CHAPTER 23 - MEDICAL ASSISTANCE ADMINISTRATION

SUBCHAPTER 23A - GENERAL PROGRAM ADMINISTRATION

SECTION .0100 - GENERAL

10A NCAC 23A .0101 SUPERVISION

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990; January 1, 1986;
Transferred from 10A NCAC 21A .0101 Eff. May 1, 2012;
Expired Eff. August 1, 2016 pursuant to G.S. 150B-21.3A.

10A NCAC 23A .0102 DEFINITIONS

For purposes of this Chapter, the following definitions apply:

(1) "M-AA" means a program of medical assistance to persons 65 years of age and older, and also means the assistance itself.
(2) "M-AB" means a program of medical assistance to blind persons, and also means the assistance itself.
(3) "M-AD" means a program of medical assistance to disabled persons less than 65 years of age, and also means the assistance itself.
(4) "M-AF" means a program of medical assistance for families and children, and also means the assistance itself.
(5) "M-IC" means a program of medical assistance for infants and children, and also means the assistance itself.
(6) "M-PW" means a program of medical assistance for pregnant women, and also means the assistance itself.
(7) "M-QB" means a program of medical assistance for qualified Medicare beneficiaries described at 42 U.S.C. 1396d(p), and also means the assistance itself.
(8) "AFDC" means a program of assistance for families with dependent children, and also means the assistance itself.
(9) "AFDC-MA" has the same meaning as "M-AF".
(10) "Adequate Notice" means a written notice to inform the client of intended action. The client must receive this notice no later than the effective date of the action.
(11) "Advance Notice" means a written notice to inform the client at least 10 work days prior to terminating assistance, beginning or increasing a deductible, or beginning or increasing patient monthly liability.
(12) "Agency" means the Division of Health Benefits and the county departments of social services, unless separately identified.
(13) "Appeal" means an oral or written request from a client for a hearing to review the action of a county department of social services or the disability decision when the client is dissatisfied with the decision in his case.
(14) "Application" means a written request for assistance on a form prescribed by the state that is signed under penalty of perjury by a client or an individual authorized by the client to be his representative for establishing his eligibility for medical assistance.
(15) "Authorization Period" means the period for which all conditions of eligibility have been established and for which the client is authorized to receive a Medicaid card and benefits.
(16) "Award Letter" means a statement to an individual from a governmental or private agency indicating benefits for which he is eligible.
(17) "BENDEX" means Beneficiary Data Exchange with the Social Security Administration for social security status and amount of benefits.
(18) "Budget Unit" means all persons whose income and needs are considered in the determination of eligibility for Medicaid.
(19) "Certification Period" means the months for which eligibility is being established.

(20) "Client" means any applicant for or recipient of Medicaid, or someone who makes inquiries, is interviewed, or has been otherwise served or someone acting for the client.
(21) "Client Information" or "Client Record" means any information, including information stored in computer data banks or computer files relating to a client that was received in connection with the performance of any function of the agency.
(22) "Collateral" means a person or agency who can substantiate or verify information necessary to establish eligibility.
(23) "Contiguous Property" means real property with boundaries joining the homesite of the client.
(24) "Court Order" means any written order from a judge or a written document from a judicial official that explicitly directs the release of client information.
(25) "Deductible" means the amount that the client or budget unit member must personally spend or incur for medical expenses before he can be authorized to receive a Medicaid card and services that may be billed to the Medicaid program.
(26) "Delegated Representative" means a staff member designated by the director to carry out the responsibilities established by the rules in this Subchapter. Designation is implied when the assigned duties of an employee require access to confidential information.
(27) "Deprivation" means the lack of support or care from one or both parents (including adoptive parents) of a dependent child, as a result of the absence, incapacity, unemployment, or death of either parent.
(28) "Director" means the head of the Division of Health Benefits or the county department of social services.
(29) "Disregard of Earned Income" means the procedure for exempting portions of earned income as a resource when determining the amount of payment.
(30) "Documentary Evidence" means information or records that can be relied on to prove the client's statements of fact.
(31) "Effective Date" means the date on which an action will take effect.
(32) "Equity" means the tax value of a resource less the amount of debts, liens, or other encumbrances.
(33) "Excluded Income" means money received by a member of the budget unit that is not counted in determining eligibility for assistance.
(34) "Foster Care Resource" means any private home or facility licensed to provide full time care to children.
(35) "Fraud" means an act in which a client makes false statements or withholds information willfully and knowingly with the intent to deceive, or both, and as a result obtains assistance for which he is not eligible.
(36) "Full-Time Student" means a student so designated by the school in which he is enrolled.
(37) "Good Cause" includes death, incapacity, hospitalization of the applicant/recipient (a/r), failure to receive written notice, or failure of a representative acting on the a/r's behalf to meet required time frames.
(38) "Grandfathered Status" means Medicaid eligibility based on the individual's status as a blind or disabled client or as an essential spouse of aged, blind, or disabled client in December, 1973.
(39) "Greater Weight of Evidence" means evidence of such quality as to persuade an ordinary and prudent person of the truth or falsity of a statement.
(40) "Guardian" means an individual, corporation, or disinterested public agent appointed by the clerk of superior court to replace an individual's authority to make decisions about his person, family, or property when the individual does not have adequate capacity to make such decisions and has been adjudicated incompetent. A guardian may be a guardian of the person, a guardian of the estate, or a general guardian which is guardian of both the person and the estate.
(41) "HCT (Healthy Children and Teens)" means a program which provides health screenings and treatment for clients from birth through age 20.
(42) "Incapacity" has the same meaning as in the North Carolina State plan approved under Part A of Title IV of the Social Security Act as in effect on July 16, 1996, as is required by 42 U.S.C. 1396u-1.
(43) "Income" means money that is available to members of the budget unit for their needs.
(44) "Income, Earned" means money received as a result of employment.
(45) "Income, Gross" means total income before allowable deductions.
(46) "Income, Net" means income after all allowable deductions.

(47) "Income, Unearned" means money received from any source other than employment.

(48) "Incompetent Adult" means an adult who lacks sufficient capacity to manage his own affairs or to make or communicate decisions concerning his person, family, or property whether such lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, senility, disease, injury, or similar cause or condition.

(49) "Inmate of a Public Institution" means a person who lives in an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control and that provides treatment or services, food and shelter.

(50) "Institutionalized Spouse" means an individual who:

(a) is in a medical institution or nursing facility or who is described under 42 U.S.C. 1396a (a)(10)(A)(ii)(VI); and

(b) is married to an individual who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of Sub-item (a) of this Item for at least 30 consecutive days.

(51) "Life Estate Interest" means the right to use property and receive income from the property for the remainder of one's life.

(52) "Long-Term Care" means care in:

(a) general or specialty hospital in excess of 30 continuous days;

(b) a state mental hospital;

(c) a skilled nursing facility; or

(d)an intermediate care facility.

(53) "Patient Monthly Liability" means the amount of a long-term care patient's income that must be paid towards his cost of care.

(54) "Remainder Interest" means ownership interest in property that will be inherited in full or jointly with other remainder interest holders at a life interest holder's death.

(55) "Representative" means a person who is authorized by the client to act on behalf of the client.

(56) "Reserve" means assets owned by members of the budget unit and that have a market value.

(57) "Residence" means the county where a client lives with intent to remain for an indefinite time as governed by 10A NCAC 23E .0103. Also, an individual under age 21 has the residence of the person with whom he resides unless he is in the custody of a social services agency, in which case he is a resident of the county of the custodial agency.

(58) "Revocable Trust" means funds held in trust that are available for the client's use.

(59) "RSDI (Retirement, Survivors, Disability Insurance)" means social security benefits.

(60) "SDX" means State Data Exchange with the Social Security Administration for the purpose of providing a listing of all persons receiving supplemental security income, their current payment status and amount of SSI and other sources of income.

(61) "SSI" means Supplemental Security Income, a federal assistance payment for aged, blind and disabled persons administered by the Social Security Administration.

(62) "Stepparent" means that a person is not the parent of a child but the person is married to the parent of the child who wants to receive Medicaid.

(63) "Timely Notice" means the same as "Advance Notice".

(64) "Time Standard" means the requirement to process an application within 45 or 90 days from the date of application in accordance with 42 C.F.R. 435.911.

(65) "Verification" means the confirmation of facts and information used in determining eligibility.

History Note: *Authority G.S. 108A-25(b); 108A-54; P.L. 99-509; P.L. 100-360; P.L. 100-485; 42 C.F.R. 431.211; 42 C.F.R. 431.214; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0201 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. May 1, 2022; March 1, 2020.

10A NCAC 23A .0103 QUALITY ASSURANCE

(a) County department of social services eligibility actions on active and negative cases, as defined by 42 C.F.R. 431.804, which is incorporated by reference including subsequent amendments and editions, and available free of charge at https://www.ecfr.gov/, shall be subject to review under State and federal quality control (QC) procedures by the Division's Office of Compliance and Program Integrity (OCPI). A statistical sample shall be selected from both active and negative case actions.

(b) The purpose of the QC review is to identify client eligibility errors and erroneous payments resulting from:

(1) Ineligibility;
(2) Recipient liability understated or overstated by the client or county;
(3) Third-party liability; and
(4) Claims processing errors.

(c) A report of an error discovered in a QC case shall be sent to the county agency for corrective action.

(d) If the county agency has verification, as defined by Rule .0102 of this Subchapter, that disputes a QC finding of error, it may submit the verification to OCPI for review. OCPI shall determine whether the error shall be coded client-responsible, county-responsible, or State-responsible. Upon its review, OCPI shall notify the county agency of its decision regarding responsibility for the error.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 431, Subpart P;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0501 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23A .0104 AVAILABILITY OF MANUALS

(a) One copy of the Medicaid Eligibility Manual and other policy issuances affecting the public is maintained in each county department of social services and each DSS Regional Office for examination by the public on regular work days during regular work hours.

(b) The state provides copies of its current eligibility policy free of charge to agencies and organizations described in 42 CFR 431.18.

(c) The state will charge agencies and groups other than those covered by Paragraph (b) of this Rule an amount related to the cost of reproduction.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 431.18;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0701 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

SUBCHAPTER 23B - BENEFITS

SECTION .0100 - GENERAL

10A NCAC 23B .0101 MEDICAID IDENTIFICATION CARD

The card shall be proof to medical providers of the client's Medicaid eligibility for a specified time.

History Note: *Authority G.S. 108A-54;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21C .0101 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23B .0102 ISSUANCE

(a) Cards shall be issued by the State at any time of the month for:

(1) Approved applications;
(2) Cases authorized after meeting a deductible;
(3) Change in primary care provider; or
(4) Change in LME/MCO catchment area.

(b) Cards shall be requested by the county agency for issuance by the State for:
(1) A legal name change;
(2) Replacement of lost, stolen, burned, destroyed, or incorrect cards;
(3) Non-receipt of a State-issued card; or
(4) Requests by a second county during a county transfer.

(c) Cards shall be issued by the State 12 months from the last issuance date if the client remains eligible.

History Note: *Authority G.S. 108A-54; S.L. 2020-78, s. 4D.2;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21C .0102 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. October 1, 2021.

SUBCHAPTER 23C – APPLICATION FOR MEDICAID BENEFITS

SECTION .0100 - APPLICATION PROCESS

10A NCAC 23C .0101 ACCEPTANCE OF APPLICATION

(a) A client shall be allowed to apply without delay. Without delay is the same day the client appears at the county department of social services expressing a financial or medical need.

(b) The county department of social services shall not act to discourage any individual from applying for Medicaid. It shall be considered discouragement if any employee of the county department of social services:
(1) requires or suggests the individual wait to apply until he applies for other benefits or until an application for other benefits has been approved or denied; or
(2) incorrectly states or suggests the individual is ineligible for Medicaid; or
(3) gives incorrect or incomplete information about Medicaid programs; or
(4) requires the individual provide or obtain any information needed to establish eligibility prior to signing an application; or
(5) discourages a client from applying and this is proven by facts to the satisfaction of the county agency or a hearing officer; or
(6) suggests that the individual make an appointment to apply when he appears at the agency; or
(7) suggests that the individual complete a mail-in application when he appears at the agency; or
(8) fails to explain the date of application when he appears at the agency and requests a mail-in application; or
(9) fails to explain and offer Medicaid to individuals requesting Work First Employment Services.

(c) The client shall be informed verbally and in writing, that:
(1) he can apply without delay;
(2) a decision shall be made concerning his eligibility within 45 calendar days from the date of application for Medicaid, except for M-AD. For M-AD the application processing standard shall be 90 calendar days from the date of application; and
(3) he shall receive a written decision concerning his eligibility.

(d) The client shall apply in his county of residence.

(e) The date of the application shall be:
(1) The date the client or his representative signs the state application form for Medicaid, including Work First, under penalty of perjury at the county department of social services; or
(2) The date a signed complete state mail-in application form is received by the county department of social services in the county of residence. Complete is defined as information that is legible,

signed, submitted to correct county of residence, and has identifying information for the person applying, including name, mailing address, date of birth and gender.

(f) If an individual requests assistance by mail, the letter shall be considered a request for information. Within three workdays following receipt of the request, the county agency shall mail follow-up information to the individual. The county agency shall advise the individual to come to the agency to apply and be interviewed, or if he is unable to come in person, to contact the agency so other arrangements can be made to take his application.

(g) If an individual requests assistance by telephone, he shall be advised to come to the county agency to sign an application and be interviewed; or, if he is unable to come to the agency in person other arrangements shall be made to take his application.

(h) If an individual sends in a complete state mail-in application form, the county department of social services shall use this application to determine eligibility for Medicaid. A mail-in application form may be picked up at a local county department of social services or other locations as determined by the State and county.

(i) An individual or his representative must request a determination for retroactive SSI Medicaid no later than 60 days from the date of the SSI Medicaid disposition notice or 90 days if good cause is established. Good cause exists when:

(1) the applicant does not receive the SSI Medicaid notice;
(2) the applicant or his representative dies;
(3) the applicant is incapacitated, incompetent, or unconscious and there is no representative acting on his behalf;
(4) the applicant or spouse, child, parent, or representative of applicant is hospitalized for an extended period of time; or
(5) the applicant's representative fails to meet the required time frame.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.906; 42 C.F.R. 435.907; 42 C.F.R. 435.911; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; April 1, 1993; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0201 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0102 FACE-TO-FACE INTERVIEW

(a) The county department of social services shall conduct a face-to-face interview with the client or his representative who appears at the agency requesting financial or medical assistance. The client may have any person or persons of his choice participate in the interview. During the interview, the Income Maintenance Caseworker shall explain the application process, the client's rights and responsibilities, the programs of public assistance and the eligibility conditions.

(b) The applicant shall be advised of his right to apply in more than one program category for which he qualifies and the advantages and disadvantages of the choices shall be explained.

(c) The client shall be informed of the following:

(1) The client shall be told what information that he is required to provide, and what third party sources the agency shall contact to check the information. Third party sources are entities, other than the client, that can provide verification of information to determine eligibility.
(2) The client has the right to:
  (A) Receive assistance if found eligible;
  (B) Be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964. He may appeal such discrimination;
  (C) Have any information given to the agency kept in confidence;
  (D) Appeal, if he believes the agency's action to deny, change, or terminate assistance is incorrect, or his request is not acted on with reasonable promptness;
  (E) Reapply at any time, if found ineligible;
  (F) Withdraw from the program at any time;

(G) Request the agency's help in obtaining third party information that he is responsible to provide;

(H) Be informed of all information he must provide and all alternative sources for obtaining the information.

(3) The client shall:

(A) Provide the county department, state and federal officials, the necessary sources from which to locate and obtain information needed to determine eligibility;

(B) Report to the county department of social services any change in situation that may affect eligibility within 10 calendar days after it happens. The Income Maintenance Caseworker shall explain the meaning of fraud and shall inform the applicant that he may be suspected of fraud if he fails to report a change in situation and that in such situations, he may have to repay assistance received in error and that he may also be tried by the courts for fraud;

(C) Inform the county department of social services of any persons or organization against whom he has a right to recover medical expenses. When he accepts medical assistance, the applicant shall assign his rights to third party insurance benefits to the state. The Income Maintenance Caseworker shall inform the applicant that it is a misdemeanor to fail to disclose the identity of any person or organization against whom he has a right to recover medical expenses;

(D) Immediately report to the county department the receipt of an I.D. card that he knows to be erroneous. If he does not report such and uses the I.D. card, he shall repay any medical expenses paid in error.

History Note: *Authority G.S. 108A-25(b); 108A-57; 42 C.F.R. 435.908; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order Filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990; March 1, 1986;
Temporary Amendment Eff. August 22, 1996;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0202 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0103 RECOMMENDATION FOR DISPOSITION

(a) When all information necessary to determine eligibility has been obtained, the Income Maintenance Caseworker shall recommend whether to approve or to deny assistance. The recommendation shall be based on all reliable, relevant information.

(b) The authority to approve or deny assistance rests with the county board of social services. The county board may, by appropriate resolution recorded in the board minutes, delegate to the county director of social services the authority to process applications, to determine eligibility, or to terminate assistance.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.913;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0205 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0104 DISPOSITION

(a) Disposition of the application shall complete the application process and shall consist of one of the following actions:

(1) Approval of assistance;

(2) Denial of assistance;
(3) Denial of assistance for ineligible month or months of the certification period and approval for eligible month or months of the certification period; or
(4) Voluntary withdrawal of the application by the client. The Income Maintenance Caseworker shall not suggest to the client that he withdraw his application and shall explain alternatives to withdrawal. The Income Maintenance Caseworker shall explain the client's right to reapply at anytime.

(b) The county department of social services shall not deny an application prior to 45 days, or for M-AD, 90 days, except when:
(1) It is established the applicant will not be able to meet the deductible;
(2) The applicant cannot be located; or
(3) The applicant refuses to cooperate or provide information to establish eligibility;

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.912; 42 C.F.R. 435.913; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order filed 15 December 1989; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0206 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0105 REFERRALS AT A FACE-TO-FACE INTERVIEW

For all Medicaid applicants who have a face-to-face interview at the county department of social services, the Income Maintenance Caseworker shall explain and make referrals for:
(1) Health Check;
(2) Family planning services;
(3) Food stamps;
(4) Governmental benefits including RSDI, SSI, VA;
(5) Women, Infants and Children Program (WIC);
(6) Carolina ACCESS;
(7) Medicaid Transportation;
(8) Life Line/Link-up;
(9) Health Insurance Premium Payment program; and
(10) Voter Registration.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 441.56; 42 U.S.C. 1396a(a); Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0207 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0106 MANDATORY USE OF OUTREACH LOCATIONS

The county department of social services shall provide for the acceptance of applications and initial interviews for M-PW and M-IC coverage groups at certain outreach locations as follows:
(1) disproportionate share acute care hospitals which serve the coverage groups listed; and
(2) Medicaid enrolled federally qualified health centers.

History Note: *Authority G.S. 108A-43; 108A-54; P.L. 101-508;*
Temporary Adoption Eff. July 1, 1991, for a period of 180 days to expire

Eff. January 1, 1992;
Transferred from 10A NCAC 21B .0208 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0107 HOURS FOR ACCEPTING FINANCIAL AND MEDICAL ASSISTANCE APPLICATIONS

The county department of social services must maintain the same number of operating hours as in February of 2002. Provisions must be made for acceptance of financial and medical assistance applications if the agency elects to close for lunch or for other reasons during the week.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0209 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

SECTION .0200 – APPLICATION PROCESSING, MONITORING AND CORRECTIVE ACTION

10A NCAC 23C .0201 APPLICATION PROCESSING STANDARDS

(a) The county department of social services shall comply with the following standards in processing applications:

(1) A decision shall be made within the timeframes set out in G.S. 108A-70.37;
(2) Only require information or verification to establish eligibility for assistance;
(3) Make a minimum of two requests for all information from the applicant or third party;
(4) Allow a minimum of 12 calendar days between the initial request and a follow-up request and at least 12 calendar days between the follow-up request and denial of the application;
(5) Inform the client in writing of the right to request help in obtaining information requested from the client. The county department of social services shall not discourage any client from requesting such help;
(6) An application may pend up to six months for verification that the deductible, as defined in 10A NCAC 23A .0102 has been met or disability established; and
(7) When a hearing decision reverses the decision of the county department of social services on an application, pursuant to 10A NCAC 21A .0303, the application shall be reopened within five business days from the date the final appeal decision is received by the county department of social services. If the county department of social services has all of the information needed to process the application, the application shall be processed within five additional business days. If additional information is needed pursuant to the final decision, the county shall make such requests in accordance with this Rule. The first request for the additional information shall be made within five business days of receipt of the final appeal decision. The application shall be processed within five business of receipt of the last piece of required information.

(b) The county department of social services shall obtain verification, as defined by 10A NCAC 23A .0102, other than the applicant's statement for the following:

(1) Any element requiring medical verification. This includes verification of disability, incapacity, emergency dates for aliens referenced in the Medicaid State Plan, incompetence, and approval of institutional care;
(2) Proof a deductible has been met;
(3) Legal alien status;
(4) Proof of the rebuttal value for resources and of the rebuttal of intent to transfer resources to become eligible for Medicaid. When a client disagrees with the determination of the county department of social services on the value of an asset, then the client must provide proof of what the value of the asset is;
(5) Proof of designation of liquid assets for burial;
(6) Proof of legally binding agreement limiting resource availability;
(7) Proof of valid social security number or application for a social security number;

(8) Proof of reserve reduction when resources exceed the allowable reserve limit for Medicaid;
(9) Proof of earned and unearned income, including deductions, exclusions, and operational expenses when the applicant or caseworker has or can obtain the verification; and
(10) Any other information for which the applicant does not know or cannot give an estimate.

(c) The county department of social services shall be responsible for verifying or obtaining an item of information when:

(1) A fee must be paid to obtain the verification;
(2) It is available within the agency;
(3) The county department of social services is required by federal law to assist or to use interagency or intra-agency verification aids;
(4) The applicant requests assistance; or
(5) A representative has not agreed to obtain the information and the applicant is:
(A) physically or mentally incapable of obtaining the information;
(B) unable to speak English or read and write in English; or
(C) housebound, hospitalized, or institutionalized.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.911; 42 C.F.R 435.912; 42 C.F.R 435.952; Alexander v. Flaherty, V.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order Filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0203 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23C .0202 MONITORING THRESHOLDS AND CORRECTIVE ACTION

(a) Division of Health Benefits employees, known as application monitors, shall review a random sample of applications in all county departments of social services and the Disability Determination Section (DDS) of the Division of Vocational Rehabilitation to determine if counties are denying and withdrawing applications in accordance with federal/state rules. The application monitors shall also review inquiries where a person comes to the agency and decides not to make an application to ensure person was given correct information under federal/state rules. A county and DDS must meet a monitoring threshold of 80 percent in each area of denials, withdrawals and inquiries in order to be found in compliance with federal/state rules.

(b) If the agency falls below the 80 percent threshold, the agency must analyze why it fell below 80 percent and implement a corrective action plan.

(c) The agency or DDS may dispute monitoring findings within 10 workdays of receipt of findings.

(d) Within 30 calendar days of the final monitoring results, the agency must take corrective action to reopen cases the application monitors determine were not handled pursuant to federal/state rules.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0605 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

10A NCAC 23C .0203 TIMELINESS

(a) Every month, each county department of social services and the Disability Determination Section (DDS) of the Division of Vocational Rehabilitation shall process applications as follows:

(1) The average processing time (APT) for the county department of social services shall be 90 days for M-AD and 45 days for all other aid program categories.
(2) APT for DDS shall be 70 days.

(3) The percentage processed timely (PPT) standard for county departments of social services: Level I counties must process 85 percent of applications within the 45/90 day time standard. Level II and III counties must process 90 percent of applications within the 45/90 day time standard. Counties are classified as Levels I through III based on population of the county with Level I counties as the smallest in population while Level III counties are the largest in population size.

(4) PPT standard for DDS: DDS must render a decision within 70 days on 85 percent of cases for Level I counties and 90 percent of cases for Level II and III counties. For county levels refer to the table below.

COUNTY LEVELS			
ALAMANCE (II)	CUMBERLAND (III)	JOHNSTON (II)	RANDOLPH (II)
ALEXANDER (I)	CURRITUCK (I)	JONES (I)	RICHMOND (I)
ALLEGHANY (I)	DARE (I)	LEE (I)	ROBESON (II)
ANSON (I)	DAVIDSON (II)	LENOIR (II)	ROCKINGHAM (II)
ASHE (I)	DAVIE (I)	LINCOLN (I)	ROWAN (II)
AVERY (I)	DUPLIN (II)	MACON (I)	RUTHERFORD (II)
BEAUFORT (II)	DURHAM (III)	MADISON (I)	SAMPSON (II)
BERTIE (I)	EDGECOMBE (II)	MARTIN (I)	SCOTLAND (II)
BLADEN (I)	FORSYTH (III)	MCDOWELL (I)	STANLY (I)
BRUNSWICK (II)	FRANKLIN (I)	MECKLENBURG (III)	STOKES (I)
BUNCOMBE (III)	GASTON (III)	MITCHELL (I)	SURRY (II)
BURKE (II)	GATES (I)	MONTGOMERY (I)	SWAIN (I)
CABARRUS (II)	GRAHAM (I)	MOORE (II)	TRANSYLVANIA (I)
CALDWELL (II)	GRANVILLE (I)	NASH (II)	TYRRELL (I)
CAMDEN (I)	GREENE (I)	NEW HANOVER (III)	UNION (II)
CARTERET (II)	GUILFORD (III)	NORTHAMPTON (I)	VANCE (II)
CASWELL (I)	HALIFAX (II)	ONSLOW (II)	WAKE (III)
CATAWBA (III)	HARNETT(II)	ORANGE (II)	WARREN (I)
CHATHAM (I)	HAYWOOD (II)	PAMLICO (I)	WASHINGTON (I)

CHEROKEE (I)	HENDERSON (II)	PASQUOTANK (I)	WATAUGA (I)
CHOWAN (I)	HERTFORD (I)	PENDER (I)	WAYNE (II)
CLAY (I)	HOKE (I)	PERQUIMANS (I)	WILKES (II)
CLEVELAND (II)	HYDE (I)	PERSON (I)	WILSON (II)
COLUMBUS (II)	IREDELL (II)	PITT (II)	YADKIN (I)
CRAVEN (II)	JACKSON (I)	POLK (I)	YANCEY (I)

(b) If a county department of social services fails to meet the standards in Paragraph (a) of this Rule, the county shall analyze the reason for failure, document findings and work with the Medicaid Program Representative (MPR) to achieve corrective action. The MPR is a Division of Health Benefits employee.
(c) Failure to meet the time standards in Paragraph (a) of this Rule, monthly shall result in corrective action to alleviate problems as outlined in Rules .0204 and .0205 of this Section. Once eligibility is determined except for the following requirements:

(1) sufficient medical expenses to meet a deductible; or
(2) the determination of need for institutionalization; or
(3) the plan of care for the home and community-based waivers; or
(4) the disability decision made by the Disability Determination Section; or
(5) medical records needed to determine emergency dates for non-qualified aliens; days shall be excluded from the time standard of 45 or 90 days. Days in the time standard are again included when the items in Subparagraph (c)(1) through (5) are received until the application is completed with a written notice to the applicant. When the 45/90th day falls on a weekend or holiday, the next workday in the month is considered the 45/90th day.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0606 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

10A NCAC 23C .0204 LOCAL CORRECTIVE ACTION TEAM

(a) The Assistant Director for Recipient and Provider Services (R&PS) in the Division of Health Benefits shall determine that a Local Corrective Action Team is needed when the county department of social services (DSS) is out of compliance with the monitoring or APT or PPT processing thresholds in any category for 3 consecutive months, or, 5 months out of any 12 consecutive months. The Local Corrective Action Team shall include the Medicaid Program Representative and any additional state staff identified by the Assistant Director for R&PS, the county department of social services director and any county staff the county director designates, the county manager or the chair of the county board of commissioners as selected by the county director, a member of the general public as selected by the county director, the social services board chairman or other board member for the county as selected by the county director, and an independent management consultant at the option and expense of the county.
(b) A Local Corrective Action Team shall not convene when:

(1) All failures are attributable to DDS.
(2) It is determined by DHB Assistant Director for Recipient and Provider Services that the reasons for non-compliance have been or are being corrected.

(3) Budgetary constraints decided by DHB Assistant Director for R&PS do not allow travel for the purpose of convening a corrective action team. Conference calls shall be held by the DHB Assistant Director for R&PS when travel is not allowed as determined by State officials due to fiscal constraints.

(c) The Local Corrective Action Team may design any remedy reasonable and necessary to bring the DSS into compliance with application processing requirements as in 10A NCAC 21B .0204 and this Subchapter.

(d) The Team shall establish a corrective action plan within 40 calendar days of notice from the Assistant Director of Recipient and Provider Services to the county director of social services that a local corrective action team was required, and a date for compliance with the plan shall be set. The corrective action plan must be submitted to the Assistant Director for R&PS. The county must meet the thresholds in 10A NCAC 23C .0203(a) within three months after the date the compliance plan was required to be established.

(e) Failure of a county to take corrective action, or meet compliance thresholds shall result in a referral by the Division of Health Benefits a State Corrective Action Team, unless the State Corrective Action Team grants an extension, not to exceed three months, for the county to meet the thresholds. In determining if an extension shall be granted, the State Corrective Action Team shall receive a recommendation from the Division of Health Benefits to grant an extension based on the Division's assessment that the county is taking action to comply with the corrective action plan. The State Corrective Action Team shall be formed by the Secretary for the Department of Health and Human Services based on a request from the Division of Health Benefits. The State Corrective Action Team shall consist of a representative from the Department of Health and Human Services appointed by the Secretary, a representative of the NC Association of County Commissioners, two representatives from county departments of social services, excluding the county in question, appointed by the presidents of the following associations: NC Social Services Association, NC Association of County Directors of Social Services, and the NC Association of County Boards of Social Services, the chairman of the Board of Legal Services of North Carolina or his designee, a recipient of Medicaid appointed by the Secretary, and a representative of the UNC School of Government.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0607 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

10A NCAC 23C .0205 STATE CORRECTIVE ACTION TEAM

(a) A State Corrective Action Team shall be convened by the Chairperson within 10 days when:

(1) The county department of social services (DSS) has failed to meet the compliance thresholds by the date established by the local corrective action team.

(2) A local corrective action team requests an extension of time, not to exceed three months, to meet the compliance thresholds.

(3) DDS fails to meet its compliance thresholds for 3 consecutive months or 5 out of 12 consecutive months.

(b) The State Corrective Action Team may design any remedy reasonable and necessary to bring the DSS or DDS into compliance with application processing requirements in 10A NCAC 21B .0204 and this Subchapter. This includes employing additional staff, altering office procedures (such procedures must be consistent with federal and state regulations, laws and Departmental rules), purchasing office equipment, retaining private consultants, reopening of cases, ordering retroactive relief to applicants harmed by violation of application processing requirements, and ordering the State to assist in the operation of a county department.

(c) The State Corrective Action Team shall establish a corrective action plan for the DSS or DDS within 45 calendar days of convening. A date for compliance shall be established. The county or DDS must meet the thresholds in 10A NCAC 23C .0203(a) within three months after the date the team was convened.

(d) Failure to achieve compliance shall result in a request from the Division of Health Benefits to the Local Government Commission to assess and determine the capacity of the county to expend resources to bring the county into compliance.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0608 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

SUBCHAPTER 23D - MEDICAID ELIGIBILITYGROUPS AND CLASSIFICATION

SECTION .0100 – COVERAGE GROUPS

10A NCAC 23D .0101 MANDATORY GROUPS

History Note: *Authority G.S. 108A-54; 42 U.S.C. 1396a(a)(10); 42 U.S.C. 1396a(e)(4); 42 U.S.C. 1396a(f); 42 C.F.R. 435.110; 42 C.F.R. 435.112; 42 C.F.R. 435.113; 42 C.F.R. 435.114; 42 C.F.R. 435.115; 42 C.F.R. 435.116; 42 C.F.R. 435.117; 42 C.F.R. 435.118; 42 C.F.R. 435.121; 42 C.F.R. 435.131; 42 C.F.R. 435.132; 42 C.F.R. 435.133;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; March 1, 1993; January 4, 1993; April 1, 1992;
Temporary Amendment September 13, 1999;
Temporary Amendment Expired June 27, 2000;
Temporary Amendment September 12, 2000;
Amended Eff. August 1, 2002;
Transferred from 10A NCAC 21B .0101 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23D .0102 OPTIONAL GROUPS

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.210; 42 C.F.R. 435.222; 42 C.F.R. 435.230; 42 C.F.R. 435.301; 42 C.F.R. 435.308; 42 C.F.R. 435.322; 42 C.F.R. 435.330; 42 U.S.C. 1396(a)(10)(A)(ii); 42 U.S.C. 1396a(a)(10)(C); S.L. 1983, c. 1034, s. 62.2; S.L. 1987, c. 738, s. 69 and 70; S.L. 1989, c. 752, s. 133;*
Eff. September 1, 1984;
Amended Eff. February 1, 1992; July 1, 1991; August 1, 1990;
Temporary Amendment Eff. September 12, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Temporary Amendment Eff. October 1, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. January 1, 1995;
Temporary Amendment Eff. February 23, 1999;
Amended Eff. August 1, 2000;
Temporary Amendment Eff. January 1, 2002;
Amended Eff. April 1, 2003;
Transferred from 10A NCAC 21B .0102 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

SECTION .0200 - CLASSIFICATION

10A NCAC 23D .0201 CLASSIFICATION

History Note: *Filed as a Temporary Amendment Eff. October 1, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;*

Filed as a Temporary Amendment Eff. September 12, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Authority G.S. 108A-54; 42 C.F.R. 435.2; 42 C.F.R. 435.4;
Eff. September 1, 1984;
Amended Eff. January 1, 1995; August 1, 1990;
Temporary Amendment Eff. September 13, 1999;
Temporary Amendment Expired June 27, 2000;
Temporary Amendment Eff. September 12, 2000;
Amended Eff. August 1, 2002;
Transferred from 10A NCAC 21B .0408 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

SUBCHAPTER 23E – MEDICAID ELIGIBILITY REQUIREMENTS

SECTION .0100 – NON-FINANCIAL REQUIREMENTS

10A NCAC 23E .0101 AGE

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.520; Alexander v. Flaherty Consent Order filed February 14, 1992;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Transferred from 10A NCAC 21B .0301 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0102 UNITED STATES CITIZEN

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.402; 8 U.S.C. 1161; 8 U.S.C. 1255a; 42 U.S.C. 1396b(v);*
Eff. September 1, 1984;
Amended Eff. August 1, 2000; December 1, 1991; August 1, 1990;
Transferred from 10A NCAC 21B .0302 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0103 RESIDENCE

(a) The requirements stated in 42 CFR 435.403 shall apply to determine residence in the State except for provisions in Paragraph (b) of this Rule.
(b) Residents of the state of Georgia who enter a long term care facility in NC within 40 miles of the resident state's border shall retain residence in Georgia. Residents of NC who enter a long term care facility in Georgia within 40 miles of the NC border retain NC residency.
(c) An individual visiting without intent to reside in the State shall be ineligible for NC Medicaid.
(d) An individual who moves to another state and intends to reside in that state shall not be eligible for NC Medicaid.
(e) County residence:

(1) Any client who moves from one county to another North Carolina county shall continue to receive assistance so long as eligibility continues.
(2) An individual has residence in the county in which he or she resides. However, if he or she is in a hospital, mental institution, intermediate care facility, skilled nursing home, boarding home, penal institution, or similar facility, the county where the facility is located shall not be his or her legal residence. Except for (e)(3) in this Rule, the county of legal residence shall be the county where the individual lived in a private living arrangement prior to entering a facility.
(3) If an individual who became disabled prior to age 18 has remained in a facility, he or she remains a resident of the county and state where his or her parent(s) had residence immediately prior to his or her reaching age 18. If, as an adult, he or she is applying for assistance and it is not possible for

the individual to trace his or her county of residence as a minor, he or she shall establish residence based on where he or she intends to reside, regardless of his or her parent's current legal residence.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-55.3; 42 C.F.R. 435.403;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0303 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0104 DEPRIVATION

History Note: *Authority G.S. 108A-28; 108A-54; 42 C.F.R. 435.510; 89 CVS 922;*
Eff. September 1, 1984;
Amended Eff. October 1, 1991; August 1, 1990;
Temporary Amendment Eff. August 5, 1999;
Amended Eff. March 19, 2001;
Transferred from 10A NCAC 21B .0304 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0105 DISABILITY

(a) As set out in the Medicaid State Plan, individuals eligible for Medicaid in December 1973 as disabled individuals and who meet conditions required by 42 CFR 435.133 shall be permanently and totally disabled based on a physical or mental impairment that precludes him or her from engaging in substantial gainful activity, as defined at 20 CFR 416.910, which is incorporated by reference with subsequent amendments and editions and available free of charge at https://www.ecfr.gov/, and such impairment can be expected to result in death, or has lasted or can be expected to last 12 months or longer.

(b) Any client who has applied for Medicaid since January 1, 1974 on the basis of disability shall be found disabled under the definition of disability and procedures established for evaluation of vocational and medical factors under the supplemental security income program.

(c) A social history shall be completed by the caseworker and submitted to the Division of Vocational Rehabilitation Services, Disability Determination Services Section with the request for disability determination. The social history shall provide information to identify and contact the claimant; contact information of anyone assisting the claimant in providing the social history; nature and onset of the impairment with the date it became disabling; date claimant stopped work or if still working, provide name of employer with contact information, how many hours worked and earnings; claimant's description of impairment; work history and educational background; contact information for all medical sources during the last 12 months with condition treated, dates seen, and whether treatment is still ongoing; Vocational Rehabilitation office, counselor's contact information, and last seen date; in cases where mental impairment is alleged or there is evidence of drug or alcohol abuse or homelessness, provide name, address, and phone number of a third party contact; signature, title, and phone number of caseworker.

(d) The Disability Determination Services Section shall determine disability for all individuals, except for those receiving social security or supplemental security income on the basis of a disability.

(e) Social Security Administration (SSA) decisions made for social security disability or supplemental security income shall be binding for persons applying for Medicaid.

(f) Disability determination shall be verified from the client's award letter, SDX, BENDEX, Disability Determination Services Section approval, Administrative Law Judge decision, or other documentary evidence. SDX and BENDEX are defined in 10A NCAC 23A .0102.

(g) Disability for purposes of Medicaid eligibility shall cease when the client is determined by the Social Security Administration or the Disability Determination Services Section to be capable of engaging in substantial gainful activity. The client may appeal the termination of Medicaid, pursuant to G.S. 108A-70.9A.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 20 C.F.R. 404.1505; 42 C.F.R. 435.540; 42 C.F.R. 435.541;*
Alexander v. Flaherty Consent Order filed February 14, 1992;
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Transferred from 10A NCAC 21B .0305 Eff. May 1, 2012;
Readopted Eff. August 1, 2019.

10A NCAC 23E .0106 BLINDNESS

(a) To qualify for Medicaid under the category of Aid to the Blind, the client shall meet one of the following conditions:

(1) receipt of Medicaid on the basis of blindness in December 1973, has continued to meet December 1973 eligibility criteria for each consecutive month thereafter, and determined by the Disability Determination Services Section to have visual acuity of 20/100 in the better eye with correction or visual field limitation in the better eye of 30 percent or less; or

(2) applied for Medicaid since January 1, 1974 and meets the definition of blindness, vocational, and medical factors applied under the Supplemental Security Income program, pursuant to 20 CFR 404, Subpart P.

(b) For clients applying for Medicaid since January 1, 1974, that do not meet the criteria in 20 CFR 404, Subpart P, blindness shall be determined by one of the following methods pursuant to 42 CFR 435.530 and 435.531:

(1) Documentary evidence including SDX, BENDEX, or an award letter that social security benefits, supplemental security income, or veterans benefits have been awarded on the basis of blindness; or

(2) A written decision from the physician consultant of the Division of Services for the Blind based on review of a medical eye examination report.

(c) Blindness shall be reverified for clients determined eligible under Paragraph (b) of this Rule at each review of the client's eligibility or when reexamination is recommended by the physician consultant in his or her professional opinion.

(d) The client shall cease to qualify for Medicaid as a blind individual when evidence is received from any of the sources described in Paragraphs (a)(1) or (b) of this Rule that the client no longer meets the conditions of blindness set out in this Rule and the Medicaid State Plan.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 20 C.F.R. 404, Subpart P; 42 C.F.R. 435.530; 42 C.F.R. 435.531;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0306 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0107 CARETAKER RELATIVE

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.310;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Transferred from 10A NCAC 21B .0307 Eff. May 1 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0108 INMATE OF PUBLIC INSTITUTION OR PRIVATE PSYCHIATRIC HOSPITAL

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.1008; 42 C.F.R. 435.1009; S.L. 1987, c. 758, s. 69;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0308 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

SECTION .0200 – FINANCIAL REQUIREMENTS

10A NCAC 23E .0201 APPLYING FOR ALL BENEFITS AND ANNUITIES

(a) Clients shall follow all processes and procedures set forth by any financial institution or agency to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, pursuant to 42 CFR 435.608, which is incorporated by reference including subsequent amendments and editions and available free of charge at https://www.ecfr.gov/, unless they have good cause for not doing so as determined by the county department of

social services. For purposes of this Rule, good cause shall be limited to physical or mental incapability to make such effort.
(b) If a client fails to comply with Paragraph (a) and does not show good cause, the client's eligibility benefits shall be terminated.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.608;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0309 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0202 WHAT RESOURCES ARE COUNTED

(a) North Carolina has contracted with the Social Security Administration under Section 1634 of the Social Security Act to provide Medicaid to all SSI recipients. Except as specified in Paragraphs (j) and (k) of this Rule, the resources that are counted for Medicaid eligibility for individuals under any aged, blind, and disabled coverage group shall be determined based on standards and methodologies in Title XVI of the Social Security Act, which is incorporated by reference including all subsequent amendments and editions. This CFR may be accessed at http://uscode.house.gov/ at no cost. Applicants for and recipients of Medicaid shall use their own resources to meet their needs for living costs and medical care to the extent that such resources can be made available.
(b) The value of resources currently available to any member of a budget unit, as defined in 10A NCAC 23A .0102, shall be considered in determining financial eligibility. A resource shall be considered available when it is actually available and when the budget unit member has a legal interest in the resource and he or she, or someone acting in his or her behalf, can take any necessary action to make it available.
(c) Resources shall be excluded in determining financial eligibility when the budget unit member with a legal interest in the resources is declared incompetent, unless:

(1) A guardian of the estate, a general guardian, or an interim guardian has been appointed in accordance with the law and is able to act on behalf of his or her ward in North Carolina and in any state where such resources are located; or
(2) A durable power of attorney, valid in North Carolina and in any state where such resource is located, has been granted to a person who is authorized and able to exercise such power.

(d) When there is a guardian, an interim guardian, or a person holding a valid, durable power of attorney for a budget unit member, but such person is unable, fails, or refuses to act within application processing time standards to make the resources available to meet the needs of the budget unit member, a referral shall be made to the services unit of the county department of social services for a determination of whether the guardian or attorney in fact is acting in the best interests of the member and if not, the county department of social services shall contact the clerk of court for intervention. The resources shall be excluded in determining financial eligibility pending action by the clerk of court.
(e) When a Medicaid application is filed on behalf of an individual who:

(1) is alleged to be mentally incompetent;
(2) has or may have a legal interest in a resource that affects the individual's eligibility; and does not have a representative with legal authority to use or dispose of the individual's resources the individual's representative or family member shall be instructed by the county department of social services to file within 30 calendar days a judicial proceeding under G.S. 35A to declare the individual incompetent and appoint a guardian. If the representative or family member either fails to file such a proceeding within 30 calendar days or fails to obtain a ruling on the filed proceeding within the deadlines set by the Clerk of Court in the county where the proceeding will be heard or causes it to be dismissed, a referral shall be made to the protective services unit of the county department of social services for guardianship services. If an allegation of incompetence is supported by competent evidence as defined in Paragraph (h) of this Rule, and the incompetence has lasted, or is expected to last, at least 30 consecutive days or until the individual's death, the resources shall be excluded beginning with the date that the evidence shows that he or she became incompetent, except as provided in Paragraphs (f) or (g) of this Rule.

(f) The budget unit member's resources shall be counted in determining his or her eligibility for Medicaid beginning the first day of the month following the month a guardian of the estate, general guardian, or interim guardian is appointed, provided that after the appointment, property that cannot be disposed of or used except by order of the

court shall continue to be excluded until completion of the applicable procedures for disposition specified in G.S. 1 or G.S. 35A.

(g) When the court rules that the budget unit member is competent or no ruling is made because of the death or recovery from incompetence of the member, his or her resources shall be counted except for periods of time for which it can be established by competent evidence as defined in Paragraph (h) of this Rule, that the member was in fact incompetent for at least 30 consecutive days, or until his or her death. Any showing of incompetence is subject to rebuttal by competent evidence as defined in Paragraph (h) of this Rule.

(h) For purposes of this Rule, "competent evidence" is defined as the written statement or testimony at a competency hearing of a physician, psychologist, nurse, or social worker with knowledge of the physical and mental condition of the individual, that contains information on the individual's condition, the basis of that information, the beginning date of incompetence, the reason the individual is incompetent, and, if no longer incompetent, when the individual recovered competence.

(i) If the value of countable resources of the budget unit exceeds the reserve allowance for the unit as set out in the Medicaid State Plan, the case shall be ineligible unless one of the following is met:

(1) For Family and Children's medically needy cases and aged, blind, or disabled cases protected by grandfathered provisions, and medically needy cases not protected by grandfathered provision, eligibility shall begin on the day countable resources are reduced to allowable limits or excess income is spent down, whichever occurs later;

(2) For categorically needy aged, blind, or disabled cases not protected by grandfathered provisions, eligibility shall begin no earlier than the month countable resources are reduced to allowable limits as of 11:59 pm on the last day of the previous month.

(j) Resources counted in the determination of financial eligibility for categorically needy aged, blind, and disabled cases, and Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individual and Qualified Disabled Working Individual cases shall be based on resource standards and methodologies in Title XVI of the Social Security Act except for the following methodologies:

(1) The value of personal effects and household goods shall be not counted.

(2) The value of tenancy in common interest in real property shall be not counted.

(3) The value of life estate interest in real property shall be not counted.

(4) The value of burial plots shall be not counted.

(5) The cash value of life insurance when the total face value of all cash value bearing life insurance policies does not exceed ten thousand dollars ($10,000) shall be not counted.

(k) Resources counted in the determination of financial eligibility for medically needy aged, blind, and disabled cases shall be based on resource standards and methodologies in Title XVI of the Social Security Act except for the following methodologies:

(1) The value of personal effects and household goods shall be not counted.

(2) The value of tenancy in common interest in real property shall be not counted.

(3) The value of life estate interest in real property shall not be counted.

(4) Individuals with resources in excess of the resource limit at 11:59 pm on the last day of the previous month, the first moment of the month may become eligible during the current month at the point that resources are reduced to the allowable limit.

(5) The value of burial plots shall be not counted.

(6) The cash value of life insurance when the total face value of all cash value bearing life insurance policies does not exceed ten thousand dollars ($10,000) shall be not counted.

(l) Resources counted in the determination of financial eligibility for Family and Children's medically needy cases are:

(1) Cash on hand;

(2) The balance of savings accounts, including savings of a student saving his or her earnings for school expenses;

(3) The balance of checking accounts, less the current monthly income, deposited to meet the budget unit's monthly needs when reserve was verified by the county department of social services or lump sum income from self-employment deposited to pay annual expenses;

(4) The cash value of life insurance policies when the total face value of all policies that accrue cash value exceeds one thousand five hundred dollars ($1,500);

(5) Stocks, bonds, mutual fund shares, certificates of deposit, and other liquid assets;

(6) Assets held in patient accounts in long term care facilities; and

(7) Equity in non-income producing personal property limited to:

(A) Mobile home not used as home;
(B) Boats, boat trailers, and boat motors;
(C) Campers;
(D) Farm and business equipment; and
(E) Equity in motor vehicles in excess of one vehicle per adult if not income-producing.

(m) Real property shall be excluded from countable resources for Family and Children's medically needy cases.

(n) One motor vehicle per adult shall be excluded for Family and Children's medically needy cases.

(o) For Family and Children's medically needy cases, income-producing vehicles and personal property shall be excluded from countable resources.

(p) For Family and Children's medically needy cases, the value of non-excluded motor vehicles is the Current Market Value as determined by the assessed county tax value, less encumbrances. If the client disagrees with the assigned value, he or she has the right to rebut the value by producing independent evidence of value.

(q) There is no resource test for Family and Children's categorically needy cases pursuant to 42 C.F.R. 435.603.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-55; 42 U.S.C. 703; 42 U.S.C. 704; 42 U.S.C. 1396; 42 C.F.R. 435.121; 42 C.F.R. 435.210; 42 C.F.R. 435.603; 4 42 C.F.R. 435.840; 42 C.F.R. 435.843; 42 C.F.R. 435.845; 45 C.F.R. 233.20;*
Eff. September 1, 1984;
Temporary Amendment Eff. September 1, 1985, for a period of 92 days to expire on December 1, 1985;
Amended Eff. January 1, 1995; November 1, 1994; September 1, 1993; March 1, 1993;
Temporary Amendment Eff. September 13, 1999;
Temporary Amendment Expired June 27, 2000;
Temporary Amendment Eff. September 12, 2000;
Amended Eff. March 19, 2001;
Temporary Amendment Eff. April 16, 2001;
Amended Eff. August 1, 2002;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0310 Eff. May 1, 2012;
Readopted Eff. August 1, 2019;
Amended Eff. March 1, 2020.

10A NCAC 23E .0203 COUNTABLE INCOME

(a) For Family and Children's medically needy cases, income from the following sources shall be counted in the calculation of financial eligibility:

(1) Unearned.
(A) RSDI, as defined in 10A NCAC 23A .0102;
(B) Veteran's Administration;
(C) Railroad Retirement;
(D) Pensions or retirement benefits;
(E) Worker's Compensation;
(F) Unemployment Insurance Benefits;
(G) All support payments, including child and spousal support;
(H) Contributions;
(I) Dividends or interest from stocks, bonds, and other investments;
(J) Trust fund income;
(K) Private disability or employment compensation;
(L) The portion of educational loans, grants, and scholarships for maintenance;
(M) Work release;
(N) Lump sum payments;
(O) Military allotments;
(P) Brown Lung benefits
(Q) Black Lung benefits
(R) Trade Adjustment benefits;
(S) SSI when the client is in long-term care;

(T) VA Aid and Attendance when the client is in long-term care;
(U) Foster Care Board payments in excess of State maximum rates for M-AF clients who serve as foster parents;
(V) Income allocated from an institutionalized spouse to the client who is the community spouse as stated in 42 U.S.C. 1396r-5(d);
(W) Income allowed from an institutionalized spouse to the client who is a dependent family member as stated in 42 U.S.C. 1396r-5(d);
(X) Sheltered Workshop income;
(Y) Loans, if repayment of a loan and not counted in reserve; and
(Z) Income deemed to Family and Children's clients.

(2) Earned Income.
(A) Income from wages, salaries, and commissions;
(B) Farm income;
(C) Small business income including self-employment;
(D) Rental income for use of real or personal property;
(E) Income for room and board in the household;
(F) Earned income of a child client who is a part-time student and a full-time employee;
(G) Supplemental payments in excess of State maximum rates for Foster Care Board payments paid by the county to Family and Children's clients who serve as foster parents; and
(H) VA Aid and Attendance paid to a budget unit member who provides the aid and attendance.

(3) Additional sources of income not listed in Subparagraphs (a)(1) or (2) of this Rule shall be considered available unless specifically excluded by Paragraph (b) of this Rule, or by State or federal regulation or statute.

(b) For Family and Children's medically needy cases, income from the following sources shall not be counted in the calculation of financial eligibility:

(1) Earned income of a child who is a part-time student but is not a full-time employee;
(2) Earned income of a child who is a full-time student;
(3) Incentive payments and training allowances made to Work Incentives Network (WIN) training participants;
(4) Payments for supportive services or reimbursement of out-of-pocket expenses made to volunteers serving as VISTA volunteers, foster grandparents, senior health aides, senior companions, Service Corps of Retired Executives, Active Corps of Executives, Retired Senior Volunteer Programs, Action Cooperative Volunteer Program, University Year for Action Program, and other programs under Titles I, II, and III of Public Law 93-113;
(5) Foster Care Board payments equal to or below the State maximum rates for Family and Children's clients who serve as foster parents;
(6) Income that is unpredictable, such as unplanned and arising only from time to time. Examples include occasional yard work and sporadic babysitting;
(7) Relocation payments;
(8) Value of the coupon allotment under the Food and Nutrition Program (FNS);
(9) Food (vegetables, dairy products, and meat) grown by or given to a member of the household. The amount received from the sale of home grown produce is earned income;
(10) Benefits received from the Nutrition Program for the Elderly;
(11) Food Assistance under the Child Nutrition Act and National School Lunch Act;
(12) Assistance provided in cash or in kind under any governmental, civic, or charitable organization whose purpose is to provide social services or vocational rehabilitation. This includes V.R. incentive payments for training, education, and allowance for dependents, grants for tuition, chore services under Title XX of the Social Security Act, and VA aid and attendance or aid to the home bound if the individual is in a private living arrangement;
(13) Loans or grants such as the GI Bill, civic, honorary and fraternal club scholarships, loans, or scholarships granted from private donations to the college, except for any portion used or designated for maintenance;
(14) Loans, grants, or scholarships to undergraduates for educational purposes made or insured under any program administered by the U.S. Department of Education;

(15) Benefits received under Title VII of the Older Americans Act of 1965;
(16) Payments received under the Housing Choice Voucher (HCV) Program, formerly known as the Experimental Housing Allowance Program (EHAP);
(17) In-kind shelter and utility contributions paid directly to the supplier;
(18) Shelter, utilities, or household furnishings made available to the client at no cost;
(19) Food/clothing contributions (except for food allowance for persons temporarily absent in medical facilities up to 12 months);
(20) Income of a child under 21 in the budget unit who is participating in the Job Training Partnership Act and is receiving Medicaid as a child;
(21) Housing Improvement Grants approved by the N.C. Commission of Indian Affairs or funds distributed per capital or held in trust for Indian tribe members under P.L. 92-254, P.L. 93-134 or P.L. 94-540;
(22) Payments to Indian tribe members as permitted under P.L. 94-114;
(23) Payments made by Medicare to a home renal dialysis patient as medical benefits;
(24) SSI, except for individuals in long-term care;
(25) HUD Section 8 benefits when paid directly to the supplier or jointly to the supplier and client;
(26) Benefits received by a client who is a representative payee for another individual who is incompetent or incapable of handling his or her affairs. Such benefits shall be accounted for by the county department of social services separate from the payee's own income and resources;
(27) Special one time payments such as energy, weatherization assistance, or disaster assistance that is not designated as medical;
(28) The value of the U.S. Department of Agriculture donated foods (surplus commodities);
(29) Payments under the Alaska Native Claims Settlement Act, P.L. 92-203;
(30) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
(31) HUD Community Development Block Grant funds received to finance the renovation of a privately owned residence;
(32) Reimbursement for transportation expenses incurred as a result of participation in the Community Work Experience Program or for use of client's own vehicle to obtain medical care or treatment;
(33) Adoption assistance;
(34) Incentive payments made to a client participating in a vocational rehabilitation program;
(35) Title XX funds received to pay for services rendered by another individual or agency;
(36) Any amount received as a refund of taxes paid;
(37) The first fifty-dollars ($50) of each child support/spousal obligation or military allotment paid monthly to the budget unit in a private living arrangement; and
(38) Income from an Achieving a Better Life Experience (ABLE) program account, pursuant to Chapter 147, Article 6F of the North Carolina General Statutes.

(c) For aged, blind, and disabled cases, income counted in the determination of financial eligibility shall be based on standards and methodologies in Title XVI of the Social Security Act.

(d) For aged, blind, and disabled cases, income from the following sources shall not be counted:
(1) Any Cost of Living Allowance (COLA) increase or receipt of RSDI benefit, that resulted in the loss of SSI for those qualified disabled and working individuals described at 42 U.S.C. 1396d(s);
(2) Earnings for those individuals who have a plan for achieving self-support (PASS) that is approved by the Social Security Administration; and
(3) Income from an Achieving a Better Life Experience (ABLE) program account, pursuant to Chapter 147, Article 6F of the North Carolina General Statutes.

(e) Income levels for purposes of establishing eligibility are those amounts approved by the N.C. General Assembly and stated in the Appropriations Act for categorically needy and medically needy classifications, except for the following:
(1) The income level shall be reduced by one-third when an aged, blind, or disabled individual lives in the household of another person and does not pay his or her proportionate share of household expenses. The one-third reduction shall not apply to children under 19 years of age who live in the home of their parents;
(2) An individual living in a long-term care facility or other medical institution shall be allowed as income level deduction for personal needs described under the Medicaid State Plan; and

(3) The income level to be applied for Qualified Medicare Beneficiaries described in 42 U.S.C. 1396d and individuals described in 42 U.S.C. 1396e shall be based on the income level for one; or two for a married couple who live together and both receive Medicare.

(f) Income for Family and Children's categorically needy cases is determined pursuant to 42 C.F.R. 435.603.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 42 C.F.R. 435.135; 42 C.F.R. 435.603; 42 C.F.R. 435.733; 42 C.F.R. 435.811; 42 C.F.R. 435.831; 42 C.F.R. 435.832; 42 C.F.R. 435.1007; 45 C.F.R. 233.20; 42 U.S.C 1383c(b); 42 U.S.C 1383c(d); P.L. 99-272, Section 12202; Alexander v. Flaherty Consent Order filed February 14, 1992;*
Eff. September 1, 1984;
Temporary Rule Effective July 1, 1987, for a period of 120 days to expire on October 31, 1987;
Amended Eff. January 1, 1996; January 1, 1995; September 1, 1994; September 1, 1993;
Temporary Amendment Eff. February 23, 1999;
Amended Eff. August 1, 2000;
Transferred from 10A NCAC 21B .0312 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0204 PERSONAL NEEDS ALLOWANCE

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 435.135; 42 C.F.R. 435.731; 42 C.F.R. 435.732; 42 C.F.R. 435.733; 42 C.F.R. 435.831; 42 U.S.C. 1383c(b); 42 U.S.C. 1383c(d);*
Eff. September 1, 1994;
Transferred from 10A NCAC 21B .0313 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0205 BUDGET UNIT MEMBERSHIP

In aged, blind, and disabled cases and medically needy cases, the budget unit shall include individuals who are required by federal and State law to be financially responsible for the support of each other or other dependents. In all other categorically needy cases, the budget unit shall be determined pursuant to 42 C.F.R. 435.603, which is incorporated by reference with subsequent amendments and editions and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.602; 42 C.F.R. 435.603; 45 C.F.R. 233.51;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0401 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0206 FINANCIAL RESPONSIBILITY AND DEEMING

History Note: *Authority G.S. 108A-54; 143-127.1; S.L. 1983, c. 761, s. 60(6); S.L. 1983, c. 1034; S.L. 1983, c. 1116; 42 C.F.R. 435.602; 42 C.F.R. 435.712; 42 C.F.R. 435.734; 42 C.F.R. 435.821; 42 C.F.R. 435.823;*
Eff. September 1, 1984;
Temporary Amendment Eff. April 1, 1990 for a period of 180 days to expire on September 30, 1990;
Amended Eff. January 1, 1995; September 1, 1992; October 1, 1990; August 1, 1990;
Temporary Amendment Eff. January 1, 2003;
Temporary Amendment Expired October 12, 2003;
Transferred from 10A NCAC 21B .0402 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

10A NCAC 23E .0207 WHOSE RESOURCES ARE COUNTED

(a) The value of resources held by the client or by a financially responsible person shall be considered by the county department of social services to be available to the client in determining countable reserve for the budget unit.

(b) Jointly owned resources shall be counted as follows:

(1) The value of resources owned jointly with a person who is not a member of the client's budget unit who is a recipient of another public assistance budget unit shall be divided in parts of equal value between the budget units.

(2) The value of liquid assets and personal property owned jointly with a person who is not a member of the client's budget unit who is also not a client of another public assistance budget unit shall be available to the client if he or she can dispose of the resource without the consent and participation of the joint-owner or the joint-owner consents to and, if necessary, participates in the disposal of the resource.

(3) The client's share of the value of real property owned jointly with a person who is not a member of the client's budget unit who is also not a member of another public assistance budget unit shall be available to the client if he or she can dispose of his or her share of the resource without the consent and participation of the joint-owner or the joint-owner consents to and, if necessary, participates in the disposal of the resource.

(c) The terms of a separation agreement, divorce decree, will, deed or other legally binding agreement or court order shall take precedence over ownership of resources as stated in Paragraphs (a) and (b) of this Rule, except as provided in Paragraph (g) of this Rule.

(d) For all aged, blind, and disabled cases, the resource limit, financial responsibility, and countable and non-countable assets shall be based on standards and methodology in Title XVI of the Social Security Act except as specified in Rule .0202 of this Section.

(e) Countable resources for Family and Children's medically needy cases shall be determined as follows:

(1) The resources of a spouse, who is not a stepparent, shall be counted in the budget unit's reserve allowance if:

(A) the spouses live together; or

(B) one spouse is temporarily absent for twelve months or less in long-term l care and the spouse is not a member of another public assistance budget unit;

(2) The resources of a client and a financially responsible parent or parents shall be counted in the budget unit's reserve limit if:

(A) the parents live together; or

(B) one parent is temporarily absent for 12 months or less in long-term care and the parent is not a member of another public assistance budget unit;

(3) The resources of the parent or parents shall not be considered if a child under age 21 requires care and treatment in a medical institution and his or her physician certifies that the care and treatment are expected to exceed 12 months.

(f) For a married individual:

(1) Resources available to the individual are available to his or her spouse who is a noninstitutionalized applicant or recipient and who is either living with the individual or temporarily absent for twelve months or less from the home, irrespective of the terms of any will, deed, contract, antenuptial agreement, or other agreement, and irrespective of whether or not the individual actually contributed the resources to the applicant or recipient. All resources available to an applicant or recipient under the rules of this Section must be considered by the county department of social services when determining his or her countable reserve.

(2) For an institutionalized spouse as defined in 42 U.S.C. 1396r-5(h), available resources shall be determined in accordance with 42 U.S.C. 1396r-5(c), except as specified in Paragraph (g) of this Rule.

(g) For an institutionalized individual, the availability of resources shall be determined in accordance with 42 U.S.C. 1396r-5. Resources of the community spouse shall not be counted for the institutionalized spouse when:

(1) Resources of the community spouse cannot be determined or cannot be made available to the institutionalized spouse because the community spouse cannot be located by the county department of social services; or

(2) The couple has been continuously separated for 12 months at the time the institutionalized spouse enters the institution.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-55; 42 U.S.C. 1396r-5; 42 U.S.C. 1396a(a)(17); 42 U.S.C. 1396a(a)(51); 42 C.F.R. 435.602; 42 C.F.R. 435.725; 42 C.F.R. 435.726; 42 C.F.R. 435.733; 42 C.F.R. 435.735; 42 C.F.R. 435.840; 42 C.F.R. 435.832; 42 C.F.R. 435.845; 45*

C.F.R. 233.20; 45 C.F.R. 233.51; Correll v. DSS/DMA/DHR, 418 S.E.2d 232 (1992); Schweiker v. Gray Panthers, 453 U.S. 34, 101 S.Ct. 2633, 69 L. Ed.2d 460 (1981);
Eff. September 1, 1984;
Amended Eff. January 1, 1995; November 1, 1994; September 1, 1993; April 1, 1993;
Temporary Amendment Eff. September 13, 1999;
Temporary Amendment Expired June 27, 2000;
Temporary Amendment Eff. September 12, 2000;
Amended Eff. August 1, 2002;
Transferred from 10A NCAC 21B .0403 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0208 CALCULATING INCOME

(a) Income that is actually available and the client or someone acting in his or her behalf has the legal authority to make available for support and maintenance shall be counted as income.

(b) Only income actually available or predicted by the county department of social services to be available to the budget unit for the certification period, as defined in 10A NCAC 23A .0102, for which eligibility is being determined shall be counted as income.

(c) For aged, blind, and disabled cases allowable disregards from income shall be based on Title XVI of the Social Security Act.

(d) Deductions subtracted after allowable disregards shall be:

(1) Incapacitated adult care not to exceed one hundred and seventy-five dollars ($175.00) per adult for Family and Children's medically needy cases.

(2) Child care not to exceed one hundred and seventy-five dollars ($175.00) per child over two years of age or two hundred dollars ($200.00) per child under two years of age for Family and Children's medically needy cases.

(3) A standard deduction of ninety dollars ($90.00) from the total earned income of each budget unit member for Family and Children's medically needy cases.

(4) For aged, blind, and disabled cases allowable deductions from income are based on Title XVI of the Social Security Act.

(e) Except for M-PW, as defined in 10A NCAC 23A .0102, the monthly amount of wages, income, and deductions shall be calculated by converting the amount received by frequency into a monthly amount as follows:

(1) If received weekly, multiply by 4.3.

(2) If received bi-weekly, multiply by 2.15.

(3) If received semi-monthly, multiply by 2.

(4) If received monthly, use the monthly gross.

(5) If salaried, and contract renewed annually, divide annual income by 12.

(f) For M-PW cases, the budget unit's actual income for the calendar month of eligibility shall be verified by the county department of social services.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108.54.1B; 42 C.F.R. 435.121; 42 C.F.R. 435.401; 42 C.F.R. 435.603; 42 C.F.R. 435.831; 45 C.F.R. 435.845; 45 C.F.R. 233.20; 45 C.F.R. 233.51;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; August 1, 1990; March 1, 1986;
Temporary Amendment Eff. August 22, 1996;
Amended Eff. August 1, 1998;
Transferred from 10A NCAC 21B .0404 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0209 DEDUCTIBLE

(a) A deductible shall apply to a client in the following arrangements:

(1) In private living quarters in the community;

(2) In a residential group facility; or

(3) In a long-term care living arrangement when the client:

(A) Has enough income monthly to pay the Medicaid reimbursement rate for 31 days, but does not have enough income to pay the private rate plus all other anticipated medical costs;

(B) Is under a sanction due to a transfer of resources as specified in the Medicaid State Plan;
(C) Does not yet have documented prior approval for Medicaid payment of nursing home care;
(D) Resided in a facility in the facility's month of certification;
(E) Chooses to remain in a decertified facility beyond the last date of Medicaid payment; or
(F) Is under a Veterans Administration (VA) contract for payment of cost of care in the nursing home.

(b) The client or his or her representative shall be responsible for providing bills, receipts, insurance benefit statements, or Medicare EOBs to establish incurred medical expenses and his or her responsibility for payment. If the client has no representative and he or she is physically or mentally incapable of accepting this responsibility, the county department of social services shall assist him or her in obtaining verification.

(c) Expenses shall be applied to the deductible when they meet the following criteria:
(1) They are for medical care or service recognized under State or federal tax law;
(2) They are incurred by a budget unit member; and
(3) They are incurred:
(A) During the certification period for which eligibility is being determined and the requirements of Paragraph (d) of this Rule are met; or
(B) Prior to the certification period and the requirements of Paragraph (e) of this Rule are met.

(d) Medical expenses incurred during the certification period shall be applied to the deductible if the requirements in Paragraph (c) of this Rule are met and:
(1) The expenses are not subject to payment by any third party including insurance, government agency or program, except when the program is entirely funded by State or local government funds, or private source;
(2) The private insurance has not paid the expenses by the end of the application time standard;
(3) For certified cases, the insurance has not paid by the time that incurred expenses equal the deductible amount; or
(4) The third party has paid and the client is responsible for a portion of the charges.

(e) The unpaid balance of a medical expense incurred prior to the certification period shall be applied to the deductible if the requirements in Paragraph (c) of this Rule are met and:
(1) The medical expense was:
(A) Incurred within 24 months immediately prior to:
(i) The month of application for prospective or retroactive certification period or both; or
(ii) The first month of any subsequent certification period; or
(B) Incurred prior to the period described in Part (e)(1)(A) of this Rule, and a payment was made on the bill during that period; and
(2) The medical expense:
(A) Is a current liability;
(B) Has not been applied to a previously met deductible; and
(C) Insurance has paid any amount of the expense covered by the insurance.

(f) The county department of social services shall apply incurred medical expenses to the deductible in chronological order of charges except that:
(1) If medical expenses for Medicaid covered services and non-covered services occur on the same date, apply charges for non-covered services first;
(2) If both hospital and other covered medical services are incurred on the same date, apply hospital charges first; and
(3) If a portion of charges is still owed after insurance payment has been made for lump sum charges, compute incurred daily expense to be applied to the deductible as follows:
(A) Determine the average daily charge, calculated by adding the charges and dividing by the number of days, excluding discharge date from hospitals;
(B) Determine the average daily insurance payment, calculated by adding the insurance payments and dividing by the number of days, for the same number of days; and
(C) Subtract average daily insurance payment from the average daily charge to establish client's daily responsibility.

(g) Eligibility shall begin on the day that incurred medical expenses reduce the deductible to $0, except that the client is financially liable for the portion of medical expenses incurred on the first day of eligibility that were applied to reduce the deductible to $0. If hospital charges were incurred on the first day of eligibility, notice of the amount of those charges applied to meet the deductible shall be sent to the hospital for deduction on the hospital's bill to Medicaid.
(h) The receipt of proof of medical expenses and other verification shall be documented by the county department of social services in the case record.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.831; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File Number C-C-74-483; Alexander v. Flaherty Consent Order filed February 14, 1992;*
Eff. September 1, 1984;
Amended Eff. June 1, 1994; September 1, 1993; April 1, 1993; August 1, 1990;
Transferred from 10A NCAC 21B .0406 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0210 PATIENT LIABILITY
(a) Patient liability shall apply to clients who live in facilities for skilled nursing, intermediate nursing, intermediate care facility for individuals with an intellectual disability, or other medical institutions.
(b) The client's patient liability for cost of care shall be computed as a monthly amount after deducting the following from his or her total income:
(1) An amount for his or her personal needs as established under the Medicaid State Plan;
(2) Income given to the community spouse to provide him or her a total monthly income from all sources, equal to the "minimum monthly maintenance needs allowance" as defined in 42 U.S.C. 1396r-5(d)(3)(A);
(3) Income given to family members described in 42 U.S.C. 1396r-5(d)(1), to provide each, from all sources of income, a total monthly income equal to:
(A) One-third of the amount established under 42 U.S.C. 1396r-5(d)(3)(A)(i); or
(B) Where there is no community spouse, an amount for the number of dependents, based on the income level for the corresponding budget unit number, as approved by the NC General Assembly and stated in the Appropriations Act for categorically and medically needy classifications;
(4) The income maintenance level provided by 42 U.S.C. 1396r-5(d)(3)(A)(i) or State statute for a single individual in a private living arrangement with no spouse or dependents at home, for whom the physician of record has provided a written statement that the required treatment is such that the patient is expected to return home within six months, shall be allowed by the county department of social services; and
(5) An amount for unmet medical needs as determined under Paragraph (f) of this Rule.
(c) Patient liability shall apply to institutional charges incurred from the date of admission or the first day of the month and shall not be prorated by days if the client lives in more than one institution during the month.
(d) The county department of social services shall notify the client, the institution, and the State of the amount of the monthly liability and any changes or adjustments.
(e) When the patient liability as calculated in Paragraph (b) of this Rule exceeds the Medicaid reimbursement rate for the institution for a 31-day month:
(1) The patient liability shall be the institution's Medicaid reimbursement rate for a 31-day month; and
(2) The client shall be placed on a deductible determined in accordance with regulations, Rules .0208 and .0209 of this Section, and the Medicaid State Plan.
(f) The amount deducted from income for unmet medical needs shall be determined as follows:
(1) Unmet medical needs shall be the costs of:
(A) Medical care covered by the program that exceeds limits on coverage of that care and is not subject to payment by a third party;
(B) Medical care recognized under State and federal tax law that is not covered by the program and that is not subject to payment by a third party; and
(C) Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.

(2) The amount of unmet medical needs deducted from the patient's monthly income shall be limited to monthly charges for Medicare and other health insurance premiums.
(3) The actual amount of incurred costs that are the patient's responsibility shall be deducted when reported from the patient's liability for one or more months.
(4) Incurred costs shall be reported by the end of the six-month Medicaid certification period following the certification period in which they were incurred.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.733; 42 C.F.R. 435.831; 42 C.F.R. 435.832; 42 U.S.C. 1396r-5;*
Eff. September 1, 1984;
Amended Eff. September 1, 1994; March 1, 1991; August 1, 1990; March 1, 1990;
Transferred from 10A NCAC 21B .0407 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23E .0211 ALIEN SPONSOR DEEMING

(a) For purposes of this Rule, a "sponsored alien" means an alien who is lawfully admitted for permanent residence sponsored by an individual who has signed an Affidavit of Support required by U.S. Citizenship and Immigration Services.
(b) For purposes of this Rule, a "sponsor" means a person who signed an Affidavit of Support on behalf of an alien as a condition of the alien's entry or admission to the United States. The sponsor is financially responsible for the alien, and the sponsor's income shall be counted by the county department of social services in determining an alien's eligibility for medical assistance.
(c) An indigent alien shall be exempt from Paragraph (b) of this Rule if the sum of Subparagraphs (1), (2), and (3) of this Paragraph does not exceed 130 percent of the poverty income guidelines, which are incorporated by reference with subsequent amendments and editions, available free of charge at https://aspe.hhs.gov/poverty-guidelines.
(1) The sum of the sponsored alien's own income;
(2) The cash contributions of the sponsor and others; and
(3) The value of any in-kind assistance the sponsor and others provide the alien.
(d) The countable income of a sponsor shall be determined in accordance with Rules .0203 and .0208 of this Section and the Medicaid State Plan.
(e) The countable resources of a sponsor shall be determined in accordance with Rules .0202 and .0207 of this Section.
(f) Verification, as defined by 10A NCAC 23A .0102, by a third party shall be required for:
(1) sponsorship;
(2) a sponsor's income; and
(3) a sponsor's resources.
The application shall be denied if verification is not received by the processing deadline set out in 42 C.F.R. 435.912.

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.1B; 108A-55; P.L. 104-208, Title II; P.L. 105-33, Title IV;*
Temporary Adoption Eff. July 3, 2003;
Eff. March 1, 2004;
Transferred from 10A NCAC 21B .0410 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

SUBCHAPTER 23F – RESERVED FOR FUTURE CODIFICATION

SUBCHAPTER 23G – MEDICAID CERTIFICATION, CORRECTION OF ELIGIBILITY AND REDETERMINATION OF ELIGIBILITY

SECTION .0100 – MEDICAID CERTIFICATION

10A NCAC 23G .0101 CERTIFICATION AND AUTHORIZATION

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.112; 42 C.F.R. 435.914;*
Eff. September 1, 1984;
Amended Eff. March 1, 1993; August 1, 1990;
Transferred from 10A NCAC 21B .0405 Eff. May 1, 2012;
Repealed Eff. June 1, 2019.

SECTION .0200 – CORRECTION OF ERRONEOUS ELIGIBILITY

10A NCAC 23G .0201 GENERAL

(a) The county department of social services shall correct prior actions according to Rules .0202 and .0203 in this Section when the county department of social services discovers that prior actions were eligibility errors, as defined by 42 CFR 431.804, which is incorporated by reference with subsequent amendments and editions, available free of charge at https://www.ecfr.gov/, or the recipient's circumstances have changed from the last eligibility determination.

(b) Information leading to corrections may be reported by the recipient, medical providers, State agencies, or any other source with knowledge about the recipient's circumstances that impact eligibility.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 431.246; 42 C.F.R. 435.916;*
Eff. September 1, 1984;
Amended Eff. June 1, 1990;
Transferred from 10A NCAC 21A .0601 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23G .0202 CORRECTIVE ACTIONS

(a) Corrections in an applicant's or recipient's case shall be made by the county department of social services when:
- (1) An individual was discouraged from filing an application, as described in 10A NCAC 23C .0101;
- (2) An appeal or court decision overturns an earlier adverse decision;
- (3) The certification periods of financially responsible persons need to be adjusted to coincide with the individual's certification period;
- (4) Information received from any source undergoes verification, as defined in 10A NCAC 23A .0102, by the county department of social services and is found to change the amount of the recipient's deductible, patient liability, authorization period, or otherwise affect the recipient's eligibility status;
- (5) Additional medical bills or medical expenses that are verified by the county department of social services establish an earlier Medicaid effective date;
- (6) The agency made an administrative error including:
  - (A) An eligibility error, as defined by 42 CFR 431.804, that resulted in assistance being incorrectly terminated or denied;
  - (B) Failure to act on information received; or
  - (C) Incorrect determination of the authorization period, Medicaid effective date, or erroneous data entry;
- (7) Monitoring of application processing by the Division of Health Benefits (Division), as required by 42 C.F.R. 431, Subpart P, shows an application was denied, withdrawn, or a person was discouraged from applying for assistance; or
- (8) The Division determines the county failed to follow federal regulations or State rules to authorize eligibility.

(b) Corrections in an applicant's or recipient's case shall be made by the Division when:
- (1) Information is received from county departments of social services, medical providers, the public, clients, or Division staff showing that a terminated case has errors in the Medicaid eligibility segments, Medicare Buy-In effective date, eligible household members, Community Alternatives Program (CAP) indicators and effective dates, or other data that is causing valid claims to be denied;
- (2) The county department of social services fails to take required corrective actions; or

(3) An audit report from State auditors or the Division shows verified errors in the Medicaid eligibility history.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 431.246; 42 C.F.R. 431, Subpart P; 42 C.F.R. 435.903;*
Eff. June 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0602 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23G .0203 TIME LIMITS FOR CORRECTIONS

(a) The county department of social services and Division shall make corrections required by Rule .0202 of this Section within 30 days after discovery of the need for action unless good cause exists to extend the time limit.

(b) For the purposes of this Rule, "good cause" is limited to:

(1) The need of the county department of social services to obtain verification, as defined at 10A NCAC 23A .0102, of other conditions of eligibility before authorizing eligibility;

(2) The county department of social services is unable to locate the applicant or recipient; or

(3) The county department of social services disagrees with a decision requiring corrective action and requests administrative review by the Division. In the case of disagreement under Rule .0202(a)(2) of this Section, administrative review by the Division shall be limited to decisions issued pursuant to G.S. 108A-79(j).

(c) To receive State and federal financial participation in any benefits authorized retroactively by corrective actions, the effective date of the correction must correspond with the date assistance would have been effective but may be no earlier than the following dates:

(1) Retroactive to the date ordered by the appeal or court decision if all eligibility conditions are met, including any legal retroactive coverage period associated with the adverse action;

(2) Retroactive to the date that all requirements of eligibility are met but no earlier than the 12th month immediately preceding the month the change is reported or the administrative error was discovered; or

(3) Retroactive to the date required for corrective action due to errors cited from monitoring under application processing standards in 10A NCAC 23C .0202.

(d) If the change is adverse to the recipient, it shall be effective the first calendar month following expiration of the 10 business day advance notice period, as defined in 10A NCAC 23A .0102.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 431.246; 42 C.F.R. 431.250; 42 C.F.R. 435.903;*
Eff. June 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0603 Eff. May 1, 2012;
Readopted Eff. August 1, 2019.

10A NCAC 23G .0204 RESPONSIBILITY FOR ERRORS

(a) The Division shall be financially responsible for costs resulting from the erroneous issuance of benefits and Medicaid claims payments when:

(1) Policy guidance given by the Division or its agents is erroneous and the Division determines that is the sole cause of any erroneous benefits or payments;

(2) A systems failure at the State computer center occurs on the last cutoff date of the month preventing the county DSS from data entering case terminations or adverse actions; or

(3) Any other failure or error the Division determines is attributable solely to the State occurs.

(b) The county department of social services shall be financially responsible for costs resulting from the erroneous issuance of benefits and Medicaid claims payments when it:

(1) Authorizes retroactive eligibility outside the dates permitted by federal regulations or Rule .0203 of this Section;

(2) Fails to send required notices of patient liability or deductible balance to medical providers;

(3) Fails to end-date special coverage indicators such as Community Alternatives Program (CAP) in the State eligibility information system;
(4) Enters an authorization date in the eligibility system that is earlier than the effective date of eligibility;
(5) Fails to determine the availability of or fails to enter data on third-party resource information in the State eligibility information system;
(6) Terminates a case or individual after the Medicaid ID card has been issued;
(7) Fails to initiate application for Medicare Part B coverage for recipients who are eligible, but refuse or are unable to apply for themselves; or
(8) Takes any other action that requires payment of Medicaid claims for an ineligible individual, for ineligible dates, or for an amount that includes a recipient's liability and for which the State cannot claim federal participation.

(c) The amounts to be charged back shall be determined pursuant to G. S. 108A-25.1A(c).

History Note: *Authority G.S. 108A-25.1A; 108A-54; 108A-54.1B; 42 C.F.R. 433.32; 42 C.F.R. 435.903; Eff. June 1, 1990; Amended Eff. May 1, 1992; Transferred from 10A NCAC 21A .0604 Eff. May 1, 2012; Readopted Eff. June 1, 2019.*

SECTION .0300 – REDETERMINATION OF ELIGIBILITY AND CHANGE IN SITUATION

10A NCAC 23G .0301 TIME AND CONTENT

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.916; Eff. September 1, 1984; Amended Eff. August 1, 1990; Transferred from 10A NCAC 21B .0501 Eff. May 1, 2012; Expired Eff. August 1, 2016 pursuant to G.S. 150B-21.3A.*

10A NCAC 23G .0302 INTERVIEW

A redetermination interview shall be conducted with the client or his representative in either the client's place of residence or the county agency office. During the interview, all eligibility requirements, rights and responsibilities and referrals for other agency services are explained.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.916; Eff. September 1, 1984; Amended Eff. August 1, 1990; Transferred from 10A NCAC 21B .0502 Eff. May 1, 2012; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.*

10A NCAC 23G .0303 RECOMMENDATION

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.919; Eff. September 1, 1984; Amended Eff. August 1, 1990; Transferred from 10A NCAC 21B .0503 Eff. May 1, 2012; Repealed Eff. June 1, 2019.*

10A NCAC 23G .0304 CHANGE IN SITUATION

(a) For the purposes of this Rule, a "change in situation" includes:
(1) Change of address;
(2) Change in living arrangement;
(3) Adding or deleting a budget unit member;
(4) Increase or decrease in income;

(5) Change in reserve;
(6) Cessation of disability or blindness;
(7) Parent or parents are no longer incapacitated or unemployed;
(8) Change in responsible relative; or
(9) Change in Medicaid program category.

(b) The Medicaid client or his or her representative shall report any change in situation in the budget unit or household as defined by 42 C.F.R. 435.603 that affects eligibility to the county department of social services within 10 calendar days of knowledge of the change. 42 C.F.R. 435.603 is incorporated by reference, including subsequent amendments and editions, available and free of charge at https://www.ecfr.gov.

(c) Once the county department of social services learns from any source that there has been a change in situation that affects eligibility, it shall verify that information by reviewing its files or electronically as defined by 42 C.F.R. 435.949, which is incorporated by reference including subsequent amendments and editions, and available free of charge at https://www.ecfr.gov. When the change in situation cannot be verified from its files or electronically, it shall send a notice of the need to obtain verification, as defined by 10A NCAC 23A .0102, of the change. No notice shall be sent if the change in situation can be verified in the county department of social services' files or electronically.

(d) For Medicaid applications, the application processing standards set forth in 10A NCAC 23C .0201 shall apply.

(e) For an active case with an ongoing certification period, once the county department of social services learns from any source that there has been a change in situation, it shall review the case and determine eligibility. Processing shall be completed within 30 calendar days after the agency learns of the change.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.603; 42 C.F.R. 435.916; 42 C.F.R. 435.949; Eff. September 1, 1984; Amended Eff. August 1, 1990; Temporary Amendment Eff. August 22, 1996; Amended Eff. August 1, 1998; Transferred from 10A NCAC 21B .0409 Eff. May 1, 2012; Readopted Eff. October 1, 2019.*

SUBCHAPTER 23H – CONFIDENTIALITY AND ACCESS TO CLIENT RECORDS

SECTION .0100 - GENERAL

10A NCAC 23H .0101 SCOPE

The rules of this Subchapter protect the client's right to confidentiality. Non-identifying statistical information, general information about the scope of any programs administered by the agency, and any written policy relevant to the administration of the Medicaid program, are not confidential information.

History Note: *Authority G.S. 108A-54; 108A-80; Eff. September 1, 1984; Amended Eff. August 1, 1990; Transferred from 10A NCAC 21A .0401 Eff. May 1, 2012; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.*

10A NCAC 23H .0102 INFORMATION FROM OTHER AGENCIES

If the agency receives information from another agency or individual, that information shall be treated as any other information generated by the Division of Health Benefits or the county department of social services, and disclosure thereof will be governed by any condition imposed by the furnishing agency or individual.

History Note: *Authority G.S. 108A-54; 108A-80; Eff. September 1, 1984; Transferred from 10A NCAC 21A .0402 Eff. May 1, 2012; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;*

Amended Eff. March 1, 2020.

10A NCAC 23H .0103 CONFIDENTIALITY

(a) Except as otherwise provided in these Rules it shall be unlawful for any person to obtain, disclose or use, or to authorize, permit or acquiesce to the use of any list of names or other information concerning any client applying for or receiving Medicaid that may be directly or indirectly derived from the records, files, or communications of the agency, or acquired in the course of performing official duties except for purposes directly connected with the administration of the Medicaid program.

(b) Whenever federal or state statutes or regulations specifically address confidentiality issues, the agency shall disclose or keep confidential client information in accordance with those federal or state statutes or regulations.

(c) Whenever there is inconsistency between federal or state statutes or regulations specifically addressing confidentiality issues, the agency shall abide by the statute or regulation which provides more protection for the client.

History Note: *Authority G.S. 108A-54; 108A-80; 42 C.F.R. 431.302;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0403 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23H .0104 OWNERSHIP OF RECORDS

(a) All client information contained in any records of the agency is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as provided by the rules of this Subchapter.

(b) Original client records may not be removed from the premises by individuals other than authorized staff of the agency, except by a court order.

(c) The agency shall be allowed to destroy records in accordance with record retention schedules promulgated by the Division of Archives and History, rules of the Division of Medical Assistance, and state and federal statutes and regulations.

History Note: *Authority G.S. 108A-54; 108A-80; 42 C.F.R. 431.306;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0404 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23H .0105 SECURITY OF RECORDS

(a) The agency shall provide a secure place or places with controlled access for the storage of records. Only individuals who must access client information in order to carry out duties assigned or approved by the agency shall be authorized access to the storage area or areas.

(b) Only authorized individuals may remove a record from the storage area or areas and the authorizing individual shall be responsible for the security of the record until it is returned to the storage area or areas.

(c) The agency shall establish procedures to prevent accidental disclosure of client information from automated data processing systems.

(d) The director shall assure that all authorized individuals are informed of the confidential nature of client information and shall disseminate written policy to and provide training for all persons with access to client information.

History Note: *Authority G.S. 108A-54; 108A-80; 42 C.F.R. 431.306;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0405 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23H .0106 LIABILITY OF PERSONS WITH ACCESS

(a) Failure to comply with the rules in this Subchapter is unlawful pursuant to G.S. 108A-80.

(b) Individuals employed by the Division and county departments of social services and governed by the State Personnel Act are subject to suspension, dismissal, or disciplinary action for failure to comply with these Rules.

(c) Individuals other than employees, including volunteers and students who are agents of the Department of Health and Human Services and who have access to client information, shall be liable in the same manner as employees.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80; 42 C.F.R. 431, Subpart F;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0406 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0107 RIGHT OF ACCESS

(a) An individual has the right to obtain information about his or her own case. Upon written or verbal request, the client shall be able to review or obtain without charge a copy of the information in his or her records with the following exceptions:

(1) Information that the agency is required to keep confidential by State or federal statutes, rules, or regulations;

(2) Confidential information originating from another agency as set forth in Rule .0104 of this Section; and

(3) Information that would breach another individual's right to confidentiality under State or federal statutes, rules, or regulations as determined by the Division or the county department of social services.

(b) The agency shall provide access within five business days.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80; 42 C.F.R. 431.306;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0407 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0108 WITHHOLDING INFORMATION FROM THE CLIENT

(a) When the director or a delegated representative determines on the basis of the exceptions in Rule .0107 of this Section to withhold information from the client, this reason shall be documented in the client record.

(b) The director or delegated representative shall inform the client that information is being withheld, and upon which of the exceptions specified in Rule .0107 of this Section the decision to withhold the information is based. If confidential information originating from another agency is being withheld, the client shall be referred to that agency for access to the information.

(c) When a delegated representative determines to withhold client information, the decision to withhold shall be reviewed by the supervisor of the person making the initial determination.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0408 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0109 PROCEDURE FOR REVIEW OF RECORDS

(a) The director or his or her delegated representative shall be present when the client reviews the record. The director or his or her delegated representative shall document in the client record the review of the record by the client.

(b) A client may contest the accuracy, completeness, or relevancy of the information in his or her record. If the Division or county department of social services determines correction is required by federal statute or regulation to support receipt of State or federal participation, the correction of the contested information shall be accomplished by inserting it in the record when the director or his or her delegated representative concurs that such correction is justified. When the director or his or her delegated representative does not concur, the client shall be allowed to

enter a statement in the record. Deletion of the contested information is not permitted. If a delegated representative decides not to correct contested information, the decision not to correct shall be reviewed by the supervisor of the person making the initial decision. All corrections and statements shall be made a permanent part of the record and shall be disclosed to any recipient of the disputed information.
(c) Upon written request from the client, his or her personal representative, including an attorney, may have access to review or obtain without charge, a copy of the information in his or her record. The client may permit the personal representative to have access to his or her entire record or may restrict access to certain portions of the record. Rules .0107 and .0108 of this Section shall apply.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0409 Eff. May 1, 2012;
Readopted Eff. August 1, 2019.

10A NCAC 23H .0110 CONSENT FOR RELEASE
(a) As a part of the application process for Medicaid, the client shall be informed of the need for and give consent to release of information for verification of statements to establish eligibility.
(b) No individual shall release any client information that is owned by the Division of Health Benefits or the county departments of social services, or request the release of information regarding the client from other agencies or individuals, without obtaining a signed consent for release of information. The procedure for disclosure without obtaining consent shall be in accordance with Rule .0111 of this Section.
(c) The consent for release of information shall contain the following:
(1) The name of the provider and the recipient of the information;
(2) The extent of information to be released;
(3) The name and dated signature of the client;
(4) A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent; and
(5) The length of time the consent is valid.
(d) The client may alter the form to contain other information, including:
(1) A statement specifying the date, event, or condition upon which the consent may expire even if the client does not expressly revoke the consent; or
(2) A specific purpose for the release.
(e) The following persons may consent to the release of information:
(1) The client;
(2) The legal guardian if the client has been judged incompetent; or
(3) The county department of social services if the client is a minor and in the custody of the county department of social services.
(f) Prior to obtaining a consent for release of information, the director or delegated representative shall explain the meaning of informed consent. The client shall be told the following:
(1) Contents to be released;
(2) That the information is needed to verify eligibility;
(3) That the client can give or withhold the consent and the consent is voluntary; and
(4) That there are statutes, rules, and regulations protecting the confidentiality of the information.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80; 42 C.F.R. 431.304; 42 C.F.R. 431.306;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0410 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0111 DISCLOSURE WITHOUT CLIENT CONSENT
(a) Client information from the Medicaid record may be disclosed without the consent of the client under the following circumstances:
(1) To other employees of the county department of social services for purpose of making referrals, supervision, consultation, or determination of eligibility;

(2) To other county departments of social services when the client moves to that county and requests Medicaid;
(3) Between the county departments of social services and the Division of Health Benefits for purposes of supervision and reporting.

(b) Client information may be disclosed without client consent to individuals approved by the Division to conduct studies of client records. The request to conduct the study shall be in writing, and shall be approved based upon:
(1) An explanation of how the findings of the study are expected to expand knowledge and improve professional practices among those who work in the field studied;
(2) A description of how the study will be conducted and how the findings will be used;
(3) The individual's credentials in the area of investigation;
(4) A description of how the individual will safeguard the information; and
(5) An assurance that no report will contain the names of individuals or other information that makes individuals identifiable.

(c) Client information may be disclosed without consent to federal, State , or county employees for the purpose of monitoring, auditing, evaluating, or to facilitate the administration of other State and federal programs, provided that the need for the disclosure of confidential information is justifiable for the purpose and that adequate safeguards, as described in 42 C.F.R. 431.300, which is incorporated by reference with subsequent amendments and editions and available free of charge at https://www.ecfr.gov/, are maintained to protect the information from re-disclosure.

(d) Client information may be disclosed without consent for purposes of complying with other State and federal statutes, rules, and regulations and court orders.

(e) When information is released without the client's consent, the client shall be informed of the disclosure in writing to explain what information was released, how it was released, and how to contact the privacy official. The writing informing the client of the disclosure shall be documented in the record.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80; 42 C.F.R. 431.306;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0411 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0112 DOCUMENTATION OF CONSENT OR DISCLOSURE

Whenever client information is disclosed in accordance with rules of this Subchapter, the director or delegated representative shall document the disclosure in the client record.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-80;*
Eff. September 1, 1984;
Transferred from 10A NCAC 21A .0412 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23H .0113 PERSONS DESIGNATED TO DISCLOSE INFORMATION

Only directors of county departments of social services and their designated representatives may disclose client information in accordance with rules of this Subchapter. The process for delegation is set out in G.S. 108A-14(b).

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-14(b); 108A-80;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21A .0413 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 25H .0205 RESTRICTIONS AND PRIOR APPROVAL

(a) The Division of Health Benefits shall have the right of prior approval for dental services except for routine and emergency services.

(b) All other dental services are subject to prior approval. Dental services categories requiring dental prior approval are as follows: Elective root canal treatment, periodontal services, orthodontic services, complex oral surgical and reconstructive procedures, complete and partial dentures, denture relines and analgesia (nitrous oxide). Each specific procedure under the American Dental Association (ADA) service category in this Paragraph will be listed in the provider dental manual and provider bulletins with the appropriate prior approval service restriction guidelines.

(c) The Division of Health Benefits may require prior approval for any services for individual providers who have been investigated by the Division under 10A NCAC 22F or by the Attorney General's Fraud Control Unit under 42 Code of Federal Regulations 455.300, and the investigation resulted in monetary recovery of payments made by Medicaid to the provider or criminal conviction of the provider.

History Note: *Authority G.S. 108A-25(b); 108A-54; S.L. 1985, c. 479, s. 86;*
Eff. February 1, 1976;
Amended Eff. September 30, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. October 1, 1992; February 29, 1980;
Transferred from 10A NCAC 22O .0205 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.