TITLE 477 MEDICAID ELIGIBILITY

CHAPTER 3 APPLICATION PROCESS

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

002. INTERVIEW. An interview is not required for a Medicaid application or renewal.

003. APPLICANT AND CLIENT RIGHTS. All applicants and clients have the following rights:

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

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

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

(D) The right to be offered the opportunity to register to vote;

(E) The right to submit an application or have an application submitted by an authorized representative;

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

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

(H) The right to receive adequate notice of any action affecting his or her application or benefit; and

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

004. APPLICANT AND CLIENT RESPONSIBILITIES. Each applicant or client is required to:

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

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

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

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

(iii) Change in residence;

(iv) Living arrangement;

(v) Disability status;

(vi) New employment;

(vii) Termination of employment; or

(viii) Change in the amount of monthly income, including:

(1) All changes in unearned income, and

(2) Changes in the source of employment, in the wage rate, or in employment status, such as part-time to full-time or full-time to part-time.

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

(C) Present his or her Medicaid card to providers;

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

(E) Enroll in a health plan and maintain enrollment if:

(i) One is available to the client;

(ii) The client is able to enroll on his or her own behalf; and

(iii) The Department has determined enrollment in the plan to be cost effective;

(F) Reimburse to the Department or pay to the provider any third-party resources received directly for services payable by Medicaid;

(G) Pay any unauthorized medical expenses;

(H) Pay any required medical copayment;

(I) Meet the requirements of Managed Care, if applicable; and

(J) Cooperate with state and federal quality control.

005. APPLICATION.

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

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

005.03 APPLICATION WITH A DESIGNATED PROVIDER. An applicant or authorized representative may apply for Medicaid with a designated outreach provider or entity which has contracted with the Department to accept Medicaid applications at its location.

005.04 ALTERATIONS. The application, when completed and signed by the applicant or authorized representative, constitutes the applicant's own statement regarding eligibility. Information may be added to an application up to the decision date.

005.05 WITHDRAWALS. An applicant may voluntarily withdraw an application verbally or in writing, which will be confirmed by the Department sending a Notice of Action to the applicant or authorized representative documenting this voluntary withdrawal.

005.06 NEW APPLICATION. A new application is required after 90 days of ineligibility.

006. AUTHORIZATION FOR INVESTIGATION. The Department may request a release of information from the applicant or authorized representative when it appears information is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

007. RENEWALS. A redetermination of eligibility for continued Medicaid benefits must be completed every 12 months.

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

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

007.03 RENEWAL FOR SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS. A renewal form is not required at the time of renewal for clients who are receiving supplemental security income (SSI).

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

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

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

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

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

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

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

008. CONTINUOUS ELIGIBILITY.

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

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

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

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

008.05 EXCEPTIONS TO CONTINUOUS ELIGIBILITY.

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

008.06 REVIEW AFTER SIX MONTHS' CONTINUOUS ELIGIBILITY. Once a household has received continuous eligibility for six months, a desk review is completed by the Department and any information known to the Department shall be acted on, accordingly.