NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

August 2, 2021
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on proposed changes to Title 477, Chapter 27 of the Nebraska Administrative Code (NAC) – *Eligibility for the Aged, Blind, and Disabled; Medically Needy; Qualified Disabled Working Individuals; Medicaid Insurance for the Workers with Disabilities; Breast and Cervical Cancer; Emergency Medical Services Assistance; and Katie Beckett.* The proposed regulations implement statutory changes to the Medicaid Insurance for the Working Disabled (MIWD) program by defining eligibility standards for the new Basic Coverage and Medical Improvement Groups; removing the former two-part income test; defining the disability requirement for the program and specifying when such determination is made; and defining the premium requirements for both the Basic Coverage and Medical Improvement Groups. The proposed changes also restore provisions regarding direct referral to the state review team (SRT), as well as clarify and update the requirements regarding review of medical documentation by the SRT; and reformat and renumber several sections in the regulations.

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

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 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax or email written comments, 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, 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 who are deaf or hard of hearing 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: Jason Davis
Chapter: 27	Date prepared: 06/02/2021
Subject: Medicaid Insurance for Workers with Disabilities	Telephone: (531) 530-7123

Type of Fiscal Impact:

Please check all that apply

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: Medicaid and Long-term Care

SFY22:

Aid Expenditures Estimate –

Total Funds $579,000
General Funds $244,338
Federal Funds $334,662

Premium Revenue Estimate –

Total Funds $8,790
General Funds $3,709
Federal Funds $5,081

Net Fiscal Impact Estimate –

Total Funds $570,210
General Funds $240,629
Federal Funds $329,581

Political Subdivision: N/A
Regulated Public: N/A
If indeterminable, explain why: N/A

TITLE 477 MEDICAID ELIGIBILITY

CHAPTER 27 ELIGIBILITY FOR THE AGED, BLIND, AND DISABLED; MEDICALLY NEEDY; QUALIFIED DISABLED WORKING INDIVIDUALS; MEDICAID INSURANCE FOR THE WORKERS WITH DISABILITIES; BREAST AND CERVICAL CANCER; EMERGENCY MEDICAL SERVICES ASSISTANCE; AND KATIE BECKETT

Chapters 477 Nebraska Administrative Code (NAC) 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance.

001. SCOPE AND AUTHORITY. These regulations are promulgated under the authority of the Medical Assistance Act, Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 68-901 et seq.

002. AGED, BLIND, AND DISABLED (ABD). Medicaid for aged, blind, and disabled (ABD) provides medical coverage for individuals who meet the criteria specified below.

002.01 MANDATORY GROUPS. Certain individuals are eligible to receive Medicaid in the aged, blind, and disabled (ABD) category due to current or prior participation in the Supplemental Security Income (SSI) program. A separate application for Medicaid must be submitted before eligibility can be determined.

002.01(A) SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS. Nebraska residents who are currently receiving benefits from the Supplemental Security Income program are eligible to receive Medicaid in the aged, blind, and disabled (ABD) category. The Supplemental Security Income (SSI) program is responsible for verifying the individual's income, resources, and the determination that an individual is disabled.

002.01(B) 1619B BENEFICIARIES. A blind or disabled individual is eligible if the individual received Medicaid and Supplemental Security Income (SSI) in the month before the month in which this reference applies and whose Supplemental Security Income (SSI) payment stopped due to the level of earnings and who is determined by the Social Security Administration (SSA) to have special Medicaid status under section 1619(b) of the Social Security Act, as amended. The Social Security Administration (SSA) is responsible for verifying the income, resources, disability status, and 1619(b) eligibility of the individual.

002.01(C) FORMER SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS. Certain former recipients of benefits from the Supplemental Security Income (SSI)

program remain eligible for Medicaid benefits after losing the ability to receive Supplemental Security Income (SSI) program benefits. For each category below, all of the following requirements must be met in order to be considered a member of the category.

002.01(C)(i) DISABLED EARLY WIDOWS OR WIDOWERS. These individuals are also referred to as additional reduction factor (ARF) widows or widowers. All of the following must be met:

(1) Have been determined disabled;
(2) Were receiving Supplemental Security Income (SSI) in December, 1983 and lost Supplemental Security Income (SSI) benefits in January, 1984 due to the elimination of a benefit reduction factor for widows or widowers before the attainment of age 60;
(3) Have been continuously entitled to the Title II widow or widowers benefit based on disability since January, 1984;
(4) Applied for benefits under this group prior to July 1, 1988 or a later date established under the court order in Darling v. Bowen; and
(5) Would continue to be eligible for Supplemental Security Income (SSI) benefits, including the resource standard, if the client had not received the increase in Title II benefits.

002.01(C)(ii) DISABLED ADULT CHILDREN (DAC). This population is also known as childhood disability beneficiaries (CDB). All of the following must be met:

(1) Lost Supplemental Security Income status after November 10, 1986 due to the mandatory receipt or increase in Title II benefits on a parent's record due to the retirement, death, or disability of the parent;
(2) Are age 18 or older;
(3) Blindness or disability began before age 22; and
(4) Would continue to be eligible for a Supplemental Security Income (SSI) payment, including the resource standard, if they were not receiving the Title II disabled adult child benefit.

002.01(C)(iii) SECTION 503 GROUP. This population is commonly referred to as the Pickle Amendment Group. All of the following factors must be met:

(1) Is currently receiving Title II income;
(2) Was eligible for and receiving Supplemental Security Income (SSI) benefits concurrently with Title II income for at least one month after April 1, 1977; and
(3) Lost Supplemental Security Income (SSI) benefits, but would continue to receive it, including the resource standard, if the amount of cost-of-living increases received from Title II income after the month in which Supplemental Security Income (SSI) benefits were lost were deducted from the current Title II benefit. The cost-of-living increases include the increases received by the individual, the individual's spouse, or a financially responsible family member.

002.01(C)(iv) EARLY WIDOWS OR WIDOWERS. This population is also known as COBRA widows or widowers. All of the following factors must be met:

(1) Lost Supplemental Security Income (SSI) benefits due to the mandatory receipt of Title II benefits;

(2) Is not yet eligible for Medicare Part A;
(3) Has attained age 50, but is not yet age 65; and
(4) Would continue to be eligible for Supplemental Security Income (SSI) if not receiving Title II benefits.

002.02 AGED, BLIND, AND DISABLED (ABD) 100% GROUP. Aged, blind, and disabled individuals who are not eligible as a member of a mandatory group may be eligible for Medicaid if all of the criteria below are met. Members of this group are entitled to all benefits under the state plan. The eligibility factors below are in addition to the requirements in chapters three, five, six, and eight of this title.

002.02(A) INCOME. Countable income for the individual must be at or below 100% of the Federal Poverty Level (FPL). Countable income is determined according to the provisions of chapter 22 of this title.

002.02(B) RESOURCES. Countable resources must be at or below the limit specified in chapter 23 of this title. The provisions of chapter 23 will determine whether or not a resource is countable toward the specified limit.

002.02(C) CATEGORICAL FACTORS. An individual must meet the categorical factors of age, blindness, or disability, as defined below.

002.02(C)(i) AGE. An individual is considered a member of the aged category at age 65 or older. A blind or disabled individual becomes a member of the aged category the month that the individual turns age 65.

002.02(C)(ii) BLINDNESS OR DISABILITY. All applicants requesting eligibility in the blind or disabled category must meet the medical definitions of blindness or disability of the Retirement, Survivors, and Disability Insurance (RSDI) or the Supplemental Security Income (SSI) programs as administered by Social Security Administration (SSA). The determination by the Social Security Administration (SSA) that an individual is disabled or blind must be accepted for eligibility for the aged, blind, or disabled (ABD). In some cases, the State Review Team (SRT) may make the determination of blindness or disability.

002.02(C)(ii)(1) DISABILITY CRITERIA. Generally, an individual is disabled if the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A child through 17 years old is considered disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity. See Titles II and XVI of the federal Social Security Act, as amended, for further disability criteria. The Social Security Administration has the primary responsibility of determining whether an individual meets the disability criteria.

002.02(C)(ii)(1)(a) DETERMINATIONS UNDER APPEAL. An individual who is determined ineligible for Medicaid for the aged, blind, or disabled (ABD)

because the individual does not meet the disability requirements of the Supplemental Security Income (SSI) program may appeal the decision to the Social Security Administration (SSA). Upon receiving an affirmative redetermination of disability from the Social Security Administration (SSA), the Department shall use the corresponding date of application in determining eligibility for Medicaid if the individual meets all of the following:

(i) Has been determined ineligible for the Supplemental Security Income (SSI) program because the individual is not considered disabled due to lack of severity;

(ii) Appeals the decision of the Supplemental Security Income (SSI) program; and

(iii) The individual wins the appeal.

002.02(C)(ii)(2) DIRECT REFERRAL TO THE STATE REVIEW TEAM. In the following situations a referral may be submitted directly to the state review team (SRT) for a determination of disability and its probable duration without waiting for a determination from the Supplemental Security Income (SSI) program if the individual is not eligible for another medical program, and during the initial intake it is apparent that:

(A) The individual has income and/or resources in excess of the limit for the Supplemental Security Income (SSI) program. The individual's potential eligibility for the Supplemental Security Income (SSI) program must be monitored. If income or resources fall below the Supplemental Security Income (SSI) limit, an immediate referral for the Supplemental Security Income (SSI) program must be made to the Social Security Administration (SSA). The individual is allowed 60 days to apply for this potential benefit;

(B) The individual requires immediate long-term hospitalization or treatment for a severe impairment before the Social Security Administration (SSA) can make a determination for the Supplemental Security Income (SSI) program, or the individual would be required to extend a hospital stay solely because of a delay in processing the Supplemental Security Income (SSI) application. An immediate referral for the Supplemental Security Income (SSI) program must be made;

(C) The individual is residing in a medical facility or public institution and the Social Security Administration (SSA) will be unable to make a disability determination for the Supplemental Security Income (SSI) program. An individual is eligible for Supplemental Security Income (SSI) benefits while institutionalized only if Medicaid will pay 50 percent of the individual's care. Therefore, the Social Security Administration (SSA) may, in some cases, wait for a determination of eligibility for Medicaid. An immediate referral for the Supplemental Security Income (SSI) program must be made;

(D) The individual is deceased and the Social Security Administration (SSA) will not make a disability determination for the Supplemental Security Income (SSI) program; or

(E) The individual is a non-citizen who the Social Security Administration (SSA) will not review for the Supplemental Security Income (SSI) program.

002.02(C)(ii)(2)(a) DOCUMENTATION STANDARD. The state review team (SRT) will review medical documentation dated no more than 12 months prior to the date for which a disability determination is requested. The individual whose disability status is being determined must have been examined by a physician, or appropriate provider, for the condition or conditions related to the disability determination within three months of the requested date.

002.02(C)(ii)(2)(~~a~~b) REFERRALS TO THE SOCIAL SECURITY ADMINISTRATION. The Department must continue to monitor the individual's potential eligibility for Retirement, Survivors, Disability Insurance (RSDI) and Supplemental Security Income (SSI) benefits even though the state review team (SRT) has made the determination of disability. A referral for the Supplemental Security Income (SSI) or Retirement, Survivors, Disability Insurance (RSDI) program, as appropriate, must be made at the time of the state review team (SRT) determination. If the individual is denied benefits under the Supplemental Security Income (SSI) or Retirement, Survivors, Disability Insurance (RSDI) programs initially for a non-disability related reason, but later appears to be eligible for such benefits, then a referral must be made. The individual's referral will allow 60 days to apply for the potential benefits.

002.02(C)(ii)(2)(~~b~~c) SOCIAL SECURITY DETERMINES THE INDIVIDUAL IS NOT DISABLED. If the state review team (SRT) has determined the individual is disabled but, the Social Security Administration (SSA) later determines that the individual is not disabled due to lack of severity or the ability to engage in substantial gainful activity, then the Department will abide by the decision of the Social Security Administration. If the individual has filed an appeal with the Social Security Administration (SSA), the individual must be considered disabled through the review period established by the state review team (SRT). If no appeal with the Social Security Administration (SSA) is filed, then the disability requirement cannot be considered to be met.

002.02(C)(iii) SUSPENSION OF BENEFITS. If Supplemental Security Income (SSI) benefits are suspended due to excess income or excess resources, the individual is still considered disabled for a period of 12 consecutive months, as long as all other eligibility factors are met. The 12 month period is effective the first day of the month in which the benefits are suspended. To continue Medicaid eligibility for the aged, blind, or disabled (ABD) category at the end of the 12 month period, a review of disability by the state review team (SRT) is necessary.

003. QUALIFIED DISABLED AND WORKING INDIVIDUALS. Individuals who were receiving Retirement, Survivors, Disability Insurance (RSDI) disability benefits and return to work, but remain disabled, may continue to be entitled to Medicare Part A at no cost for 48 months. The Omnibus Budget Reconciliation Act of 1989 allows these individuals, at the end of 48 months, to enroll in Medicare Part A and pay a premium. The act also requires state Medicaid programs to purchase Medicare Part A premiums for these individuals. To be eligible for this program, an individual must meet all of the following requirements.

003.01 AGE. To be eligible for the payment of the Medicare premium, an individual must be 64 years old or younger.

003.02 DISABILITY. To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by the Social Security Administration (SSA). The Social Security Administration (SSA) has the responsibility to verify periodically that the disability continues. If the Social Security Administration (SSA) determines through a continuing disability review that the individual is no longer disabled, the Department is notified and eligibility ceases. If the individual voluntarily withdraws from Medicare Part A premium coverage, then eligibility ceases.

003.03 INCOME. To be eligible for the Qualified Disabled and Working Individuals benefit, the unit must have income above 100%, but at or below 200% of the Federal Poverty Level (FPL). In determining countable income, the amount of medical insurance premiums is not allowed.

003.04 RESOURCES. The resource limit for the program is four thousand ($4,000) for an individual or six thousand ($6,000) for a couple.

003.05 NOT OTHERWISE ELIGIBLE. An individual eligible as a Qualified Disabled and Working Individual cannot be eligible for any other Medicaid program.

004. MEDICARE BUY-IN. The Medicare buy-in programs assist those eligible for both Medicare and Medicaid cover the costs of Medicare.

004.01 ELIGIBILITY REQUIREMENTS. The eligibility requirements of the Medicare buy-in programs are listed below. Specific requirements vary according to the program. An individual must:

(A) Be a resident of Nebraska;
(B) Be a United States citizen or qualified non-citizen;
(C) Receive, or be eligible to receive, Medicare benefits; and
(D) Meet the income and resource requirements of the program.

004.02 QUALIFIED MEDICARE BENEFICIARIES. Qualified Medicare Beneficiaries (QMBs) are Medicare recipients with low income. A Qualified Medicare Beneficiary (QMB) may be eligible to receive Medicaid benefits under another category.

004.02(A) BENEFITS. Qualified Medicare Beneficiaries (QMBs) receive a buy-in of the Medicare premium, as well as payment of any Medicare co-pays or deductibles.

004.02(B) EFFECTIVE DATE. Qualified Medicare Beneficiary (QMB) begins the month after the month in which eligibility is determined.

004.02 (C) INCOME AND RESOURCE LIMITS. Qualified Medicare Beneficiaries (QMBs) must have income at or below 100% of the Federal Poverty Level (FPL). The resource limit for a Qualified Medicare Beneficiary (QMB) is located at 477-000-012. The resource guideline is adjusted annually. Income is counted in accordance with 477 NAC 22. Resources are counted in accordance with 477 NAC 23.

004.02(C)(i) AGED, BLIND, AND DISABLED QUALIFIED MEDICARE BENEFICIARIES. Individuals who are eligible for Medicare and who are also eligible to receive Medicaid in the aged, blind, and disabled (ABD) category will automatically qualify as a Qualified Medicare Beneficiary. The joint benefit is referred to as the aged, blind, and disabled Qualified Medicare Beneficiary (ABD/QMB).

004.02(C)(ii) MEDICARE SAVINGS PROGRAM QUALIFIED MEDICARE BENEFICIARY. Individuals who have excess resources for the aged, blind, and disabled (ABD) category may still be eligible to receive the Qualified Medicare Beneficiary (QMB) benefit if within the resource limit for the Qualified Medicare Beneficiary (QMB) program. These individuals are only eligible for the Medicare buy-in, payment of co-pays, and deductibles. This benefit is referred to as the Medicare Savings Program Qualified Medicare Beneficiary (MSP/QMB).

004.03 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB). Specified Low Income Medicare Beneficiaries (SLMBs) are Medicare recipients who have income just above the level of a Qualified Medicare Beneficiary (QMB).

004.03(A) BENEFITS. Specified Low Income Medicare Beneficiaries (SLMBs) only receive payment of the Medicare Part B premium. An individual may be eligible as a Specified Low Income Medicare Beneficiary (SLMB) and as medically needy in the same month.

004.03(B) EFFECTIVE DATE. Eligibility for a Specified Low Income Medicare Beneficiary (SLMB) is determined from the date of the application. Eligibility may be determined for up to three months before the date of application, if the individual was eligible for those months and requests the benefit.

004.03(C) INCOME AND RESOURCES. A Specified Low Income Medicare Beneficiary must have income above 100% of the Federal Poverty Level (FPL) but at or below 120% of the Federal Poverty Level (FPL). Income and resources are determined for only a one or two person household. The resource limit for this eligibility group is located at 477-000-012, and is adjusted annually. Income is counted in accordance with 477 NAC 22. Resources are counted in accordance with 477 NAC 23.

004.04 QUALIFIED INDIVIDUALS (QI-1). A Qualified Individual (QI-1) has income just above the limit of an eligible Specified Low Income Medicare Beneficiary (SLMB).

004.04(A) BENEFITS. A Qualified Individual (QI-1) is only eligible for the payment of the Medicare Part B premium.

004.04(B) EFFECTIVE DATE. Eligibility for a Qualified Individual (QI-1) is determined from the date of application. Eligibility for up to three months before the month of application may be available if the individual was eligible and the month is within the current calendar year.

004.04(C) INCOME AND RESOURCES. A Qualified Individual (QI-1) must have income above 120% of the Federal Poverty Level (FPL) but at or below 135% of the Federal Poverty Level. Income and resources are determined for only a one or two person household. The resource limit for this eligibility group is located at 477-000-012, and is adjusted annually. Income is counted in accordance with 477 NAC 22. Resources are counted in accordance with 477 NAC 23.

004.04(D) PROHIBITION ON OTHER BENEFITS. A Qualified Individual (QI-1) cannot be eligible for Medicaid coverage under any other category in the same month that the individual is eligible as a Qualified Individual (QI-1). The individual must choose between either Medicaid coverage for medical costs or the Qualified Individual (QI-1) benefit, but cannot have both.

005. MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD). ~~Working i~~Individuals who meet the necessary disability criteria, have income within income guidelines, and are working may be eligible for Medicaid Insurance for Workers with Disabilities (MIWD). An individual may be eligible for Medicaid Insurance for Workers with Disabilities (MIWD) in either the Basic Coverage Group or the Medical Improvement Group, as defined by The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. After application of income disregards, individuals with income less than 200% of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with incomes of 200, but less than 250 ~~through 249~~% of the Federal Poverty Level (FPL) are eligible for Medicaid with a monthly premium payment. ~~See 477-000-046 for procedures.~~

005.01 TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) BASIC COVERAGE GROUP ELIGIBILITY REQUIREMENTS. In order to receive Medicaid in the Basic Coverage Group, the individual must meet the requirements below:

~~(A)~~005.01(A) AGE. An individual must be at least 16, but less than 65 years old. ~~Qualify for Medicaid except for income;~~

~~(B)~~005.01(B) DISABILITY. An individual must be determined disabled by the Social Security Administration (SSA) or state review team (SRT). This determination is made without regard to earnings. ~~Not be eligible for Medicaid for the aged, blind, or disabled (ABD), but may be eligible as medically needy blind or disabled;~~

~~(C)~~005.01(C) EARNED INCOME. Participants must have earned income, which includes self-employment. ~~Meet the Social Security Administration (SSA) or state review team (SRT) definition of disability;~~

~~(D)~~005.01(D) INCOME LIMIT. Combined countable earned and unearned income of the household is more than 100%, but less than 250% of the Federal Poverty Level (FPL). ~~Be at least 18, but no more than 64 years old;~~

~~(E)~~0050.1(E) RESOURCE LIMIT. Countable resources are no more than $4,000 for an individual or $6,000 for a couple. ~~Be working;~~

~~(F) Using a two-part income test, have income that is equal to or less than 200% of the Federal Poverty Level (FPL);~~

~~(G) Meet Medicaid resource limits; and~~
~~(H) Pay a premium if income is above 200% of the Federal Poverty Level (FPL) and equal to or less than 250% of the Federal Poverty Level (FPL).~~

005.02 TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) MEDICAL IMPROVEMENT GROUP ELIGIBILITY REQUIREMENTS. In order to receive Medicaid in the Medical Improvement Group, the individual must meet the requirements below: ~~DISABILITY DETERMINATION. Individuals who are not receiving a Social Security Disability payment must be determined disabled by the state review team (SRT). Receipt of a Social Security Disability Insurance (SSDI) payment meets the disability requirement.~~

005.02(A) AGE. An individual must be at least 16, but less than 65 years old.

005.02(B) EARNED INCOME. Participants must have earned income, which includes self-employment.

005.02(B)(i) MINIMUM AMOUNT. Medical Improvement Group participants must earn at least the Federal minimum wage and be employed at least 40 hours per month.

005.02(C) INCOME LIMIT. Combined countable earned and unearned income of the household is more than 100%, but less than 250% of the Federal Poverty Limit (FPL).

005.02(D) RESOURCE LIMIT. Countable resources are no more than $4,000 for an individual and $6,000 for a couple.

005.02(E) BASIC COVERAGE GROUP. Medical Improvement Group participants must have been enrolled in the Basic Coverage Group, but lost eligibility due to a medically improved disability.

005.02(F) MEDICALLY IMPROVED DISABILITY. Medical Improvement Group participants no longer meet the medical criteria for disability as defined by the Social Security Administration (SSA) or state review team (SRT) under section 002.02(C)(ii)(1). Medical Improvement Group participants must continue to have a medically improved disability.

005.02(F)(i) DEFINITION. A medically improved disability is determined by the Department, and is defined as:

(1) A medically determinable severe impairment which continues to substantially limit the ability to work or conduct daily life activities;
(2) The mental or physical health condition has been stabilized by assistive technology, medication, treatment, monitoring by medical professionals, or a combination of these factors, and the loss of medical services may result in a deterioration of the condition; and
(3) The loss of medical assistance could result in the individual's inability to continue in the workforce or health problems would regress to the point where the individual would meet the Social Security Administration (SSA) or state review team (SRT) definition of disabled.

005.02(F)(ii) DOCUMENTATION. The determination that an individual has a medically improved disability is reviewed by the Department every 12 months. During this review, the Department will analyze findings reported by a physician following a diagnostic examination of the individual. The report may be made from information in existing medical records from a physician, clinic, or hospital where the individual has been treated if the treatment was directly related to the impairment. The medical documentation must reflect examination or treatment received within the prior 12 months. There must be medical information from an examination which has occurred within three months of the time period for review.

005.03 DISABILITY DETERMINATION. Individuals who are not receiving a Social Security Disability payment must be determined disabled by the state review team (SRT). Receipt of a Social Security Disability Insurance (SSDI) payment meets the disability requirement ~~INCOME DETERMINATION. The income calculation for Medicaid Insurance for Workers with Disabilities (MIWD) is a two-step process. The income of the disabled individual and the individual's spouse must be considered. See 477-000-009 for calculation procedures~~.

005.04 PREMIUM PAYMENT. Participants in either the Basic Coverage Group or the Medical Improvement Group who have income of 200% or more of the Federal Poverty Level (FPL) but less than 250% must pay a monthly premium in order to receive coverage. The amount of the monthly premium is calculated according to the chart at 477-000-012.

005.04(A) PREMIUM DUE. If the individual is determined eligible for Medicaid with a premium, the individual must pay the full premium no later than the 21st day of the month following the month for which the payment is designated. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

006. BREAST AND CERVICAL CANCER PROGRAM. Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, certain individuals who need treatment for breast or cervical cancer may be eligible for Medicaid. Neb. Rev. Stat. ~~section~~ § 68-1020 authorizes this coverage in Nebraska.

006.01 ELIGIBILITY REQUIREMENTS. In order to receive Medicaid, the individual must:

(A) Be screened for breast and cervical cancer by Every Woman Matters;
(B) Be found to need treatment for breast or cervical cancer, including a precancerous condition or early stage cancer;
(C) Be 64 years old or younger;
(D) Not be otherwise eligible for any category of Medicaid;
(E) Not be covered by creditable health insurance;
(F) Be a Nebraska resident; and
(G) Be a United States citizen or a qualified non-citizen.

006.02 CREDITABLE HEALTH INSURANCE. For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that:

(A) Provides limited scope coverage such as plans that only cover dental, vision, or long-term care;
(B) Provides coverage for only a specified disease or illness;

(C) Does not include treatment for breast or cervical cancer, such as a period of exclusion; or
(D) Has exhausted the individual's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

006.03 ELIGIBILITY PERIOD. Eligibility begins the first of the month in which the individual signs the application for the Breast and Cervical Cancer Program. Eligibility continues as long as the treatment for breast or cervical cancer is required, as determined by a physician, unless the individual becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

006.03(A) PRE-CANCEROUS CONDITIONS. For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the Department with a monthly statement indicating continued treatment is required. Continued treatment does not include continued surveillance, testing, or screening.

006.03(B) BREAST AND CERVICAL CANCER. For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the Department every six months for the individual to remain eligible for Medicaid coverage.

006.03(C) PRESUMPTIVE ELIGIBILITY. Eligibility may be presumptively determined by a qualified Medicaid provider. See 477 NAC 19 for presumptive eligibility requirements.

007. MEDICALLY NEEDY. Parents or caretaker relatives, children, pregnant women, and aged, blind, or disabled (ABD) individuals with a medical need and high medical expenses whose income exceeds the guidelines for Medicaid eligibility in another eligibility category may be eligible as medically needy if all other eligibility requirements are met. A medically needy individual must incur and obligate a certain amount of medical expenses each month before Medicaid will provide coverage for the rest of the month. These medical expenses must be at least equal to the difference between the individual's income and the applicable income standard. The share of cost obligation varies depending on the individual's household size and income. Each month is determined separately and continuous eligibility does not apply. Individuals without a demonstrated medical need are not eligible under this category.

007.01 AGE. A medically needy child is eligible through age 18 years old if the child is a citizen or is a qualified non-citizen.

007.01(A) EXCEPTION. A medically needy child may be found eligible under this category if the child is receiving inpatient care in an institution for mental disease (IMD). If an individual is an inpatient in an institution for mental disease (IMD) when the individual reaches 21 years old, the individual may remain eligible either until discharge or until reaching 22 years old, whichever comes first.

007.02 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.

007.03 SHARE OF COST OBLIGATION. The share of cost (SOC) obligation for medically needy individuals is calculated in accordance with the provisions of 477 NAC 25.

008. TRANSITIONAL MEDICAL ASSISTANCE (TMA)

008.01 TRANSITIONAL MEDICAL ASSISTANCE (TMA) ELIGIBILITY. A household may receive up to 12 months of Transitional Medical Assistance (TMA) if the parent or caretaker relative:

(1) Is in the household;
(2) Has earned income that results in ineligibility for Medicaid as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology; and
(3) Is employed.

008.01(A) PRIOR ELIGIBILITY REQUIREMENT. The parent or caretaker relative must have received, or met income and resource eligibility to receive, a grant or Medicaid for which the individual was eligible in three of the last six months preceding ineligibility.

008.01(B) FRAUD EXCLUSION. The household is ineligible for Transitional Medical Assistance (TMA) if it received Medicaid as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology in one or more of the three qualifying months as a result of convicted fraud during the last six months before the beginning of the transitional period.

008.01(C) EFFECTIVE DATE. Transitional medical assistance (TMA) begins with the month of ineligibility for Medicaid as a parent or caretaker relative.

008.02 RESOURCES. There is no resource test while the household is receiving Transitional Medical Assistance (TMA).

008.03 SANCTIONS. A parent who has been sanctioned for noncooperation with child support or third-party liability (TPL) provisions is not eligible for Transitional Medical Assistance (TMA) until cooperation is resolved.

008.04 CHANGES IN HOUSEHOLD COMPOSITION. When an individual is added, returns, or leaves a household, eligibility is impacted according to the provisions below.

008.04(A) INDIVIDUAL RETURNS OR IS ADDED TO THE HOUSEHOLD. When an individual returns or is added to the household, eligibility must be reassessed for the entire household.

(i) If the individual is a responsible relative, their income must be used when reassessing eligibility, regardless of whether this individual requests Medicaid coverage;
(ii) If the individual is a parent included in the tax household of the parent eligible for Transitional Medical Assistance (TMA), and the household remains ineligible for Medicaid as a parent or caretaker relative based on modified adjusted gross income (MAGI) methodology, this individual is added to the Transitional Medical Assistance (TMA) household; or

(iii) If the individual is a child included in the tax household of the parent eligible for Transitional Medical Assistance (TMA), the child is added to the Transitional Medical Assistance (TMA) cycle of that parent.

008.04(A)(1) APPLICATION REQUIREMENT. An individual who returns or is added to the household must submit an application for Medicaid if the individual has been ineligible for more than 90 days and requests Medicaid coverage.

008.04(B) FAMILY MEMBER LEAVES THE HOUSEHOLD. If a family member leaves the home, Medicaid eligibility for the remaining household members must be reassessed.

(i) If a parent or caretaker relative leaves the household, and the remaining parent or caretaker relative continues to be ineligible as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology, the Transitional Medical Assistance cycle continues;
(ii) If the only dependent child leaves the household, the entire household loses eligibility for Transitional Medical Assistance (TMA); or
(iii) If the only dependent child no longer meets the age qualification, the entire household loses eligibility for Transitional Medical Assistance (TMA).

008.05 BREAKS IN THE TRANSITIONAL MEDICAL ASSISTANCE (TMA) CYCLE. A change in circumstances may or may not restart the Transitional Medical Assistance (TMA) eligibility cycle.

008.05(A) If a temporary reduction or loss of income results in eligibility as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology, but eligibility in that category is lost within one or two months due to income, then the original Transitional Medical Assistance (TMA) cycle continues.

008.05(B) If the Transitional Medical Assistance (TMA) case is closed for any reason, then reopened within 90 days of closure, and eligibility for Transitional Medical Assistance (TMA) continues, the original Transitional Medical Assistance (TMA) cycle resumes.

008.05(C) A new Transitional Medical Assistance (TMA) cycle begins if an individual receives Medicaid as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology for three or more months, then loses eligibility in that category because of income.

008.06 CLOSING TRANSITIONAL MEDICAL ASSISTANCE (TMA). Before closing a Transitional Medical Assistance (TMA) case for any reason, it must first be determined if the individuals in the household are eligible for another Medicaid program.

008.07 TRANSITIONAL MEDICAL ASSISTANCE (TMA) TIMELINE. The transitional medical assistance (TMA) program follows a defined timeline. Eligibility and cost sharing may change throughout the timeline in accordance with the provisions below.

008.07(A) MONTHS ONE THROUGH SIX. Eligibility for months one through six are subject to the following provisions.

008.07(A)(i) INCOME. Individuals in the first six months of Transitional Medical Assistance (TMA) coverage are exempt from income tests.

008.07(A)(ii) REPORT REQUIREMENT. The gross monthly earnings and child care costs for employment, as billed or paid, for each of the first three months of the transitional period must be verified. The first report or verification is due no later than the 21st of the fourth month.

008.07(A)(iii) CAUSES FOR CLOSURE. The household becomes ineligible for Transitional Medical Assistance (TMA) during the first six-month period if any of the following occur:

(1) The household becomes eligible for Medicaid as a parent or caretaker relative using modified adjusted gross income (MAGI) methodology;
(2) The household moves out of the state; or
(3) There is no longer an eligible dependent child in the household.

008.07(B) MONTHS SEVEN THROUGH TWELVE. If the household has earned income and child care deductions for employment that are equal to or less than 185% of the Federal Poverty Level (FPL), it is eligible for transitional medical assistance (TMA).

008.07(B)(i) REPORT REQUIREMENT. The gross monthly earnings and child care costs for employment, as billed or paid, for months seven through 12 must be verified. The second report or verifications of income and child care are due no later than the 21st of the seventh month. The third report or verifications of income or child care are due no later than the 21st of the tenth month.

008.07(B)(ii) INCOME ELIGIBILITY. The household's earned income less any child care costs for employment, as billed or paid, for the three-month report period is averaged to determine income eligibility.

008.07(B)(iii) PREMIUM DUE. Beginning with month seven, the household is subject to payment of a monthly premium if its countable income is between 100% and 185% of the Federal Poverty Level (FPL). Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

008.07(B)(iv) CAUSES FOR CLOSURE. The household is ineligible for the remaining months of Transitional Medical Assistance (TMA) if it:

(1) Fails, without good cause, to submit required verification of earnings and child care costs for employment;
(2) No longer includes a dependent child;
(3) Has gross monthly earnings and child care deductions for employment in excess of 185% of the Federal Poverty Level (FPL) during the preceding three-month period;
(4) The household moves out of the state; or
(5) An adult in the household regains eligible as a parent or caretaker relative using modified adjusted gross income methodology.

008.07(B)(iv)(a) GOOD CAUSE. Good cause for failing to submit the required program information exists when any of the following occur:

(i) Death of the parent or caretaker relative;
(ii) Verified hospitalization of a household member during the scheduled receipt period for required information; or
(iii) Natural disaster as determined by the Department.

008.07(C) AFTER MONTH 12. Eligibility for another Medicaid program will be determined at the end of the Transitional Medical Assistance (TMA) cycle.

009. EMERGENCY MEDICAL SERVICES ASSISTANCE (EMSA). Emergency medical services may be provided to certain individuals who do not have a qualified non-citizen status for Medicaid. The individual must be eligible for a category of Medicaid assistance except for citizenship or a qualified non-citizen status. Only coverage for emergency services will be authorized.

009.01 EMERGENCY MEDICAL CONDITION. An emergency medical condition is defined as a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, where the absence of immediate medical attention could reasonably result in:

(A) Serious jeopardy to the patient's health;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part.

009.02 EMERGENCY SERVICE AUTHORIZATION. To be considered eligible for emergency medical services for aliens (EMSA), the state review team (SRT) will determine that the individual has an emergency medical condition.

009.03 EFFECTIVE DATE. Emergency medical services for aliens (EMSA) is not subject to the provisions at 477 NAC 4 regarding the effective date of Medicaid eligibility. Eligibility for the program is limited to the time necessary to treat the emergency medical condition. The state review team (SRT) will determine the effective date of eligibility based upon the emergency medical condition.

010. KATIE BECKETT. The Katie Beckett program provides Medicaid coverage to children age 18 or younger with severe disabilities who live in their parent's household, but who otherwise would require hospitalization or institutionalization due to their high level of health care needs.

010.01 ELIGIBILITY REQUIREMENTS. In order to receive Katie Beckett Medicaid, a child must meet all of the following:

(A) Not be eligible for the Supplemental Security Income (SSI) program or eligible for Medicaid based on parental income;
(B) Be age 18 or younger;
(C) Reside at home with a parent or legal guardian;
(D) Be certified by the Department's Central Office designee as having hospital level of care needs; and
(E) Not incur in-home service costs to be funded by Medicaid that would exceed the costs Medicaid would pay if the child were in a hospital setting.

010.02 INCOME AND RESOURCES. Parental income and resources are not deemed for a child determined eligible for Katie Beckett Medicaid. Financial eligibility is based solely upon any income or resources belonging to the child.

010.03 REFERRALS. Medicaid accepts referrals for Katie Beckett eligibility determinations in the following situations:

(A) It is anticipated that a child will be discharged from a hospital to the child's home and the child is not currently eligible for Medicaid;
(B) Notice has been received from SSI that a child's benefits are being discontinued;
(C) The medical need of a child currently eligible for Home and Community-Based Waiver has been determined to have increased beyond the level applicable to the waiver program; or
(D) A child is not financially eligible for Medicaid based on family income.

010.04 HOSPITAL LEVEL OF CARE. Hospital level of care means that a child requires an extensive array of health care services throughout the day. This level of care may only be provided by highly skilled medical professionals in amounts normally available in a hospital but not in a skilled nursing facility. Lack of these services would be expected to result in hospitalization of the child.

010.04(A) CERTIFICATION OF HOSPITAL LEVEL OF CARE. Department certification for hospital level of care will be provided based upon the following criteria:

(i) A child needs frequent and complex medical care, as defined below, that requires the use of equipment to prevent life-threatening situations;
(ii) A child's complex skilled medical interventions are expected to persist for a specific duration of time; and
(iii) A child's overall health condition must require continuous assessment of a medical condition to prevent a life-threatening situation.

010.04(B) FREQUENT AND COMPLEX MEDICAL CARE. A child must need frequent and complex skilled medical interventions that require the use of medical equipment to prevent life-threatening situations. Tasks which are provided only when necessary and are not continuously required do not meet the criteria for frequent and complex medical care. SiteCare is not considered skilled medical task for the purpose of these requirements. The child's health status must require both of the following:

(i) Provision of skilled medical assessment and interventions multiple times every 24-hour period; and
(ii) At least one of the following complex skilled medical interventions:
  (a) Tracheostomy care requiring regular bronchial tree suctioning;
  (b) Tracheostomy care with a dependency on a ventilator, for which the average use must be equal to or greater than 10 hours per day;
  (c) Intravenous (IV) therapy involving central lines, including peripherally inserted central catheters (PICCs), for daily fluids or parenteral nutrition, for which the average use must be equal to or greater than ten hours per day; or
  (d) Oxygen use that includes only skilled tasks requiring daily continuous oxygen, daily continuous assessments with titrations according to oxygen saturation levels, and daily bronchial tree suctioning.

010.04(C) DURATION. To meet hospital level of care, a child's qualifying frequent and complex medical care need must be expected to be required for at least six months.

010.05 DISABILITY AND CARE LEVEL REVIEW. The Department will review a child's Katie Beckett Medicaid eligibility on an annual basis.