CHAPTER 18-001 – PREGNANT WOMEN, PARENTS/CARETAKER RELATIVES, CHILDREN, 599 CHIP, FORMER WARDS, and HOSPITAL PRESUMPTIVE

18-001.01 Pregnant Women

18-001.01A Pregnancy Verification: Verification of pregnancy shall not be required unless information is not reasonably compatible with the applicant or beneficiary's attestation.

18-001.02 Presumptive Eligibility (PE): Under Section 1920 of the Social Security Act, Medicaid covers ambulatory prenatal care for pregnant women on the basis of presumptive eligibility. The qualified provider may authorize a period of presumptive eligibility once per pregnancy.

Note: There is no presumptive eligibility for 599 CHIP unborn.

18-001.02A Ambulatory Prenatal Care: See 471 NAC 28-001.

18-001.02B Qualified Provider: Only a qualified provider is allowed to make the presumptive eligibility determinations. See 471 NAC 28-001.01 for requirements of a qualified provider.

18-001.02C Qualified Provider Responsibilities: The qualified provider makes a presumptive determination of the woman's eligibility based only on declared income and citizenship/eligible alien status.

1. Income of the woman and spouse (if he is in the home) or the responsible parent(s) of a pregnant minor is counted.
2. The provider does not investigate other eligibility requirements.
3. The provider must forward the application form, along with the attestation form if applicable to the Department within five (5) working days after the determination of presumptive eligibility.

18-001.02D Effective Date: The date the provider determines presumptive eligibility for assistance.

18-001.02D Presumptive Eligibility Period: Presumptive eligibility begins on the day a qualified provider determines that a woman meets any of the income eligibility levels. Eligibility shall be determined within 45 days.

If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the presumptive eligibility ends on the day that the State agency makes the determination of Medicaid eligibility based on that application.

If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the presumptive eligibility ends on that last day.

A presumptive application approved in error will be closed by the Department upon discovery of the error.

The Department is not required to notify the woman that her PE case has closed, but the Department is required to send a notice when Medicaid eligibility has been determined.

18-002 Parents/Caretaker Relatives

18-002.01 Special Provisions for Two Parent Families

18-002.01A Two Parent Families: If unmarried parents are living together as a family and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

18-002.01B Deprivation Requirements for Two Parent Families: Two-parent families must meet the following eligibility requirements:

18-002.01B1 Hundred-Hour Rule: Neither medically needy parent can be working more than 100 hours in a calendar month. The parent(s) must not have worked more than 100 hours in any of the three previous calendar months, or if the parent(s) is scheduled to work more than 100 hours for the month of application. Work study is considered employment when determining the 100 hours.

18-002.01B2 Physical or Mental Incapacity of a Parent: A needy child is considered deprived of parental support or care if either parent has a physical or mental incapacity. If the parent is receiving Aid to the Aged, s/he must be determined incapacitated according to provisions set forth below.

18-002.01B3 Determination of Incapacity: If a parent is receiving RSDI, SSI, AABD, or SDP based on disability or blindness, s/he qualifies as incapacitated. For all others the determination of incapacity is made by the State Review Team (SRT).

18-002.01B4 Requirement to Cooperate: The incapacitated parent is required to cooperate in obtaining treatment or rehabilitative or vocational services that are recommended on Form DM-5R. If the incapacitated parent fails to obtain the treatment or services, the case is ineligible.

18-003 Children/Children in an Institution for Mental Disease (IMD)

18-003.01 Medical Assistance for Individuals 18 or Younger: Children may receive Medicaid if they meet the eligibility requirements outlined in this material. See 477-000-012 for the applicable federal poverty levels.

1. Newborn child(ren): Newborn child(ren) born to Medicaid eligible pregnant women are eligible at the time of birth, if the family income equals the applicable federal poverty level, through the month of the child's first birthday.
2. Children up to age one: Children up to the age of one are eligible if the family income equals the applicable federal poverty level.
3. Children age five or younger: Children age one through five (through the month of their sixth birthday) are eligible if the family income equals the applicable federal poverty level.
4. Children ages six and older: Children ages 6 through 18 are eligible if the family income equals the applicable federal poverty level. Eligibility continues through the month of the child's 19th birthday.
5. Children's Health Insurance Program (CHIP): Children age 18 or younger who do not meet income limits for Medicaid are eligible for CHIP if the family income is at or below the applicable Federal Poverty Level and are not covered by creditable health insurance.
6. Minor pregnant women: Minor pregnant women who do not meet the income limits for children's Medicaid are eligible under the Pregnant Woman category if the family income equals the applicable federal poverty level. Ongoing Medicaid eligibility must be reviewed prior to the end of the 60-day postpartum period.

18-003.02 Child in an IMD

18-003.2A Child in an IMD: If a child who is placed in an IMD is a ward of the Department or another public agency or if the placement is court-ordered, see 477 NAC 25-001. If the child who is placed in an IMD is still considered part of the household, the parent(s)' income is deemed. See 477-000-009 for calculation procedures.

18-003.02B Individuals Age 19 and 20: May be found eligible under this category if they are receiving inpatient care in an Institution for Mental Disease (IMD). If an individual is an inpatient in an IMD when s/he reaches 21 years of age, s/he may remain eligible either until discharge or until s/he reaches age 22, whichever comes first.

18-003.03 Children Ineligible Due to MAGI Methodologies: Children who lose Medicaid or CHIP eligibility (with or without health insurance) due to the elimination of disregards as a result of the conversion to MAGI shall have protective Medicaid coverage for one year if the child had Medicaid as of December 31, 2013. Unless the following conditions are met previously:

1. Attain age 19;
2. Move out of Nebraska;
3. Request removal from the program; or

4. Deceased.

Exceptions to the protective status:

1. Children who are inmates of a public institution; or
2. Children who are patients in an institution for mental disease (IMD).

This protected group expires December 31, 2015.

18-003.04 Children receiving CHIP who move to Medicaid due to the increased Federal Poverty Levels under the ACA:

Children who move from CHIP to Medicaid as a result of increased Federal Poverty Levels effective January 1, 2014 shall qualify for CHIP funding for up to one year if the child was CHIP eligible as of December 31, 2013 and continues to meet Medicaid eligibility requirements.

This group expires December 31, 2015.

18-004 599 CHIP

18-004.01 Eligibility Requirements: A pregnant woman, who is not otherwise eligible for Medicaid, may apply to have her unborn child(s) eligibility reviewed under the 599 CHIP program. Eligibility for Medicaid must first be determined before 599 CHIP eligibility can be reviewed. Eligibility is determined for unborn children from conception through birth, if the pregnant woman and spouse's income is at or below the Federal Poverty Level (FPL). See 477-000-012 for the applicable FPL.

599 CHIP has no requirement for citizenship or alien status due to the unborn(s) status being independent of the pregnant woman.

There is no eligibility for the unborn(s) if the pregnant woman has creditable health insurance. Health insurance that does not provide prenatal or maternity care is not considered creditable coverage. For a definition of creditable health insurance, see 477 NAC 1-001.

The pregnant woman will not be eligible for post-partum services under 599 CHIP. If post-partum care is needed for complications following labor and delivery, the woman may apply for EMSA.

18-004.02 Nebraska Residence: The residency of the unborn(s) will follow the residency of the pregnant woman.

18-004.03 Relative Responsibility: Relative responsibility for 599 CHIP has the following exception: For a pregnant minor, their financially responsible parent(s) income shall not be used in the unborn child(s) 599 CHIP budget.

18-004.04 Age Requirement: For receipt of 599 CHIP benefits, an individual is considered an unborn child from conception to birth.

18-004.05 Unborn 599 CHIP Eligibility if Parent(s) Does Not Cooperate: If an ineligible pregnant woman or her spouse fails or refuses to cooperate with third party liability, the unborn(s) is ineligible for 599 CHIP.

18-004.06 Effective Date of Medical Eligibility: The effective date of eligibility for 599 CHIP is no earlier than the first day of the application month.

Note: There is no retroactive eligibility for the 599 CHIP Program.

18-004.07 Continuous Eligibility: Unborn children are continuously eligible up to six months or through their month of birth, whichever comes first. After the six months of continuous eligibility, a full eligibility review is not required. However, information reported or known to the Department must be acted upon.

Note: The unborn must have at least a 30 day period of ineligibility before they would qualify for another six month period of continuous eligibility.

- Following the birth of the child, eligibility will be determined for medical assistance based on any changes reported or known to the Department.

Note: Following the birth, if the newborn is determined eligible for medical assistance, the newborn is eligible for six months of continuous medical eligibility.

18-005 Former Wards

18-005.01 Eligibility Requirements: If the ward is eligible for the former ward program (see 479 NAC 6-000), the former ward must:

1. Be within age limits;
2. Have been a ward of the Department immediately before entering the program for former wards;
3. Have been in out-of-home care at the time of discharge and continue to be in out of home care while in the program;
4. Be single;
5. Be attending or enrolled in a secondary educational program, college or vocational program and maintaining a passing average;
6. Meet income standards (see 477-000-012); and
7. Enroll in an available health plan.

18-005.02 Age Requirement: A former ward is eligible for medical assistance from age 18 through the month of his/her 21st birthday.

18-005.03 Living Arrangement: The former ward must continue to be in an out-of-home situation to remain eligible for the program.

18-006 Hospital Presumptive

The department shall provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital. The determination is on the basis of preliminary information, that the individual has gross income at or below the income standard established for the applicable group, has attested to being a citizen or national of the United States or is in satisfactory immigration status, and is a resident of Nebraska, to be presumptively eligible in accordance with the policies and procedures established by the department. Determinations are limited to:

1. Children (see 477 NAC 18-003);
2. Pregnant women (see 477 NAC18-001.01);
3. Breast and Cervical Cancer (see Women's Cancer Program at 477 NAC 24-004);
4. Parents and caretaker relatives (see 477 NAC 18-002); and
5. Former foster care children (see 477 NAC 24-006).

A presumptive eligibility determination is limited to no more than one period within two calendar years per person.

A pregnant woman is eligible for ambulatory care only. The qualified provider may authorize a period of presumptive eligibility once per pregnancy.

Notice and fair hearing regulations do not apply to determinations of presumptive eligibility.

18-006.01 Qualified Entities Responsibilities:

1. Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, that-
   a. If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individuals presumptive eligibility will end on that last day; and
   b. If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individuals presumptive eligibility will end on the day that a decision is made on the Medicaid application; and
   c. If the individual is not determined presumptively eligible, the qualified entity shall notify the appropriate individual of the reason for the determination and that he or she may file an application for Medicaid with the Medicaid agency.
2. Provide the individual with an agency approved application for Nebraska Medicaid;
3. Within five working days after the date that the determination is made, notify the agency that the individual is presumptively eligible; and
4. Shall not delegate the authority to determine presumptive eligibility to another entity.

18-006.02 Qualified Hospital Criteria:

1. Participate as a Medicaid provider;
2. Notify the Department of its decision to make presumptive determinations;
3. Agree to make determinations consistent with state policy and procedures;

4. Assist individuals in completing and submitting full applications;
5. Assist individuals in understanding required documentation requirements; and
6. Shall not be disqualified by the Department.