CHAPTER 75-02-02
MEDICAL SERVICES

75-02-02-28 Drug Use Review Board and Appeals
75-02-02-29 Primary Care Provider [Repealed]

SECTION 1. Section 75-02-02-09.5 is amended as follows:

75-02-02-09.5. Limitations on personal care services - Grievance.

1. No payment for personal care services may be made unless an assessment of the recipient is made by the department or the department's designee in the home where the recipient resides, and the recipient is determined to be impaired in at least one of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring or in at least three of the instrumental activities of daily living of medication assistance, laundry, housekeeping, and meal preparation.

2. No payment may be made for personal care services unless prior authorization has been granted by the department in accordance with a service plan approved by the department.

3. Payment for personal care services may only be made to an enrolled qualified service provider who meets the standards described in chapter 75-03-23 or to a basic care assistance provider that qualifies for a rate under chapter 75-02-07.1.

4. No payment may be made for personal care services provided in excess of the services, hours, or time frame authorized by the department in the recipient's approved service plan.

5. Personal care services may not include skilled health care services performed by individuals with professional training.

6. An inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental diseases may not receive personal care services.

7. No payment may be made for personal care services unless a recipient resides in a dwelling as defined under subsection 8 of North Dakota Century Code section 14-02.5-01 or in a basic care facility that qualifies for a rate under chapter 75-02-07.1.

8. Personal care services may not include home-delivered meals, services performed primarily as housekeeping tasks, transportation, social activities, or services or tasks not directly related to the needs of the recipient such as doing laundry for family members, cleaning of areas not occupied by the recipient, shopping for items not used by the recipient, or for tasks when they are completed for the benefit of both the recipient and the provider.

~~8.~~9. Payment for the tasks of laundry, shopping, meal preparation, money management, and communication may be made to a provider if the activity benefits the recipient. The department may pay a provider for housekeeping activities involving the recipient's personal private space and if the recipient is living with an adult, the recipient's share of common living space.

~~9.~~10. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housekeeping tasks when provided as personal care services must be incidental to the provision of other personal care tasks and cannot exceed thirty percent of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.

~~10.~~11. No payment may be made for personal care services provided to a recipient by the recipient's spouse, parent of a minor child, or legal guardian.

~~11.~~12. No payment may be made for care needs of a recipient which are outside the scope of personal care services.

~~12.~~13. Authorized personal care services may only be approved for:

a. Up to one hundred twenty hours per month;

b. Up to two hundred forty hours per month, if the recipient meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; or

c. Up to three hundred hours per month if the recipient is determined to be impaired in at least five of the activities of daily living of bathing, dressing, eating, incontinence, mobility, toileting, and transferring; meets the medical necessity criteria for nursing facility level of care described in section 75-02-02-09 or intermediate care facility for individuals with intellectual disabilities level of care; and none of the three hundred hours approved for personal care services are allocated to the tasks of laundry, shopping, or housekeeping.

~~13.~~14. Personal care services may be provided to a recipient who has natural supports. For purposes of this subsection, "natural supports" means an informal, unpaid caregiver that provides care to an applicant or recipient.

~~14.~~15. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages

of development.

~~15.~~16. The authorization for personal care services may be terminated if the services are not used within sixty days, or if services lapse for at least sixty days, after the issuance of the authorization to provide personal care services.

~~16.~~17. The department may deny or terminate personal care services when service to the recipient presents an immediate threat to the health or safety of the recipient, the provider of services, or others, or when services that are available are not adequate to prevent a threat to the health or safety of the recipient, the provider of services, or others.

~~17.~~18. Decisions regarding personal care services for an incapacitated recipient are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

~~18.~~19. The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

20. The applicant or recipient or the guardian or legal representative of the applicant or recipient shall comply with requests for a specific medical record; an evaluation, such as from physical therapy, occupational therapy, or speech therapy; or a neuropsychological evaluation.

~~19.~~21. Payment for personal care services may not be made unless the recipient has been determined eligible to receive Medicaid benefits.

~~20.~~22. A daily rate for personal care may be authorized, at the discretion of the department, when determined necessary to maintain a recipient in the least restrictive setting.

23. Personal care services may be denied if an applicant or a recipient does not agree to the service plan developed for the provision of home and community-based services.

24. An applicant or a recipient shall cooperate with quality assurance reviews, which may include unannounced in-home or onsite quality assurance visits.

25. An applicant must be capable of directing self-care or must have a guardian or legal representative to act on the applicant's behalf.

26. An applicant is not eligible for personal care services if the care provided is

court-ordered.

27. Payment for personal care services may not be made unless the recipient's functional impairment has lasted, or can be expected to last, three months or longer.

28. The recipient or legal representative may submit a grievance to the department concerning the recipient's service plan.

History: Effective July 1, 2006; amended effective January 1, 2010; July 1, 2012; October 1, 2012; April 1, 2016; April 1, 2018; January 1, 2022; January 1, 2024; January 1, 2027.
General Authority: NDCC 50-24.1-18
Law Implemented: NDCC 50-24.1-18; 42 CFR Part 440.167

CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

75-02-02.1-30 Contractual Rights to Receive Money Payments
75-02-02.1-30.1 Annuities [Repealed]
75-02-02.1-31 Trusts
75-02-02.1-31.1 Trusts Established by Applicants, Recipients, or Their Spouses After August 10, 1993
75-02-02.1-32 Valuation of Assets
75-02-02.1-33 Disqualifying Transfers Made on or Before August 10, 1993 [Repealed]
75-02-02.1-33.1 Disqualifying Transfers Made Before February 8, 2006 [Repealed]
75-02-02.1-33.2 Disqualifying Transfers Made on or After February 8, 2006
75-02-02.1-34 Income Considerations
75-02-02.1-34.1 MAGI-Based Methodology
75-02-02.1-34.2 Income Conversion for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-34.3 Reasonable Compatibility of Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-35 Budgeting [Repealed]
75-02-02.1-36 Disregarded Income [Repealed]
75-02-02.1-37 Unearned Income
75-02-02.1-37.1 Unearned Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-38 Earned Income
75-02-02.1-38.1 Post-Eligibility Treatment of Income
75-02-02.1-38.2 Disregarded Income
75-02-02.1-38.3 Disregarded Income for Certain Individuals Subject to a MAGI-Based Methodology
75-02-02.1-38.4 Earned Income for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-39 Income Deductions
75-02-02.1-39.1 Income Deductions for Individuals Subject to a MAGI-Based Methodology
75-02-02.1-40 Income Levels
75-02-02.1-41 Deeming of Income
75-02-02.1-41.1 Recipient Liability
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75-02-02.1-42 Eligibility Under 1972 State Plan
75-02-02.1-43 Payment for Services by Attorney-in-Fact
75-02-02.1-44 Children's Health Insurance Program

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

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

1. **Application.**

a. All individuals wishing to make application for Medicaid must have

the opportunity to do so, without delay.

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

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

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

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

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

2. **Redetermination.** A redetermination must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category, and in any event, no less than six months for Medicaid expansion recipients and annually for all other coverage groups, except for native Americans and pregnant women, who are exempt from this requirement. A recipient has the same responsibility to furnish information during a redetermination as an applicant has during an application.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; May 1, 2006; January 1, 2022; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 3. Section 75-02-02.1-05 is amended as follows:

75-02-02.1-05. Coverage groups.

Within the limits of legislative appropriation, the department may provide benefits to coverage groups described in the approved Medicaid state plan in effect at the time those benefits are sought. These coverage groups do not define eligibility for benefits.

Any individual who is within a coverage group must also demonstrate that all other eligibility criteria are met.

1. The categorically needy coverage group includes:

    a. Children for whom adoption assistance maintenance payments are made under title IV-E;

    b. Children for whom foster care maintenance payments are made under title IV-E;

    c. Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state;

    d. Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state;

    e. Caretakers of deprived children who meet the parent and caretaker relative eligibility criteria;

    f. Families who were eligible under the family coverage group in at least three of the six months immediately preceding the month in which the family became ineligible because of the caretaker relative's earned income or because a member of the unit has a reduction in the time-limited earned income disregard;

    g. Families who were eligible under the family coverage group in at least three of the six months immediately preceding the month in which they became ineligible as a result, wholly or partly, of the collection or increased collection of child or spousal support continue eligible for Medicaid for four calendar months;

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

    i. Eligible pregnant women who applied for and were eligible for Medicaid as categorically needy during pregnancy continue to be eligible for twelve months beginning on the last day of the pregnancy, and through the end of the month in which the twelve-month period ends;

    j. Children born to the categorically needy eligible pregnant women who applied for and were found eligible for Medicaid on or before the day of the child's birth, for twelve months beginning on the day of the child's birth and through the end of the month in which the twelve-

month period ends;

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

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

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

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

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

(4) Who meet the community engagement requirement as set forth by 42 U.S.C. 1396a(xx).

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

n. Aged, blind, or disabled individuals who are receiving supplemental security income payments or who appear on the state data exchange as zero payment as a result of supplemental security income's recovery of an overpayment or who are suspended because the individuals do not have a protective payee, provided that the more restrictive Medicaid criteria is met; and

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

2. The optional categorically needy coverage group includes:

a. Individuals under age twenty-one who are residing in adoptive homes and who have been determined under the state-subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the department;

b. Uninsured individuals under age sixty-five, who are not otherwise eligible for Medicaid, who have been screened for breast or cervical cancer under the centers for disease control and prevention breast and cervical cancer early detection program, and who need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix;

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

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

3. The medically needy coverage group includes:

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

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

c. Eligible pregnant women who applied for Medicaid during pregnancy, and for whom recipient liability for the month was met no later than on the date each pregnancy ends, continue to be eligible for twelve months beginning on the last day of pregnancy and through the end of the month in which the twelve-month period ends;

d. Children born to eligible pregnant women who have applied for and been found eligible for Medicaid on or before the day of the child's birth, for twelve months beginning on the day of the child's birth, and through the end of the month in which the twelve-month period ends;

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

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

4. The poverty level coverage group includes:

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

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

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

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

e. Individuals eligible for the Medicare part B immunosuppressive drug benefit are entitled to coverage for the Medicare part B immunosuppressive drug benefit only, and who are not eligible for Medicaid under any other provision.

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

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; January 1, 1994; January 1, 1997; July 1, 2003; June 1, 2004; April 1, 2008; January 1, 2010; April 1, 2012; January 1, 2014; April 1, 2018; January 1, 2020; January 1, 2023; January 1, 2024; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-31, 50-24.1-37; 42 USC 1396a(e)

SECTION 4. Section 75-02-02.1-10 is amended as follows:

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

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

2. Retroactive eligibility may be established for as many as ~~three~~two calendar months prior to the month in which the application was received depending on the type of coverage for which the applicant or recipient is eligible. Eligibility can be established in each of those months for which benefits are sought and if all factors of eligibility are met during each such month. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application. This subsection does not apply to qualified Medicare beneficiaries.

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

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

   b. An individual entering the state is eligible for Medicaid as of the date the individual entered the state; or

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

4. Eligibility for qualified Medicare beneficiaries begins in the month following the month in which the individual is determined eligible.

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

6. A child cannot be eligible for Medicaid for the same period of time the child is covered under the children's health insurance program.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; January 1, 2020; January 1, 2022; January 1, 2024; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 5. Section 75-02-02.1-13 is amended as follows:

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

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

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

2. Coverage of emergency services provided to ~~illegal aliens~~non-citizens; and

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

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 2003; July 1, 2016; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

SECTION 6. Section 75-02-02.1-18 is amended as follows:

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

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

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

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

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

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

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

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

   d. ~~Crewmen on shore leave;~~

   e. ~~Treaty traders and investors and their families;~~

   f. ~~Foreign students;~~

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

   h. ~~Temporary workers, including agricultural contract workers; and~~

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

5. ~~Except for aliens identified in subsection 4, aliens~~Non-Citizens who are not lawfully admitted for permanent residence in the United States are not eligible for Medicaid, except they may be eligible for emergency services.

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

~~7.~~4. ~~Aliens~~Non-citizens who lawfully entered the United States for permanent residence before August 22, 1996, and who meet all other Medicaid criteria may be eligible for Medicaid.

~~8.~~5. ~~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:~~As a condition of eligibility, applicants or recipients must be:

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

b. ~~Refugees and asylees;~~Lawful permanent residents;

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

~~d.~~ Cuban and Haitian entrants; or

~~e. Aliens admitted as Amerasian immigrants;~~

~~f. Victims of a severe form of trafficking;~~

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

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

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

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

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

~~l. All other aliens, other than for emergency services, only after five~~

~~years from the date they entered the United States, and then only if the individual is a lawful permanent resident who has been credited with forty qualifying quarters of social security coverage~~

d. Migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of the Palau and are subject to Compacts of Free Association.

6. The following lawful permanent residents do not have to meet the five-year waiting period and forty quarters work history if they meet the applicable United States citizenship and immigration services code of admission:

a. Active-duty members of the armed services of the United States;

b. Veterans honorably discharged from the armed services of the United States;

c. Amerasian immigrants;

d. American Indians born in Canada with at least fifty percent American Indian blood;

e. Asylees;

f. Cuban and Haitian entrants;

g. Current spouses of veterans;

h. Current spouses of active-duty members of the armed services of the United States;

i. Refugees;

j. Unmarried children of veterans;

k. Unmarried children of active-duty members of the armed services of the United States; or

l. Widows of veterans who are not married.

~~9.~~7. ~~An alien~~A non-citizen who is not eligible for Medicaid because of the time limitations or lack of forty qualifying quarters of social security coverage may be eligible to receive emergency services that are not related to an organ transplant procedure if the conditions of subdivisions a through c are met. Eligibility for emergency services under this subsection ends when the emergency services have been provided and does not include coverage of

follow-up care if the follow-up care is not an emergency service. Eligibility for emergency services under this subsection requires that:

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

(1) Placing health in serious jeopardy;

(2) Serious impairment to bodily functions; or

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

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

c. The ~~alien's~~non-citizen's need for the emergency service continues.

~~10.~~8. Pregnant women who are lawfully present in the United States and are otherwise eligible for Medicaid are not subject to the five-year, forty-quarter ban through the twelve months postpartum coverage.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; January 1, 2010; January 1, 2011; January 1, 2014; January 1, 2022; January 1, 2024; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01, 50-24.1-37

SECTION 7. Section 75-02-02.1-22 is amended as follows:

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

1. Qualified Medicare beneficiaries are entitled only to Medicare cost-sharing benefits described in subsection ~~19~~27 of section 75-02-02.1-01, beginning in the month following the month in which the individual is determined eligible.

2. Special low-income Medicare beneficiaries are entitled only to Medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection ~~19~~27 of section 75-02-02.1-01. Eligibility may be established for as many as ~~three~~two calendar months prior to the month in which the application was received.

3. Qualifying individuals are entitled only to Medicare cost-sharing benefits described in paragraph 2 of subdivision a of subsection ~~19~~27 of section 75-

02-02.1-01. Eligibility may be established for as many as ~~three~~two calendar months prior to the month in which the application was received unless the individual was in receipt of any other Medicaid benefits for the same period. Eligibility shall be established on a first-come, first-served basis to the extent of funding allocated for coverage of this group under section 1933 of the Act [42 U.S.C. 1396u-3].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; May 1, 2006; January 1, 2010; January 1, 2022; January 1, 2024; January 1, 2027.

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

SECTION 8. Section 75-02-02.1-24.4 is amended as follows:

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

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

   a. Is a Medicaid provider;

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

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

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

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

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

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

   d. Pregnant women; and

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

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

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

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

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

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

   b. North Dakota residency;

   c. Gross income amount;

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

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

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

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

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

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

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

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

11. An individual may not appeal presumptive eligibility determinations.

12. Qualified hospitals shall:

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

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

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

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

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

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

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

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

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

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

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

13. Qualified hospitals shall meet the following performance standards:

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

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

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

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

History: Effective July 1, 2016; amended effective January 1, 2023; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-37; 42 U.S.C. 1396a(e)

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

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

3. One motor vehicle.

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

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

6. a. In determining the eligibility of an individual with respect to skilled nursing services, swing-bed, or home and community-based benefits, the individual will be ineligible for those Medicaid benefits if the individual's equity interest in the individual's home exceeds five hundred thousand dollars.

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

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

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

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

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

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

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

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

(4) Is sold to an individual who:

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

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

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

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

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

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

8. Property that is essential to earning a livelihood.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The burial fund must be identifiable and irrevocable.

(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 lesser of the face value or the premiums that have been paid.

(4) Any fund, insurance, or other property given to another person or entity in contemplation that its value will be used to meet the burial needs of the applicant or recipient must be irrevocable.

(5) ~~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~~A burial fund which is established at the time of application can apply retroactively to the two-month prior period and period in which the application is pending, if the value of all assets are within the Medicaid limits for each of the prior months. Future earnings on the newly established burial fund must be excluded.

(6) The department must be named as secondary beneficiary after the funeral home on life insurance that is used to fund an

irrevocable burial contract.

b. A burial plot for each family member.

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

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

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

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

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

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

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

18. For nine months beginning after the month of receipt, any educational

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

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

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

21. The value of a life estate.

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

23. The value of mineral acres.

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

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

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

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

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

    d. Property with unique Indian significance such as ownership interests in or usage rights to items not covered by subdivisions a through c

that have unique religious, spiritual, traditional, or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

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

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

28. An annuity or individual retirement account may be excluded in the month of application and requested prior months as long as the department is made aware that the necessary updates are being done to meet Medicaid's requirements. The updates need to be started within the processing timeframe of an application.

History: Effective December 1, 1991; amended effective December 1, 1991; July 1, 1993; July 1, 2003; June 1, 2004; August 1, 2005; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014; April 1, 2018; January 1, 2020; January 1, 2027.
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 14 of section 75-02-02.1-28.1 is amended as follows:

14. Payments to ~~certain United States citizens of Japanese ancestry, resident Japanese aliens,~~eligible individuals and eligible Aleuts made under the ~~Wartime Relocation of Civilians Reparations Act~~Civil Liberties Act of 1988 [50 U.S.C. ~~App. 1989~~4201 et seq.] are excluded.

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; April 1, 2012; April 1, 2018; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

SECTION 11. Section 75-02-02.1-33.2 is amended as follows:

75-02-02.1-33.2. Disqualifying transfers made on or after February 8, 2006.

1. This section applies to transfers of income or assets made on or after February 8, 2006.

2. Except as provided in subsections 7 and 16, an individual is ineligible for skilled nursing care, swing-bed, or home and community-based benefits if the individual or the individual's spouse disposes of assets or income for less than fair market value on or after the look-back date. The look-back date is a date that is sixty months before the first date on which the individual is both receiving skilled nursing care, swing-bed, or home and community-

based services and has applied for benefits under this chapter, without regard to the action taken on the application.

3. An applicant, recipient, or anyone acting on behalf of an applicant or recipient, has a duty to disclose any transfer of any asset or income made by or on behalf of the applicant or recipient, or the spouse of the applicant or recipient, for less than full fair market value:

   a. When making an application;

   b. When completing a redetermination; and

   c. If made after eligibility has been established, by the end of the month in which the transfer was made.

4. The date that a period of ineligibility begins is the latest of:

   a. The first day of the month in which the income or assets were transferred for less than fair market value;

   b. The first day on which the individual is receiving nursing care services and would otherwise have been receiving benefits for institutional care but for the penalty;

   c. The first day thereafter which is not in a period of ineligibility; or

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

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

   b. A fractional period of ineligibility may not be rounded down or otherwise disregarded with respect to any disposal of assets or income for less than fair market value.

   c. Notwithstanding any contrary provisions of this section, in the case of an individual or an individual's spouse who makes multiple fractional transfers of assets or income in more than one month for less than fair market value on or after the look-back date established under subsection 2, the period of ineligibility applicable to such individual must be determined by treating the total, cumulative uncompensated value of all assets or income transferred during all

months on or after the look-back date as one transfer and one penalty period must be imposed beginning on the earliest date applicable to any of the transfers.

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

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

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

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

(1) The individual's spouse;

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

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

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

b. The income or assets:

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

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

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

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

c. The individual makes a satisfactory showing that:

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

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

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

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

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

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

(3) Excluded home replacement funds;

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

(5) Life estate interests;

(6) Mineral interests;

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

(8) An annuity; or

(9) A motor vehicle.

8. a. An individual shall not be ineligible for Medicaid by reason of

subsection 2 to the extent the individual makes a satisfactory showing that an undue hardship exists for the individual. Upon imposition of a period of ineligibility because of a transfer of assets or income for less than fair market value, the department shall notify the applicant or recipient of the right to request an undue hardship exception. An individual may apply for an exception to the transfer of asset penalty if the individual claims that the ineligibility period will cause an undue hardship to the individual. A request for a determination of undue hardship must be made within ninety days after the circumstances upon which the claim of undue hardship is made were known or should have been known to the affected individual or the person acting on behalf of that individual if incompetent. The individual ~~must~~shall 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~~meets the conditions ~~are met:~~of subdivision b of subsection 8; and

b. There is proof that:

(1) ~~Application of the period of ineligibility would deprive~~If the undue hardship waiver is not approved, the individual ~~of~~will be without food, clothing, shelter, or other necessities of ~~life or would deprive the individual of~~, and may not receive 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 reasonable means to recover the assets or income or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer; and~~The transfer was a result of financial exploitation such as fraud, misrepresentation, or coercion against the individual or their spouse.

(3) If the individual lives in a facility and will be involuntarily discharged, the individual shall provide proof of:

(a) The date of discharge;

(b) The reason for the discharge; and

(c) Where they will be discharged to.

(4) All lawful means to get back the transferred assets or income, or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer have been tried, including:

(a) Contacting the individual who took or received the assets or income and asking that they be returned;

(b) Filing criminal charges with law enforcement to pursue criminal investigation or prosecution if the transferred assets or income were stolen or improperly acquired in violation of the law; and

(c) Filing a civil court action and diligently pursuing the civil action to its conclusion, including enforcement of any judgment.

~~(3)~~c. The individual's remaining available assets and the remaining assets of the individual's spouse are less than the asset limit in subsection 1 of section 75-02-02.1-26, or if applicable, the minimum allowed under section 75-02-02.1-24, counting the value of all assets except:

~~(a)~~(1) A home, exempt under section 75-02-02.1-28, but not if the individual or the individual's spouse has equity in the home in excess of twenty-five percent of the amount established in the approved state plan for medical assistance which is allowed as the maximum home equity interest for nursing facility services or other long-term care services;

~~(b)~~(2) Household and personal effects;

~~(c)~~(3) 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)~~(4) Funds for burial up to the amount excluded in subsection 10 of section 75-02-02.1-28 for the individual and the individual's spouse.

~~b.~~d. 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.~~e. 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.

f. The agency may not make a determination of undue hardship exception if the eligibility determination is actively being appealed.

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~~must be apportioned equally between the spouses. If one such spouse dies or stops receiving nursing care services, any months remaining in that spouse's apportioned period of ineligibility must be assigned or reassigned to the spouse who continues to receive nursing care services.

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

    a. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or assistance or in absence of a valid written contract, evidence is provided the services were required and provided;

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

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

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

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

restoration of ownership.

15. For purposes of this section:

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

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

c. "Fair market value" means:

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

(2) In the case of real or personal property that is subject to reasonable dispute concerning its value, seventy-five percent of the estimated fair market value; and

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

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

e. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1965, as amended [42

U.S.C. 1395 et seq; Pub. L. 92-603; 86 Stat. 1370].

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

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

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

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

(4) Includes:

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

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

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

(d) Skilled nursing coinsurance;

(e) Medicare part A deductible coverage;

(f) Medicare part B deductible coverage;

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

(h) Foreign travel emergency coverage.

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

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

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 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.

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

the individual has in force home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage, purchased on or after August 1, 2003, and before January 1, 2007, with a daily benefit at least equal to 1.57 times the average daily cost of nursing care for the year in which the policy is issued or an aggregate benefit at least equal to 1,095 times that daily benefit, and:

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

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

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

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

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

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

d. The annuity provides substantially equal payments of principal and interest, no less frequently than annually, that vary by five percent or

less from the total annual payment of the previous year, and does not have a balloon or deferred payment of principal or interest; and

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

f. An annuity or individual retirement account satisfies Medicaid's requirements in the month of application and requested prior months if the department is made aware that the necessary updates are being made to meet the requirements. The updates need to be started within the process timeframe.

History: Effective April 1, 2008; amended effective January 1, 2010; January 1, 2011; April 1, 2012; April 1, 2014; April 1, 2018; January 1, 2024; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

SECTION 12. Subdivision c of subsection 1 of section 75-02-02.1-38.1 is amended as follows:

c. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens,eligible individuals and eligible Aleuts made under the Wartime Relocation of Civilians Reparations ActCivil Liberties Act of 1988 [50 U.S.C. App. 19894201 et seq.];

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

SECTION 13. Subsection 21 of section 75-02-02.1-38.2 is amended as follows:

21. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens,eligible individuals and eligible Aleuts made under the Wartime Relocation of Civilians Reparations ActCivil Liberties Act of 1988 [Pub. L. 100-383; 50 U.S.C. App. 19894201 et seq.];

History: Effective July 1, 2003; amended effective June 1, 2004; May 1, 2006; April 1, 2008; January 1, 2010; January 1, 2011; April 1, 2012; July 1, 2012; January 1, 2014; January 1, 2026; January 1, 2027.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-37; 42 USC 1396a(e)