CHAPTER 4-000 REFUGEE MEDICAL ASSISTANCE PROGRAM (RMAP): RMAP provides medical care and services to refugees who do not have sufficient income to meet their medical needs, and who qualify according to the program definitions. RMAP is a time-limited program; the number of months of medical assistance is determined by the amount of federal funds that are available.

RMAP is governed by the requirements and limitations of the Nebraska Medical Assistance Program (see Title 471).

4-001 Individuals Eligible for an Assistance Grant and MA: Clients who receive an assistance grant, including clients who do not receive a payment because of the $10 minimum payment, are automatically eligible for MA without a separate eligibility determination.

4-002 Individuals Ineligible for Assistance Grant but Eligible for MA: Eligibility for the following individuals is determined using eligibility requirements listed in 470 NAC 4-003.

1. Those who have resources in excess of resource limits for an RRP grant; and
2. Those who have income in excess of budgetary standards for an RRP grant.

4-002.01 Individuals Sanctioned for Not Cooperating: Individuals who have been sanctioned for noncooperation with employability requirements are automatically eligible for MA without a separate eligibility determination. Income and resources are used in determining eligibility for a grant for the rest of the unit.

4-002.02 Individuals Eligible for Transitional MA: An RRP/MA client who becomes ineligible for a grant because of increased earnings or increased hours of employment is eligible for medical assistance without a Share of Cost for the remaining months of his/her eligibility without regard to income.

4-003 Eligibility Requirements: To be eligible for RRP/MA only, the individual must meet the following requirements:

1. Application (see 470 NAC 2-001);
2. Refugee status (see 480 NAC 2-002);
3. Time limit (see 470 NAC 2-003);
4. Nebraska residence (see 470 NAC 2-004);
5. Social Security number (see 470 NAC 2-005);
6. Resources (see 470 NAC 4-005);
7. Income (see 470 NAC 4-006);
8. Enrollment in an available health plan (see 470 NAC 4-009); and
9. Cooperation with requirements for third party medical payments (see 470 NAC 4-011).

4-004 Effective Date of Medical Eligibility: The effective date of eligibility for MA is determined according to the following regulations. If an individual is eligible one day of the month, s/he is eligible the entire month.

4-004.01 Prospective Eligibility: Prospective eligibility is effective the first day of the month of request if the client was eligible for RMAP in that same month and had a medical need.

4-004.02 Retroactive Eligibility: Retroactive eligibility is effective no earlier than the first day of the third month before the month of request or the date of entrance in the U.S.

4-005 Resources

4-005.01 Maximum Resource Levels: The established maximums for available resources which the client may own and still be eligible for MA only are as follows:

One member unit		$4,000
Two member unit or family		$6,000
Three member unit or family		$6,025
Four member unit or family		$6,050
Each additional individual	+	$ 25

4-005.02 Determination of Resource Levels: The resource level is based on the number of eligible unit members.

4-005.03 Treatment of Resources: For the treatment of all resources except those in the following regulations, the criteria outlined in 470 NAC 2-007 are used.

4-005.03A Motor Vehicles: The worker must disregard one motor vehicle regardless of its value as long as it is necessary for the client or a member of his/her household for employment or medical treatment. If the client has more than one motor vehicle, s/he may designate which vehicle should be disregarded. Any other motor vehicles are treated as nonliquid resources and the equity is counted in the resource limit. The client's verbal statement that the motor vehicle is used for employment or medical treatment is sufficient.

4-005.03B Essential Property: See 468 NAC 4-005.03B.

4-005.03C Funds Set Aside for Burial: See 468 NAC 2-008.07A3.

4-006 Treatment of Income: For the treatment of income in RMAP, the criteria outlined in 470 NAC 2-007 are used, with the exceptions in the following regulations.

4-006.01 Earned Income: A $100 disregard is applied to earned income of each employed individual. For other earned income treatment, see 470 NAC 2-008.03.

4-006.02 Unearned Income: See 470 NAC 2-008.04.

4-006.02A Medical Insurance Disregards: The cost of medical insurance premiums is deducted if a member of the unit is responsible for payment.

Exception: The cost of premiums for income-producing policies is not allowed as medical deduction (see 470 NAC 2-008.05A).

4-007 Prospective Budgeting: For medical budgeting policies, see 468 NAC 4-009.

4-008 Medically Needy Income Level (MNIL): The medically needy income level is determined by the number of family members.

The net income is compared to the appropriate MNIL to determine eligibility for MA only or MA with a share of cost.

If the net income is equal to or less than the MNIL, the unit may be eligible for MA only; if the net income is more than the MNIL, the unit may be eligible for MA with a share of cost.

4-009 Cooperation in Obtaining Health Insurance: As a condition of eligibility for MA, 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.

4-010 Required Copayments: Effective April 1, 1994, RRP adults are required to pay a copayment for the medical services listed at 470-000-205. Copayment amounts are listed at 470-000-205.

4-010.01 Covered Persons: With the exceptions listed at 470 NAC 4-010.02, RRP adults are subject to the copayment requirement.

The provider must verify the client's copayment status by accessing the Department's Internet Access for Enrolled Providers; the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580); or the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128).

4-010.02 Exempted Persons: The following individuals are exempted from the copayment requirement:

1. Individuals age 18 or younger;
2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);

3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;
4. Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes;
5. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Developmental Disabilities or Related Conditions; the Home and Community-Based Model Waiver for Children with Developmental Disabilities and Their Families; or the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities;
6. Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met); and
7. Individuals who receive assistance under SDP (program 07).

4-010.03 Covered Services: For covered and excluded services, see 470-000-205.

4-010.04 Client Rights: If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.

If the client is unable to pay the required copayment, s/he may inform the provider of the inability to pay. While the provider must not refuse to provide services to the client in this situation, the client is still liable for the copayment and the provider may attempt to collect it from the client.

The client has the right to appeal under 465 NAC 2-001.02.

4-010.05 Collection of Copayment: For provider procedures, see 471 NAC 3-008.04.

4-011 Assignment of Third Party Medical Payments: Application for medical assistance constitutes an automatic assignment to the Nebraska Department of Health and Human Services of the client's rights to third party medical payments. This assignment includes the rights of the client as well as the rights of any other member of the Refugee Cash/Medical Assistance unit. As a requirement for assistance the client must cooperate (unless s/he has good cause for noncooperation, (see 470 NAC 4-011.03B3). in securing any third party medical payments. This includes payments from:

1. The client's own medical coverage for any member of the unit, e.g., the client's health insurance; and
2. An individual not in the unit who has medical coverage for any member of the unit, e.g., health insurance of an absent parent or another individual which covers a child in the unit.

This assignment gives the Department the right to pursue and receive payments from any third party liable to pay for the cost of medical care and services of the client or any other unit member and which otherwise would be covered by RMAP. The assignment of the rights to third party medical payments is effective with the date of eligibility for assistance. For MA cases with a Share of Cost, the assignment becomes effective the first day of the month when the case status changes to 450, "Share of Cost met."

4-011.01 (Reserved)

4-011.02 Third Party Payments Not Assigned: The following third party payments are not subject to the automatic assignment provision:

1. Medicare benefits; and
2. Payments from income-producing policies which subsidize the client's income while s/he is hospitalized or receiving care, regardless of the type of medical service being provided.

4-011.03 Cooperation in Obtaining Third Party Payments: Cooperation includes any or all of the following:

1. Providing complete information regarding the extent of third party coverage which s/he or any other unit member has or may have. This includes coverage provided by a person not in the unit or by an agency;
2. Providing any additional information or signing claim forms which may be necessary for identification and collection of potential third party payments;
3. Appearing as a witness in a court or another proceeding, if necessary;
4. Notifying the Department of any action s/he is initiating to recover money from a liable third party for medical care or services. This includes the identity of the third party as well as the entire amount of any settlement, court award, or judgment;
5. Reimbursing the Department or paying to the provider any payments received directly from a third party for any services payable by RMAP; and
6. Taking any other reasonable steps to secure medical support payments.

4-011.03A Refusal to Cooperate: The worker is responsible for determining noncooperation by the client. This determination is based on the client's failure or refusal to fulfill the requirements listed in 470 NAC 4-011.03.

4-011.03B Opportunity to Claim Good Cause

4-011.03B1 Notification of Right: The worker must notify the client of the right to claim good cause for noncooperation at the intake interview, redetermination, and whenever cooperation becomes an issue.

The worker must give the client a verbal explanation of good cause and the opportunity to ask questions.

A written explanation of good cause is included in the Application for Assistance.

4-011.03B2 Worker's Responsibilities If Good Cause Claimed: If the client claims good cause, the worker must:

1. Explain that the client has the burden of establishing the existence of a good cause circumstance; and
2. Obtain a signed statement from the client listing the reason(s) for claiming good cause. The client is allowed 20 days to present evidence of the claim.

4-011.03B3 Acceptable Circumstances for Good Cause: Good cause claims must be substantiated by signed statements. When documentary evidence is not available the client shall furnish sufficient information as to the location of the information.

To establish good cause, the evidence must show that cooperation would not be in the best interest of the client or another unit member for whom assignment is sought. Good cause includes the following circumstances, provided proper evidence is obtained.

4-011.03B3a Physical or Emotional Harm to the Client or Other Unit Member: Good cause exists if the client's cooperation in assigning benefits is reasonably anticipated to result in physical or emotional harm to the client or another unit member. Emotional harm must only be based upon a demonstration of an emotional impairment that substantially reduces the individual's functioning.

4-011.03B3a(1) Documentary Evidence: Documentary evidence which indicates these circumstances includes:

1. Medical records which document emotional health history and present emotional health status of the client or other unit member;
2. Written statements from a mental health professional indicating the diagnosis or prognosis concerning the emotional health of the client or other unit member;
3. Court, medical, criminal, protective services, social services, psychological, or law enforcement records which indicate that the third party might inflict serious physical or emotional harm on the child or parent/needy caretaker relative; or
4. Signed statements from individuals other than the client with knowledge of the circumstances which provide the basis for the claim.

4-011.03B3a(2) Evidence Not Submitted by Client: When the claim is based on the client's anticipation of physical harm and corroborative evidence is not submitted in support of the claim the worker must:

1. Investigate the good cause claim when s/he believes that the claim is credible without corroborative evidence and corroborative evidence is not available; and
2. Find good cause if the client's statement and the investigation indicate that the client has good cause for refusing to cooperate.

4-011.03B3a(3) Worker Considerations: If the determination of good cause is not substantiated by documentary evidence, the worker must consider and document the following evidence:

1. The present physical or mental state of the client;
2. The physical or mental health history of the client;
3. Intensity and probable duration of the physical or mental upset; and
4. The degree of cooperation required by the client.

4-011.03B4 Decision On Good Cause: Within 30 calendar days of receiving the good cause claim, HHS staff must evaluate the evidence and determine whether good cause exists. In determining good cause, HHS staff must consider the recommendations of the case manager. HHS staff must notify the custodial party and the case manager of the determination in writing. If the client does not cooperate, withdraw the application, or request the case closed, a sanction is imposed (see 470 NAC 4-011.03C).

4-011.03B5 Delay of Assistance Pending Determination: The agency must not deny, delay, or discontinue assistance pending a determination of good cause if the client has complied with the requirements of providing acceptable evidence or other necessary information. In most instances, a good cause determination must be made within 30 days following the receipt of a claim.

4-011.03C Sanction for Refusal to Cooperate: If the client fails or refuses to cooperate and there is no good cause claim or determination, the appropriate sanction is applied. If the reason for noncooperation is the client's failure or refusal to provide information about or obtain third party medical payments (see 470 NAC 4-011.03), the client is ineligible for grant and medical assistance. Ineligibility continues for the client until s/he cooperates or cooperation is no longer an issue, and the grant is increased effective the first day of the month during which cooperation is restored. A protective payee is required for the case unless the worker is unable to find a protective payee.

4-011.04 Third Party Payments Received Directly: If the client receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by RMAP, the worker must take the following actions:

1. Send a demand letter advising the client that s/he must reimburse the Department or the provider. The client is allowed ten days from the date of notification to reimburse the medical payment. For an applicant, the worker must not delay determination of eligibility for assistance and authorization for payment pending the applicant's reimbursement. At the time the application is approved, the worker must notify the client of the number of days left in which to reimburse the payment;
2. If the client refunds within ten days, take no further action; or
3. If the client fails or refuses to refund within ten days, consider the entire third party payment as unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

If the insurance payment exceeds RMAP rates, the excess is considered unearned income unless paid out on other medical services or supplies.

Regardless of the existence of a good cause claim, any third party medical payment that is received directly by the client must be reimbursed.

4-011.05 Willfully Withheld Information: When the evidence clearly establishes that a client willfully withheld information regarding a third party medical payment which resulted in an overpayment of RMAP expenditures, the worker must refer the case 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 must 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 must complete normal case actions which include applying the appropriate sanction in this section

4-011.06 Termination of Assignment: When a client’s grant and medical case is rejected or closed, or an individual is removed from the medical unit, the assignment provision is terminated. The client’s rights to any future third party and medical support payments are automatically restored effective with the date of ineligibility. However, the assignment remains in effect for the time period during which the client was on medical assistance.