CHAPTER 24-001 – AGED, BLIND AND DISABLED MEDICAID (AABD/MA), MEDICALLY NEEDY (MN), MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD), WOMEN'S CANCER PROGRAM, FORMER FOSTER CARE, CHILD WELFARE MEDICAID AND EMERGENCY MEDICAL ASSISTANCE

24-001 AABD/MA

24-001.01 Age Requirement/Age Limit: To be eligible for Medicaid, the individual must meet the age requirements set by each applicable Medicaid category.

For AABD/MA individuals, an individual must meet the following age limits:

1. To qualify as aged, an individual must be age 65 or older;
2. To qualify as blind, an individual must be age 64 or younger; and
3. To qualify as disabled, an individual must be age 64 or younger.

The month that a blind or disabled person becomes 65, s/he becomes eligible for assistance to the aged.

24-001.02 Eligibility Categories

24-001.02A Blind or Disabled Recipients Eligible for Medicaid: A blind or disabled recipient who has earned income is eligible for MA without regard to share of cost if s/he meets specified guidelines. If a blind or disabled person reaches the age of 65, the Social Security Administration (SSA) may continue 1619(b) eligibility.

24-001.02B Current and Former SSI Recipients: A blind or disabled recipient who has earned income is eligible for MA without share of cost if s/he:

1. Received Medicaid in the month before the month in which this reference applies and continues to receive SSI (regular SSI payments or special SSI payments under section 1619(a) of the Social Security Act); or
2. Received Medicaid and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the Social Security Act.

The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field). If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible considering the ten-day notice requirement.

24-001.02C Former State (1619b) Supplemental Payment Recipients: A blind or disabled recipient who has earned income is eligible for MA without excess income if s/he:

1. Received a state supplemental payment and Medicaid (but not SSI) in the month before the month in which this reference applies;
2. Except for earnings continues to meet all of the eligibility requirements for AABD/MA and has unearned income less than the AABD/MA standard of need;

3. Continues to be blind or have a disabling impairment as determined by the State Review Team (SRT);
4. Would be seriously inhibited from working without Medicaid; and
5. Has earned income in an amount insufficient to provide the same level of benefits available from SSP, MA, and Title XX attendant care.
    a. The income threshold used by SSA for purposes of determining eligibility for 1619(b) status will be used for this determination.
    b. The continuing blindness/disability review in number 3 must be completed before the end of the 12th month after this section applies, and annually thereafter. See "Forms Necessary" at 477-000-040 to make the referral to the SRT for this review.

24-001.03 Blindness or Disability Determination

24-001.03A Eligibility Requirements Applicable Only to Blind or Disabled: All applicants for Aid to the Blind or Aid to the Disabled after January 1, 1974, must meet the medical definitions of blindness or disability of the RSDI/SSI Programs as administered by the Social Security Administration (SSA). The determination by SSA that an individual is disabled or blind must be accepted for eligibility for AABD/MA. In some cases, the State Review Team (SRT) may make the determination of blindness or disability.

24-001.03B Determination of Eligibility for the Blind or Disabled

24-001.03B1 Disability Determination: In the determination of eligibility for aid to the blind or disabled, all eligibility requirements except that of the disability determination are the responsibilities of the SSA.

24-001.03B2 Direct Referral to the State Review Team: In the following situations a referral may be submitted directly to the SRT for a determination of disability and its probable duration without waiting for an SSI determination if the individual is not eligible for another assistance program, and during the initial interview it is apparent that:

1. The individual has income and/or resources in excess of the limit for the SSI Program. The client's potential eligibility for SSI must be monitored. If income and/or resources fall below the SSI limit, a referral must be made immediately. The client is allowed 60 days to apply for this potential benefit;
2. The individual requires immediate long term hospitalization and/or treatment for a severe impairment before SSI can make a determination, or would be required to extend his/her hospital stay solely because of a delay in processing the SSI application, i.e., due to SSI's required waiting periods before a decision on certain types of disability can be made such as cancer or stroke (this does not include diagnostic examinations or tests, routine medications, or drug/alcohol treatment). An immediate referral must be made to SSI;
3. The individual is institutionalized (e.g., nursing home or public institution) and SSI will be unable to make a determination. An individual is eligible for SSI benefits while institutionalized only if Medicaid will pay 50 percent of his/her

care. Therefore, SSI may, in some cases, wait for a determination of eligibility for Medicaid. An immediate referral must be made to SSI;

4. The individual is deceased and SSI will not make a disability determination; or
5. The individual is a non-U.S. citizen who SSI will not review.

24-001.03B3 Subsequent Referrals to SSA: The agency shall continue to monitor the client's potential eligibility for RSDI and SSI benefits even though the SRT has made the determination of disability.

24-001.04 SSI Program: If a client has not applied for SSI, an application must be filed immediately. A client must be referred to SSI if:

1. The client lives alone and has monthly unearned income less than the referral amount for an individual;
2. An eligible couple are living together and have monthly unearned income less than the referral amount for a couple (Note: both must apply for SSI); or
3. An individual is in a nursing home and has unearned income of less than $50 per month.

Exception: If income is less than these amounts but resources are less than levels for MA, an SSI referral is not made but must consider eligibility for Medicaid.

24-001.05 Institutionalization: An individual may qualify for AABD/MA while living in an institution only if the institution is subject to the licensing requirements of the Nebraska Department of Health and Human Services, Division of Public Health.

24-001.05A Patients in a Medical Institution and Convalescent Leave: Assistance may be provided for a client who is a patient in a medical institution (e.g., hospital, nursing home, etc.) if all other eligibility factors are met. Psychiatric wards of medical hospitals are considered part of the medical institution and are not subject to the restriction on psychiatric care identified previously.

The Central Office is responsible for determining the public or private nature of an institution, and whether a public institution is one in which otherwise eligible individuals may receive assistance.

24-001.05B Criteria for Determining Public Nature of Institutions: Prisons, jails, etc., are designated in the law as public institutions whose inmates are ineligible to receive assistance. Governmental participation in financial support of an institution, in policy formulation, or in the application of policy to specific situations, is evidence of the public control which makes it a public institution. Payment from public funds to, or in support of, individuals in a private institution is not considered governmental participation in support of the institution.

24-001.06 Factors Relating to Eligibility of Clients in Institutions

24-001.06A Private Institution and Home: The private institution in which the client chooses to reside may be a fraternal, benevolent, or charitable institution, or the client may make plans for living in a home which is privately owned and operated and which furnishes shelter, board, and care according to the client's needs. In determining the eligibility of a person living in a private institution or home, it is necessary to determine if

s/he has entered into any agreement with the institution that s/he is to receive shelter and care in return for a transfer of property, insurance, or other assets.

In determining eligibility of an individual in a private institution, it is necessary to determine what the institution is able to furnish its guests from its own resources. The individual may be eligible to receive assistance if residing in one of the facilities previously described if the terms of his/her stay do not in any way restrict the use of his/her personal assets or income and if the individual has a need.

24-001.07 Working Disabled Part A Medicare Beneficiaries: Individuals who were receiving RSDI disability benefits and return to work but remain disabled may continue to be entitled to Part A Medicare at no cost for 48 months. The Omnibus Budget Reconciliation Act of 1989 allowed these individuals, at the end of 48 months, to enroll in Part A Medicare and pay a premium. It also required state Medicaid programs to purchase Medicare Part A premiums for these individuals.

24-001.07A Age: To be eligible for the payment of the Medicare premium, an individual must be age 64 or younger.

24-001.07B Disability: To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by SSA. SSA has the responsibility to periodically verify that the disability continues. If SSA determines through a continuing disability review that the client is no longer disabled, SSA notifies the Department and eligibility for AABD/MA cases. If the client voluntarily withdraws from Medicare Part A premium, eligibility for AABD/MA cases.

21-001.07C Receipt of Other Assistance: Through the AABD/MA program an individual may choose to receive either payment of the Medicare Part A premium or full Medicaid benefits but not both at the same time. While receiving either form of assistance, the client may request the other; however, the client is not eligible for full Medicaid benefits for any month for which the Department has paid the Medicare Part A premium.

If a client who is on AABD/MA with excess and is paying his/her own Part A Medicare premium fails to meet his/her excess obligation, the Department retroactively pays the Medicare Part A premium for the excess cycle. At the end of this excess cycle, the client must decide whether to continue with the state paying the Part A premium or to begin a new excess cycle and assume payment of the Part A premium him/herself.

24-002 Medicare Part B Buy-In

24-002.01 Medicare Savings Program / Qualified Medicare Beneficiaries (MSP/QMB): For MSP/QMB eligibility, an individual must meet the following

1. Income equal to or less than 100% FPL;
2. With resources in excess of the $4,000 and $6,000 limits.

MSP/ QMB individuals who are within specific resource guidelines at 477 NAC 21-000 are eligible for payment of deductibles and co-pay costs associated with Medicare claims. They are not eligible for additional medical services. An annual review is required to verify income and resources. The resource limit amounts are adjusted annually.

24-002.02 Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI-1): For SLMB and QI-1 eligibility, an individual must meet the following:

1. Current Medicare beneficiaries who meet the required income guidelines;
2. and all other eligibility requirements of the AABD/MA program are eligible for payment of their Part B Medicare premiums.

These individuals are eligible only for payment of the Medicare premium; they are not eligible for any additional medical services.

SLMB and QI-1 eligibility is determined by income guidelines based on the Federal Poverty Limits. The resource limits are adjusted annually.

24-002.03 Income Treatment: Income limit under this section are in accordance with regulations for AABD/MA. The income limits are based on the Federal Poverty Level.

1. If total net earned and unearned income is equal to or less than the required income limit, the client is eligible for payment of the Medicare premium.
2. If the income is more than the income limit, the client is ineligible for payment of the Medicare premium.

24-002.03A The client may choose to receive AABD/MA with a share of cost and attempt to spend down if there is a medical need.

1. If a client who is on AABD/MA with a share of cost fails to meet any of his/her share of cost by the next case review and a medical need cannot be anticipated, a SLMB or QI-1 budget should be authorized.
2. If a client has been SLMB and later wants Medicaid share of cost for the same month(s) and up to three months before, a share of cost budget should be authorized.
3. If a client has been QI-1 and later wants Medicaid share of cost for the same month(s), only the current month share of cost budget shall be authorized.

24-003 Medicaid Insurance for Workers with Disabilities (MIWD)

24-003.01 Medicaid Insurance for Workers with Disabilities: Working individuals who meet the necessary disability criteria, have income within income guidelines, and are working, are eligible for Medicaid. After application of income disregards, individuals with income less than 200 percent of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with income of 200 through 249 percent of the FPL are eligible for Medicaid with a monthly premium payment.

24-003.02 Eligibility Requirements: In order to receive Medicaid under this section, the individual(s) must:

1. Qualify for Medicaid except for income;
2. Not be eligible for AABD/MA, but may be a share of cost;
3. Meet Social Security or State Review Team definition of disability;
4. Be working;
5. Using a two-part income test have income within income guidelines;
6. Meet Medicaid resource limits; and
7. Pay a premium, if required.

24-003.03 Disability Determination: Individuals who are not receiving a Social Security Disability payment must be determined disabled by the State Review Team. Receipt of an SSDI payment meets the disability requirement.

24-003.04 Income Determination: The income calculation is a two-step process. The income of the disabled individual and his/her spouse must be considered. See 477-000-009 for calculation procedures.

24-003.05 Premium Payment: If the individual is determined eligible for Medicaid with a premium, s/he must pay the full premium no later than the 21st day of the month following the month for which the payment is designated.

24-004 Women's Cancer Program

24-004.01 Women's Cancer Program: The Breast and Cervical Cancer Prevention and Treatment Act of 2000 authorizes Medicaid for women who need treatment for breast or cervical cancer. Section 68-1020, Neb. Rev. Stat. authorizes this coverage in Nebraska.

24-004.02 Eligibility Requirements: In order to receive Medicaid under this section, the woman must:

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a precancerous condition or early stage cancer;
3. Be age 64 or younger;
4. Not be otherwise eligible for Medicaid;
5. Not be covered by creditable health insurance;
6. Be a Nebraska resident; and
7. Be a U.S. citizen or a qualified alien.

24-004.03 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that:

1. Is limited scope coverage such as those which only cover dental, vision, or long term care;
2. Is coverage for only a specified disease or illness;
3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or
4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

24-004.04 Eligibility Period: Eligibility begins with the first of the month that the client signs the application for the Women's Cancer Program on the prescribed application see appendix 477-000-061. Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the agency with a monthly statement that continued treatment is required.

Continued treatment does not include continued surveillance, testing, or screening.

For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the agency every six months for the woman to remain eligible for Medicaid coverage.

24-004.05 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date that the qualified provider determines that the client appears to meet eligibility criteria.

24-005 Medically Needy

24-005.01 Individuals Ineligible for Medicaid Due to Income: Parents/caretaker relatives, children, pregnant women, and AABD/MA individuals with a medical need whose income exceeds the guidelines for Medicaid eligibility may be eligible for a share of cost if all other eligibility requirements are met. Once excess income is met for the month Medicaid eligibility is established for that month. Each month is determined separately and continuous eligibility does not apply. See 477-000-045 for examples.

24-005.02 Age: Medically needy children are eligible through the month of his/her 19th birthday if s/he is a U.S. Citizen or is a qualified alien.

24-005.02A Exception: A Medically needy child may be found eligible under this category if they are receiving impatient 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 22, whichever comes first.

24-005.03 Special Provisions for Two Parent Families

24-005.03A 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.

24-005.03B Deprivation Requirements for Two Parent Families: Two-parent families must meet the following eligibility requirements:

24-005.03C 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.

24-005.03D 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.

24-005.03D1 Determination of Incapacity: If a parent is receiving RSDI, SSI, AABD/MA, 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).

24-005.03E 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.

24-005.04 Transitional Medicaid Assistance (TMA): A client may receive up to 12 months of Transitional Medicaid without a share of cost subject to the following:

24-005.04A TMA Eligibility: A client may receive TMA if:

1. The case has earned income which results in ineligibility for a grant and/or ADC related Medicaid. Note: The parent or needy caretaker relative or guardian or conservator must be in the household.
2. The unit received, or met income and resource eligibility to receive, a grant and/or ADC related Medicaid for which they were eligible in three of the last six months preceding ineligibility;
3. The parent or needy caretaker relative or needy guardian or conservator is employed.

24-005.04B Resources There is no resource test while the unit is in TMA.

24-005.04C Start of a TMA Case: TMA begins with the month of ineligibility for a grant and/or ADC related Medicaid. If it was determined that the unit was ineligible for a grant, TMA shall be determined beginning with the first month in which the grant was erroneously paid.

24-005.04DC Report Requirement: The unit must submit the required reports in order to continue to receive TMA in the second six months. See Appendix 477-000-047 for the Transitional Timeline.

Note: The unit is ineligible for TMA if it received a grant and/or ADC related Medicaid in one or more of the three qualifying months as a result of convicted fraud during the last six months before the beginning of the transitional period.

24-005.04E Changes in Unit:

1. If a family member, such as a parent or a child, returns to the home, grant or ADC related Medicaid eligibility for the whole family must be reviewed. If the returning family member is a responsible relative, the relative's income must be used to compare the family's income to the income guideline for the unit plus the responsible relative. If the family is ineligible for a grant or ADC related Medicaid, the returning family member is added to the TMA unit.
2. A child who is born or adopted while the family is receiving TMA is added to the TMA unit.
3. A parent who has been sanctioned while on grant for failure to cooperate with Employment First may be included in the TMA unit.
4. A parent who has been sanctioned for noncooperation with child support or TPL is not eligible until cooperation is resolved. Note: Once a client is in TMA, s/he is not required to cooperate with program requirements such as Employment First, TPL, and child support.
5. If a unit member leaves the home, grant eligibility for the remaining unit members must be considered.
   a. If the family is ineligible for a grant and/or ADC related Medicaid, the remaining unit members may continue to be eligible for TMA.
   b. If it is the only dependent child who leaves, the whole unit loses eligibility for TMA.
   c. If the only child no longer meets the age qualification, the unit loses eligibility for TMA.
   d. Before closing the case, it must first be determined if the child is eligible for another Medicaid program.

24-005.05 TMA Requirements during Months 1 through 6

24-005.05A Report Requirement: The unit must report the gross monthly earnings and child care costs as billed or paid for each of the first three months of the transitional period. The first report is due by the 21st of the fourth month.

Note: The unit is not required to report unearned income.

24-005.05B Causes of Termination: The unit becomes ineligible for TMA if:

1. The unit becomes eligible for a grant or ADC related Medicaid;
2. The unit moves out of the state; or
3. There no longer is an eligible dependent child in the unit.

Note: If the only child is receiving AABD/MA or SSI, the parent(s) may be eligible for TMA.

24-005.06 TMA Requirements during Months 7 through 12: If the unit has earned income (minus the cost of childcare) equal to or less than 185 percent of the Federal Poverty Level, they are eligible for TMA.

24-005.06A Premium Due: Beginning with month 7, the household is subject to payment of a monthly premium if their countable income is between 100 and 185 percent of the Federal Poverty Level. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

24-005.06B Report Requirement: The unit must provide a report of gross monthly earnings and child care costs as billed or paid for each three-month period of months 7 through 12.

1. The second report is due by the 21st of the seventh month.
2. The third report is due by the 21st of the tenth month.

Note: The unit is not required to report unearned income.

24-005.06C Causes for Termination: The unit is ineligible for the remaining months of TMA if it:

1. Fails without good cause to submit required verification of earnings and child care costs;
2. No longer includes a dependent child; or
3. Has gross monthly earnings (less child care costs) during the preceding three-month period in excess of 185 percent of the FPL.

24-005.06D Changes in Unit:

1. If a unit member leaves, income eligibility for the remaining unit members must be re-determined.
2. If a responsible relative returns to the home, the unit size is increased and the responsible relative's income is budgeted to the TMA unit.

24-005.06E Income Eligibility: The unit's earned income for the three-month report period is averaged to determine income eligibility.

24-005.07 Good Cause for Failing to Submit information required from the Quarterly Report Form (QRF):

1. Death of the parent or caretaker relative;
2. Hospitalization of a unit member during the due period for the QRF (the client is responsible for providing verification of hospitalization); or
3. Natural disaster (the Central Office will issue instructions when these situations occur).

Note: Eligibility for TMA shall not be terminated for failing to provide the QRF if the needed information from the QRF, for the applicable months, was received.

24-005.08 After Month 12: When a client has exhausted his/her months of TMA, a redetermination of eligibility for another Medicaid program must be completed.

If the unit regains grant or ADC related Medicaid eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant or ADC related Medicaid eligibility because of earnings, the original TMA cycle resumes.

If the unit receives three or more ADC grants or months of ADC related Medicaid, then again loses grant or ADC related Medicaid eligibility because of earnings, a new TMA cycle begins.

If the unit becomes grant or ADC related Medicaid eligible again because of loss of income, the client may refuse the grant or ADC related Medicaid in order to continue receiving TMA.

24-006 Former Foster Care Children

24-006.01 Former Foster Care Children: Individuals under age 26 who were in foster care and receiving Medicaid when the individual attained age 18 or such higher age at which Nebraska's federal foster care assistance ends.

These individuals are exempt from income and resource tests.

24-006.01A Eligibility Requirements: In order to receive Medicaid, the individual must:

1. Be under age 26;
2. Have received Medicaid at the time they aged out;
3. Have been in foster care under Nebraska or a Nebraska tribe's responsibility; and
4. Not be eligible for and enrolled in mandatory Medicaid coverage through Parent/Caretaker relatives, Pregnant Women, Children, or AABD/MA.

For Former Ward, see 477 NAC 18-005.

24-007 Emergency Medical

24-007.01 Emergency Medical Assistance for Undocumented and Ineligible Aliens: An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably result in:

1. Serious jeopardy to the patient's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

24-007.02 Eligibility for Emergency Medical Services for Undocumented and Ineligible Aliens:

24-007.02A Restricted Medical Assistance: To be considered eligible for Emergency Medical Assistance Services, the State Review Team (SRT) shall determine that the individual has an emergency medical condition.

The alien shall be determined eligible under the appropriate Medicaid category by meeting all eligibility criteria except citizenship or qualified alien status.