

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Repealed Eff.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Repealed Eff.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 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.*