

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NOTICE OF PUBLIC HEARING

June 8, 2020  
10:00 a.m. Central Time  
Nebraska State Office Building – Lower Level A  
301 Centennial Mall South, Lincoln, Nebraska  
Phone call information: 877-399-0501; Participant code: 3213662#

The purpose of this hearing is to receive additional comments on the proposed amendment to Title 477 Chapters 3, 4, 19, and the proposed adoption of Title 477 Chapter 29 of the Nebraska Administrative Code (NAC) – *Medicaid Eligibility*.

The following regulations are proposed for AMENDMENT:

Title 477 NAC 3 – *Application Process*

The proposed changes will provide the eligibility regulations for the new adult group required by Neb. Rev. Stat. § 68-992. Additional proposed changes include removing the interview requirement for an application or renewal.

Title 477 NAC 4 – *Effective Date of Medicaid Eligibility*

The proposed changes will provide the eligibility regulations for the new adult group required by Neb. Rev. Stat. § 68-992. Additional proposed changes include updating retroactive eligibility language to remove the elimination of retroactive coverage.

Title 477 NAC 19 – *Modified Adjusted Gross Income (MAGI)-Based Programs*

The proposed changes will provide the eligibility regulations for the new adult group required by Neb. Rev. Stat. § 68-992. Additional proposed changes add language pertaining to the responsibilities of presumptive eligibility providers.

The following regulations are proposed for ADOPTION:

Title 477 NAC 29 – *Heritage Health Adult Program*

The adoption of these regulations will provide the eligibility for the new adult group required by Neb. Rev. Stat. § 68-992. Additional proposed changes removes language regarding benefit tier reviews, wellness and personal responsibility, and good cause reasons.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In

order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 877-399-0501; Participant code: 3213662#.

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or [dhhs.regulations@nebraska.gov](mailto:dhhs.regulations@nebraska.gov), respectively.

A copy of the proposed changes is available online at <http://www.sos.ne.gov>, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

## FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 477	Prepared by: Jeremy Brunssen
Chapter: 3, 4, 19, and 29	Date prepared: 4/27/2020
Subject: Medicaid Eligibility	Telephone: 402.471.5046

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	( <input type="checkbox"/> )	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )
Increased Costs	( <input checked="" type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Increased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Indeterminable	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )

Provide an Estimated Cost & Description of Impact:

State Agency: MLTC anticipates significant fiscal impact for the expansion of eligibility for Medicaid. Not all chapters of Title 477 contain fiscal impacts, and if they are not explicitly noted below, there is not an expected fiscal impact associated with that chapter. Additionally, some impacts are increased costs to the agency, while others may be decreased costs to the agency, however in aggregate there is a significant increase in costs to the agency as noted below.

Title 477 Chapter	SFY	Total Funds	Federal Funds	State Funds
<b>Chapter 4 - Retro Eligibility</b>	2021	\$ (43,224,233)	\$ (38,901,810)	\$ (4,322,423)
	2022	\$ (50,936,604)	\$ (45,842,944)	\$ (5,093,660)
<b>Chapter 10 - Hearing</b>	2021	\$178,965	\$161,069	\$17,897
	2022	\$178,321	\$160,489	\$17,832
<b>Chapter 29 - Newly Eligibles</b>	2021	\$375,392,415	\$337,853,174	\$37,539,242
	2022	\$701,650,738	\$631,485,664	\$70,165,074
Title 477	SFY	Total Funds	Federal Funds	State Funds
<b>Total (Aggregate)</b>	2021	\$332,347,147	\$299,112,432	\$33,234,715
	2022	\$650,892,454	\$585,803,209	\$65,089,245

The original fiscal impact statement (dated January 23, 2020) for chapters 5, 9, 10, 11, 25, 26, & 27 remains unchanged.

Political Subdivision: N/A

Regulated Public: N/A

If indeterminable, explain why: N/A

TITLE 477

MEDICAID ELIGIBILITY

CHAPTER 3-~~000~~

APPLICATION PROCESS

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by the Medical Assistance Act, Nebraska Revised Statute § 68-901 et seq.

~~3-004~~002. INTERVIEW.:- An interview ~~shall not be~~ is not required ~~for either an~~ for a Medicaid application or ~~a~~ renewal.

~~3-002~~003. APPLICANT/ AND CLIENT RIGHTS.:- ~~An applicant/client has~~ All applicants and clients have the following rights:

~~(A1.)~~ The right to have the Medicaid application process and the Medicaid requirements, responsibilities, and benefits reasonably explained ~~to him/her~~ by the Department, including by written translations, oral interpretation, and taglines for individuals with disabilities or limited English proficiency;

~~(B2.)~~ The right to have other potential sources of assistance explained ~~to him/her~~ by the Department, including, as applicable: income that may be currently or potentially available such as Retirement, Survivors, and Disability Insurance (RSDI);<sup>;</sup> Supplemental Security Income (SSI);<sup>;</sup> or, Veteran's Assistance benefits (VA); social and other financial services available through the Department, such as social services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and family planning; and, receive a referral to other agencies, if appropriate.<sup>;</sup>

~~(C3.)~~ The right to have his/ or her civil rights upheld. No applicant/ or client may be subjected to discrimination on the grounds of ~~his/her~~ race, color, national origin, sex, age, disability, religion, political belief, or any other classification protected by law;

~~(D4.)~~ The right to be offered the opportunity to register to vote ~~(see Appendix 477-000-061).~~<sup>;</sup>

~~(E5.)~~ The right to submit an application ~~for him/herself~~ or have an application submitted by ~~his/her~~ an authorized representative;

~~(F6.)~~ The right to have his/ or her application and any personal information treated confidentially according to the applicable privacy laws;

~~(G7.)~~ The right to receive reasonably prompt action on his/ or her application ~~that~~ which is pending. A determination of eligibility must be made by the Department about an application within ~~forty-five (45)~~ days of the date the complete and signed application has been received by the Department; except for applications under the disability category, for which a determination of eligibility must be made within ~~ninety (90)~~ days;

~~(H8.)~~ The right to receive adequate notice of any action affecting his/ or her application or benefit; and

~~(I9.)~~ The right to appeal to the Director for a hearing about any action or inaction regarding his/ or her application, or failure to act with reasonable promptness. Any appeal must be filed with the Department in writing within ~~ninety (90)~~ days of the decision date.

~~3-003004.~~ APPLICANT/ AND CLIENT RESPONSIBILITIES. Each applicant or client is required to:

~~(A4.)~~ Provide complete and accurate information. State and federal law provides penalties that may include a fine, imprisonment, or both, for persons found guilty of making false statements or failing to report promptly any changes in their circumstances to obtain assistance or services for which they are not eligible;

~~(B2.)~~ Report a change in circumstances no later than ~~ten (10)~~ days following the change. This ~~may~~ includes information regarding:

~~a.(i)~~ Change or receipt of a resource including cash, stocks, bonds, or a motor vehicle. Changes in resources do not apply to clients whose eligibility is determined using modified adjusted gross income (MAGI)-based methodology;

~~b.(ii)~~ Change in unit composition, such as the addition, loss of, or temporary absence of a unit member;

~~c.(iii)~~ Change in residence;

~~d.(iv)~~ Living arrangement;

~~e.(v)~~ Disability status;

~~f.(vi)~~ New employment;

~~g.(vii)~~ Termination of employment; or

~~h.(viii)~~ Change 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, or in employment status, such as part-time to full-time or full-time to part-time.

~~(a)~~ For reporting purposes, full-time employment is considered at least ~~thirty (30)~~ hours per week. The client must report new employment within ~~ten (10)~~ days of receipt of the first paycheck, and a change in wage rate or hours within ~~ten (10)~~ days of the change. To avoid adverse action, a ~~C~~client must prove good cause for any failure to report a change to the Department within ~~ten (10)~~ days. Unconfirmed statements do not constitute good cause;

~~(C3.)~~ Present his/ or her Medicaid card to providers;

~~(D4.)~~ Inform the medical provider and the Department of any third-party resources ~~that~~ which may be liable for his/ or her medical expenses, in whole or in part, and cooperate in obtaining these third-party resources;

~~(E5.)~~ Enroll in a health plan and maintain enrollment if:

~~a.(i)~~ One is available to the client;:

~~b.(ii)~~ The client is able to enroll on his/ or her own behalf;:

~~c.(iii)~~ The Department has determined ~~that~~ enrollment in the plan is to be cost effective;

~~(F6.)~~ Reimburse to the Department or pay to the provider any third-party resources received directly for services ~~that are~~ payable by Medicaid;

~~(G7.)~~ Pay any unauthorized medical expenses;

~~(H8.)~~ Pay any required medical copayment;

~~(I9.)~~ Meet the requirements of Managed Care, if applicable; and

~~(J10.)~~ Cooperate with state and federal quality control.

### 3-004.005. APPLICATION

~~3-004.01 Application Submittal:~~005.01 APPLICATION SUBMITTAL. An application may be submitted by an applicant, an adult member of the applicant's immediate family, an adult member of the applicant's tax household, an or his/her authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. A medical provider may submit an application on behalf of an individual whom the provider is treating if the individual is unconscious or otherwise unable to apply and does not have an existing power of attorney or court-appointed individual to apply on his or her behalf. An application may be signed in writing, by telephonic acknowledgment, or by electronic signature. An application may be submitted in person, by mail, by telephone, by fax, or by electronic submission. An application may be taken on behalf of a deceased person, including a miscarriage or a stillborn. If there is no one to represent a deceased person, the administrator of the estate may sign the application.

~~3-004.02 Application Date:~~005.02 APPLICATION DATE. An application is considered valid the date it is received by the Department if it contains the applicant's name, address, and proper signature of the applicant or authorized representative.

- ~~1.—Applicant's name,~~
- ~~2.—Address, and~~
- ~~3.—Proper signature of the applicant or authorized representative~~

~~An application may be taken on behalf of a deceased person (including a miscarriage or a stillborn). If there is no one to represent a deceased person, the administrator of the estate may sign the application.~~

~~3-004.03 Application with a Designated Provider:~~005.03 APPLICATION WITH A DESIGNATED PROVIDER. An applicant or ~~his/her~~ authorized representative may apply for Medicaid with a designated outreach provider or entity ~~that~~ which has contracted with the Department to accept Medicaid applications at its location.

~~3-004.04 Alterations:~~005.04 ALTERATIONS. The application, when completed and signed by the applicant or ~~his/her~~ authorized representative, constitutes the applicant's own statement regarding eligibility. Information may be added to an application up to the decision date.

~~3-004.05 Withdrawals:~~005.05 WITHDRAWALS. An applicant may voluntarily withdraw an application verbally or in writing, which will be confirmed by the Department sending a Notice of Action to the applicant or ~~his/her~~ Aauthorized Representative documenting this voluntary withdrawal.

~~3-004.06 New Application:~~005.06 NEW APPLICATION. A new application is required after ~~ninety (90)~~ days of ineligibility.

~~3-005006.~~ AUTHORIZATION FOR INVESTIGATION. The Department may request a release of information from the applicant or ~~his/her~~ Aauthorized ~~R~~representative when it appears ~~that~~ information is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

~~3-006007.~~ RENEWALS. A redetermination of eligibility for continued Medicaid benefits must be completed every 12 months.

~~3-006.01 Renewal of Eligibility:~~ A redetermination of eligibility for continued Medicaid benefits must be completed every twelve (12) months.

007.01 RENEWAL OF ELIGIBILITY FOR MODIFIED ADJUSTED GROSS INCOME (MAGI) PROGRAMS. A renewal of modified adjusted gross income (MAGI)-based eligibility shall be completed on the basis of information available to the Department without requiring information from the individual. Information will only be required from the individual when not available through other sources. If information is not available to complete a renewal, a prepopulated renewal form shall be sent by the Department to the applicant or authorized representative. The completed renewal form and necessary verifications shall be returned within 30 days of the date the renewal form was sent. (see Appendix 477-000-002).

007.02 RENEWAL OF ELIGIBILITY FOR NON-MODIFIED ADJUSTED GROSS INCOME (non-MAGI) PROGRAMS. A prepopulated renewal form shall be required every ~~twelve (12)~~ months for ~~non-MAGI~~ non-modified adjusted gross income (non-MAGI) based eligibility renewals.

~~If information is not available to complete a renewal, a prepopulated renewal form shall be sent by the Department to the applicant or his/her authorized representative. The completed renewal form and necessary verifications shall be returned within thirty (30) days of the date the renewal form was sent.~~

~~If the renewal form and necessary information are submitted within ninety (90) days after termination, a new application shall not be required.~~

~~For the Medically Needy category, a client is ineligible if no medical need exists. The client shall be informed in writing that s/he may reapply if there is a medical need at a later date.~~

~~3-006.02 Renewal for SSI Recipients;~~ 007.03 RENEWAL FOR SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS. ~~An application~~ A renewal form is not required at the time of renewal for clients who are receiving supplemental security income (SSI). ~~If SSI is discontinued and~~

007.03(A) RENEWAL WHEN SUPPLEMENTAL SECURITY INCOME (SSI) IS DISCONTINUED. If supplemental security income (SSI) is discontinued and:

- ~~1-~~(i) The last application was completed more than ~~twelve (12)~~ months from the last month of eligibility for supplemental security income (SSI), a ~~complete renewal determination~~ of eligibility must be ~~done~~ completed within the next ~~thirty (30)~~ days, including completion of an application; or



~~2-(ii)~~ It has been less than ~~twelve (12)~~ months since completion of the last application, a review of all eligibility requirements ~~that are~~ necessary for continued assistance must be completed.

~~007.03(B) RENEWAL DURING NON-PAY SUPPLEMENTAL SECURITY INCOME (SSI) STATUS.~~ A renewal is not required for periodic non-pay ~~status for income~~ due to an extra pay period ~~in a month~~.

~~007.03(C) SUPPLEMENTAL SECURITY INCOME (SSI) CLIENTS ELIGIBLE UNDER 1619(b).~~ Supplemental security income (SSI) clients who are determined eligible for Medicaid by the Social Security Administration (SSA) under the provisions of 1619(b) are not required to complete ~~an application at renewal a renewal form~~, and resources do not need to be verified.

~~3-006.03 Income Review for ABD Clients:007.04 INCOME REVIEW FOR AGED, BLIND, AND DISABLED (ABD) CLIENTS.~~ For eligibility purposes, a review of income must be completed every ~~twelve (12)~~ months. An income review is completed by ~~the Social Security Administration (SSA)~~ for ~~supplemental security income (SSI)~~ clients, including those placed in 1619(b) status.

~~3-006.04 Disability Review for ABD Clients:007.05 DISABILITY REVIEW FOR AGED, BLIND, AND DISABLED (ABD) CLIENTS.~~ For clients whose disability status is approved by the State Review Team (SRT), ~~A~~ review of disability for ~~aged, blind, and disabled (ABD) eligibility cases~~ must be completed by the State Review Team ~~at least every 12 months~~.

### ~~3-007008. CONTINUOUS ELIGIBILITY~~

~~3-007.01 Continuous Eligibility for Pregnant Women:008.01 CONTINUOUS ELIGIBILITY FOR PREGNANT WOMEN.~~ Once a pregnant woman is determined Medicaid eligible, she remains continuously eligible through the post-partum period, ~~regardless of her category of eligibility at the time the pregnancy began. Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.~~

~~Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.~~

~~3-007.02 Continuous Eligibility for a Newborn:008.02 CONTINUOUS ELIGIBILITY FOR A NEWBORN.~~ Children born to Medicaid-eligible mothers are deemed eligible for Medicaid and remain Medicaid eligible for one ~~(1)~~ year after birth. For 599 ~~Children's Health Insurance Program (CHIP)~~, see 477 ~~Nebraska Administrative Code (NAC) 19-004.07~~.

~~3-007.03 Six Months' Continuous Eligibility for Children:008.03 SIX MONTHS' CONTINUOUS ELIGIBILITY FOR CHILDREN.~~ Children from birth through age ~~eighteen (18)~~ are eligible for six ~~(6)~~ months of continuous Medicaid from the date of initial eligibility. ~~Retroactive months do not count in the six months of continuous eligibility unless there is no prospective eligibility. For 599 Children's Health Insurance Program (CHIP), see 477 NAC 19.~~

008.04 CONTINUOUS ELIGIBILITY FOR HOSPITALIZED CHILDREN. Children who are eligible and enrolled in Medicaid, and are receiving inpatient services covered by Medicaid on the date they lose eligibility due to age are continuously eligible until the end of their inpatient stay if the child would remain eligible but for attaining such age.

~~Retroactive months do not count in the six (6) months of continuous eligibility unless there is no prospective eligibility. For 599 CHIP, see 477 NAC 19-004.07.~~

~~3-007.04 Exceptions to Continuous Eligibility;~~008.05 EXCEPTIONS TO CONTINUOUS ELIGIBILITY.

- ~~1.(A)~~ The child turns ~~nineteen (19)~~ years old within ~~the~~ six ~~(6)~~ months of initial eligibility;
- ~~2.(B)~~ The client moves out of state;
- ~~3.(C)~~ It is determined ~~that the~~ original eligibility was based on erroneous or incomplete information;
- ~~4.(D)~~ The client dies;
- ~~5.(E)~~ The client enters an ineligible living arrangement; or
- ~~6.(F)~~ The child or child's representative requests voluntary disenrollment.

~~3-007.05 Review After Six Months' Continuous Eligibility for Children;~~008.06 REVIEW AFTER SIX MONTHS' CONTINUOUS ELIGIBILITY.

Once a household has received continuous eligibility for six ~~(6)~~ months, a desk review is completed by the Department and any information known to the Department shall be acted on, accordingly.

DRAFT  
01-21-2020

NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

477 NAC 4

~~REV. MARCH 13, 2018~~ ~~NEBRASKA DEPARTMENT OF~~ ~~MEDICAID ELIGIBILITY~~  
~~MANUAL LETTER # 15-2018~~ ~~HEALTH AND HUMAN SERVICES~~ ~~477 NAC 4~~

TITLE 477

MEDICAID ELIGIBILITY

CHAPTER 4-~~000~~

EFFECTIVE DATE OF MEDICAID ELIGIBILITY

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by the Medical Assistance Act, Nebraska Revised Statute § 68-901 et seq.

~~4-004~~ 002. EFFECTIVE DATE OF MEDICAID ELIGIBILITY. If an individual is eligible one (1) day of the month, ~~she~~ he or she is eligible the entire month.

~~This provision is not applicable to Emergency Medical Services Assistance (EMSA). See 477 NAC 247-008.02A.~~

002.01 EFFECTIVE DATE EXCEPTIONS. This provision does not apply to the following groups:

- (A) Emergency Medical Services Assistance (EMSA). Individuals eligible under this category are eligible only for the dates of the determined emergency medical condition;
- (B) Presumptive eligibility begins on the date the provider completes a presumptive eligibility determination; and
- (C) Individuals who are inmates of a public institution and meet inpatient status in a medical institution as defined by 42 Code of Federal Regulations (CFR) 435.1010 are only eligible for the dates of a qualifying inpatient stay.

~~4-001.01 Retroactive Eligibility;~~ 003. RETROACTIVE ELIGIBILITY. ~~Retroactive eligibility is applicable if the following conditions are met: The effective date of Medicaid can be determined up to three months prior to the month of application when the following conditions are met:~~

~~(A) The individual is a child from birth through age 18, a pregnant woman, an individual dually enrolled in Medicare and Medicaid, or an individual residing in a nursing facility during the month for which eligibility is being determined;~~

~~(AB1.)~~ Eligibility is determined and a budget computed separately for each of the three (3) months;

~~(E)~~ An applicant may be eligible for any or all months of the retroactive period even though ineligible for the prospective period. Continuous eligibility may begin in a retroactive month.

~~(BD2.)~~ A medical need exists; and

~~(CE3.)~~ Elements of eligibility were met at some time during each month. and

~~(F) Until October 1, 2020, all applicants can receive a determination for retroactive eligibility, regardless of whether they are included in a population described in item number one in this list. Applications received on or after October 1, 2020 will be subject to all of the above criteria.~~

~~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. Six (6) months of continuous eligibility may begin in a retroactive month; in that case, no further budgeting is required.~~

~~The effective date for an otherwise eligible pregnant woman can be determined up to three (3) months before the application, as long as the pregnancy existed at the beginning of this retroactive period.~~

DRAFT  
01-27-2020

NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

477 NAC 19

~~REV. MARCH 13, 2018  
MANUAL LETTER # 15-2018~~

~~NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES~~

~~MEDICAID ELIGIBILITY  
477 NAC 19~~

TITLE 477

MEDICAID ELIGIBILITY

CHAPTER 19

MODIFIED ADJUSTED GROSS INCOME (MAGI)-BASED PROGRAMS

Chapters 477 Nebraska Administrative Code (NAC) 14 through 19 apply to the following: Parents/ and Caretaker Relatives, Children/~~Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance~~, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by the Medical Assistance Act, Nebraska Revised Statute § 68-901 et seq.

~~19-0042.~~ PREGNANT WOMEN.

~~19-0042.01 Pregnant Women:~~ PREGNANT WOMEN. In order to be eligible as a pregnant woman, an individual must be pregnant and have income equal to or less than 194% of the Federal Poverty Level (FPL).

002.01(A) POST-PARTUM ELIGIBILITY. In order for a pregnant woman to be eligible for the post-partum period, she must have been eligible for and enrolled in Medicaid on the date her pregnancy ends. If a pregnant woman is found to be retroactively eligible for the date her pregnancy ends, she is eligible for the post-partum period.

~~19-0042.02 Pregnancy Verification:~~PREGNANCY VERIFICATION. Verification of pregnancy shall is not be required unless information is not reasonably compatible with an applicant or client's attestation.

~~19-001.03 Presumptive Eligibility:~~ 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 unborns.

~~19-001.03A Ambulatory Prenatal Care:~~ See 471 NAC 28-001.

~~19-001.03B Qualified Provider:~~ Only a qualified provider is allowed to make presumptive eligibility determinations. See 471 NAC 28-001.01 for requirements of a qualified provider.

~~19-001.03C Qualified Provider Responsibilities: A qualified provider makes a presumptive determination of a 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 presumptive eligibility form to the Department within five (5) working days after the determination of presumptive eligibility.~~

~~19-001.03D Effective Date: The date a provider determines presumptive eligibility for assistance.~~

~~19-001.03E Presumptive Eligibility Period: Presumptive eligibility begins on the day a qualified provider determines that a woman meets any of the income eligibility levels.~~

~~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 Department 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 presumptive eligibility case has closed, but the Department is required to send a notice when Medicaid eligibility has been determined.~~

~~19-001.03F Failure to Meet Categorical Eligibility: If a woman fails to satisfy any of the eligibility criteria for the Pregnant Women's category, other than income, at any time during her presumptive eligibility period, presumptive eligibility must be discontinued regardless of the woman's submission of an application for Medicaid.~~

### 19-0023. PARENTS/ AND CARETAKER RELATIVES.

~~19-0023.01 Parents/Caretaker Relatives: PARENTS AND CARETAKER RELATIVES. In order to be eligible as a Parent/ or Caretaker Relative, an individual must:~~

- ~~1.(A) Have a dependent child, (Ssee 477 NAC 1-000 for the definition of a dependent child), and~~
- ~~2.(B) Have household income equal to or less than 58% of the Federal Poverty Level (FPL).~~

~~19-002.02 Two-Parent Families: If unmarried parents are living together and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.~~

~~19-0034. CHILDREN/CHILDREN IN AN INSTITUTION FOR MENTAL DISEASE (IMD)/CHILDREN ELIGIBLE FOR NON-IV-E ASSISTANCE~~

~~19-0034.01 Medicaid for Individuals Under Age 19: MEDICAID FOR CHILDREN UNDER AGE 19. Children may receive Medicaid if they meet one of the following the eligibility requirements: outlined in this material.~~

- ~~1-(A) Newborn children(ren): Newborn children(ren) born to Medicaid eligible pregnant women are eligible at the time of birth for one (1) year.;~~
- ~~2-(B) Infants under age one: Children under age one (1) are eligible if their household income is equal to or less than 162% of the Federal Poverty Level (FPL).;~~
- ~~3-(C) Children age one through age five: Children age one (1)-year-old through age five (5)-years-old are eligible if their family household income is equal to or less than 145% of the Federal Poverty Level (FPL).;~~
- ~~4-(D) Children age six through age 18: Children age six (6) years-old through age (18) years-old are eligible if their household income is equal to or less than 133% of the Federal Poverty Level (FPL).;~~
- ~~5-(E) Children's Health Insurance Program (CHIP): Children age eighteen-(18)-years old or younger who do not meet income limits for Medicaid are eligible for Children's Health Insurance Program (CHIP) if their household income is equal to or less than 213% of the Federal Poverty Level (FPL) and ~~if~~ the children are not covered by creditable health insurance. or~~
- ~~6-(F) Minor pregnant women: Minor pregnant women who do not meet the income limits for children's Medicaid are eligible under the Pregnant Women's category if their household income is at or below the applicable Federal Poverty Level (FPL). Ongoing Medicaid eligibility must be reviewed prior to the end of the 60-day postpartum period.~~

~~19-0034.02 Child in an CHILDREN IN AN INSTITUTION FOR MENTAL DISEASE (IMD).~~

~~19-0034.02(A) Individuals Age INDIVIDUALS AGE 19 and 20. Individuals age nineteen (19) and twenty (20) years-old may be found eligible for services under this category if they are receiving inpatient care in an institution for mental disease IMD. If an individual is an inpatient in an institution for mental disease IMD when s/he he or she reaches age twenty-one (21) years-old, s/he he or she may remain eligible for services either until discharge or until s/he he or she reaches age twenty-two (22) years-old, whichever comes first.~~

~~19-003.03 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 FPL 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.~~

~~19-0034.023 Children Who are State Wards not Eligible for IV-E Assistance:CHILDREN WHO ARE STATE WARDS NOT ELIGIBLE FOR IV-E ASSISTANCE. Children who are state~~

wards not eligible for IV-E assistance must complete an application for Medicaid. Eligibility will be determined using modified adjusted gross income (MAGI)-based methodologies.

~~19-0034.024 Children Eligible for IV-E Assistance:~~CHILDREN ELIGIBLE FOR IV-E ASSISTANCE. See 477 NAC 28-000.

~~19-0045.~~ 599 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP).

~~19-0045.01 Eligibility Requirements:~~ELIGIBILITY REQUIREMENTS. A pregnant woman, who is not otherwise eligible for Medicaid or Children's Health Insurance Program (CHIP), may have her unborn child~~(ren)s~~'s eligibility reviewed under the 599 Children's Health Insurance Program (CHIP) program. Eligibility for Medicaid must first be determined before 599 Children's Health Insurance Program (CHIP) eligibility can be reviewed. Eligibility is determined for unborn children from conception through birth, if the ~~pregnant woman and spouse's~~ household income is equal to or less than 197% of the Federal Poverty Level (FPL).

005.01(A) CITIZENSHIP AND NON-CITIZEN STATUS. 599 Children's Health Insurance Program (CHIP) has no requirement for citizenship or alien status, as the unborn~~(s)~~ child's status is independent of that of the pregnant woman.

005.01(B) CREDITABLE HEALTH INSURANCE. There is no eligibility for the unborn~~(s)~~ child if the pregnant woman has creditable health insurance. Health insurance ~~that~~ which does not provide prenatal or maternity care is not considered creditable coverage. For a definition of creditable health insurance, see 477 NAC 1-000.

~~19-0045.021(C) Nebraska Residence:~~NEBRASKA RESIDENCE. The residency of the unborn~~(s)~~ child will follow the residency of the pregnant woman.

~~19-0045.021(D) Relative Responsibility:~~RELATIVE RESPONSIBILITY. Relative responsibility ~~for in the 599 Children's Health Insurance Program (CHIP) has the following exception:~~ is determined using relative responsibility regulations for modified adjusted gross income (MAGI) programs. For a pregnant minor, the income of her financially responsible parent~~(s)~~ shall not be used to determine eligibility for the in the unborn child~~(s)s~~'s 599 CHIP budget.

~~19-0045.021(E) Age Requirement:~~AGE REQUIREMENT. For receipt of 599 Children's Health Insurance Program (CHIP) benefits, an individual is considered an unborn child from conception ~~to~~ until birth.

~~19-0045.021(F) Unborn 599 CHIP Eligibility if Parent(s) Does Not Cooperate:~~THIRD PARTY LIABILITY. If an ineligible pregnant woman or her spouse fails or refuses to cooperate with third party liability, the unborn~~(s)~~ child is ineligible for 599 Children's Health Insurance Program (CHIP).

~~19-0045.02 Effective Date of Medical Eligibility:~~EFFECTIVE DATE OF ELIGIBILITY. The effective date of eligibility for 599 Children's Health Insurance Program (CHIP) is no earlier than the first day of the application month. Note: There is no retroactive eligibility for 599 Children's Health Insurance Program (CHIP).



~~19-0045.073~~ ~~Continuous Eligibility:~~CONTINUOUS ELIGIBILITY. Unborn children are continuously eligible for up to six ~~(6)~~ months or through their month of birth, whichever comes first. After ~~the~~ six ~~(6)~~ months of continuous eligibility, a full eligibility review is not required. However, information reported or known to the Department must be acted upon. Note: An unborn child must have at least a thirty ~~(30)~~-day period of ineligibility before ~~s/he~~ he or she would qualify for another six-month period of continuous eligibility.

005.03(A) ELIGIBILITY FOR THE CHILD UPON BIRTH. 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~~ Medicaid eligibility.

005.03(B) POST-PARTUM SERVICES. The pregnant woman will not be eligible for post-partum services under 599 Children's Health Insurance Program (CHIP). If post-partum care is needed for complications following labor and delivery, the woman may apply for Emergency Medical Services Assistance (EMSA).

~~19-0056.~~ FORMER WARDS.

~~19-0056.01~~ Eligibility Requirements:ELIGIBILITY REQUIREMENTS. In order for ~~a ward~~ an individual to be eligible ~~for~~ in the former ward program, ~~(see 479 NAC 6-000), s/he~~ he or she must:

- (A) Meet non-financial eligibility requirements for Medicaid;
- ~~1.(B) Be within age limits 18 through age 20;~~
- ~~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.(C) Have income equal to or less than 51% of the Federal Poverty Level (FPL); and~~
- ~~7. Enroll in an available health plan.~~
- (D) Be a former ward of the Department; and
- (E) Be regularly attending a school, college, or a course of vocational or technical training designed to prepare the individual for gainful employment.

~~19-005.02 Age Requirement:~~ A former ward is eligible for Medicaid if s/he is under the age of twenty-one (21) years old.

~~19-005.03 Living Arrangement:~~ A former ward must continue to be in an out-of-home situation to remain eligible for the program.

~~19-0067.~~ NON-IV-E SUBSIDIZED ADOPTIONS AND GUARDIANSHIPS FOR YOUNG ADULTS.

~~19-0067.01 Eligibility Requirements:~~ELIGIBILITY REQUIREMENTS. In order for ~~a young adult~~ an individual to be eligible for Medicaid in this program, ~~s/he~~ he or she must:

- ~~1.(A) Be at least nineteen (age 19) years old and under twenty-one (21) years old through age 20;~~
- ~~2.(B) Have entered into a subsidized guardianship agreement or a subsidized adoption agreement after reaching sixteen ( age 16) years old;~~
- ~~3.(C) Meet at least one of the following criteria:~~
  - ~~1.(i) The young adult individual is completing secondary education or in an educational program leading to an equivalent credential;~~
  - ~~2.(ii) The young adult individual is enrolled in an institution that provides postsecondary or vocational education;~~
  - ~~3.(iii) The young adult individual is employed for at least eighty (80) hours per month;~~
  - ~~4.(iv) The young adult individual is participating in a program or activity designed to promote employment or remove barriers to employment; or~~
  - ~~5.(v) The young adult individual is incapable of doing any part of these activities due to a medical condition, which incapacity must be supported by regularly updated information in the case plan of the young adult individual; and~~
- ~~4.(D) Have income equal to or less than 23% of the Federal Poverty Level (FPL).~~

#### 008. PRESUMPTIVE ELIGIBILITY.

~~008.01 ELIGIBILITY REQUIREMENTS. 19-007. HOSPITAL PRESUMPTIVE ELIGIBILITY:~~  
~~The Department shall provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital.~~ To be presumptively eligible in accordance with the policies and procedures established by the Department, a presumptive eligibility determination ~~shall~~ must be made by a qualified provider on the basis of preliminary information indicating 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~~ non-citizen status, and is a resident of Nebraska.  
~~Determinations are limited to~~

- ~~1. Children (see 477 NAC 19-003);~~
- ~~2. Pregnant women (see 477 NAC 19-001.02);~~
- ~~3. Parents and caretaker relatives (see 477 NAC 19-002);~~
- ~~4. Former foster care children (see 477 NAC 27-007); and~~
- ~~5. Breast and cervical cancer patients (see Women's Cancer Program at 477 NAC 27-004).~~  
~~Hospitals that may determine presumptive eligibility for such patients are limited to those participating in the National Breast and Cervical Cancer Early Detection Program under authority of the Centers of Disease Control and Prevention.~~

~~A presumptive eligibility determination is limited to no more than one (1) period within two (2) calendar years per person.~~

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

008.02 EFFECTIVE DATE. Presumptive eligibility begins on the date the provider completes a presumptive eligibility determination.

008.03 ELIGIBILITY PERIOD. If the individual 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 the Department makes the determination of Medicaid eligibility based on that application. If the individual 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 day. A presumptive application approved in error will be closed by the Department upon discovery of the error.

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

008.05 RESPONSIBILITIES OF QUALIFIED ENTITIES. An entity qualified to make presumptive eligibility determinations must:

- (A) Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, and of the presumptive eligibility period, and
  - (i) If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day;
  - (ii) If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application;
  - (iii) If the individual is not determined presumptively eligible, the qualified entity must notify the appropriate individual of the reason for the determination and he or she may file an application for Medicaid with the Department;
- (B) Provide the individual with a Department approved application for Nebraska Medicaid;
- (C) Notify the Department the individual is presumptively eligible within five working days from the date the determination is made; and
- (D) Refrain from delegating the authority to determine presumptive eligibility to another entity.

~~19-0078.016~~ Failure to Meet Categorical Eligibility: FAILURE TO MEET CATEGORICAL ELIGIBILITY. If a client fails to satisfy any of the eligibility criteria for a presumptive eligibility Medicaid category, other than income, at any time during the client's presumptive eligibility period, presumptive eligibility must be discontinued regardless of the client's submission of an application.

~~19-007.02 Responsibilities of Qualified Entities: An entity qualified to make presumptive eligibility determinations shall~~

- ~~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 individual's presumptive eligibility will end on that last day;~~

- ~~b. If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's 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 Department;~~
- ~~2. Provide the individual with a Department approved application for Nebraska Medicaid;~~
- ~~3. Notify the Department that the individual is presumptively eligible within five working days from the date that the determination is made; and~~
- ~~4. Refrain from delegating the authority to determine presumptive eligibility to another entity.~~

008.07 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN. 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. There is no presumptive eligibility under the 599 Children's Health Insurance Program (CHIP).

008.07(A) AMBULATORY PRENATAL CARE. See 471 NAC 28.

010.07(B) QUALIFIED PROVIDER. Only a qualified provider may make presumptive eligibility determinations. See 471 NAC 28 for requirements of a qualified provider.

008.08 HOSPITAL PRESUMPTIVE ELIGIBILITY. The Department will provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital.

008.08(A) ELIGIBLE GROUPS. Determinations are limited to:

- (i) Children, see 477 NAC 19;
- (ii) Pregnant women, see 477 NAC 19. A pregnant woman is eligible for ambulatory care only;
- (iii) Parents and caretaker relatives, see 477 NAC 19;
- (iv) Effective October 1, 2020, the Heritage Health Adult Program, see 477 NAC 29;
- (v) Former foster care children, see 477 NAC 28; and
- (vi) Breast and cervical cancer patients, see Women's Cancer Program at 477 NAC 27. Hospitals which may determine presumptive eligibility for such patients are limited to those participating in the National Breast and Cervical Cancer Early Detection Program under authority of the Centers of Disease Control and Prevention.

008.08(B) FREQUENCY. Presumptive eligibility determination is limited to no more than one period within two calendar years per person. A qualified provider may authorize a period of presumptive eligibility once per pregnancy.

~~19-0078.038(C) Qualified Hospital Criteria:~~ QUALIFIED HOSPITAL CRITERIA. A hospital qualified to make presumptive eligibility determinations shall must:

- 1.(i) Participate as a Medicaid provider;
- 2.(ii) Notify the Department of its decision to make presumptive determinations;

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- ~~3.~~(iii) Agree to make determinations consistent with state policy and procedures;
- ~~4.~~(iv) Assist individuals in completing and submitting full Medicaid applications;
- ~~5.~~(v) Assist individuals in understanding required documentation requirements; and
- ~~6.~~(vi) Not be disqualified by the Department.

TITLE 477            MEDICAID ELIGIBILITY

CHAPTER 29        HERITAGE HEALTH ADULT PROGRAM

The regulations contained in this chapter will become effective on October 1, 2020.

001. SCOPE AND AUTHORITY. These regulations govern the services provided under Nebraska's Medicaid program as defined by the Medical Assistance Act, Nebraska Revised Statute § 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 ANNUAL HEALTH VISIT. At minimum, a visit occurring no less frequently than once every 12 months with a primary care provider or specialist practicing within the scope of their respective practice acts, with the nature of a comprehensive exam. See 477-000-018 for the list of approved Current Procedure Terminology codes.

002.02 BENEFIT TIER PERIOD. A six-month period of enrollment in either the Basic or Prime benefit tier. The first benefit tier period begins with the month of approval for Medicaid in the Heritage Health Adult program.

002.03 BENEFIT TIER REVIEW DATE. The date on which the Department reviews benefit tier eligibility criteria in order to determine benefit tier eligibility for the next benefit tier period. This occurs 60 days prior to the end of the current benefit tier period.

002.04 CASE AND CARE MANAGEMENT. A cooperative effort between an individual and his or her managed care organization to improve health care outcomes and address social determinants of health. As a part of this initiative, individuals enrolled in the Heritage Health Adult program must complete an annual health risk screening.

002.05 HERITAGE HEALTH ADULT PROGRAM. The Medicaid program which includes individuals eligible for Medicaid under the policies outlined in this chapter.

002.06 LOCKOUT. A period of time, lasting two benefit tier periods, during which an individual is excluded from the Prime benefit tier.

002.07 PERSONAL RESPONSIBILITY ACTIVITIES. A group of activities individuals are required to maintain order to earn the Prime benefit tier. These activities include attending appointments, maintaining commercial coverage, and timely change reporting.

~~002.08 WELLNESS ACTIVITIES. A group of activities a Heritage Health Adult enrollee must complete to earn the Prime benefit tier. These activities include selection or assignment of a primary care provider, attending an annual health visit, and participation in case and care management through the individual's managed care organization.~~

~~003. ELIGIBILITY CRITERIA. 002. HERITAGE HEALTH ADULT PROGRAM. In order to be eligible for Medicaid under the Heritage Health Adult program, an individual must meet the following eligibility criteria.~~

~~003.04 002.01 METHODOLOGY AND INCOME LIMIT. Eligibility for the Heritage Health Adult program is determined using the modified adjusted gross income (MAGI) methodology. In order to be eligible in the Heritage Health Adult program, an individual must have household income equal to or less than 133% of the Federal Poverty Level (FPL). 477 Nebraska Administrative Code (NAC) 14 through 18 apply to eligibility determinations in the Heritage Health Adult program.~~

~~003.02 002.02 NON-FINANCIAL CRITERIA. In order to be eligible in the Heritage Health Adult program, an individual must:~~

- ~~(A) Be age 19 or older and under age 65;~~
- ~~(B) Not be pregnant;~~
- ~~(C) Not be entitled to or enrolled in Medicare part A or B; and~~
- ~~(D) Not be eligible for or enrolled coverage in any of the following groups: parents and caretaker relatives, pregnant women, children under age 19, former foster care, individuals receiving IV-E assistance, transitional medical assistance (TMA) with or without a premium, and Medicaid for the aged, blind, and disabled.~~

~~003.03 002.03 COVERAGE FOR DEPENDENT CHILDREN. Parents and caretaker relatives of dependent children are ineligible for coverage under the Heritage Health Adult program unless all dependent children living in the household are enrolled in Medicaid, the Children's Health Insurance Program (CHIP), or are otherwise enrolled in minimum essential coverage as defined at 26 United States Code (U.S.C.) 5000(A).~~

~~003.04 002.04 INDIVIDUALS WHO BECOME PREGNANT WHILE ENROLLED IN THE HERITAGE HEALTH ADULT PROGRAM. If an individual becomes pregnant during enrollment in the Heritage Health Adult program, the individual will remain in the Heritage Health Adult program until eligibility is redetermined during the annual eligibility renewal unless the individual becomes otherwise ineligible in this category, see 477 NAC 3.~~

~~004. 003. BENEFIT TIERS. Individuals eligible in the Heritage Health Adult program will be eligible for coverage in one of two benefit tiers, the Nebraska Basic Alternative Benefit Plan, also known as the Basic benefit tier, and the Nebraska Prime Alternative Benefit Plan, also known as the Prime benefit tier. For plan benefits, see 471 NAC 39.~~

~~004.04 003.01 BASIC BENEFIT TIER. Individuals newly enrolled in the Heritage Health Adult program who are not targeted for enrollment in the Prime benefit tier will be enrolled in the Basic benefit tier. Individuals who have not completed the defined wellness activities and personal responsibility activities, or are in a lockout period will remain in the Basic benefit tier. This includes individuals whose Medicaid has been closed for more than 90 days.~~

004.02 003.02 PRIME BENEFIT TIER. Individuals who have completed the defined wellness activities and personal responsibility activities, and who are not in a lockout period at the time of their benefit tier review will be approved for coverage in the Prime benefit tier. Individuals in the following groups will be targeted for enrollment in the Prime benefit tier. When an individual no longer meets the criteria of a targeted group, he or she will be placed in the Basic benefit tier for the first month available, allowing for adequate and timely notice. without regard to wellness activities, personal responsibility activities, or lockout:

- (A) Individuals determined to be medically frail;
- (B) Pregnant individuals; and
- (C) Individuals age 19 and 20.

004.03 003.03 MEDICALLY FRAIL.

004.03(A) 003.03(A) MEDICALLY FRAIL DETERMINATION. For an individual to be determined medically frail, he or she must have a documented medical condition attested to by a healthcare provider who is able to diagnose within the scope of his or her respective practice act and is licensed and in good standing within the state in which they practice, identified through analysis and evaluation of historical claims data performed by the Medicaid managed care organization, or identified through information supplied by the Department, that falls into one or more of the following categories:

- (i) A disabling mental disorder;
- (ii) A chronic substance abuse disorder;
- (iii) A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs, see 471 NAC 12 for the definition of activities of daily living for adults;
- (iv) A disability determination based on Social Security criteria;
- (v) A serious and complex medical condition; or
- (vi) Chronically homeless as defined by the United States Department of Housing and Urban Development.

004.03(B) 003.03(B) ACTIVITIES OF DAILY LIVING. For each activity of daily living an individual must require help to complete the task safely and the helper is required to be physically present throughout the task for each occurrence.

004.03(C) 003.03(C) REFERRALS FOR DETERMINATION. Individuals may be referred to the Department in the following ways:

- (i) The individual may self-identify as medically frail;
- (ii) Referral by the Medicaid managed care organization after interaction with a case and care manager or through analysis of historical claims data; and
- (iii) Identification by the Department.

004.03(D) 003.03(D) MEDICALLY FRAIL PERIOD. The Department will approve medically frail determinations for a period of either 12 or 36 months. The medically frail period will be based on the individual's health care condition and the Department's established clinical guideline criteria. At the end of the approved medically frail period, a review must be completed to determine whether the individual remains medically frail.



~~004.03(E) 003.03(E) EFFECTIVE DATE OF MEDICALLY FRAIL DETERMINATION. Medically frail determinations approved by the Department on or before the last business day of the month will become effective on the first calendar day of the following month.~~

~~004.04 BENEFIT TIER REVIEW. Eligibility within the benefit tier system will be reviewed every six months, when an individual turns age 21, or at the end of the post-partum period.~~

~~004.04(A) MEDICALLY FRAIL BENEFIT TIER REVIEW. Benefit tier reviews for individuals determined to be medically frail will occur only when the individual's medically frail status ends and he or she must be determined eligible in either the Basic or Prime benefit tier.~~

~~004.04(B) MEDICAID CLOSURES LASTING FEWER THAN 90 DAYS. Individuals reopened in the Heritage Health Adult program whose Medicaid has been closed for fewer than 90 days will resume the benefit tier period in which they were enrolled at the time of closure. If a benefit tier review is due when Medicaid is reopened, the review will be completed and the individual placed in the appropriate benefit tier.~~

~~005. WELLNESS ACTIVITIES. In order to become and remain eligible for the Prime benefit tier, individuals must complete wellness activities, including selection of a primary care physician, attending an annual health visit, and participation in case and care management.~~

~~005.01 PRIMARY CARE PHYSICIAN. Upon enrollment with a managed care organization, individuals will have the opportunity to select a primary care provider. If a selection is not made, the individual will be assigned to a primary care provider by the managed care organization.~~

~~005.02 ANNUAL HEALTH VISIT. Individuals must attend a qualifying annual health visit within the 12 months prior to the benefit tier review date.~~

~~005.03 CASE AND CARE MANAGEMENT. Individuals must complete a health risk screening within 90 days of enrollment in a managed care plan, and annually thereafter, in order to maintain active participation in case and care management.~~

~~006. PERSONAL RESPONSIBILITY ACTIVITIES. In order to be eligible for the Prime benefit tier, individuals must maintain personal responsibility activities. Individuals who do not maintain the following activities will be locked out of the Prime benefit tier for two benefit tier periods:~~

~~(A) Attending Appointments: Individuals must attend scheduled appointments or give reasonable notice of cancellation as defined by the provider. If an individual misses three or more appointments in the six month period beginning 12 months prior to the benefit tier review date, he or she will be subject to a lockout period;~~

~~(B) Maintaining Commercial Coverage: Individuals who voluntarily discontinue employer-sponsored health coverage up to 90 days prior to the date of application, or who voluntarily cancel coverage after enrolling in Medicaid will be subject to a lockout period;~~  
~~and~~

~~(C) Timely Change Reporting: Individuals who do not notify the Department within 10 days of a change which impacts Medicaid eligibility or benefit tier determination will be subject to a lockout period.~~

~~007. GOOD CAUSE. When an individual is assigned to the Basic benefit tier based on lack of participation in wellness or personal responsibility activities, he or she may provide good cause for not completing an activity in order to receive a redetermination for benefit tier eligibility.~~

~~007.01 REQUEST FOR GOOD CAUSE REVIEW. An individual may request a good cause review via any mode of communication currently use for application submission listed at 42 Code of Federal Regulations (CFR) 435.907(a). A request to review good cause must be received within 90 days of the date of the Notice of Action.~~

~~007.02 BENEFIT TIER ELIGIBILITY DURING A GOOD CAUSE REVIEW. Unless a request for fair hearing has been submitted, the individual will remain in the Basic benefit tier during the good cause review.~~

~~007.03 GOOD CAUSE REASONS. The Department will review good cause claims and supporting documentation for the following reasons:~~

~~(A) Good cause reasons for not completing an annual health visit:~~

- ~~(i) Physical or mental health emergency;~~
- ~~(ii) Acute or chronic medical conditions;~~
- ~~(iii) Weather related travel difficulty;~~
- ~~(iv) Unforeseen transportation difficulty;~~
- ~~(v) Family emergency or crisis;~~
- ~~(vi) Unforeseen work schedule change; and~~
- ~~(vii) Other reasons as approved by the Department;~~

~~(B) Good cause reasons for not completing the health risk screening:~~

- ~~(i) Physical or mental health emergency;~~
- ~~(ii) Acute medical condition;~~
- ~~(v) Lack of access to mail or telephone; and~~
- ~~(vi) Other reasons as approved by the Department;~~

~~(C) Good cause reasons for missed appointments:~~

- ~~(i) Physical or mental health emergency;~~
- ~~(ii) Acute or chronic medical conditions;~~
- ~~(iii) Weather related travel difficulty;~~
- ~~(iv) Unforeseen transportation difficulty;~~
- ~~(v) Family emergency or crisis;~~
- ~~(vi) Unforeseen work schedule change; and~~
- ~~(vii) Other reasons as approved by the Department;~~

~~(D) Good cause reasons for not maintaining commercial health coverage:~~

- ~~(i) The coverage is not cost effective for the household;~~
- ~~(ii) Change in employment;~~
- ~~(iii) The plan does not provide adequate coverage of health conditions;~~
- ~~(iv) Extended leave from employment in an unpaid status, resulting in non-payment of the employer-paid portion of the plan;~~
- ~~(v) Change in status of the policy holder, or a qualifying life event; and~~
- ~~(vi) Other reasons as approved by the Department;~~

~~(E) Good cause reasons for not reporting a change timely:~~

- ~~(i) Physical or mental health emergency;~~
- ~~(ii) Acute or chronic medical condition;~~
- ~~(iii) Family emergency or crisis; and~~

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~~(iv) Other reasons as approved by the Department.~~

~~007.04 GOOD CAUSE DECISION. The Department will make a decision regarding good cause within 30 days of the request for review. If good cause has been met, the individual will be placed back into the Prime benefit tier for the current enrollment period and any applicable lockout removed. If good cause has not been met, the individual will remain in the Basic benefit tier and any applicable lockout will be applied. The outcome of the Department's determination regarding good cause is not an appealable action.~~