TITLE 469 ASSISTANCE TO THE AGED, BLIND, OR DISABLED PROGRAM

CHAPTER 4 STATE DISABILITY PROGRAM – MEDICAL

001. DESCRIPTION OF BENEFITS. The State Disability Medical Program 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 Social Security Administration Disability application denied due to lack of duration, then determined blind or disabled by the Department of Health and Human Services designated medical consultant reviewer.

001.01 REFERENCES TO MEDICAL. 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.

002. ELIGIBILITY CATEGORIES. To qualify for the disability determination for the State Disability Program:

002.01 INDIVIDUALS ELIGIBLE FOR STATE DISABILITY MEDICAL PROGRAM. Individuals who would have been denied disability by the Social Security Administration due to lack of duration but found disabled by the medical consultant review and meet all other State Disability Program eligibility criteria except eligibility for a grant.

002.02 INDIVIDUALS INELIGIBLE FOR STATE DISABILITY PROGRAM GRANT BUT ELIGIBLE FOR STATE DISABILITY MEDICAL ONLY. Individuals who have income or resources in excess of the budgetary standards for the State Disability Program are ineligible for an assistance grant but must be reviewed for State Disability Medical. The eligibility criteria for State Disability Medical Program are the same as for Assistance to the Aged, Blind, or Disabled and State Disability Program payments, with the exception of income and resource standards to be used if over the income or resource standards for a grant.

003. COOPERATION IN OBTAINING HEALTH INSURANCE. As a condition of eligibility for the State Disability Program, an individual is required to enroll in an available health plan if the Department has determined that it is cost effective and the individual is able to enroll. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations.

004. EFFECTIVE DATE OF STATE DISABILITY MEDICAL ELIGIBILITY. If an individual is eligible for medical assistance one day of the month, the individual is eligible the entire month. The effective date of eligibility for State Disability Program Medical is determined as follows:

(A) Prospective eligibility is effective the first day of the month of request if the individual was eligible for State Disability Program Medical in that same month and had a medical need.
  (i) The State Disability Program Medical eligibility cannot begin prior to the start date of the disability as determined by the medical consultant review.
(B) Retroactive State Disability Program Medical eligibility can be 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:
  (i) Eligibility is determined and a budget calculated separately for each of the three months;
  (ii) A medical need exists; and
  (iii) Elements of eligibility are met for each month.

005. USE OF MEDICAL BUDGET FOR STATE DISABILITY PROGRAM MEDICAL. Determine eligibility for medical assistance only and medical assistance share of cost cases. If at any time factors change that affect the budget, the budget must be recomputed.

006. TREATMENT OF RESOURCES FOR STATE DISABILITY PROGRAM MEDICAL. The application for an individual who has excess resources, other than real property, may be held pending until the resources are reduced. Excess resources may be reduced by paying obligations for medical costs. State Disability Program 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. Medical eligibility may not be established earlier than the three-month retroactive period.

006.01 MAXIMUM AVAILABLE RESOURCE LEVELS. The established maximum for available resources which the recipient, or the recipient and responsible relative, may own and still be considered eligible for Medical under the State Disability Program according to unit size, are as follows:

(1) One member unit - recipient only $4,000
  (a) If a couple has a valid designation of resources and:
    (1) There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is $4,000; or
    (2) The ineligible spouse later becomes eligible, each spouse is allowed $4,000.
(2) Two member unit $6,000
  (a) Applicant or recipient and eligible spouse; or
  (b) Applicant or recipient and ineligible spouse.
(3) If two or more related Assistance to the Aged, Blind, Disabled, or State Disability Program applicants or recipients, other than a married couple, such as an eligible Assistance to the Aged, Blind, or Disabled parent or eligible Blind or Disabled minor child, or two or more unrelated eligible Assistance to the Aged, Blind, or Disabled recipients, reside in the same household, each applicant or recipient is entitled to a resource maximum of $4,000.
(4) If the total equity value of available non-excluded resources exceeds the maximums specified above, the applicant or recipient is ineligible. Resources must be below the maximum resource level for one day in the month in order for the applicant or recipient to be eligible for that month.

006.01(A) DEEMING RESOURCES OF A PARENT. In considering the resources of a parent, who is not considered an Essential Person in another case, towards an eligible

child age 17 or younger and who is living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

(i) All resources exceeding $4,000 in the case of one parent;
(ii) All resources exceeding $6,000 in the case of:
  (1) Two parents:
  (2) One parent and spouse of the parent; or
  (3) One parent and one minor sibling;
(iii) $25 for each additional minor sibling in the parents' household; and
(iv) If income of a parent is not deemed, resources are also not deemed.

007. TREATMENT OF INCOME. The following disregards are allowed:

007.01 MEDICAL INSURANCE DISREGARDS. A deduction for the cost of medical insurance premiums is allowable in the State Disability Program budget. The cost of premiums for policies that are not considered health insurance are not allowed as a deduction for medical budgeting.

007.02 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 or 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.

007.03 REPAYMENT OF STATE DISABILITY MEDICAL BENEFITS PROVIDED IN ERROR. When an error has occurred in the paid amount of State Disability Program Medical benefits received by the recipient because of erroneously reported income, changes in income, or private health insurance premiums, not including Medicare, under Neb. Rev. Stat. § 68-138, repayment cannot be required unless such benefits were obtained through misrepresentation or fraud. Voluntary repayment in the following situations:

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

007.03(A) AMOUNT OF BENEFITS IN ERROR. The amount of benefits in error for a recipient of the Assistance to the Aged, Blind, Disabled or State Disability grant or medical, or State Disability Program Medical only, but should have been, State Disability Program Medical with a share of cost, or who was State Disability Program Medical with share of cost but who should have had a larger share of cost, is the smaller of:

(i) The amount of State Disability Program Medical services received for that month; or,
(ii) The amount of share of cost in error.

008. COMPUTING A STATE DISABILITY MEDICAL BUDGET. When computing a State Disability Medical budget, the amount of income when compared to the Federal Poverty Level will determine the applicant or recipient’s State Disability Medical eligibility for medical, medical with a share of cost, or ineligibility.

008.01 ENTERING LONG TERM CARE. When a recipient 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 recipient resides in long term care, or at a later month if certain other criteria is are met, such as home liquidation.

008.02 INCOME WHEN ONE RECIPIENT OF THE HOUSEHOLD IS IN A SPECIFIED LIVING ARRANGEMENT. The following definitions apply when the eligible spouse is in a specified living arrangement and the ineligible spouse or family member is in the community:

(A) COMMUNITY SPOUSE. A spouse who is:
  (i) Not applying for or receiving assistance;
  (ii) 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,
  (iii) Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with developmental disabilities.

(B) 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.

(C) MAINTENANCE ALLOWANCE. The amount deducted from an alternate care spouse's income to meet the home maintenance needs of the community spouse and family members.

(D) 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.

008.03 ALLOCATION OF INCOME. When computing the State Disability Program medical assistance budget for an alternate care spouse in a specified living arrangement, only that individual’s income 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 or family members to bring their income up to a minimum monthly allowable amount.

(A) The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:
  (i) A long term care facility;
  (ii) An adult family home;
  (iii) A licensed assisted living facility;
  (iv) A center for the developmentally disabled; or
  (v) Receiving services in a Home and Community Based Service Waiver.

008.04 DETERMINING OWNERSHIP OF INCOME. All income must be verified and the amount of income received by each individual determined. If payment is made in the name of both spouses, half is considered available to each spouse. If the income received does not specify either spouse, one-half of the amount is considered available to each spouse. Ownership of income may be appealed by the recipient.

009. REQUIRED COPAYMENTS. Individuals who receive State Disability Program assistance are exempt from paying copayments.