Chapters 477 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

CHAPTER 25-000 ABD BUDGETING

25-001 ABD BUDGETING

25-001.01 Medical Budget Periods: The medical budget is normally computed on a monthly basis. See Appendix 477-000-009 for procedures.

25-001.02 Alternate Living Arrangements Standard of Need: The standard of need for alternate living arrangements is a consolidated allowance for items necessary for basic subsistence. Included in this standard are

1. Board;
2. Room;
3. Clothing;
4. Personal needs;
5. Laundry;
6. Transportation; and
7. Medical and remedial services. (The consolidated standard of need for board and room [see 477 NAC 25-001.02B] includes items 1 through 6 but does not include remedial services.)

25-001.02A Licensing of Facilities: In determining the appropriate standard to be allowed, the current licensure/certification of the facility shall be verified. If the facility is covered under more than one licensure/ certification, it shall be verified in which section the client is residing and which licensure/certification applies.

Nebraska law directs the Department and other public and private agencies who arrange and supervise living arrangements to report any facility which is not currently licensed and serves more than three individuals. Central Office, Aged and Disabled Services, must be contacted if an unlicensed facility is identified.

25-001.02B Board and Room: Board and room does not include care or supervision and may be with a relative.

In addition to the actual amount of board and room paid, the client is allowed a personal needs allowance. The total allowance must not exceed the standard for Board and Room, see Appendix 477-000-044.

25-001.02C Licensed Assisted Living Facility: An Assisted Living facility provides accommodation and board and care (e.g., personal assistance in feeding, dressing, and other essential daily living activities) for four or more individuals not related to the owner, occupant, manager, or administrator. These individuals are unable to care for themselves sufficiently or properly or manage their own affairs because of illness, disease, injury, deformity, disability, or physical or mental infirmity.

Individuals residing in Assisted Living facilities do not require the daily services of licensed, registered, or practical nurses. However, staff in an assisted living facility may assist the individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication. See Appendix 477-000-043 for procedures.

The monthly standard for an Assisted Living facility includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02D Certified Adult Family Home: An Adult Family Home is a residential living unit that provides full-time residence with minimal supervision and guidance to not more than three individuals age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, and facilities to ensure client comfort. These individuals are essentially capable of managing their own affairs but are in need of supervision. This may include supervision of nutrition by the facility on a regular, continuing basis, but not necessarily on a consecutive 24-hour basis.

The monthly standard for an Adult Family Home includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02E Residential Child-Caring Agencies: This group care facility provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

The monthly standard for a Licensed Group Home for Children or a Child Caring Agency includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02F Licensed Center for the Developmentally Disabled: A center for the developmentally disabled is any facility, place, or building not licensed as a hospital that provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled.

Staff in a center for the developmentally disabled may assist individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication.

The term "center" includes:

1. Group Residence - Any group of rooms located within a dwelling and forming a single habitable unit with living, sleeping, cooking, and eating facilities for 4 through 15 developmentally disabled persons.
2. Institution for the Developmentally Disabled - Any facility other than a skilled nursing facility or an intermediate care facility I or II where 16 or more developmentally disabled persons reside.

The monthly standard for a Licensed Center for the Developmentally Disabled includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02G Long-Term Care (LTC) Facility: The payment to a long-term care facility includes an allowance for personal needs of the client, which is determined by the licensure or certification of the facility where the client resides (see 477 NAC 25-001.02).

This facility may be considered for all alternate care standards. The maximum amount allowed is the Assisted Living standard; see Appendix 477-000-044. For a client living in a long-term care facility, see 477 NAC 26-004.03D.

25-001.02H Assisted Living Waiver: See Appendix 477-000-012, 477-000-028, and 477-000-043 for the standard for an individual receiving Assisted Living Waiver services. The monthly standard includes an allowance for personal needs of the client.

25-001.02I Licensed Mental Health Center: Mental health center means a facility where shelter, food, counseling, diagnosis, treatment, care, or related services are provided for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability.

25-001.03 ABD Continuation for SSI Clients: The standard of need is used for independent living and shelter costs or the consolidated standard for alternate living when the Social Security Administration notifies the Department that a client will continue to receive full Supplemental Security Income (SSI) payments for up to three months because the individual is likely to return to his/her previous living arrangement. The procedures at 477 NAC 26-004.04D are followed for allowing shelter and/or utilities when

1. SSI reduces or terminates the payment at the end of the three-month extension;
2. SSI determines that the client does not qualify for the full benefit for the three-month period; or
3. The client was not receiving SSI before admission to the medical facility.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need that most accurately reflects the client's living arrangement must be used.

25-001.04 Budgeting for ABD

25-001.04A ABD Budget: A budget or system must be used to determine eligibility for Medicaid and Medicaid share of cost cases. If at any time factors change that affect the budget, the budget must be re-computed.

For ABD change report procedures, see Appendix 477-000-009.

If a parent(s)' income has been deemed to a child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost. See Appendix 477-000-045.

Note: Current share of cost amounts must be applied to current monthly medical expenses, not previous months' medical expenses.

25-001.04B Methodology Used:

1. The treatment of income and resources for medically needy individuals is based on Aid to Families with Dependent Children (AFDC) methodology for parent/caretakers and children.
2. The treatment of income and resources for individuals who are aged, blind, or disabled is based on SSI methodology.

25-001.04C Standard Levels: When computing a Medicaid budget for medically needy children and parent/caretaker relatives, the following individuals shall be considered in determining the unit or family size:

1. Client;
2. Spouse; and
3. The applicant/spouse's minor child(ren) residing in the household.

When computing a Medicaid budget for ABD, only the client and his/her spouse is considered in determining the medically needy or Federal Poverty income level.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need shall be used that most accurately reflects the client's living arrangement.

When computing a medical budget, the following steps shall be used to determine if the client is eligible for Medicaid only or Medicaid with share of cost:

1. The client's net income shall be compared to the percentage of the Federal Poverty Level (FPL) (see Appendix 477-000-012). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, step 2 determines the amount of share of cost. For clients in long-term care, go directly to step 2.

2. The medically needy income level shall be subtracted from the client's net income to determine the amount of share of cost (see Appendix 477-000-045).

When a client 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 client resides in long-term care.

25-001.04D Computation of Net Income:

25-001.04D1 Income Disregarded: Income disregarded for the ABD client is not considered in determining the eligibility of or the amount of assistance for the client or any other individual.

Savings from disregarded income are considered the same as assets accumulated from any other source.

25-001.04E Budget Disregards: In addition to disregards outlined in 477 NAC 22-005, the following disregards are allowed:

25-001.04E1 Clients in a Long-Term Care Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to guardian/conservator fee disregard and the maintenance allowance for long-term care or the standard for Assisted Living, the cost of homeownership or rent expense, including utilities up to six (6) months is deducted. The allowances must not exceed the maximum shelter amount for one (see Appendix 477-000-044) if the client does not have a spouse.

25-001.04E2 Budgeting Individuals in Nursing Home or Acute Care Hospitalization for Three Continuous Months: Non-SSI budgeting procedures shall be used for individuals in nursing home or acute care hospitalization when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the Federal Benefit Rate (FBR) for a single individual in an institution (see Appendix 477-000-037).

25-001.04F Buy-In of Part B: A client is eligible for state payment of Medicare Part B premium (buy-in) if his/her income is equal to or less than 100 percent of the FPL. Buy-in begins the month following the month of processing. See Appendix 477-000-012 for the buy-in procedure.

For Medicare beneficiaries, see 477 NAC 27-002.

25-001.05 Client Living in a Long-Term Care Facility: The budget of a client living in a long-term care facility (i.e., a nursing home, Assisted Living Waiver, or an acute care hospital) shows

1. The standard of need; and
2. An amount up to $10 when the client has a guardian or conservator who requests a fee (see 477 NAC 22-005.02D).

The expense of home ownership and/or utilities may be allowed only until it is apparent that the client cannot live there again (not to exceed six months).

The budget may allow for the expense of rent and/or utilities for up to six months. The total time for either allowance shall not exceed six months. The allowances must not exceed the maximum shelter amount for on (see Appendix 477-000-044) if the client does not have a spouse.

Exception: See 477 NAC 25-001.03 for budgeting a client who continues to receive full SSI benefits for up to three months.

Note: If a client in an alternate care facility goes to a long-term care facility, the budget must continue to allow the alternate care standard until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the long-term care facility beyond two months, Central Office approval is required to continue using the alternate care standard.