1) Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the behavioral health division ~~of mental health~~ of the department ~~of human services~~;

      (2) Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01;

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

      (4) Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation; and

   b. "Institution" means an establishment that furnishes, in single or multiple facilities, food, shelter, and some treatment or services to

four or more individuals unrelated to the proprietor.

5. Notwithstanding any other provision of this section except subsections 6 through 9, individuals placed in out-of-state institutions by a state retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. The application of this subsection ends when a person capable of indicating intent leaves an institution in which the person was placed by this state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

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

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

8. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of an affected individual is the state determined under that agreement.

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

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2010; January 1, 2014; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 CFR Part 435

SECTION 5. Section 75-02-02.1-18 is amended as follows:

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

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

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

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

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

   a. Foreign government representatives on official business and their families and servants;

   b. Visitors for business or pleasure, including exchange visitors;

   c. Aliens in travel status while traveling directly through the United States;

   d. Crewmen on shore leave;

   e. Treaty traders and investors and their families;

   f. Foreign students;

   g. International organization representatives and personnel and their families and servants;

   h. Temporary workers, including agricultural contract workers; and

   i. Members of foreign press, radio, film, or other information media and their families.

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

6. Individuals from the compact of free associated states, including the Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau, pursuant to section 208 of division CC of the Consolidated Appropriations Act of 2021 [Pub. L. 116-260], are eligible for Medicaid benefits without the five-year, forty-quarter ban.

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

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

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

   b. Refugees and asylees;

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

   d. Cuban and Haitian entrants;

   e. Aliens admitted as Amerasian immigrants;

   f. Victims of a severe form of trafficking;

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

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

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

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

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

   l. All other aliens, other than for emergency services, only after five years from the date they entered the United States, and then only if

the individual is a lawful permanent resident who has been credited with forty qualifying quarters of social security coverage.

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

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

      (1) Placing health in serious jeopardy;

      (2) Serious impairment to bodily functions; or

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

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

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

10. Pregnant women who are lawfully present in the United States and are otherwise eligible for Medicaid are not subject to the five-year, forty-quarter ban through the twelve months postpartum coverage.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2010; January 1, 2011; January 1, 2014; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

SECTION 6. Section 75-02-02.1-22 is amended as follows:

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

1. Qualified Medicare beneficiaries are entitled only to Medicare cost-sharing benefits described in subsection 19 of section 75-02-02.1-01, beginning in the month following the month in which the individual is determined eligible.

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

application was received.

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

4. Individuals eligible for the Medicare part B immunosuppressive drug benefit are entitled to coverage for the Medicare part B immunosuppressive drug benefit only. To be eligible, the individual is required to have Medicare coverage under Medicare end stage renal disease and this benefit ends thirty-six months after a successful transplant.

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

~~5.~~6. No ~~person~~individual may be found eligible for the Medicare savings programs unless the total value of all nonexcluded assets does not exceed:

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

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

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

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

~~6.~~7. Provisions of this chapter governing asset considerations at section 75-02-02.1-25, valuation of assets at section 75-02-02.1-32, excluded assets at section 75-02-02.1-28.1, and forms of asset ownership at section 75-02-02.1-29 apply to eligibility determinations for Medicare savings programs except:

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

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

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

~~7.~~8. a. Income calculations must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-37, unearned income; section 75-02-02.1-38, earned income; section 75-02-02.1-38.2, disregarded income; and section 75-02-02.1-39, income deductions; except:

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

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

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

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

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

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

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

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

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

requirements described in this section.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; January 1, 2010; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 7. Section 75-02-02.1-33.1 is repealed.

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

[Repealed effective January 1, 2024]

~~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 reduces 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;

(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 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. "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 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.~~

~~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.~~

~~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 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 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.~~

~~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 8. Subsection 4 of section 75-02-02.1-33.2 is amended as follows:

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; or

   d. The date of discovery after eligibility has been established.

History: Effective April 1, 2008; amended effective January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014; April 1, 2018; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

SECTION 9. Section 75-02-02.1-40 is amended as follows:

75-02-02.1-40. Income levels.

1. Levels of income for maintenance shall be used as a basis for establishing financial eligibility for Medicaid. The income levels applicable to individuals and units are:

   a. Categorically needy income levels.

      (1) Family coverage income levels established in the Medicaid state plan are applied to the family coverage group. The family size is increased for each unborn child when determining the appropriate family size.

      (2) Except for individuals subject to the nursing care income level, the income level for categorically needy aged, blind, or disabled recipients is that which establishes supplemental security income eligibility.

   b. Medically needy income levels.

      (1) Medically needy income levels established in the Medicaid state plan are applied when a Medicaid individual or unit resides in the individual's or the unit's own home or in a specialized facility, and when a Medicaid individual has been screened as requiring nursing care, but elects to receive home and community-based services. The family size is increased for each unborn child when determining the appropriate family size.

      (2) The nursing care income levels established in the Medicaid state plan are applied to residents receiving care in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, the state hospital, an institution for mental disease, a psychiatric residential treatment facility, or receiving swing-bed care in a hospital.

      (3) The community spouse income level for a Medicaid eligible community spouse is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the greater of two thousand ~~two~~five

hundred ~~sixty-seven~~fifty 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 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 ~~fifty-seven~~seventy 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.

(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.

(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.

(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.

(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.

(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.

(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.

(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.

2. Determining the appropriate income level in special circumstances.

a. During a month in which an individual enters a specialized facility or leaves a specialized facility to return home, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate income level. An individual residing in a specialized facility shall be allowed the appropriate medically needy, workers with disabilities, or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

b. During a month in which an individual with eligible family members in the home enters or leaves a nursing facility to return home, or elects to receive home and community-based services or terminates that election, the individual shall be included in the family unit in the home for the purpose of determining the family size and the appropriate medically needy, workers with disabilities, or children with disabilities income level. An individual in a nursing facility shall be allowed ~~sixty-five~~one hundred dollars to meet maintenance needs during all full calendar months in which the individual resides in the nursing facility. A recipient of home and community-based services shall be allowed the medically needy income level for one

during all full calendar months in which the individual receives home and community-based services. In determining eligibility for workers with disabilities or children with disabilities coverage, individuals in a nursing facility, or in receipt of home and community-based services, will be allowed the appropriate workers with disabilities or children with disabilities income level for one during all full calendar months in which the individual resides in the facility.

c. For an institutionalized spouse with an ineligible community spouse, the ~~sixty-five~~one hundred dollar income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse and any other family members remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

d. For a spouse electing to receive home and ~~community based~~community-based services, who has an ineligible community spouse, the medically needy income level for one is effective in the month the home and community-based services begin, during full calendar months, and in the month the home and community-based services are terminated. The ineligible community spouse and any other family members remaining in the home shall have the income levels described in paragraphs 3 and 4 of subdivision b of subsection 1.

e. An individual with no spouse, disabled adult child, or child under age twenty-one at home who enters a nursing facility may receive the medically needy income level for one if a physician certifies that the individual is likely to return to the individual's home within six months. The six-month period begins with the first full calendar month the individual is in the nursing facility. If, at any time during the six-month period, the individual's status changes and the stay in the nursing facility is expected to exceed the six months, the individual may have only the nursing care income level beginning in the month following the month of the status change. An individual may receive the medically needy income level for only one six-month period per stay in a nursing facility. If an individual is discharged, then readmitted to a nursing facility, there must be a break of at least one full calendar month between the periods of institutionalization in order for the new stay to be considered a new period of institutionalization.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; January 1, 2011; July 1, 2012; January 1, 2014; January 1, 2020; January 1, 2024.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.7, 50-24.1-21, 50-24.1-37, 50-24.1-41

SECTION 10. Subsection 5 of section 75-02-02.1-44 is amended as follows:

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 <u>health insurance</u> 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; amended effective January 1, 2024.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-24.1-37, 50-29; 42 U.S.C. 1397aa et seq.