TITLE 477
CHILDREN'S MEDICAL ASSISTANCE PROGRAMS (CMAP)

CHAPTER 1-000 GENERAL BACKGROUND

1-001 Legal Basis: The Nebraska Medical Assistance Program (NMAP) was established under Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska in Neb. Rev. Stat. Section 68-903.

The Medically Needy Program for Individuals Age 18 or Younger (Ribicoff) and Poverty Level medical assistance for children age 18 or younger are authorized by Neb. Rev. Stat. Section 68-1020.

{Effective 8/18/03}

1-002 Purpose: The purpose of the CMAP is to provide medical services to individuals who do not have sufficient income and resources to meet their needs.

1-003 Administration: CMAP is administered by the Nebraska Department of Health and Human Services in accordance with state laws and with the rules, regulations, and procedures established by the Director.

1-004 Definition of Terms: For use within CMAP, the following definition of terms will apply unless the context in which the term is used denotes otherwise.

Adequate Notice: Notice of case action which includes a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s), (see 477 NAC 1-009.03A1).

Applicant: An individual who applies for assistance.

Application: The action by which the individual indicates in writing the desire to receive assistance by submission of an application.

Application Date: For new and reopened cases, the date a properly signed application for assistance is received.

Application Signature: Applications may be signed in writing or by electronic signature.

Application Submission: Applications may be submitted in person, by mail, by fax, or by electronic transmission.

Approval/Rejection Date: The date that the new or reopened case is determined eligible or rejected by the local office.

Assignment means the legal transfer of an individual's right to third party medical coverage to the Nebraska Department of Health and Human Services Finance and Support.

Categorical Assistance means assistance administered by the Department. For the purposes of this definition it includes Aid to Dependent Children/Medical Assistance (ADC/MA); Child Welfare Payment and Medical Services Program (CWP)/MA; Assistance to the Aged, Blind, and Disabled (AABD)/MA; State Disability Program (SDP)/MA; Refugee Resettlement Program (RRP)/MA; and Children's Medical Assistance Programs (CMAP).

Client means an individual applying for or receiving CMAP. This term is used when the same policies apply to an applicant and a recipient.

Creditable Health Insurance Coverage means any current health insurance coverage except a plan that is limited to a single condition, such as cancer insurance, dental insurance, long term care insurance, etc. Insurance to which the individual does not have reasonable geographic access is not creditable coverage. The health insurance policy should be submitted to Central Office for consideration when it is questionable that it meets this definition.

Department means the Nebraska Department of Health and Human Services.

Emancipated Minor means a child age 18 or younger who is considered an adult because s/he has:

1. Married; or
2. Moved away from the parent(s)' home and is not receiving support from the parent(s).

Equity means the fair market value of property minus the total amount owed on it.

Fair Market Value means the price an item of a particular make, model, size, material, or condition will sell for on the open market in the geographic area involved.

Fugitive Felon means a person who has been charged with a felony and who has fled from the jurisdiction of the court where the crime was committed.

Inquiry means any question received by phone, letter, or personal contact without any indication that the individual wishes to apply. This may or may not be followed by a request or application for assistance.

Minor Parent means an individual age 18 or younger, with a child (see 468 NAC 2-007.01). If emancipated, a minor parent is treated as an adult for assistance purposes.

Note: For treatment of child support when a noncustodial parent pays support for his/her child who is a minor parent, see 468 NAC 2-009.04A1.

Need means economic need when referred to as a condition of eligibility.

Needy Individual: One whose income and other resources for maintenance are found under assistance standards to be insufficient for meeting the basic requirements, and to be within the resource limits allowed an individual.

Pending Case: A case in which the application has been taken and eligibility is yet undetermined. All pending cases must be entered into the N-FOCUS system within two working days.

Post-Partum Period: The period beginning on the last day of pregnancy and continuing through the month in which the 60-day period following the termination of pregnancy ends.

Power of Attorney: A written statement allowing one person to act for another person. A power of attorney may be authorized generally for the management of a specified business or enterprise or more often specifically for the accomplishment of a particular transaction. There is no court involvement or supervision in the appointment. The statement does not have to be notarized.

A standard or non-durable power of attorney automatically becomes null and void when the appointing individual becomes incompetent. A durable power of attorney continues in effect even when the appointing individual becomes incompetent. The power of attorney document should clearly specify if it is a durable power of attorney.

Prospective Eligibility for Medical Assistance (MA): The date of eligibility beginning the first day of the month of the date of request if the client was eligible for MA in that same month.

Prudent Person Principle: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility.

Recipient: An individual who is receiving medical assistance.

Rejected Case: A case in which an application was completed and signed, but the applicant did not meet the categorical, procedural, or financial requirements of the program.

Request: An action by which an individual's desire to receive assistance is made known to the local office. A request may be made by telephone, letter, fax, electronic transmission, or in person.

Request Date: The date the client requests assistance. For reopened cases, this is the date of the new request. For program changes, this is the request date for the new program.

Retroactive Eligibility for MA: The date of eligibility beginning no earlier than the first day of the third month before the month of request if the following conditions were met:

1. Eligibility was determined and a budget computed separately for each of the three months;
2. A medical need existed; and
3. Eligibility requirements were met at some time during each month.

Six months continuous eligibility may begin in a retroactive month; in that case, no further budgets are required.

Share of Cost: A client's financial out-of-pocket obligation for medical services when countable income exceeds the medical maintenance income level. The Share of Cost amount is the difference between the unit's countable income and the appropriate medical maintenance income level. This amount must be obligated or paid to medical providers before Medicaid will pay on the remaining medical bills.

Spousal Support: Alimony or maintenance support for a spouse or former spouse.

Third Party Medical Payment: A payment from any health insurance plan, individual, or group for medical expenses.

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective (see 477 NAC 1-009.03A2).

Unit: Individuals considered in determining the grant and/or medical assistance.

Withdrawal: A voluntary written retraction of an application.

1-005 Worker Responsibilities: The worker has the following responsibilities.

1-005.01 Duties at Initial Application or Redetermination: At the time of initial application and redetermination, the worker must:

1. Allow anyone who requests assistance to complete an application;
2. Give an explanation of the program requirements;
3. Collect and review the information entered on the application form;
4. Explain the eligibility factors and how changes will affect eligibility;
5. Explain the eligibility factors that require verification;

6. ~~Obtain the client's written consent for the needed verifications;~~
7. ~~Explore income that may be currently or potentially available such as Retirement, Survivors, and Disability Insurance (RSDI), Supplemental Security Income (SSI), veteran's assistance benefits (VA), etc.;~~
8. ~~Give information about the social and other financial services available through the agency, such as social services; HEALTH CHECKS (Early and Periodic Screening, Diagnosis, and Treatment); family planning; ADC; and AABD;~~
9. ~~Inform the client about his/her rights and responsibilities (see 477 NAC 1-006 and 1-007);~~
10. ~~Inform the client that s/he must show his/her medical card to all providers and must inform the worker of any health insurance plan, any individual(s), or any group that may be liable for the client's medical expenses;~~
11. ~~Explain the assignment of third party medical payments and the requirement to cooperate in obtaining third party medical payments and refund any payments received directly;~~
12. ~~Complete necessary reports and information forms;~~
13. ~~Act with reasonable promptness on the client's application for assistance;~~
14. ~~Provide adequate notice to the client of -~~
    a. ~~Approval for medical assistance;~~
    b. ~~Rejection of the application and the reason; or~~
    c. ~~Confirmation of the client's voluntary withdrawal; and~~
15. ~~Explain the appeal process (see 465 NAC 2-001.02).~~

~~1-005.02 Continuing Responsibilities: The worker has the continuing responsibility to -~~

1. ~~Provide adequate notice of any action affecting the client's assistance case (see 477 NAC 1-009.03A2 if timely notice is necessary);~~
2. ~~Treat the client's information confidentially;~~
3. ~~Uphold the client's civil rights; and~~
4. ~~Inform the client when his/her case is closed that s/he has the right to reapply.~~

~~1-006 Client Responsibilities: The client (or the individual applying on behalf of the client) is required to -~~

1. ~~Provide complete and accurate information. State and federal law provides penalties of a fine, imprisonment, or both for persons found guilty of obtaining assistance or services for which they are not eligible by making false statements or failing to report promptly any changes in their circumstances;~~

2. Report a change in circumstances no later than ten days following the change. This includes information regarding:
   a. Monthly expenses;
   b. Resources or other financial matters;
   c. Employment status;
   d. Composition of the household;
   e. The living arrangements;
   f. Address;
   g. A temporary absence from the home of any unit member; and
   h. Changes in the amount of monthly income, including:
      (1) All changes in unearned income; and
      (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for CMAP, 30 hours per week is considered full-time;
3. Present his/her medical card to providers;
4. Inform the medical provider and worker of any health insurance plan, any individual, or any group that may be liable for his/her medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Enroll in a health plan and maintain enrollment if:
   a. One is available to the client;
   b. The client is able to enroll on his/her own behalf; and
   c. The Department has determined that enrollment in the plan is cost effective;
7. Reimburse to the Department or pay to the provider any third party medical payments received directly for services which are payable by NMAP;
8. Pay any unauthorized medical expenses;
9. Pay any required medical copayment (see 477 NAC 2-013 ff.);
10. Meet the requirements of the Nebraska Health Connection, if applicable (see 477 NAC 2-014 ff.);
11. Cooperate with state and federal quality control; and
12. Contact the agency for an interview within 30 days of the date of application if notified that an interview is required.

{Effective 6/28/11}

1-006.01 Sanction for Noncooperation with Quality Control: A client (or an individual applying on behalf of the client) must cooperate with state and federal quality control as a condition of eligibility. If a client fails to cooperate, the whole unit is ineligible for one month only. The worker closes the case for one month, considering adequate and timely notice. The following month the worker reopens the case, if the unit is otherwise eligible. If at anytime QC notifies the worker that the client has cooperated, assistance is restored for the month of closing.
Note: This requirement does not apply to a child who is receiving a year of medical eligibility following birth (see 477 NAC 1-012.02C) or a child in six months continuous eligibility.

1-007 Client Rights: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for assistance must be given the opportunity to do so. No one may be denied the right to apply for public assistance;
2. Reasonably prompt action on his/her application for assistance (see 477 NAC 1-009.02B);

3. ~~Adequate notice of any action affecting his/her application or assistance case (see 477 NAC 1-009.03C to determine if timely notice is necessary);~~
4. ~~Appeal to the Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;~~
5. ~~Have his/her information treated confidentially;~~
6. ~~Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;~~
7. ~~Have the program requirements and benefits fully explained;~~
8. ~~Be assisted in the application process by the person of his/her choice;~~
9. ~~Receive medical assistance without a separate application if s/he is eligible for categorical assistance; and~~
10. ~~Referral to other agencies.~~

~~1-008 Prudent Person Principle: When the statements of the client (or the individual applying on behalf of the client) are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker shall obtain additional verification before eligibility is determined. The client has primary responsibility for providing verification of information relating to eligibility. Verification may be supplied in person, through the mail, or from another source (as an employer). If it would be extremely difficult or impossible for the client to furnish verification in a timely manner, the worker shall offer assistance.~~

~~1-009 Application Processing~~

~~1-009.01 Request: A request for assistance may be made in person, by letter, telephone, fax, or electronic submission and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney (see 477 NAC 1-004), or another person authorized to act for the applicant. The worker must record the request date on the application. For Ribicoff, if an interview cannot be scheduled within 14 days from the date of request, an application must be mailed promptly or the client must be informed of the electronic application.~~

~~A request is terminated:~~

1. ~~When a properly signed application is received;~~
2. ~~When the applicant or his/her representative notifies the worker of withdrawal; or~~

3. After 30 days if the worker has heard nothing further from the applicant or his/her representative. However, the worker may continue to hold a request pending if there is reason to believe the applicant intends to complete his/her application.

1-009.02 Application: A request becomes an application when a properly signed application is received. A properly signed application contains:

1. Name;
2. Address; and
3. Proper signature, as defined by the appropriate program.

An application may be signed by an individual for himself/herself or by the applicant's guardian, conservator, or an individual acting under a duly executed power of attorney. If the application is for medical benefits only, the client's relative or another individual acting on the client's behalf may sign the application.

An application for medical benefits only may be taken on behalf of a deceased person (including a miscarriage or stillborn). If there is no one to represent the deceased person, the administrator of the estate may sign the application. The eligibility requirements must have been met at the time medical services were rendered.

See 477-000-305 for application procedures for individuals in Institutions for Mental Disease (IMD's).

1-009.02A Alterations: The application, when completed and signed by the client or his/her representative, constitutes his/her own statement in regard to eligibility. If the worker adds information received from a client to a properly signed application, the worker must date the information and:

1. Note the information received from the client; or
2. If the information is not received from the client, identify the source of the information, if the client is not present.

The worker may add information to an application up to the date of approval or completed redetermination.

~~1-009.02B Prompt Action on Applications: The worker must act with reasonable promptness on all applications for assistance. The worker must make a determination of eligibility on an application within 45 days from the date of the request. If circumstances beyond the control of the worker prevent action within 45 days, the worker must send a Notice of Action informing the applicant of the reason for the delay.~~

~~1-009.02C Application with a Designated Provider: Any individual may apply for medical assistance with a designated provider who has contracted with the Department to accept Medicaid applications at their location.~~

~~{Effective 6/28/11}~~

~~1-009.02D Withdrawals: The applicant may voluntarily withdraw an application. If the applicant verbally withdraws the application, the worker must request a written statement of withdrawal. The worker must make note of the withdrawal in the case record and give written confirmation of withdrawal to the applicant on the Notice of Action.~~

~~If the applicant does not provide written confirmation of the withdrawal within 30 days from the application date, the worker must reject the application. The worker must send a Notice of Action to the applicant notifying him/her of the rejection.~~

~~1-009.02E Authorization for Investigation: For some sources the worker asks the client to sign a release of information when it appears that information given is incorrect, when the client is unable to furnish the necessary information, or for sample quality control verification. A copy of the authorization for release of information from the application may be used if the source will accept it.~~

~~1-009.02F New Application: A new application is required after one calendar month of ineligibility. If eligible, children must receive a new period of six months' continuous eligibility (see 477 NAC 1-013).~~

~~{Effective 10/15/2002}~~

~~1-009.03 Notice of Action: The worker shall send adequate notice on a Notice of Action to notify the client of any action affecting his/her assistance case. The Notice of Action must be sent to the last-reported address. If the form is inadvertently sent to the wrong address, the worker shall send a new form, allowing the client ten days from the date the corrected form is sent (if adequate and timely notice is required).~~

~~1-009.03A Types of Notices~~

~~1-009.03A1 Adequate Notice: An adequate notice must include a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action. The worker shall send an adequate notice no later than the effective date of the action.~~

~~1-009.03A2 Timely Notice: A timely notice must be dated and mailed at least ten calendar days before the date that action would become effective, which is always the first day of the month.~~

~~1-009.03B Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, or reduce assistance or to change the manner or form of payment or service to a more restrictive method, i.e., protective payee, medical lock-in), the worker must give the client adequate and timely notice.~~

~~1-009.03C Situations Requiring Adequate Notice Only: In the following situations, the worker may dispense with timely notice but shall send adequate notice no later than the effective date of action.~~

1. ~~The agency has factual information confirming the death of a client;~~
2. ~~The agency receives a written and signed statement from the client -~~
   a. ~~Stating that assistance is no longer required; or~~
   b. ~~Giving information which requires termination or reduction of assistance, and indicating, in writing, that the client understands the consequence of supplying such information;~~
3. ~~The client has been admitted or committed to an institution, and no longer qualifies for assistance;~~
4. ~~The client has been placed in skilled nursing care, intermediate care, or long-term hospitalization;~~
5. ~~The client's whereabouts are unknown and agency mail directed to the client has been returned by the post office indicating no known forwarding address. The agency shall make the client's check available to the client if his/her whereabouts become known during the payment period covered by a returned check;~~
6. ~~The client has been accepted for assistance in another state and that fact has been established; or~~
7. ~~A child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.~~

~~1-009.03D Waiver of Notice: If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, the worker shall obtain a statement signed by the client to be filed in the case record.~~

~~1-009.03E In Fraud Cases: At least five days' advance written notice must be given if -~~

1. ~~The agency has facts indicating that action should be taken to discontinue, terminate, or reduce assistance because of probable fraud by the client; and~~
2. ~~The facts have been verified where possible through collateral sources.~~

1-009.03F Continuation of Benefits: The worker must not carry out an adverse action pending an appeal hearing if:

1. The case action being appealed required adequate and timely notice (see 477 NAC 1-009.03B and 1-009.03C);
2. The client requests an appeal hearing within ten days following the date the Notice of Action is mailed; and
3. The client does not refuse continued assistance.

In the situations listed in 477 NAC 1-009.03C, benefits are not restored pending a hearing.

This regulation does not restrict the worker from continuing normal case activities and implementing changes to the assistance case that are not directly related to the appeal issue.

1-009.03F1 Refusal of Continued Benefits: A client may refuse continuation of benefits pending an appeal hearing. The client may refuse benefits by checking the statement to that effect on Form DA-6 or handwriting a refusal.

1-010 Redetermination of Eligibility: The worker must redetermine eligibility every 12 months. Eligibility may be redetermined in less than 12 months to coordinate review dates for more than one program. An early review does not shorten six months of continuous eligibility.

For NMAP, an application may be signed by the client's relative or another individual acting on the client's behalf.

If the client is eligible for medical assistance only or medical assistance with share of cost but no further medical needs are apparent or indicated, or the case is ineligible, the worker must determine if the client has a medical need by discussing the situation with the client, using the client's medical profile, etc.

Note: The worker must explain on the Notice of Action that the client may reapply if there is a medical need at a later date.

{Effective 6/28/11}

1-010.01 Review After Six Months' Continuous Eligibility: Once a household has received six months' continuous eligibility, any significant change in the family's circumstances which occurs after the six-month period of continued eligibility must be acted upon to determine if eligibility still exists. This review may be as a result of the family reporting a change in circumstances, information received on the N-FOCUS Interfaces, or information from another source(s). The review as a result of a significant change may result in the children losing eligibility at any point after they have received their initial six months' continuous eligibility. See 477 NAC 1-006 for reporting requirements.

{Effective 6/28/11}

~~1-011 (Reserved)~~

~~1-012 Effective Date of Medical Eligibility: The effective date of eligibility for MA is determined according to regulations in the following material. If an individual is eligible one day of the month, s/he is eligible the entire month.~~

~~1-012.01 Prospective Eligibility: Prospective eligibility is effective the first day of the month of request if the client was eligible for NMAP in that same month and had a medical need.~~

~~1-012.02 Retroactive Eligibility: Retroactive eligibility is effective no earlier than the first day of the third month before the month of request if the following conditions are met:~~

1. ~~Eligibility is determined and a budget computed separately for each of the three months;~~
2. ~~A medical need exists; and~~
3. ~~Elements of eligibility were met at some time during each month.~~

~~An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period (see 477-000-301).~~

~~Six months continuous eligibility may begin in a retroactive month; in that case, no further budgets are required.~~

~~{Effective 10/15/2002}~~

If a client, at the time of application, declares that s/he incurred medical expenses during the retroactive period and eligibility is not approved, the case record must contain documentation of the reason the client was not eligible in one or more months of the retroactive period.

1-012.02A Medicaid Effective Date for the Pregnant Woman: The Medicaid effective date for a pregnant woman is determined from when pregnancy begins based on the physician's statement.

If the physician verifies that the woman was pregnant during one or more of the three months before the month of request, application for retroactive Medicaid eligibility may be approved for the month(s) in which all other criteria were met and medical expenses were incurred. The worker shall determine eligibility for each month individually.

See 477 NAC 2-004.02 for the requirement for an SSN for a newborn.

1-012.02B Presumptive Eligibility (PE) for Pregnant Women: A pregnant woman may apply at a qualified provider's office (see 471 NAC 28-001.01) for ambulatory prenatal services. The provider makes a presumptive determination of the woman's eligibility based only on declared income and citizenship/eligible alien status. Income of the woman and spouse (if he is in the home) or the responsible parent(s) of a pregnant minor is counted. The provider does not investigate resources or other eligibility requirements. For income levels see 471-000-202.

The provider must forward the application, along with the attestation form if applicable to the Department within five working days after the determination of presumptive eligibility. The application date is the date the provider determines presumptive eligibility for assistance. The presumptive eligibility application is an application for Medicaid for the pregnant woman and serves as verification of pregnancy. This form also serves as a Medicaid application for the pregnant woman's children. The presumptive application includes the requirement of attestation of citizenship/eligible alien status, third party liability insurance cooperation, child support cooperation and options to claim good cause. Upon receiving the presumptive eligibility form, the Department opens the PE case on N-FOCUS and also pends the application for the pregnant woman and children listed on the Medicaid application. The Department reviews the application and mails a verification checklist requesting all verifications needed to determine eligibility. The presumptive case remains open until a determination of eligibility is made. The determination of eligibility must be made within 45 days. PE will automatically close when Medicaid is approved or denied. 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.

A pregnant woman may receive only one period of presumptive eligibility per pregnancy.

~~1-012.02C Continued Eligibility for a Newborn: Once a newborn has been determined eligible for the month of birth or if Medicaid pays for the birth, eligibility continues through the month the child turns age one, without regard to changes in the household income, as long as the newborn continues to reside in Nebraska. The worker must add the child as EMAC.~~

~~A woman is eligible for only one presumptive eligibility period per pregnancy.~~

~~1-013 Six Months Continuous Eligibility: Children from birth through age 18 are eligible for 6 months of continuous Medicaid from the date of initial eligibility unless:~~

1. ~~The child turns 19 within the 6 months;~~
2. ~~The child moves out of state;~~
3. ~~The worker determines that the original eligibility was based on erroneous or incomplete information;~~
4. ~~The child dies; or~~
5. ~~The child enters an ineligible living arrangement (see 477 NAC 2-008.01).~~

~~No income or resource review is required.~~

~~{Effective 10/15/2002}~~

~~1-014 Forms: For a list of forms that are used in Children's Medical Assistance Programs, see 477-000-410. Instructions for the forms are contained in the Public Assistance Forms Manual.~~