CHAPTER 4-000 STATE DISABILITY PROGRAM – MEDICAL (SDP Medical): SDP Medical provides medical care and services to those who do not have sufficient income to meet their medical needs and who qualify according to the program definitions as blind or disabled but only if they have also had their SSA disability application denied due to lack of duration; but, determined blind or disabled by the DHHS-designated medical consultant reviewer.

All references to medical in this Chapter refer to the State Disability Program cases only. Nebraska Medicaid eligibility guidelines are found in Title 477 NAC.

4-001 Eligibility Categories

4-001.01 Individuals Eligible for SDP Medical: Individuals who would have been denied disability by SSA due to lack of duration but found disabled by the medical consultant review and meet all other SDP eligibility criteria except eligibility for a grant.

4-001.02 Individuals Ineligible for SDP Payment But Eligible for SDP Medical Only: Individuals who have income or resources in excess of the budgetary standards for SDP grants (see 469 NAC 3) are ineligible for an assistance grant but must be reviewed for SDP Medical. The eligibility criteria for SDP Medical are the same as for AABD and SDP payments, with the exception of income and resource standards to be used if over the income or resource standards for a grant.

4-002 Cooperation in Obtaining Health Insurance: As a condition of eligibility for SDP, a client is required to enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations.

4-003 Effective Date of SDP Medical Eligibility: If an individual is eligible for medical assistance one day of the month, s/he is eligible the entire month. The effective date of eligibility for SDP Medical is determined as follows:

1. Prospective eligibility is effective the first day of the month of request if the client was eligible for SDP Medical in that same month and had a medical need.

   Exception: The SDP Medical eligibility cannot begin prior to the start date of the disability as determined by the medical consultant review.

2. Retroactive SDP Medical eligibility is no earlier than the first day of the third month before the month of request date or application date if there is no request date, if the following conditions are met:

   a. Eligibility is determined and a budget computed separately for each of the three months;
   b. A medical need exists; and
   c. Elements of eligibility are met for each month.

   An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

   If the client was not eligible for one or more months of the retroactive period, the case must contain documentation of the ineligibility.

4-004 Use of Medical Budget for SDP Medical: The worker determines eligibility for medical assistance only and medical assistance share of cost cases. If at any time factors change that affect the budget, the worker must recomputed the budget. See 469-000-335 for medical budget periods and 469-000-305 for examples of medical budgeting procedures.

If the parent(s)' income has been deemed to the child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost.

4-005 Treatment of Resources for SDP Medical: For the treatment of resources, the criteria outlined in 469 NAC 2-009 are used. The application for an individual who has excess resources other than real property may be held pending until the resources are reduced. For the liquidation of real property, see 469 NAC 2-009.07B4. Excess resources may be reduced by paying obligations for medical costs. SDP Medical eligibility begins with the first day of the month of the incurred obligation which was used to reduce the resources to the allowable maximum (see 469 NAC 2-009.11). Medical eligibility may not be established earlier than the three-month retroactive period.

4-005.01 Maximum Available Resource Levels: The established maximum for available resources which the client, or the client and responsible relative, may own and still be considered eligible for SDP Medical, according to unit size, are as follows:

1. One member unit - client only $4000
   If a couple has a valid designation of resources and -
   a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is $4,000; or
   b. The ineligible spouse later becomes eligible, each spouse is allowed $4,000.

2. Two member unit - $6000
   a. Client and eligible spouse;
   b. Client and ineligible spouse; or
   c. Client and ineligible spouse who have designated resources but the client returns home or no longer is eligible for waiver services.

For procedures on designating resources, see 469 NAC 2-009.02C. For determination of ownership of resources, see 469 NAC 2-009.03. For resource levels for grant, see 469 NAC 2-009.08.

If two or more related AABD or SDP clients (other than a married couple), i.e., an eligible AABD parent and his/her eligible AABD minor child or two or more unrelated eligible AABD clients, reside in the same household, each client is entitled to a resource maximum of $4000.

The treatment of resources of a spouse or a parent is the same as for a client (see 469 NAC 2-009).

If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below the maximum resource level for one day in the month in order for the client to be eligible for that month.

4-005.01A Deeming Resources of a Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

1. All resources exceeding $4,000 in the case of one parent; or
2. All resources exceeding $6,000 in the case of -
   a. Two parents;
   b. One parent and spouse of the parent; or
   c. One parent and one minor sibling.
3. $25 each additional minor sibling in the parent(s)' household.

Resource exclusions listed in 469 NAC 2-009.02B apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed according to 469 NAC 2-010.01F1, resources are also not deemed.

4-005.02 Resource Review: The amount of total resources determines how often verification is required. Verification is completed on the following schedule:

One Person

Resource Total	Verification Frequency
$3,925 to $4,000	Monthly
$3,850 to $3,924.99	Quarterly
$3,500 to $3,849.99	Semi-Annually
$0.00 to $3,499.99	Annually

Two Persons

Resource Total	Verification Frequency
$5,850 to $6,000	Monthly
$5,700 to $5,849.99	Quarterly
$5,550 to $5,699.99	Semi-Annually
$0.00 to $5,549.99	Annually

If a worker has reason to believe that at any time there has been an increase in resources which may affect eligibility all resources must be verified immediately.

A resource review is not required for SSI recipients.

4-006 Treatment of Income: For treatment of income, use criteria outlined in 469 NAC 2-010.

4-006.01 Disregards for Medical Budgets

4-006.01A Medical Insurance Disregards: In addition to disregards outlined in 469 NAC 2-010.01E1, the cost of medical insurance premiums is deducted (including Medicare if the individual is responsible for paying it) (see 469 NAC 3-006.01C).

The cost of premiums for policies that are not considered health insurance are not allowed as a deduction for medical budgeting (see 469 NAC 2-010.01B2d).

4-006.01B Guardian or Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month. If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

4-006.02 Repayment of SDP Medical Benefits Provided in Error: When an error has occurred in the amount of SDP Medicaid benefits received by the client because of erroneously reported income or changes in income and/or private health insurance premiums (not Medicare), the worker shall send Form IM-64 requesting voluntary repayment in the following situations:

1. The client failed to report a change timely and the amount of benefits in error is $76 or more;
2. The client reported a change timely but the worker failed to take action in the first month possible and the amount of benefits in error is $251 or more; or
3. The client failed to report a change timely, the worker failed to take action in the first month possible, and the amount of benefits in error is $251 or more.

In determining if there was an error in SDP Medical benefits and the period for which repayment should be requested, the worker shall keep in mind that the client is allowed ten days to report a change and must be given a ten-day notice of an adverse action. When repayment is requested, the worker should attempt voluntary restitution from the client effective with the first month that the worker should have correctly adjusted the budget.

Note: In cases of suspected fraud, the social service worker shall refer the case via Form ASD-63 to the Special Investigation Unit, Central Office, or in the Omaha Office, to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker shall take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker should complete normal case actions, including closing a case that is found to be ineligible and recovering benefits received in error.

4-006.02A Amount of Benefits in Error: The amount of benefits in error for a client who was AABD grant or SDP grant/medical or SDP Medical only but should have been SDP Medical with a Share of Cost, or who was SDP Medical with a Share of Cost but who should have had a larger Share of Cost, is the smaller of -

1. The amount of SDP Medical services received for that month; or
2. The amount of Share of Cost in error.

4-007 Computing an SDP Medical Budget: When computing an SDP medical budget, the worker uses the following steps to determine if the client is eligible for SDP/Medical only or SDP/Medical with excess:

1. Compare the client's net income to the percent of the Federal Poverty Level (FPL) (see 469-000-207). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, go to step 2 to determine the amount of Share of Cost. For clients in long term care, go directly to step 2.
2. Subtract the medically needy income level from the client's net income to determine the amount of Share of Cost (see 469-000-203).

When a client enters long term care, the standard is not reduced to the long term care level or Assisted Living Waiver level until the first full month that the client resides in long term care or at a later month if criteria in 3-004.01A are met.

4-007.01 Income When the Eligible Spouse is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) is in the Community

4-007.01A Definitions

Community Spouse: A spouse who is -

1. Not applying for or receiving assistance;
2. Not residing with the alternate care spouse unless the alternate care spouse is in the home and eligible for Home and Community-Based Waiver Services; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with developmental disabilities.

Family Members: Minor children residing with a community spouse, or dependent parents or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance which may be made from the alternate care spouse's income.

4-007.01B Allocation of Income: When computing the SDP medical assistance budget for an alternate care spouse in a specified living arrangement, only his/her income (calculated on side 1 of Form DA-4M) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount which may be allocated is computed on side 2 of Form DA-4M. If the community spouse does not provide verification of his/her income, Form DA-4M budget is not used. Form DA-3M budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, the worker shall not deduct these allowances from the client's income on side one of Form DA-4M. The worker shall deduct allowances for other family members even if the institutionalized spouse does not make these allowances available to the family members.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long term care facility;
2. An Adult Family Home;
3. A Licensed Assisted Living Facility;
4. A Center for the Developmentally Disabled; or
5. Receiving services in a Home and Community Based Service Waiver.

If the spouse no longer meets the definition of a community spouse, i.e., s/he enters a specified living arrangement, spousal impoverishment budgeting stops the first month possible considering adequate and timely notice.

These budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full month the alternate care spouse is no longer in a specified living arrangement. An assessment and designation of resources must be completed.

The community spouse or other family member(s) must not be on assistance if s/he is included in this budgeting procedure. They may be eligible for assistance in their own right, but may choose not to apply if this is to their benefit.

4-007.01C Determining Ownership of Income: The worker shall verify all income to determine the amount of the income and the individual in whose name the income is received. If payment is made in the name of both spouses, half is considered available to each spouse. The worker shall divide income by the number of payees if payment is made in the name of one or both spouses and a third party. Only the spouse's proportionate share is considered available to him/her. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, the worker shall include both spouses in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

4-007.01D Determining the Family Member's Maintenance Need Standard: To determine each family member's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203);
2. Subtracts the family member's gross income; and
   Note: SSI is included as income.
3. Divides the result by 3.

The worker does a separate calculation for each family member. This is calculated on side 2 of Form DA-4M.

4-007.01E Determining the Spousal Maintenance Need Standard: To determine the community spouse's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203); and
2. Adds excess shelter costs, if any.

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g. mortgage, taxes, insurance, cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit. The worker shall allow a utility standard even if utilities are included in the rent. The worker shall not prorate shelter costs even if someone lives with the community spouse. If the community spouse is paying board and room, the worker subtracts the food stamp allotment for one from the actual board and room paid to determine shelter. See 469-000-203 for the utility standard and the shelter limit. This is calculated on side 2 of Form DA-4M.

4-007.01F Determining the SDP Maintenance Allowance: To determine the amount of income from the alternate care spouse that may be allocated to the community spouse and other family members, the worker -

1. Takes the family maintenance need standard;
2. Adds the spousal maintenance need standard; and
3. Subtracts the gross income of the community spouse. SSI is included. If the community spouse has self-employment income, the worker uses adjusted gross income (after deducting the cost of operation).

This is calculated on side 2 of Form DA-4M.

The spousal maintenance allowance must not exceed the maximum in 469-000-203. However, if a court has ordered the client to make support payments to the spouse in excess of the maximum, the court order takes precedence over the maximum.

The worker shall notify the couple on Form IM-8 of the actual amount of the maintenance allowance, if any, which is being deducted from the alternate care spouse's income.

The couple may appeal the maintenance allowance. To support an increase in the maintenance allowance, either spouse must establish that the community spouse needs income above the maintenance allowance because of exceptional circumstances resulting in significant financial duress. If the couple wins their appeal, the community spouse may reserve more than the maximum maintenance allowance.

4-007.01F1 Income Provisions: The worker includes all income in the calculation, including SSI and income of minors. If the primary income - RSDI, SSI, earnings, etc., - is equal to or exceeds the maintenance need standard, the worker does not need to verify other income. The worker does not need to verify income for anyone if it is $10 or less.

4-007.01G Budgeting the Alternate Care Spouse: The worker deducts the following amounts from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. MNIL or FPL level (see 469 NAC 4-007, step 1 or step 2);
2. Guardian/Conservator fee;
3. Amount allocated to the community spouse and/or family member(s);
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, the worker allows one-half of the amount on the client's budget.

This is calculated on side 1 of Form DA-4M.

For budget instructions see Appendix 469-000-340.

4-008 Required Copayments: Individuals who receive SDP assistance are exempt from paying copayments.