CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

SECTION 1. Subsection 12 of section 75-02-02.1-01 is amended as follows:

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

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.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 2. Subsection 16 of section 75-02-02.1-01 is amended as follows:

16. "Institutionalized individual" means an individual who is an inpatient in a nursing facility, an intermediate care facility for the mentally retarded, the state hospital, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations, or the Anne Carlsen facility~~, an institution for mental disease, or who receives swing-bed care in a hospital.

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.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 3. Section 75-02-02.1-04 is amended as follows:

75-02-02.1-04. Screening of recipients of certain services. All applicants or recipients who seek nursing care services in nursing facilities, swing-bed facilities, ~~institutions for mental disease,~~ or intermediate care facilities for the mentally retarded, or who seek home and community-based services, must demonstrate a medical necessity for the service sought on or prior to admission to a facility, upon application for medicaid while in a facility, or upon request for home and community-based services. That demonstration must be ~~based on a~~ through the department's established screening ~~provided by the department~~ process.

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

SECTION 4. 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 of the annuity, pension, retirement, or disability benefit would result in a loss of health insurance coverage.

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

SECTION 5. Subsection 8 of section 75-02-02.1-18 is amended as follows:

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. ~~For the first eight months after entry into the United States,~~ 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.

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.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 6. Subsection 2 of section 75-02-02.1-24 is amended as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) ~~An institutionalized spouse or a home and community-based services spouse may transfer an amount equal to the community spouse countable asset allowance, but only to the extent the assets of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse.~~

~~(2)~~ When an eligible institutionalized spouse or home and community-based services spouse exceeds the asset limits due to an increase in the value of assets or the receipt of assets not previously owned, the institutionalized spouse or home and community-based services spouse may transfer additional assets to the community spouse equal to no more than the current community spouse countable asset allowance less the total value of assets owned by the community spouse, previously transferred to, or for the sole benefit of, the community spouse under ~~paragraph 1, or previously transferred under this paragraph~~ this subdivision.

~~(3)~~(2) If a transfer made under ~~paragraph 1 or 2~~ this subdivision causes the total value of all assets owned by the community spouse immediately prior to the transfer ~~under paragraph 1~~, plus the value of all assets transferred at any time under ~~paragraph 1, plus the value of all assets transferred under paragraph 2~~ this subdivision, to equal or exceed the current community spouse asset allowance, no further transfer may be made under paragraph ~~2~~ 1.

~~(4)~~(3) If a court has entered an order against an institutionalized spouse for the support of a community spouse, assets required by such order to be transferred, by the institutionalized spouse to the community spouse, may not be counted as available to the institutionalized spouse even though the assets are not yet transferred.

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

SECTION 7. Section 75-02-02.1-24.2 is amended as follows:

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

1. An individual shall be enrolled as a member of the workers with disabilities coverage if that individual:
   a. Is gainfully employed;
   b. Is at least sixteen, but less than sixty-five, years of age;
   c. Is disabled as determined by the social security administration or the state review team;
   d. Meets the requirements of this section; and
   e. Is not in receipt of any other medicaid benefits under this chapter other than coverage as a qualified medicare beneficiary or a special low-income medicare beneficiary.
2. An individual may be regarded as gainfully employed only if, taking all factors into consideration, the individual shows that the activity asserted as employment:
   a. Produces a product or service that someone would ordinarily be employed to produce and for which payment is received;
   b. Reflects a relationship of employer and employee or producer and customer;
   c. Requires the individual's physical effort for completion of job tasks, or, if the individual has the skills and knowledge to direct the activity of others, reflects the outcome of that direction; and
   d. The employment setting is not primarily an evaluative or experiential activity.
3. Asset considerations provided under section 75-02-02.1-25, asset limits provided under section 75-02-02.1-26, exempt assets provided under section 75-02-02.1-27, and excluded assets provided under section 75-02-02.1-28.1 are applicable to the workers with disabilities coverage except that each individual enrolled as a member of the workers with disabilities coverage group is allowed an additional ten thousand dollars in assets.
4. ~~No~~ Except for Indians who are exempt from cost-sharing under federal law, an individual who has not paid a one-time enrollment fee of one hundred dollars may not be enrolled.

5. Any individual who fails to pay the premium established under this section for three months shall be disenrolled and may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding enrollment fees and premiums. Any month in which no premium is due shall not be counted as a month in which the individual failed to pay a premium.
6. Payments received by the department from an individual claiming eligibility under this section shall be credited first to unpaid enrollment fees and then to the oldest unpaid premium. The department shall credit payments on the day received, provided that credit for any payment made by an instrument that is not honored shall be reversed. The department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.
7. A monthly premium is due on the tenth day of each month for which coverage is sought and shall be equal to five percent of the individual's gross countable income. This requirement does not apply to Indians who are exempt from cost-sharing under federal law.
8. No individual may be found eligible under this section if the individual and the individual's family have total net income equaling or exceeding two hundred twenty-five percent of the poverty level.
9. This section becomes effective on the effective date of approved amendments to the medicaid state plan sufficient to secure federal financial participation in the cost of services provided to individuals found eligible under this section, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

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

SECTION 8. Section 75-02-02.1-24.3 is amended as follows:

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

1. A child must be enrolled as a member of the children with disabilities coverage if that child:
   a. Is under age nineteen, including the month the child turns age nineteen;
   b. Is disabled;
   c. Meets the requirements of this section; and
   d. Is not in receipt of any other medicaid benefits under this chapter.
2. As a condition of eligibility, a child must be enrolled in a health insurance policy if:
   a. The child's family has an employer-based health insurance plan available to them; and
   b. The employer pays at least fifty percent of the premium.

3. A monthly premium is due on the tenth day of each month for which coverage is sought and is equal to five percent of the family's gross countable income. This premium may be offset by any other health insurance premium the family pays for a health insurance plan that provides coverage for the individual claiming eligibility under this section. This subsection does not apply to Indians who are exempt from cost-sharing under federal law.
4. If the premium established for an individual's coverage under this section is not paid for three months, the individual will be disenrolled and may not be reenrolled without first reestablishing eligibility under this section and paying all outstanding premiums. Any month in which no payment is due may not be counted as a month in which the individual's premium failed to be paid.
5. Payments received by the department from or on behalf of an individual claiming eligibility under this section will be credited first to the oldest unpaid premium. The department will credit payments on the day received, provided that credit for any payment made by an instrument that is not honored will be reversed. The department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.
6. No individual may be found eligible under this section if the individual and the individual's family have total net income in excess of two hundred percent of the poverty level.
7. This section becomes effective March 1, 2008, remains effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.
8. For purposes of this section, "family" means any member of the medicaid unit who is a spouse, parent, financially responsible caretaker relative, sibling, or child of the individual requesting benefits under this section.

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

SECTION 9. 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. 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.

2. 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 <u>or a mobile home</u> 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.

(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.

3. a Any 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.

(3) The prepayments on a whole life insurance policy or annuity are 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.

(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.

4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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].
11. 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.
12. 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.
13. 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.

14. The value of a life estate.
15. Allowances paid to children of Vietnam veterans who are born with spina bifida. This asset must be identifiable and not commingled with other assets.
16. The value of mineral acres.
17. 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].
18. Property connected to the political relationship between Indian tribes and the federal government which consist 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 the Interior.
    b. Property located within the most recent boundaries of a prior federal reservation, including former reservations in Oklahoma and Alaska native regions established by the Alaska native claims settlement act.
    c. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights.
    d. Property with unique Indian significance such as ownership interests in or usage rights to items not covered by paragraphs (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.

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

SECTION 10. Subsection 5 of section 75-02-02.1-31.1 is amended as follows:

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

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

SECTION 11. 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:

1. With respect to liquid assets: reliable account records.
2. With respect to personal property other than liquid assets:
   a. Publicly traded stocks, bonds, and securities: stockbrokers.
   b. Autos, trucks, mobile homes, boats, farm equipment, or any other property listed in published valuation guides accepted in the trade: the valuation guide.
   c. With respect to harvested grains or produce: grain buyers, grain elevator operators, produce buyers; and, for crops grown on contract: the contract.
   d. With respect to stock in corporations not publicly traded: appraisers, accountants.
   e. With respect to other personal property: dealers and buyers of that property.
   f. With respect to a life insurance policy: the life insurance company.
3. Real property.
   a. With respect to mineral interests: ~~appraisers, specializing in minerals, mineral buyers, geologists~~
      (1) If determining current value, the best offer received following a good faith effort to sell the mineral interests. A good faith effort to sell means offering the mineral interests to at least three companies purchasing mineral rights in the area, or by offering for bids through public advertisement.
      (2) If determining a past value for mineral rights previously sold or transferred:
         (a) If producing, the value is an amount equal to three times the annual royalty income based on actual

royalty income from the thirty-six months following the transfer, or if thirty-six months have not yet passed, based on actual royalty income in the months that have already passed plus an estimate for the remainder of the thirty-six month period.

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

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

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

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

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

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

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

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

c. Life estates and remainder interests.

(1) The life estate and remainder interest tables must be used to determine the value of a life estate or remainder interest. In order to use the table, it is necessary to first know the age of the life tenant or, if there are more than one life tenants, the age of the youngest life tenant; and the fair market value of

the property which is subject to the life estate or remainder interest. The value of a life estate is found by selecting the appropriate age in the table and multiplying the corresponding life estate decimal fraction times the fair market value of the property. The value of a remainder interest is found by selecting the appropriate age of the life tenant in the table and multiplying the corresponding remainder interest decimal fraction times the fair market value of the property.

Life Estate and Remainder Interest Table

Age	Life Estate	Remainder Interest
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392

34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643

80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(2) The life estate and remainder interest tables are based on the anticipated lifetimes of individuals of a given age according to statistical tables of probability. If the life tenant suffers from a condition likely to cause death at an unusually early age, the value of the life estate decreases and the value of the remainder interest increases. An individual who requires long-term care, who suffers from a condition that is anticipated to require long-term care within twelve months, or who has been diagnosed with a disease or condition likely to reduce the individual's life expectancy is presumed to suffer from a condition likely to cause death at an unusually early age, and may not rely upon statistical tables of probability applicable to the general population to establish the value of a life estate or remainder interest. If an individual is presumed to suffer from a condition likely to cause death at an unusually early age, an applicant or

recipient whose eligibility depends upon establishing the value of a life estate or remainder interest must provide a reliable medical statement that estimates the remaining duration of life in years. The estimated remaining duration of life may be used, in conjunction with a life expectancy table, to determine the comparable age for application of the life estate and remainder interest table.

5. Contractual rights to receive money payments:
   a. Except during any disqualifying transfer penalty period as ~~provided in~~ established by subdivision d, the value of contractual rights to receive money payments in which payments are current is an amount equal to the total of all outstanding payments of principal required to be made by the contract unless evidence is furnished that establishes a lower value.
   b. Except during any disqualifying transfer penalty period as ~~provided in~~ established by subdivision d, the value of contractual rights to receive money payments in which payments are not current is the current fair market value of the property subject to the contract.
   c. Except during any disqualifying transfer penalty period as ~~provided in~~ established by subdivision d, if upon execution the total of all principal payments required under the terms of the contract is less than the fair market value of the property sold, the difference is a disqualifying transfer governed by section 75-02-02.1-33.1 or 75-02-02.1-33.2, and the value of the contract is determined under subdivision a or b.
   d. A contractual right to receive money payments that consists of a promissory note, loan, or mortgage is a disqualifying transfer governed by section 75-02-02.1-33.2 of an amount equal to the outstanding balance due as of the date the lender or purchaser, or the lender's or purchaser's spouse, first applies for medicaid to secure nursing care services, as defined in section 75-02-02.1-33.2, if:
      (1) Any payment on the contract is due after the end of the contract payee's life expectancy as established in accordance with actuarial publications of the office of the chief actuary of the social security administration;
      (2) The contract provides for other than equal payments or for any balloon or deferred payment; or
      (3) The contract provides for any payment otherwise due to be diminished after the contract payee's death.
   e. The value of a secured contractual right to receive money payments that consists of a promissory note, loan, or mortgage not described in subdivision d shall be determined under subdivision a or b. For an unsecured note, loan, or mortgage, the value is the outstanding payments of principal and overdue interest unless evidence is furnished that establishes a lower value.

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

SECTION 12. 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 6 and 15, 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 first application.
   b. A fractional period of ineligibility may not be rounded down or otherwise disregarded with respect to any disposal of assets or income for less than fair market value.
   c. Notwithstanding any contrary provisions of this section, in the case of an individual or an individual's spouse who makes multiple fractional transfers of assets or income in more than one month for less than fair market value on or after the look-back date

established under subsection 2, the period of ineligibility applicable to such individual must be determined by treating the total, cumulative uncompensated value of all assets or income transferred during all months on or after the look-back date as one transfer and one penalty period must be imposed beginning on the earliest date applicable to any of the transfers.

6. For purposes of this section, "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

7. ~~Except as limited by subdivision i of subsection 2 of section 75-02-02.1-24, an~~ An individual ~~shall~~ 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 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 or exempted for medicaid purposes other than:
(1) The home or residence of the individual or the individual's spouse;
(2) Property that is not saleable without working an undue hardship;
(3) Excluded home replacement funds;
(4) Excluded payments, excluded interest on those payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;
(5) Life estate interests;
(6) Mineral interests;
(7) An asset received from a decedent's estate during any period it is considered to be unavailable under subsection 5 of section 75-02-02.1-25; or
(8) An annuity.

8. a. An individual shall not be ineligible for medicaid by reason of subsection 2 to the extent the individual makes a satisfactory showing that an undue hardship exists for the individual. Upon imposition of a period of ineligibility because of a transfer of assets or income for less than fair market value, the department shall notify the applicant or recipient of the right to request an undue hardship exception. An individual may apply for an exception to the transfer of asset penalty if the individual claims that the ineligibility period will cause an undue hardship to the individual. A request for a determination of undue hardship must be made within ninety days after the circumstances upon which the claim of undue hardship is made were known or should have been known to the affected individual or the person acting on behalf of that individual if incompetent. The individual must provide to the department sufficient documentation to support the claim of undue hardship. The department shall determine whether a hardship exists upon receipt of all necessary documentation submitted in support of a request for a hardship exception. An undue hardship exists only if the individual shows that all of the following conditions are met:
(1) Application of the period of ineligibility would deprive the individual of food, clothing, shelter, or other necessities of life or would deprive the individual of medical care such that the individual's health or life would be endangered;
(2) The individual who transferred the assets or income, or on whose behalf the assets or income were transferred, has exhausted all lawful means to recover the assets or income

or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer;

(3) A person who would otherwise provide care would have no cause of action, or has exhausted all causes of action, against the transferee of the assets or income of the individual or the individual's spouse under North Dakota Century Code chapter 13-02.1, the Uniform Fraudulent Transfers Act, or any substantially similar law of another jurisdiction; and

(4) The individual's remaining available assets and the remaining assets of the individual's spouse are less than the asset limit in subsection 1 of section 75-02-02.1-26 counting the value of all assets except:

(a) A home, exempt under section 75-02-02.1-27, 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 3 of section 75-02-02.1-28 for the individual and the individual's spouse.

b. Upon the showing required by this subsection, the department shall state the date upon which an undue hardship begins and, if applicable, when it ends.

c. The agency shall terminate the undue hardship exception, if not earlier, at the time an individual, the spouse of the individual, or anyone with authority to act on behalf of the individual, makes any uncompensated transfer of income or assets after the undue hardship exception is granted. The agency shall deny any further requests for an undue hardship exception due to either the disqualification based on the transfer upon which the initial undue hardship determination was based, or a disqualification based on any subsequent transfer.

9. If a request for an undue hardship waiver is denied, the applicant or recipient may request a fair hearing in accordance with the provisions of chapter 75-01-03.

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

a. In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer produce income which, when added to other income available to the individual and to the individual's spouse, total an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual and by the individual's spouse in the month of transfer and in the fifty-nine months following the month of transfer;

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

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

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

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

11. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for medicaid must show that a desire to receive medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subsection 10. The fact, if it is a fact, that the individual would be eligible for the medicaid coverage for nursing care services, had the individual or the individual's spouse not transferred income or assets for less than fair market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for medicaid.

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

13. No income or asset transferred to a parent, stepparent, child, stepchild, grandparent, grandchild, brother, sister, stepsister, stepbrother, great-grandparent, great-grandchild, aunt, uncle, niece, or nephew of the individual or the individual's spouse, purportedly for services or assistance furnished by the transferee to the individual or the individual's spouse, may be treated as consideration for the services or assistance furnished unless:
    a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance;
    b. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract;
    c. Compensation is consistent with rates paid in the open market for the services or assistance actually provided; and
    d. The parties' course of dealing included paying compensation upon rendering services or assistance, or within thirty days thereafter.
14. A transfer is complete when the individual or the individual's spouse making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.
15. For purposes of this section:
    a. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future, but does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals must begin by age seventy and one-half.
    b. "Average monthly cost of nursing facility care" means the cost determined by the department under section 1917(c)(1)(E)(i)(II) of the Act [42 U.S.C. 1396p(c)(1)(E)(i)(II)].
    c. "Fair market value" means:
        (1) In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of apparent fair market value;
        (2) In the case of real or personal property that is subject to reasonable dispute concerning its value:
            (a) If conveyed in an arm's-length transaction to someone not in a confidential relationship with the individual or anyone acting on the individual's behalf, seventy-five percent of estimated fair market value; or
            (b) If conveyed to someone in a confidential relationship with the individual or anyone acting on the individual's behalf, one hundred percent of estimated fair market value; and

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

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

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

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

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

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

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

(4) Includes:

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

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

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

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;
(f) Medicare part B deductible coverage;
(g) Medicare part B excess benefits at one hundred percent coverage; and
(h) Foreign travel emergency coverage.

g. "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.

h. "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.

i. "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.

j. "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, 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.

19. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was

transferred, the individual has in force home care and long-term care coverage, purchased on or before July 31, 2003, with a daily benefit at least equal to 1.25 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

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

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

20. An individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid if, for a period of at least thirty-six consecutive months, beginning on the date the asset was transferred, the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, and before January 1, 2007, with a daily benefit at least equal to 1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

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

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

21. With respect to an annuity transaction which includes the purchase of, selection of an irrevocable payment option, addition of principal to, elective withdrawal from, request to change distribution from, or any other transaction that changes the course of payments from an annuity which occurs on or after February 8, 2006, an individual may demonstrate that an asset was transferred exclusively for a purpose other than to qualify for medicaid, if the asset was used to acquire an annuity, only if:

a. The owner of the annuity provides documentation satisfactory to the department that names the department as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant or the department is named in the second position after the community spouse or minor or disabled child, and that establishes that any attempt by such spouse or a representative of such child to dispose

of any such remainder shall cause the department to become the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant;

b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;

c. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;

d. The annuity provides substantially equal monthly payments of principal and interest that vary by five percent or less from the total annual payment of the previous year, and does not have a balloon or deferred payment of principal or interest;

e. The annuity will return the full principal and interest within the purchaser's life expectancy as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration; and

f. All annuities owned by the purchaser produce total monthly gross income that:

(1) Does not exceed the minimum monthly maintenance needs allowance for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5; and

(2) When combined with the purchaser's other monthly income at the time the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse applies for benefits under this chapter, does not exceed one hundred fifty percent of the minimum monthly maintenance needs allowance allowed for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5.

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

SECTION 13. Section 75-02-02.1-37 is amended as follows:

75-02-02.1-37. Unearned income. Unearned income is income that is not earned income. Unearned income received in a fixed amount each month shall be applied in the month in which it is normally received.

1. Recurring unearned lump sum payments received after application for medicaid shall be prorated over the number of months the payment is intended to cover. When a payment is received and prorated in an ongoing case, or after a period of medicaid eligibility or eligibility for the children's health insurance program as provided in chapter 75-02-02.2, and the case is closed and then reopened during the prorated period, or within the following proration period, the lump sum payment proration must continue. All other recurring unearned lump sum payments received before application for medicaid or for the children's health insurance

program as provided in chapter 75-02-02.2 are considered income in the month received and are not prorated.

2. All nonrecurring unearned lump sum payments, except health or long-term care insurance payments, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and veterans administration homebound benefits intended for medical expenses shall be considered as income in the month received and assets thereafter.

3. ~~One-twelfth of the annual amount of lease payments, not otherwise required to be disregarded under section 75-02-02.1-38.2, deposited in individual Indian moneys accounts by the bureau of Indian affairs is income in each month and may be determined:~~

   ~~a. By totaling all payments in the most recent full calendar year and dividing by twelve;~~

   ~~b. By totaling all payments in the twelve-month period ending with the previous month and dividing by twelve; or~~

   ~~c. If the applicant or recipient demonstrates, by furnishing lease documents or reports, that the deposit amount will be substantially different than the annual amount which would be determined under subdivision a or b, by totaling all payments likely to be made in the twelve-month period beginning with the month in which the lease arrangement changed and dividing by twelve.~~

4. One-twelfth of annual conservation reserve program payments, less expenses, such as seeding and spraying, necessary to maintain the conservation reserve program land in accordance with that program's requirements, is unearned income in each month.

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

SECTION 14. Section 75-02-02.1-38.1 is amended as follows:

75-02-02.1-38.1. Post-eligibility treatment of income. Except in determining eligibility for workers with disabilities or children with disabilities, this section prescribes specific financial requirements for determining the treatment of income and application of income to the cost of care for an individual screened as requiring nursing care services who resides in a nursing facility, the state hospital, ~~the Anne Carlsen facility~~ an institution for mental disease, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations~~, or an intermediate care facility for the mentally retarded, or who receives swing-bed care in a hospital.

1. The following types of income may be disregarded in determining medicaid eligibility:
   a. Occasional small gifts;
   b. For so long as 38 U.S.C. 5503 remains effective, ninety dollars of veterans administration improved pensions paid to a veteran, or a

surviving spouse of a veteran, who has neither spouse nor child, and who resides in a medicaid-approved nursing facility;

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

d. Agent orange payments;

e. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

f. Netherlands reparation payments based on Nazi, but not Japanese, persecution during World War II [Pub. L. 103-286; 42 U.S.C. 1437a, note];

g. Radiation Exposure Compensation Act [Pub. L. 101-426; 42 U.S.C. 2210, note]; and

h. Interest or dividend income from liquid assets.

2. The mandatory payroll deductions under the Federal Insurance Contributions Act [26 U.S.C. 3101 et seq.] and medicare are allowed from earned income.

3. In establishing the application of income to the cost of care, the following deductions are allowed in the following order:

a. The nursing care income level;

b. Amounts provided to a spouse or family member for maintenance needs;

c. The cost of premiums for health insurance in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage;

d. The cost of premiums for long-term care insurance carried by an individual or the individual's spouse in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage;

e. Medical expenses for necessary medical or remedial care that are each:

(1) Documented in a manner which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider;

(2) Incurred in the month for which eligibility is being determined, or was incurred in a prior month but was actually paid in the month for which eligibility is being determined and was not previously allowed as a deduction or offset of recipient liability, and was not applied previously to recipient liability;

(3) Provided by a medical practitioner licensed to furnish the care;

(4) Not subject to payment by any third party, including medicaid and medicare;

(5) Not incurred for nursing facility services, swing-bed services, or home and community-based services during a period of ineligibility because of a disqualifying transfer; and

(6) Claimed; and

f. The cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

4. For purposes of this section, "premiums for health insurance" include any payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:
   a. Limited to disability or income protection coverage;
   b. Automobile medical payment coverage;
   c. Supplemental to liability insurance;
   d. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or
   e. Credit accident and health insurance.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010 January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 15. Section 75-02-02.1-38.2 is amended as follows:

75-02-02.1-38.2. Disregarded income.

1. This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs, but does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, ~~the Anne Carlsen facility~~ an institution for mental disease, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations~~, an intermediate care facility for the mentally retarded, or receiving swing-bed care in a hospital. The following types of income shall be disregarded in determining medicaid eligibility:
   a. Money payments made by the department in connection with foster care, subsidized guardianship, or the subsidized adoption program;
   b. Occasional small gifts;
   c. County general assistance that may be issued on an intermittent basis to cover emergency-type situations;
   d. Income received as a housing allowance by a program sponsored by the United States department of housing and urban development or rent supplements or utility payments provided through a housing assistance program;
   e. Income of an individual living in the parental home if the individual is not included in the medicaid unit;

f. Educational loans, scholarships, grants, awards, workers compensation, vocational rehabilitation payments, and work study received by a student, or any fellowship or gift, or portion of a gift, used to pay the cost of tuition and fees at any educational institution;

g. In-kind income except in-kind income received in lieu of wages;

h. Per capita judgment funds paid to members of the Blackfeet Tribe and the Gross Ventre Tribe under Pub. L. 92-254, to any tribe to pay a judgment of the Indian claims commission or the court of claims under Pub. L. 93-134, or to the Turtle Mountain Band of Chippewa Indians, the Chippewa Cree Tribe of Rocky Boy's Reservation, the Minnesota Chippewa Tribe, or the Little Shell Tribe of Chippewa Indians of Montana under Pub. L. 97-403;

i. Compensation received by volunteers participating in the action program as stipulated in the Domestic Volunteer Service Act of 1973 [Pub. L. 93-113; 42 U.S.C. 4950 et seq.], including foster grandparents, older American community service program, retired senior volunteer program, service corps of retired executives, volunteers in service to America, and university year for action;

j. Benefits received through the low income home energy assistance program;

k. Training funds received from vocational rehabilitation;

l. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the job opportunity and basic skills program;

m. Income tax refunds and earned income credits;

n. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act [29 U.S.C. 2801 et seq.], and through the job opportunities and basic skills program;

o. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by section 6 of Pub. L. 94-114 [~~42 U.S.C. 301, note~~ 25 U.S.C. 459e];

p. Income earned by a child who is a full-time student or a part-time student who is not employed one hundred hours or more per month;

q. Payments from the family subsidy program;

r. The first fifty dollars per month of current child support, received on behalf of children in the medicaid unit, from each budget unit that is budgeted with a separate income level;

s. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 [Pub. L. 91-646, 42 U.S.C. 4621 et seq.];

t. Payments made tax exempt as a result of section 21 of the Alaska Native Claims Settlement Act [Pub. L. 92-203];

u. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383; 50 U.S.C. App. 1989 et seq.];
v. Agent orange payments;
w. A loan from any source that is subject to a written agreement requiring repayment by the recipient;
x. The medicare part B premium refunded by the social security administration;
y. Payments from a fund established by a state as compensation for expenses incurred or losses suffered as a result of a crime;
z. Temporary assistance for needy families benefit and support service payments;
aa. Lump sum supplemental security income benefits in the month in which the benefit is received;
bb. German reparation payments made to survivors of the holocaust and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
cc. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288; 42 U.S.C. 5121 et seq.], or some other federal statute, because of a presidentially declared major disaster, and interest earned on that assistance;
dd. Refugee cash assistance or grant payments;
ee. Payments from the child and adult food program for meals and snacks to licensed families who provide day care in their home;
ff. Extra checks consisting only of the third regular payroll check or unemployment benefit payment received in a month by an individual who is paid biweekly, and the fifth regular payroll check received in a month by an individual who is paid weekly;
gg. All income, allowances, and bonuses received as a result of participation in the job corps program;
hh. Payments received for the repair or replacement of lost, damaged, or stolen assets;
ii. Homestead tax credit;
jj. Training stipends provided to victims of domestic violence by private, charitable organizations for attending their educational programs;
kk. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects, under 38 U.S.C. 1805 or 38 U.S.C. 1815;
ll. Netherlands reparation payments based on Nazi, but not Japanese, persecution during World War II [Pub. L. 103-286; 42 U.S.C. 1437a, note];
mm. Radiation Exposure Compensation Act [Pub. L. 101-426; 42 U.S.C. 2210, note];

nn. ~~The first two thousand dollars per year of payments derived from individual interests in Indian trust or restricted lands;~~

~~oo.~~ Interest or dividend income from liquid assets;

~~pp.~~oo. Additional pay received by military personnel as a result of deployment to a combat zone; and

~~qq.~~pp. All wages paid by the census bureau for temporary employment related to census activities.

2. For purposes of this section:
   a. "Full-time student" means a person who attends school on a schedule equal to a full curriculum; and
   b. "Student" means an individual who regularly attends and makes satisfactory progress in elementary or secondary school, general equivalency diploma classes, home school program recognized or supervised by the student's state or local school district, college, university, or vocational training, including summer vacation periods if the individual intends to return to school in the fall.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 16. Section 75-02-02.1-39 is amended as follows:

75-02-02.1-39. Income deductions. This section applies to an individual residing in the individual's own home or in a specialized facility, workers with disabilities coverage, children with disabilities coverage, and to the medicare savings programs, but does not apply to an individual receiving nursing care services in a nursing facility, the state hospital, ~~the Anne Carlsen facility~~ an institution for mental disease, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations~~, an intermediate care facility for the mentally retarded, or receiving swing-bed care in a hospital. No deduction not described in subsections 1 through 14 may be allowed in determining medicaid eligibility.

1. Except in determining eligibility for the medicare savings programs, the cost of premiums for health insurance may be deducted from income in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage. In determining eligibility for the workers with disabilities coverage, the workers with disabilities enrollment fee and premiums are not deducted. In determining eligibility for the children with disabilities coverage, the children with disabilities premiums are not deducted. For purposes of this subsection, "premiums for health insurance" include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:
   a. Limited to disability or income protection coverage;
   b. Automobile medical payment coverage;

c. Supplemental to liability insurance;
d. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or
e. Credit accident and health insurance.

2. Except in determining eligibility for the medicare savings programs, medical expenses for necessary medical or remedial care may be deducted only if each is:
   a. Documented in a manner which describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider;
   b. Incurred by a member of a medicaid unit in the month for which eligibility is being determined, or was incurred in a prior month but was actually paid in the month for which eligibility is being determined and was not previously allowed as a deduction or offset of recipient liability, and was not previously applied to recipient liability;
   c. Provided by a medical practitioner licensed to furnish the care;
   d. Not subject to payment by any third party, including medicaid and medicare;
   e. Not incurred for nursing facility services, swing-bed services, or home and community-based services during a period of ineligibility determined under section 75-02-02.1-33.1; and
   f. Claimed.
3. Reasonable expenses such as food and veterinarian expenses necessary to maintain a service animal that is trained to detect seizures for a member of the medicaid unit.
4. Except for a support payment withheld from an extra check that is disregarded, nonvoluntary child and spousal support payments may be deducted if actually paid by a member of the medicaid unit.
5. The cost of premiums for long-term care insurance carried by an individual or the individual's spouse may be deducted from income in the month the premium is paid or prorated and deducted from income the months for which the premium affords coverage. No premium deduction may be made in determining eligibility for the medicare savings programs.
6. Reasonable child care expenses, not otherwise reimbursed, may be deducted to the extent necessary to permit a caretaker or a spouse to work or participate in training.
7. With respect to each individual in the medicaid unit who is employed or in training, but who is not aged, blind, or disabled, thirty dollars may be deducted as a work or training allowance, but only if the individual's income is counted in the eligibility determination.
8. Except in determining eligibility for the medicare savings programs, transportation expenses may be deducted if necessary to secure medical care provided for a member of the medicaid unit.
9. Except in determining eligibility for the medicare savings programs, the cost of remedial care for an individual residing in a specialized facility,

limited to the difference between the recipient's cost of care at the facility and the regular medically needy income level, may be deducted.

10. A disregard of twenty dollars per month is deducted from any income, except income based on need, such as supplemental security income and need-based veterans' pensions. This deduction applies to all aged, blind, and disabled applicants or recipients, provided that:
    a. When more than one aged, blind, or disabled person lives together, no more than a total of twenty dollars may be deducted;
    b. When both earned and unearned income is available, this deduction must be made from unearned income; and
    c. When only earned income is available, this deduction must be made before deduction of sixty-five dollars plus one-half of the remaining monthly gross income made under subdivision b of subsection 13.
11. Reasonable adult dependent car expenses for an incapacitated or disabled adult member of the medicaid unit may be deducted to the extent necessary to permit a caretaker or a spouse to work or participate in training.
12. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.
13. The deductions described in this subsection may be allowed only on earned income.
    a. For all individuals except aged, blind, or disabled applicants or recipients, deduct:
        (1) Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
        (2) Mandatory retirement plan deductions;
        (3) Union dues actually paid; and
        (4) Expenses of a nondisabled blind person, reasonably attributable to earning income.
    b. For all aged, blind, or disabled applicants or recipients, deduct sixty-five dollars plus one-half of the remaining monthly gross earned income, provided that, when more than one aged, blind, or disabled person lives together, no more than sixty-five dollars, plus one-half of the remaining combined earned income, may be deducted.
14. A deduction may be made for the cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

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

SECTION 17. Subdivision b of subsection 1 of section 75-02-02.1-40 is amended as follows:

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 the mentally retarded, the state hospital, ~~the Anne Carlsen facility~~ an institution for mental disease, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations~~, or receiving swing-bed care in a hospital.

(3) The community spouse income level for a medicaid eligible community spouse is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the greater of two thousand two hundred sixty-seven dollars per month or the minimum amount permitted under section 1924(d)(3)(c) of the Act [42 U.S.C. 1396r-5(d)(3)(C)], as adjusted pursuant to section 1924(g) of the Act [42 U.S.C. 1396r-5(g)].

(4) The income level for each ineligible family member in a spousal impoverishment prevention case is equal to one-third of an amount determined in accordance with section 1924(d)(3)(A)(i) of the Act [42 U.S.C. 1396r-5(d)(3)(A)(i)], less the monthly income of that family member. For purposes of this paragraph, "family member" has the meaning given in subsection 1 of section 75-02-02.1-24.

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

SECTION 18. Subsection 4 of section 75-02-02.1-41 is amended as follows:

4. The excess income of a spouse or parent may not be deemed to a recipient to meet medical expenses during any full calendar month in which the recipient receives nursing care services in a nursing facility, an intermediate care facility for the mentally retarded, the state hospital, ~~the~~

~~Anne Carlsen facility~~ an institution for mental disease, or a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of healthcare organizations~~, receives swing bed care in a hospital, or receives home and community-based services. Income of any eligible spouse or parent shall be deemed to an individual who is ineligible for supplemental security income, up to the appropriate income level.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2011.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 19. Subsection 13 of section 75-02-02.2-01 is amended as follows:

13. "Institutionalized individual" means an individual who is an inpatient in a nursing facility, an intermediate care facility for the mentally retarded, the state hospital, a psychiatric residential treatment facility ~~accredited by the joint commission on accreditation of health care organizations, the Anne Carlsen center for children~~, an institution for mental disease, or an individual who receives swing-bed care in a hospital.

History: Effective October 1, 1999; amended effective August 1, 2005; January 1, 2011.
General Authority: NDCC 50-29
Law Implemented: NDCC 50-29-01; 42 USC 1397aa et seq.

north dakota
department of
human services

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John Hoeven, Governor
Carol K. Olson, Executive Director

August 24, 2010

RE: Proposed Amendments to N.D. Admin. Code Chapters 75-02-02.1 and 75-02-02.2, Eligibility for Medicaid and Children's Health Insurance Program

TO WHOM IT MAY CONCERN:

The Department of Human Services is proposing amendments to N.D. Admin. Code chapters 75-02-02.1 and 75-02-02.2, Eligibility for Medicaid and Children's Health Insurance Program. The department has adopted procedures to assure public input into the formulation of such rules prior to adoption.

In conformity with those procedures, we are providing you with a copy of the proposed rules and are requesting that you provide any written data, views, or arguments no later than 5:00 p.m. on October 11, 2010.

The department has scheduled an oral hearing on September 29, 2010. Further information concerning the public hearing is included in the attached notice of proposed rulemaking and public hearing.

Your participation is welcomed, as are your suggestions. Please send all written data, views, or arguments to: Rules Administrator, Department of Human Services, State Capitol - Judicial Wing, 600 E. Boulevard Ave., Bismarck, ND 58505-0250.

Sincerely,

Carol K. Olson

Carol K. Olson,
Executive Director

CKO/kkh

Attachments

Cc: John Walstad, Legislative Council
Curtis Volesky, Medical Services