TITLE 477 MEDICAID ELIGIBILITY

CHAPTER 25 BUDGETING FOR THE MEDICALLY NEEDY

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 govern services provided by the Nebraska Medicaid program as defined by the Medical Assistance Act, Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 68-901 et seq.

002. ELIGIBILITY FOR THE MEDICALLY NEEDY.

002.01 WHEN APPLICABLE. Children, parents or caretaker relatives, pregnant women, and the aged, blind, and disabled who have income above the limit for categorical eligibility may be eligible for Medicaid with a share of cost if a medical need exists or can be reasonably expected to exist. A medical need exists if medical costs for the financial unit exceed the Medically Needy Income Limit (MNIL) for the unit size.

002.02 BUDGET. A budget or system must be used to determine eligibility for medically needy individuals. Each month is determined separately. If an individual is eligible for one day of the month, then that person is considered to be eligible for the entire month. If at any time factors change that affect eligibility, then eligibility must be re-determined.

002.03 METHODOLOGY USED. The methodology used for the medically needy is based upon the most closely related cash assistance methodology. Income is counted in accordance with 477 NAC 22. Resources are counted in accordance with 477 NAC 23.

002.03(A) MEDICALLY NEEDY CHILDREN, FAMILIES, AND PREGNANT WOMEN. The treatment of income and resources for medically needy children, parents or caretaker relatives, and pregnant women is based on § 1931 of the Social Security Act.

002.03(B) MEDICALLY NEEDY AGED, BLIND, AND DISABLED. The treatment of income and resources for individuals who are aged, blind, or disabled is based on the methodology of the Supplemental Security Income (SSI) program.

002.04 STANDARD LEVELS. When computing a budget for medically needy individuals, the unit or family size is determined according to 477 NAC 24.

003. CALCULATING THE SHARE OF COST.

003.01 MEDICALLY NEEDY NOT RECEIVING LONG-TERM CARE SERVICES AND SUPPORTS. Medically needy individuals who are not residing in a medical institution or who do not receive Home and Community-Based Services (HCBS) have a share of cost (SOC) calculated according to the factors below. When countable income is reduced to at or below the appropriate Medically Needy Income Limit (MNIL), the individual is eligible to receive Medicaid.

003.01(A) MEDICAL EXPENSES. The individual must obligate payment for medical and remedial care expenses incurred by the individual or another person in the individual's financial unit. This may include medical costs not covered by Medicaid or medical premiums paid by the members of the unit. See 477-000-045 for the process by which these expenses are counted and recorded. Expenses are used to meet the share of cost (SOC) obligation in the order in which the expenses are received.

003.01(B) EFFECTIVE DATE. The individual is eligible for Medicaid on the first day of the month in which the share of cost (SOC) obligation is met, and remains eligible for the entire month.

003.01(C) COSTS NOT COVERED. Medical and remedial care costs used to meet the share of cost (SOC) obligation will not be covered by Medicaid.

003.02 MEDICALLY NEEDY WHO RECEIVE HOME AND COMMUNITY-BASED SERVICES. A medical need is established for a medically needy individual using a hypothetical amount of services in order to begin receiving Home and Community-Based Services. The share of cost (SOC) for medically needy individuals who receive Home and Community-Based Services is calculated according to the provisions below.

003.02(A) INCOME USED. The gross income is used to determine the share of cost for medically needy individuals. Income which is excluded or disregarded in determining eligibility is used to calculate the share of cost (SOC).

003.02(B) DEDUCTIONS. The following deductions are made to determine the share of cost (SOC) owed to the Home and Community-Based Services (HCBS) provider:

(i) The appropriate personal needs allowance is deducted from an individual's income. The personal needs allowance will vary according to the living arrangement in which the individual resides and the type of waiver used to provide the Home and Community-Based Services (HCBS);
(ii) The expense of a guardian or conservator of up to ten dollars ($10) per month, or as ordered by a court, is allowed as a deduction; and
(iii) Expenses for medical services not provided by the Home and Community-Based Services (HCBS) provider which are incurred by the individual may be deducted from the share of cost (SOC) owed to the provider. This may include medical expenses not covered by Medicaid or medical premiums paid by the individual.

003.02(C) EFFECTIVE DATE. These budgeting regulations are effective the first full month that an individual is both eligible as medically needy and receiving Home and Community-Based Services.

003.02(D) COSTS NOT COVERED. Medical and remedial care costs used to meet the share of cost (SOC) obligation will not be covered by Medicaid.

003.03 MEDICALLY NEEDY RESIDING IN MEDICAL INSTITUTIONS. A medically needy individual who resides in a medical institution may establish a medical need using a reasonable projection of institutional expenses. The share of cost (SOC) for a medically needy individual who resides in a medical institution is calculated according to the provisions below.

003.03(A) INCOME USED. The gross income is used to determine the share of cost (SOC) for medically needy individuals. Income that is excluded or disregarded in determining eligibility is used to calculate the share of cost (SOC).

003.03(B) DEDUCTIONS. The following deductions are made in determining the share of cost (SOC) due to the provider of institutional services:

(i) A personal needs allowance appropriate to the type of facility in which the individual resides is deducted from income;
(ii) The expense of a guardian or conservator of up to ten dollars ($10) per month, or as ordered by a court, is an allowable deduction;
(iii) An allowance for the cost of mortgage, rent, utilities, real estate taxes, or homeowner's insurance may be allowed for up to six months if it is possible that the individual will return home. This amount may not exceed the maximum shelter amount for a single individual listed in 477-000-012; and
(iv) Medical expenses not provided by the institutional service provider are deducted from the share of cost (SOC) amount owed to the provider. This may include expenses not covered by Medicaid or medical insurance premiums.

003.03(C) EFFECTIVE DATE. This budget procedure is used the first full month that a budget for a medical institution is used for the individual.

003.03(D) COSTS NOT COVERED. Medical and remedial care costs used to meet the share of cost obligation will not be covered by Medicaid.