NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

December 12, 2023
1:00 p.m. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on the adoption of amendments to the following regulations:

The following chapters are proposed for AMENDMENT:

Title 477 NAC 1 – *General Definitions*

The proposed changes add title and chapter name; incorporate the regulations scope and authority; update definitions; update postpartum coverage period from 60 days to an extended 12 month period effective January 1, 2024, for Medicaid and Children's Health Insurance Program (CHIP) recipients; correct punctuation; remove unnecessary, redundant, or unclear language from the regulation; add clarification language; update section headings; and renumber the regulatory chapter.

Title 477 NAC 3 – *Application Process*

The proposed changes add title and chapter name; remove the application process when renewal of Supplemental Security Income is discontinued; update disability review requirements; incorporate continuous coverage periods for pregnant women and children as allowed by the Consolidated Appropriations Act of 2023; update the extended period of eligibility for eligible Medicaid children from a 6 month period to a 12 month period effective January 1, 2024; correct grammar and punctuation; update section headings; and renumber the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-908(2)(b).

Interested persons may provide written comments by mail, fax, or email, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 477	Prepared by: Jeremy Brunssen
Chapter: 1 and 3	Date prepared: August 4, 2023
Subject: General Definitions and Application Process	Telephone: 402-471-5046, 402-540-0380

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Extended 12 Month Postpartum Coverage:
SFY24 impact $9,366,610 (FF: $5,497,853; SF: $3,868,756, SFY25 impact $18,809,451 (FF: $10,992,243; SF: $7,817,208)

A monthly capitation payment is made to a Managed Care Organization (MCO) to cover medical services for the pregnant member. The average cost of coverage for a pregnant woman is $628.21 per month in Capitation Payments to the MCOs. In State Fiscal Year 2023, medical assistance coverage for pregnant women was provided for 70,917 Member Months (per member per month). Based on income data for the month of April 2023, approximately 50% of women would no longer be eligible for coverage after the existing sixty-day period after birth. The estimated cost is based on a minimum of 29,645 (10-months / 12-months) Member Months x 50.16% x $628.21 = $18,623,219 (FF: $10,913,206; SF: $7,771,013). The extension of postpartum coverage will be implemented in the latter half of the SFY 24. Therefore, the SFY24 impact would be $9,311,610 (FF: $5,456,603; SF: $3,855,006).

The Centers for Medicare and Medicaid Services (CMS) introduced an approved proxy-method for states to claim the newly eligible FMAP for individuals receiving

extended postpartum coverage. The CMS approved proxy methodology is used to determine the proportion of expenditures for beneficiaries receiving extended postpartum coverage which are for individuals who would be eligible for the adult group and qualify as newly eligible if a redetermination was completed. This methodology will allow the state to claim the newly eligible FMAP while not transitioning beneficiaries into the adult group during the postpartum period, effectively eliminating an administratively burdensome redetermination at the end of the 60-day postpartum period.

Approximately 50% of individuals eligible in the pregnant women's category in April 2023 would be considered newly eligible based on the FPL (50%-133% FPL). The estimated cost is based on a minimum of 29,452 (10-months / 12-months) Member Months x 49.84% x $628.21 = $18,502,289 (FF: $16,652,060; SF: $1,850,229). However, these individuals would be Medicaid eligible regardless of an extension to postpartum coverage. As a result, there would be no additional fiscal impact for this sub-group of women.

Additional system updates would be needed in order to implement the proxy methodology in the Nebraska Family Online Client User System (NFOCUS), which will allow claiming of the expansion 'newly eligible' FMAP for individuals enrolled in the pregnant women's Medicaid category who meet eligibility for this funding.

In order to implement the system updates and changes described above, an estimated 500 business analyst hours would be needed for analysis, design, and testing. The estimated cost for this time is $40,000. An estimated 150 technical analyst hours would also be needed for analysis, design, coding, and testing. The estimated cost for this time is $15,000. In total, for system updates and changes, the total estimated absorbed cost is $55,000 (FF: $41,250; SF: $13,750).

A one percent increase was used to account for using historical data, future program changes, cost, or utilization and was applied to the SFY25 calculations.

<u>12 Months Continuous Eligibility for Children</u>:
SFY24 $18,446,856 (FF $10,776,653 / GF $7,670,203) SFY25 $52,145,913 (FF $30,494929 / GF $21,650,984)

Extending continuous eligibility for children 18 years old and younger will impact the agency through increased costs in capitation payments and FFS (fee-for-service) expenditures. To determine the fiscal impact of adding an additional 6 month coverage, for a total of 12 months continuous eligibility, we identified the average newly enrolled member count based on historical enrollment changes prior to initiation of the PHE unwinding. Nebraska Medicaid estimates it will see around 3,692 children in SFY24 and 7,458 in SFY25 who will be subject to a full 12 months of continuous eligibility under the new regulations.

The estimated cost of capitation used an average blended rate based on age group by historical enrollment factors and an estimated FFS (fee-for-service) expense based on the impacted population. The estimate consists of only the additional added months of continuous enrollment for SFY24 and SFY25 with the expected implementation date of January 1st, 2024.

Changes in SRT Review Periods:
SFY24 Impact $0.00, SFY 25 Impact $0.00

Clients whose disability status is approved by the State Review Team (SRT) are currently reviewed at least every 12 months. The length of time during which a beneficiary is considered to be disabled is dependent on the beneficiary's medical condition. A shorter time period is assigned if the medical evidence indicates that the beneficiary's medical condition may improve in order to ensure that the beneficiary continues to meet the disability criteria. The beneficiary's condition, and length of the disability review period, is re-determined at each review. Depending on the beneficiary's medical condition, a review will be conducted every 12 months, three years, or five years period. The change will likely result in fewer disability reviews needed to be conducted, but no change to the number of people eligible. As a result, no fiscal impact is anticipated.

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why: N/A.

TITLE 477 MEDICAID ELIGIBILITY

CHAPTER 1 GENERAL DEFINITIONS

~~CHAPTER 1-000 GENERAL DEFINITIONS~~

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. DEFINITIONS.

002.01 ABSENT PARENT. ~~Absent Parent:~~ A parent who is not living with ~~his/her~~ his or her child(ren).

002.02 ADEQUATE NOTICE. ~~Adequate Notice:~~ Notice of case action, which includes a statement of what action(s) are intended, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

002.03 AFFORDABLE CARE ACT (ACA). ~~Affordable Care Act (ACA):~~ The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, as amended by the Three Percent Withholding Repeal and Job Creation Act.

002.04 A-NUMBER. ~~A-Number:~~ Alien registration number, which is assigned to ~~an alien~~ a noncitizen when ~~s/he~~ he or she enters the United States.

002.05 APPLICANT. ~~Applicant:~~ An individual who is seeking an eligibility determination through submission of an application or a transfer from another agency or insurance affordability program.

002.06 APPLICATION. ~~Application:~~ A request for Medicaid benefits submitted by an applicant or ~~his/her~~ his or her authorized representative via a Department-approved format.

002.07 APPLICATION DATE. ~~Application Date:~~ For new and reopened cases, the date a properly signed application is received.

002.08 APPLICATION SIGNATURE. ~~Application Signature:~~ Applications may be signed in writing, by telephonic signature, or by electronic signature.

002.09 APPLICATION SUBMISSION. ~~Application Submission:~~ Applications may be submitted in person, by mail, by telephone, by fax, or by electronic transmission.

002.10 APPROVAL OR DENIAL DATE. ~~Approval/Denial Date:~~ The date that a new or reopened case is determined eligible or denied by the ~~Nebraska~~ Department ~~of Health and Human Services~~.

002.11 ASSIGNMENT. ~~Assignment:~~ The transfer of a client's right to third-party resources to the Department, which is accomplished by the submission and approval of an application.

002.12 AUTHORIZED REPRESENTATIVE. ~~Authorized Representative:~~ A person or organization authorized by an applicant, client, or court of competent jurisdiction to represent the applicant or client in any matter(s) with the Department.

002.13 BUDGET MONTH(S). ~~Budget Month(s):~~ The calendar month(s) for which verification of eligibility factors is used to compute eligibility.

002.14 CASUALTY. ~~Casualty:~~ The legal obligation of a third party to indemnify an injured person for damages caused by the third party or for which the third party is otherwise responsible.

~~Categorical Assistance: Assistance administered by the Department, including; Assistance to the Aged, Blind, and Disabled (AABD)/MA; and Children's Medical Assistance Program.~~

002.15 CHILD SUPPORT. ~~Child Support:~~ Money that is ordered by a court of competent jurisdiction to be paid by a noncustodial parent of behalf of a minor child or money that is paid by a noncustodial parent on behalf of a minor child without a court order.

~~1. Ordered by a court of competent jurisdiction to be paid by a noncustodial parent on behalf of a minor child, or~~
~~2. Paid by a noncustodial parent on behalf of a minor child without a court order.~~

002.16 CLIENT. ~~Client:~~ An individual who has been determined eligible for and is currently receiving Medicaid.

002.17 COURT OR TRIBAL WARD. ~~Court or Tribal Ward:~~ A child whose custody is committed to a court or other public agency. In order to receive payment from the Department that is otherwise permitted or required, the court or other public agency must be authorized under state law for the placement and supervision of children, and the court or other public agency must have a written agreement with the Department to ensure that Title IV-E requirements are met.

002.18 COURT ORDER. ~~Court Order:~~ A document signed by a judge and entered into the court record in a court of competent jurisdiction.

002.19 CREDITABLE HEALTH INSURANCE COVERAGE. ~~Creditable Health Insurance Coverage:~~ Any current health insurance coverage, except a plan that is limited to a single condition, such as cancer insurance, dental insurance, or long-term care insurance. Insurance to which an individual does not have reasonable geographic access is not creditable coverage.

002.20 CURRENT SUPPORT. ~~Current Support:~~ The monthly amount of child support or spousal support ordered by a court of competent jurisdiction.

002.21 DEEMING. ~~Deeming:~~ The process of determining the amount of income and resources of a parent or sponsor that must be considered available to meet the client's needs. Deeming does not apply to pregnant women or children.

002.22 DENIAL. ~~Denial:~~ A case in which an application was completed, signed, and submitted, but the applicant did not meet eligibility requirements.

002.23 DEPARTMENT. ~~Department:~~ The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC). The Department is the single state agency designated to administer and supervise the administration of the Medicaid program under Title XIX of the federal Social Security Act, as amended.

002.24 DEPENDENT CHILD. ~~Dependent Child:~~ A child from birth through ~~seventeen (~~17~~)~~ years old; or who is ~~eighteen (~~18~~)~~ years old and a full-time student in secondary school ~~(~~or equivalent vocational or technical training~~)~~, if before attaining ~~nineteen (~~19~~)~~ years of age the child may reasonably be expected to complete school or training.

002.25 DIRECTOR. ~~Director:~~ The director of Medicaid and Long-Term Care.

002.26 DISCHARGED WARD. ~~Discharged Ward:~~ An individual who has been discharged as a ward of a court or tribe.

002.27 EDUCATIONAL INSTITUTION. ~~Educational Institution:~~ A properly licensed or credentialed school, college, university, or vocational or technical training facility.

002.28 EFFECTIVE INCOME LEVEL. ~~Effective Income Level:~~ The income standard applicable under the State Plan for an eligibility group, after taking into consideration any income disregards applied in determining financial eligibility for the group.

002.29 ELECTRONIC ACCOUNT. ~~Electronic Account:~~ An electronic file consisting of information collected or generated by the Department regarding client Medicaid~~/~~ or Children's Health Insurance Program (CHIP) eligibility and enrollment.

002.30 ELIGIBILITY DETERMINATION. ~~Eligibility Determination:~~ An approval or denial of eligibility, as well as any renewal or termination of eligibility.

002.31 EMANCIPATED MINOR. ~~Emancipated Minor:~~ A child ~~eighteen~~ ~~(~~18~~)~~ years old or younger who is considered an adult because ~~s/he~~ he or she has:

(~~1.~~A)Married;

(~~2.~~B)Moved away from ~~his/her~~ his or her parent's(s') home and is not receiving support from ~~his/her~~ his or her parent(s); or

(~~3.~~C)If a pregnant child, ~~eighteen~~ ~~(~~18~~)~~ years old or younger, is denied financial support by her parents, guardians, or custodians due to her refusal to obtain an abortion, the pregnant child shall be deemed emancipated for purposes of eligibility, except that benefits may not be used to obtain an abortion.

002.32 FEDERAL POVERTY LEVEL (FPL). ~~Federal Poverty Level (FPL):~~ The current federal poverty level in effect for the applicable budget period used to determine an applicant's eligibility or a client's continued eligibility.

002.33 GUARDIAN OR CONSERVATOR. ~~Guardian/Conservator:~~ A person appointed by a court of competent jurisdiction to be in charge of the affairs of another person who cannot effectively manage ~~his/her~~ his or her own affairs because of ~~his/her~~ his or her age or incapacity.

002.34 GUARDIAN AD LITEM (GAL). ~~Guardian Ad Litem (GAL):~~ A person appointed by a court of competent jurisdiction to protect the best interests of a minor or vulnerable adult in a specific legal action.

002.35 HEARING. ~~Hearing:~~ An administrative proceeding before the Director or ~~his/her~~ his or her designee. During a hearing, a client, applicant, or ~~his/her~~ his or her authorized representative may present evidence with or without the help of witnesses to show why the action as indicated on the relevant Notice of Action or inaction of the Department should be corrected by the Department.

002.36 INCAPACITY (PHYSICAL OR MENTAL). ~~Incapacity (Physical or Mental):~~ As determined by the Social Security Administration (SSA) or the State Review Team (SRT), any physical or mental illness, impairment, or defect, which is expected to last at least ~~thirty~~ ~~(~~30~~)~~ days, that is so severe as to reduce substantially or eliminate a parent's ability to provide support or care for a child(ren). Age itself is not considered incapacity.

002.37 INQUIRY. ~~Inquiry:~~ Any question received by phone, letter, electronically, or personal contact without any indication that the individual wishes to apply. This may or may not be followed by an application for Medicaid.

002.38 IRREGULAR INCOME. ~~Irregular Income:~~ Income, earned or unearned, that varies in amount from month to month or that is received at irregular intervals. ~~See 477-000-009 for budgeting procedures.~~

002.39 LAWFULLY RESIDING. ~~Lawfully Residing:~~ Qualified alien pregnant women and children who are lawfully present in the United States and who are residents of Nebraska.

002.40 MEDICAID. ~~Medicaid:~~ A joint federal and state program under Title XIX of the federal Social Security Act, as amended, that provides medical assistance to eligible low-income individuals.

002.41 MEDICAL NEED. ~~Medical Need:~~ A condition of eligibility referring to a medical need.

002.42 MEDICAL PAYMENT. ~~Medical Payment:~~ Payment from any health insurance plan, individual, or group or entity for medical expenses, whether for a client or any other member of ~~his/her~~ his or her household.

002.43 MEDICAL SUPPORT. ~~Medical Support:~~ The obligation of a noncustodial parent to provide health insurance or pay medical costs.

002.44 MINIMUM ESSENTIAL COVERAGE. ~~Minimum Essential Coverage:~~ Coverage under a specified government-sponsored program, an eligible employer-sponsored plan, a health plan offered in the individual market, a grandfathered health plan, or other health benefits coverage that is recognized by the federal government.

002.45 MINOR PARENT. ~~Minor Parent:~~ An individual ~~eighteen (~~18~~)~~ years old or younger, with a child. ~~For treatment of child support when a noncustodial parent pays support for his/her his or her child who is a minor parent, see 477 NAC 22-003.02C.~~

002.46 NON-APPLICANT. ~~Non-Applicant:~~ An individual who is not seeking an eligibility determination for ~~him/herself~~ himself or herself and is included in an applicant's or client's household to determine eligibility for the applicant or client.

002.47 NOTICE OF ACTION (NOA). ~~Notice of Action (NOA):~~ A statement sent by the Department to an applicant, client, or ~~his/her~~ his or her Authorized Representative that includes a reasonably short, plain statement of the action(s) taken by the Department, the factual reason(s) for the action, and reference to the applicable regulatory law(s) or otherwise that authorizes the action(s).

002.48 PARENT OR CARETAKER RELATIVE (PCR). ~~Parent/Caretaker Relative (P/CR):~~ A relative of a dependent child by blood, adoption, or marriage, with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(~~1.~~A)The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece~~.~~;

(~~2.~~B)The spouse of the parent or relative, even if the marriage is terminated by death or divorce~~.~~; or

(~~3.~~C)Another relative of the child based on blood, adoption, or marriage, or an adult with whom the child is living and who has provided sufficient documentation of a court-ordered guardianship~~/~~ or conservatorship of the child.

002.49 PENDING. ~~Pending:~~ A case in which a complete and signed application has been received and eligibility has not yet been determined by the Department.

002.50 POSTPARTUM PERIOD. ~~Post-Partum Period:~~ The period following the end of a pregnancy, which begins on the last day of pregnancy, then extends ~~sixty (~~60~~)~~ days, and ends on the last day of the month in which the ~~sixty (~~60~~)~~-day period ends.

002.51 POSTPARTUM PERIOD (EFFECTIVE JANUARY 1, 2024). A continuous 12-month period directly following the end of a pregnancy, which begins on the last day of pregnancy, regardless of the reason the pregnancy ends and extends through the end of the month in which the 12-month period ends.

002.52 POWER OF ATTORNEY (POA). ~~Power of Attorney (POA):~~ A written and notarized authorization allowing one person to act for another person. The powers granted may be general or may be limited to specific circumstances. A power of attorney (POA) may be durable, in which case the powers continue to exist even if the appointing individual becomes legally incompetent. A power of attorney (POA) ceases to be effective upon the death of the appointing individual.

002.53 PREGNANT WOMAN. ~~Pregnant Woman:~~ A woman during pregnancy and the post-partum period.

002.54 PROSPECTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE. ~~Prospective Eligibility for Medical Assistance:~~ The date of eligibility beginning the first day of the month of the date of application if the client was eligible for Medicaid in that same month.

002.55 REASONABLY COMPATIBLE. ~~Reasonably Compatible:~~ For each eligibility factor, ~~(~~except ~~for~~ ~~SSN~~ social security number, citizenship, and immigration status~~)~~, reasonable compatibility shall be applied. Electronic data matches shall be used when applicable and compared to an ~~applicant's/client's~~ applicant's or client's self-attestation of information. ~~See Appendix 477-000-004 for Verification Plan.~~

002.56 RETROACTIVE ELIGIBILITY. ~~Retroactive Eligibility:~~ The date of eligibility beginning no earlier than the first day of the third month before the month of application. ~~See 477 NAC 4-001.01.~~

002.57 SECURE ELECTRONIC INTERFACE. ~~Secure Electronic Interface:~~ An interface which allows for the exchange of data between Medicaid and insurance affordability programs.

002.58 SPONSOR. ~~Sponsor:~~ ~~A sponsor is an individual who~~ A citizen or national of the United States, or an alien who is lawfully admitted to the United States for permanent residence, living in any state or the District of Columbia, who is 18 years of age or older and is petitioning or has petitioned for the admission of a noncitizen(s) under Section 204 of the Immigration and Nationality Act. An organization cannot be a sponsor.

~~1. Is a citizen or national of the United States, or an alien who is lawfully admitted to the United States for permanent residence;~~
~~2. Is eighteen (18) years of age or older;~~

~~3. Lives in any state or the District of Columbia; and~~
~~4. Is the person petitioning for the admission of the alien under Section 204 of the Immigration and Nationality Act.~~

~~An organization cannot be a sponsor.~~

002.59 SPOUSAL SUPPORT. ~~Spousal Support:~~ Alimony or maintenance support for a spouse or former spouse.

002.60 STANDARD OF NEED. ~~Standard of Need:~~ The maximum standard according to eligible unit size and living arrangement.

002.61 STATE PLAN. ~~State Plan:~~ The written plan between the Department and the federal government that authorizes and describes how the Department administers Medicaid.

002.62 STUDENT. ~~Student:~~ An individual who is ~~eighteen (18)~~ years old or younger and attending a secondary school ~~(~~or the equivalent level of vocational or technical training~~)~~.

002.63 THIRD-PARTY RESOURCES. ~~Third-Party Resources:~~ The legal obligation of a third party, ~~(~~including certain individuals, entities, insurers, and programs~~),~~ to pay for or provide monies or benefits. ~~Medicaid is the payer of last resort. A client must cooperate with the Department to ensure this.~~ Third-Party Resources include Casualty, Child Support, Medical Payment, Medical Support, and Spousal Support. Medicaid is the payer of last resort.

002.64 TIMELY NOTICE. ~~Timely Notice:~~ A notice of case action dated and mailed at least ~~ten~~ 10 calendar days before the date the action becomes effective.

002.65 UNIT. ~~Unit:~~ The number of individuals in a household.

~~Unsubsidized Employment: Employment for which the salary is paid wholly by the employer.~~

002.66 WITHDRAWAL. ~~Withdrawal:~~ A voluntary written or verbal retraction of an application.

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~~ Affairs (VA) 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 ~~s~~Supplemental ~~s~~Security ~~i~~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~~A) 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~~B) SUPPLEMENTAL SECURITY INCOME (SSI) CLIENTS ELIGIBLE UNDER 1619(b). Supplemental ~~s~~Security ~~i~~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 ~~s~~Supplemental ~~s~~Security ~~i~~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 periodic review of the disability determination is required ~~for aged, blind, and disabled (ABD) eligibility must be completed by the State Review Team at least every 12 months~~. Reviews of the disability determination are conducted consistent with the relevant portions of the Supplemental Security Income program and 20 Code of Federal Regulations (CFR) Part 416 Subpart I.

007.05(A) REQUIRED DISABILITY REVIEWS. A review of a beneficiary's disability status will occur in the following circumstances:

(i) The previous determination period has ended;

(ii) The beneficiary was determined disabled as a child, and is now turning age 18;

(iii) The beneficiary begins, or returns, to work, and the income earned is greater than the Substantial Gainful Activity (SGA) amount published by the Social Security Administration (SSA);

(iv) The Department receives credible evidence or reports that the beneficiary is no longer disabled; or

(v) The beneficiary reports that the disability has ended.

007.05(B) REQUIRED DOCUMENTATION. The State Review Team (SRT) requires contemporaneous documentation of a beneficiary's health condition in order to determine whether the beneficiary meets the disability criteria. The medical documentation must be dated no more than 12 months prior to the date for which a disability determination is requested. The medical documentation must include an examination by a physician or another appropriate provider for the condition or conditions related to the disability determination dated no more than 12 months prior to the date for which a disability determination is requested. A failure to provide all necessary documentation will result in a denial of disability status.

007.05(C) DURATION OF DISABILITY DETERMINATION. The length of time during which a beneficiary is considered to be disabled is dependent on the beneficiary's medical condition. A shorter time period is assigned if the medical evidence indicates that the beneficiary's medical condition may improve in order to ensure that the beneficiary continues to meet the disability criteria. The beneficiary's condition, and length of the disability review period, is re-determined at each review. The review schedule is determined as follows:

(i) A disability review will be conducted every 12 months when the disability may reasonably be expected to improve;

(ii) A disability review will be conducted every three years if the disability is not permanent, but the possibility for medical improvement cannot be accurately predicted; or

(iii) A disability review will be conducted every five years if it is unlikely that the medical condition will improve.

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.

008.03(A) CONTINUOUS ELIGIBILITY FOR CHILDREN (EFFECTIVE JANUARY 1, 2024). Children from birth through age 18 are eligible for one year of continuous Medicaid from the date of initial eligibility. Retroactive months do not count in the one year 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. Exceptions to continuous eligibility are:

~~(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.~~

(A) A child attaining age 19 who does not meet another level of continuous eligibility, such as pregnancy or hospitalization;
(B) The individual requests voluntary termination;
(C) The individual ceases to be a state resident;
(D) The agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or
(E) The individual dies.

~~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.~~