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 27-000 AGED, BLIND AND DISABLED MEDICAID (ABD); MEDICALLY NEEDY (MN); MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD); WOMEN'S CANCER PROGRAM; EMERGENCY MEDICAL SERVICES ASSISTANCE (EMSA); AND KATIE BECKETT

27-001 ABD

27-001.01 ABD: In order to be eligible in the ABD category, an applicant/client must have income equal to or less than 100% of the FPL.

27-001.02 Age Requirement/Age Limit: To be eligible for Medicaid, an applicant/client must meet the age requirements for the applicable Medicaid category.

For ABD individuals, an individual must meet the following age limits:

1. To qualify as aged, an individual must be sixty-five (65) years old or older;
2. To qualify as blind, an individual must be sixty-four (64) years old or younger; or
3. To qualify as disabled, an individual must be sixty-four (64) years old or younger.

The month a blind or disabled person turns sixty-five (65) years old, s/he becomes eligible for Assistance to the Aged.

27-001.03 Eligibility Categories

27-001.03A Blind or Disabled Recipients Eligible for Medicaid: A blind or disabled client who has earned income is eligible without regard to share of cost if s/he meets specified guidelines. If a blind or disabled client reaches sixty-five (65) years old, the SSA may continue eligibility under section 1619(b) of the Social Security Act, as amended.

27-001.03B Current and Former SSI Recipients: A blind or disabled client who has earned income is eligible without share of cost if s/he

1. Received Medicaid in the month before the month in which this reference applies and continues to receive Supplemental Security Income (SSI) either in the form of regular SSI payments or special SSI payments under section 1619(a) of the federal Social Security Act, as amended; or
2. Received Medicaid and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the federal Social Security Act, as amended.

The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field). If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible, considering the ten (10)-day notice requirement.

27-001.04 Blindness or Disability Determination

27-001. 04A Eligibility Requirements Applicable Only to the Blind or Disabled: All applicants for Aid to the Blind or Aid to the Disabled after January 1, 1974, must meet the medical definitions of blindness or disability of the Retirement, Survivors, and Disability Insurance (RSDI)/SSI Programs as administered by SSA. The determination by SSA that an individual is disabled or blind must be accepted for eligibility for ABD. In some cases, the State Review Team (SRT) may make the determination of blindness or disability.

Generally, an individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months. A child through seventeen (17) years old is considered disabled of s/he suffers from any medically determinable physical or mental impairment of comparable severity. See Titles II and XVI of the federal Social Security Act, as amended, for further disability criteria.

SRT shall review medical documentation dated no more than twelve (12) months prior to the request. An individual requesting a determination by SRT must have seen a doctor for condition(s) related to the alleged condition for which they are seeking a determination within three (3) months of the request.

27-001.04B Determination of Eligibility for the Blind or Disabled

27-001. 04B1 Disability Determination: In the determination of eligibility for Aid to the Blind or Disabled, all eligibility requirements except that of the disability determination are the responsibility of the Department.

27-001.04B2 Appeal to SSA: An individual who is determined ineligible for ABD because s/he does not meet SSI disability requirements may appeal the decision to SSA. Upon receiving an affirmative redetermination of disability from SSA, the Department shall use the original date of application in determining eligibility for Medicaid if the applicant

1. Has been determined ineligible for SSI because s/he is not considered disabled due to lack of severity;
2. Appeals SSA's decision; and
3. Wins his/her appeal.

27-001.04B3 Direct Referral to the State Review Team: In the following situations a referral may be submitted directly to SRT for a determination of disability and its probable duration without waiting for an SSI determination if the individual is not eligible for another medical program, and during the initial intake it is apparent that

1. The individual has income and/or resources in excess of the limit for the SSI program. The client's potential eligibility for SSI must be monitored. If income and/or resources fall below the SSI limit, an immediate referral for the SSI program must be made to SSA. The client is allowed 60 days to apply for this potential benefit;
2. The individual requires immediate long-term hospitalization and/or treatment for a severe impairment before SSA can make a determination for the SSI program, or would be required to extend his/her hospital stay solely because of a delay in processing the SSI application, i.e., due to SSA's required waiting periods before a decision on certain types of disability can be made such as cancer or stroke (this does not include diagnostic examinations or tests, routine medications, or drug/alcohol treatment). An immediate referral for the SSI program must be made to SSA;
3. The individual is institutionalized (e.g., in a nursing home or public institution) and SSA will be unable to make a disability determination for the SSI program. An individual is eligible for SSI benefits while institutionalized only if Medicaid will pay 50 percent of his/her care. Therefore, SSA may, in some cases, wait for a determination of eligibility for Medicaid. An immediate referral for the SSI program must be made to SSA;
4. The individual is deceased and SSA will not make a disability determination for the SSI program; or
5. The individual is a non-U.S. citizen who SSA will not review for the SSI program.

See 477 NAC 27-001.04A regarding disability criteria.

27-001.04B4 Subsequent Referrals to SSA: The Department shall continue to monitor the client's potential eligibility for RSDI and SSI benefits even though SRT has made the determination of disability.

27-001.04B5 SSA Determines that the Client is Not Disabled After SRT Approval: If the SRT has determined disability for the client, SSI later determines that the client is not disabled due to lack of severity or the ability to engage in substantial gainful activity, and the client has filed an appeal with SSA, the client must be considered disabled through the review period established by the SRT.

If no appeal has been filed the Medicaid case must be closed. If the case is closed before the end of the current SRT period, the closing notice must instruct the client to contact the Department immediately if an appeal is filed and the Mediciad case can be opened for the remainder of the SRT period. At the end of the current review period, the Medicaid case is closed without a referral to the SRT.

27-001.05 SSI Program: If a client has not applied for SSI, an application must be filed immediately. A client must be referred to SSA for an SSI determination if

1. The client lives alone and has monthly unearned income less than the referral amount for an individual;
2. An eligible couple is living together and has monthly unearned income less than the referral amount for a couple (Note: both spouses must apply for SSI); or
3. An individual is in a nursing home and has monthly unearned income that is less than the SSI personal needs allowance.

If income is less than these amounts but resources are less than levels for ABD, an SSI referral is not made but eligibility for ABD must be considered.

27-001.05A Suspension of SSI Benefits: If a client's SSI benefits are suspended due to excess income and/or resources, the client is still considered disabled according to SSI standards for a period of twelve (12) consecutive months, as long as all other eligibility factors are met. The twelve (12)-month period is effective the first day of the month in which the client's benefits are suspended. To continue ABD at the end of the twelve (12)-month period, a review of disability by SRT is needed.

27-001.06 Institutionalization: An individual may qualify for ABD while living in an institution only if the institution is subject to the licensing requirements of the Department's Public Health Licensure Unit.

27-001.06A Definitions: The following definitions are used in the administration of Medicaid to individuals who are institutionalized:

27-001.06A1 Institution: An establishment that furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor and, in addition, provides some treatment or services that meet some need beyond the basic provision of food and shelter.

27-001.06A2 Medical Institution: An institution that is organized to provide medical care, including nursing and convalescent care, and has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards. The institution must be authorized under state law to provide medical care.

27-001.06A3 Inpatient: A patient who has been admitted to a medical institution on the recommendation of a physician or dentist and is receiving room, board, and professional services in the institution on a continuous 24-hour-a-day basis.

27-001.06A4 Public Institution: An institution that is the responsibility of a governmental unit, or over which a governmental unit exercises administrative control.

27-001.06A5 Publically Operated Community Residence: A publically operated residence to serve no more than sixteen (16) residents and provide some services beyond food and shelter, such as social services, help with personal living activities, or training in socialization or life skills. Occasional or incidental medical or remedial care may also be provided.

27-001.06A5a Exclusions: The following facilities are not considered publically operated community residences, even if their accommodations are for 16 or fewer residents:

1. Residential facilities adjacent to any large institution or multi-purposes complex;
2. Educational or vocational training institutions;
3. Correctional or holding facilities for individuals whose personal freedom is restricted because of a court sentence, holding, or pending disposition; and
4. Medical treatment facilities such as hospitals and skilled nursing facilities.

27-001.06A6 Inmate of a Public Institution: A person who is living in a public institution and receiving treatment and/or services that are appropriate to the person's requirements. A person is not considered an inmate when s/he is in a public educational or vocational training institution for purposes of securing educational or vocational training, or s/he is in a public institution for a temporary period pending other arrangements appropriate to his/her needs.

27-001.06A7 Institution for Mental Disease: An institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Such care includes medical attention, nursing care, and related services.

27-001.06A8 Institution for Developmental Disabilities: An institution (or distinct part of an institution) that is primarily for the diagnosis, treatment, or rehabilitation of persons with developmental disabilities. The institution provides, in a protected residential setting, ongoing evaluation, planning twenty-four (24)-hour supervision, and coordination and integration of health and rehabilitative services to help each individual function as his/her greatest ability.

27-001.06B Levels of Care: The previously listed facilities must be licensed by the Department's Public Health Licensure Unit, and certified by Medicaid as one or more of the following types of facilities:

1. Acute hospital;
2. Psychiatric care facility; or
3. Intermediate care facility for the developmentally disabled (ICF/DD).

Coverage may be provided to persons of all ages in the previously listed facilities for acute hospital and ICF/DD levels of care if the individuals are otherwise determined eligible.

Psychiatric care is provided only to individuals in an Institute for Mental Disease who are twenty-one (21) years old or younger and sixty-five (65) years old or older. If an individual is receiving treatment in a facility on his/her twenty-first (21st) birthday, s/he is eligible until the sooner of

1. Release; or
2. The month of his/her twenty-second (22nd) birthday.

27-001.06C Patients in a Medical Institution: Medicaid may be provided for a client who is a patient in a medical institution (e.g., hospital, nursing home) if all other eligibility factors are met. Psychiatric wards of medical hospitals are considered part of the medical institution and are not subject to the restriction on psychiatric care identified at 477 NAC 27-001.05A5a.

27-001.06D Convalescent Leave: Eligibility for applicants/clients on convalescent leave or visit from public medical institutions is determined in accordance with the applicable program standards. Eligibility is based on an applicant's/client's living situation and needs while on leave.

27-001.06E Responsibility for Determining Nature of Institution: Central Office is responsible for determining the public or private nature of an institution, and whether a public institution is one in which otherwise eligible individuals may receive Medicaid.

27-001.06F Criteria for Determining Public Nature of Institutions: Prisons, jails, etc., are designated in the law as public institutions whose inmates are ineligible to receive Medicaid. Governmental participation in financial support of an institution, in policy formulation, or in the application of policy to specific situations, is evidence of the public control that makes it a public institution. Payment from public funds to, or in support of, individuals in a private institution is not considered governmental participation in support of the institution.

27-001.07 Factors Relating to Eligibility of Clients in Institutions

27-001.07A Private Institution and Home: The private institution in which a client chooses to reside may be a fraternal, benevolent, or charitable institution, or a client may make plans for living in a home that is privately owned and operated and that furnishes shelter, board, and care according to the client's needs. In determining the Medicaid eligibility of a person living in a private institution or home, it is necessary to determine if s/he has entered into any agreement with the institution that s/he is to receive shelter and care in return for a transfer of property, insurance, or other assets.

In determining Medicaid eligibility of an applicant/client in a private institution, it is necessary to determine what the institution is able to furnish its guests from its own resources. The individual may be eligible to receive Medicaid if residing in one of the facilities previously described if the terms of his/her stay do not in any way restrict the use of his/her personal assets or income and if the applicant/client has a medical need.

27-001.08 Working Disabled Part A Medicare Beneficiaries: Individuals who were receiving RSDI disability benefits and return to work, but remain disabled, may continue to be entitled to Part A Medicare at no cost for forty-eight (48) months. The Omnibus Budget Reconciliation Act of 1989 allows these individuals, at the end of forty-eight (48) months, to enroll in Part A Medicare and pay a premium. The act also requires state Medicaid programs to purchase Medicare Part A premiums for these individuals.

27-001.08A Age: To be eligible for the payment of the Medicare premium, an individual must be sixty-four (64) years old or younger.

27-001.08B Disability: To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by SSA. SSA has the responsibility to verify periodically that the disability continues. If SSA determines through a continuing disability review that the client is no longer disabled, SSA notifies the Department and eligibility for ABD ceases. If the client voluntarily withdraws from Medicare Part A premium, eligibility for ABD ceases.

27-001.08C Receipt of Other Assistance: Through the ABD program an individual may choose to receive either payment of the Medicare Part A premium or full Medicaid benefits but not both at the same time. While receiving either form of assistance, the client may request the other; however, the client is not eligible for full Medicaid benefits for any month for which the Department pays the Medicare Part A premium.

If a client who is on ABD with share of cost and is paying his/her own Part A Medicare premium fails to meet his/her share-of-cost obligation, the Department retroactively pays the Medicare Part A premium for the excess cycle. At the end of this excess cycle, the client must decide whether to continue to have the state pay the Part A premium or to begin a new excess cycle and assume payment of the Part A premium him/herself.

27-002 MEDICARE PART B BUY-IN

27-002.01 Medicare Savings Program/ Qualified Medicare Beneficiaries (MSP/QMB): In order to meet eligibility for MSP or QMB, an applicant/client must have

1. Income equal to or less than 100 percent of the Federal Poverty Level (FPL); and
2. Resources in excess of the $4,000 and $6,000 limits.

MSP/QMB individuals who are within specific resource guidelines at 477 NAC 23 are eligible for payment of deductibles and co-pay costs associated with Medicare claims. They are not eligible for additional medical services. An annual review is required to verify income and resources. The resource limit amounts are adjusted annually.

27-002.02 Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI-1): In order to meet eligibility as an SLMB or QI-1, an individual must

1. Be a current Medicare beneficiary who meets the required income guidelines:
   a. In order to qualify in the SLMB category, an individual must have income equal to or less than 120% of the FPL
   b. In order to qualify in the QI-1 category, an individual must have income equal to or less than 135% of the FPL; and
2. Fulfill all other eligibility requirements of the ABD program and be eligible for payment of his/her Part B Medicare premium.

These clients are eligible only for payment of the Medicare premium; they are not eligible for any additional medical services.

27-002.03 Income Treatment: In accordance with regulations for ABD. The income limits are based on the FPL.

1. If total net earned and unearned income is equal to or less than the required income limit, the client is eligible for payment of the Medicare premium.
2. If the income is more than the income limit, the client is ineligible for payment of the Medicare premium.

27-002.03A The client may choose to receive ABD with a share of cost and attempt to spend down if there is a medical need.

1. If a client who is on ABD with a share of cost fails to meet any of his/her share of cost by the next case review and a medical need cannot be anticipated, an SLMB or QI-1 budget shall be authorized.

2. If a client has been an SLMB and later wants Medicaid with a share of cost for the same month(s) and up to three months before, a share of cost budget shall be authorized.
3. If a client has been a QI-1 and later wants Medicaid with a share of cost for the same month(s), only the current month's share of cost budget shall be authorized.

27-003 MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD)

27-003.01 Medicaid Insurance for Workers with Disabilities: Working individuals who meet the necessary disability criteria, have income within income guidelines, and are working are eligible for Medicaid. After application of income disregards, individuals with income less than 200 percent of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with incomes of 200 through 249 percent of the FPL are eligible for Medicaid with a monthly premium payment. See Appendix 477-000-046 for procedures.

27-003.02 Eligibility Requirements: In order to receive Medicaid, the individual must

1. Qualify for Medicaid except for income;
2. Not be eligible for ABD, but may be eligible with a share of cost;
3. Meet the Social Security Administration (SSA) or State Review Team (SRT) definition of disability;
4. Be working;
5. Using a two-part income test, have income that is equal to or less than 200% of the FPL;
6. Meet Medicaid resource limits; and
7. Pay a premium, if required (If income is above 200% of the FPL and equal to or less than 250% of the FPL).

27-003.03 Disability Determination: Individuals who are not receiving a Social Security Disability payment must be determined disabled by SRT. Receipt of a Social Security Disability Insurance (SSDI) payment meets the disability requirement.

27-003.04 Income Determination: The income calculation for MIWD is a two-step process. The income of the disabled individual and his/her spouse must be considered. See Appendix 477-000-009 for calculation procedures.

27-003.05 Premium Payment: If the individual is determined eligible for Medicaid with a premium, s/he must pay the full premium no later than the 21st day of the month following the month for which the payment is designated.

27-004 WOMEN'S CANCER PROGRAM

27-004.01 Women's Cancer Program: Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, certain women who need treatment for breast or cervical cancer may be eligible for Medicaid. Neb. Rev. Stat. section 68-1020 authorizes this coverage in Nebraska.

27-004.02 Eligibility Requirements: In order to receive Medicaid, the woman must

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a precancerous condition or early stage cancer;
3. Be sixty-four (64) years old or younger;
4. Not be otherwise eligible for Medicaid;
5. Not be covered by creditable health insurance;
6. Be a Nebraska resident; and
7. Be a U.S. citizen or a qualified alien.

27-004.03 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that

1. Provides limited scope coverage such as plans that only cover dental, vision, or long-term care;
2. Provides coverage for only a specified disease or illness;
3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or
4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

27-004.04 Eligibility Period: Eligibility begins the first of the month in which the client signs the application for the Women's Cancer Program. Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the Department with a monthly statement indicating continued treatment is required.

Continued treatment does not include continued surveillance, testing, or screening.

For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the Department every six months for the woman to remain eligible for Medicaid coverage.

27-004.05 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date a qualified provider determines that the client appears to meet eligibility criteria.

For limits on Hospital Presumptive Eligibility see 477 NAC 19-006 #4.

27-005 MEDICALLY NEEDY

27-005.01 Individuals Ineligible for Medicaid Due to Income: Parents/caretaker relatives, children, pregnant women, and ABD individuals with a medical need and high medical expenses whose income exceeds the guidelines for Medicaid eligibility may be eligible for a share of cost if all other eligibility requirements are met. A medically needy individual must incur and obligate a certain amount of medical expenses each month before Medicaid will provide coverage for the rest of the month. These medical expenses must be at least equal to the difference between the individual's income and the applicable income standard. Such share of cost varies depending on the individual's household size and income. Each month is determined separately and continuous eligibility does not apply. See Appendix 477-000-045 for examples. Individuals without a demonstrated medical need are not eligible under this category.

27-005.02 Age: A medically needy child is eligible through eighteen (18) years old if s/he is a U.S. citizen or is a qualified alien.

27-005.02A Exception: A medically needy child may be found eligible under this category if they are receiving inpatient care in an Institution for Mental Disease (IMD). If an individual is an inpatient in an IMD when s/he reaches twenty-one (21) years old, s/he may remain eligible either until discharge or until s/he reaches twenty-two (22) years old, whichever comes first.

27-005.03 Two-Parent Families: If unmarried parents are living together and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

27-006 TRANSITIONAL MEDICAL ASSISTANCE (TMA)

27-006.01 TMA Eligibility: A household may receive up to twelve (12) months of Transitional Medical Assistance without a share of cost if the parent/caretaker relative

1. Is in the household;
2. Has earned income that results in ineligibility for a grant and/or Medicaid; and
3. Is employed.

27-006.01A Prior Eligibility Requirement: The parent/caretaker relative (P/CR) must have received, or met income and resource eligibility to receive, a grant and/or Medicaid for which s/he was eligible in three (3) of the last six (6) months preceding ineligibility.

27-006.01B Fraud Exclusion: The household is ineligible for TMA if it received a grant and/or Medicaid in one or more of the three qualifying months as a result of convicted fraud during the last six (6) months before the beginning of the transitional period.

27-006.02 Resources: There is no resource test while the household is receiving TMA.

27-006.03 Sanctions: A parent who has been sanctioned for noncooperation with child support or TPL is not eligible for TMA until cooperation is resolved.

27-006.04 Changes in Household Composition

27-006.04A New Individual Added to Household: An individual who was not previously part of the household but who is added (e.g., a child who is born or adopted, a spouse) while the family is receiving TMA is also added to the TMA household.

27-006.04B Family Member Returns to Household: If a family member returns to the home, Medicaid eligibility for the whole household must be reviewed.

1. If the returning family member is a responsible relative, his/her income must be used to compare the family's income to the income guideline for the household plus the responsible relative.
2. If the family is ineligible for a grant or Medicaid, the returning family member is added to the TMA household.

27-006.04C Family Member Leaves Household: If a family member leaves the home, Medicaid eligibility for the remaining household members must be reconsidered.

1. If the family is ineligible for a grant and/or Medicaid, the remaining household members may continue to be eligible for TMA.
2. If it is the only dependent child who leaves, the whole household loses eligibility for TMA.
3. If the only child no longer meets the age qualification, the household loses eligibility for TMA.

In order to be eligible for Medicaid, and added or returning household member must have a valid Medicaid application on file (See 477 NAC 3-005).

27-006.05 Changes in Circumstances

1. If the household regains grant or P/CR Medicaid eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant or P/CR Medicaid eligibility because of earnings, the original TMA cycle resumes.
2. If the household receives three or more grants or months of P/CR Medicaid coverage, then again loses grant or P/CR Medicaid eligibility because of earnings, a new TMA cycle begins.
3. Before closing the TMA case, it must first be determined if children in the household are eligible for another Medicaid program.

27-006.06 Effective Date of TMA Eligibility: TMA begins with the month of ineligibility for a grant and/or P/CR Medicaid.

Note: If it is determined that the household was ineligible for a grant, TMA shall be determined beginning with the first month in which the grant was erroneously paid.

27-006.07 TMA Timeline

27-006.07A Months 1 Through 6

27-006.07A1 Report Requirement: The gross monthly earnings and child care costs for employment (as billed or paid) for each of the first three months of the transitional period must be provided. The first report is due no later than the 21st of the fourth month. See Appendix 477-000-047 for the Transitional Medical Timeline.

24-006.07A2 Causes for Closure: The household becomes ineligible for TMA during the first six-month period if

1. The household becomes eligible for P/CR Medicaid;
2. The household moves out of the state; or
3. There is no longer an eligible dependent child in the household.

27-006.07B Months 7 Through 12: If the household has earned income and child care deductions for employment that are equal to or less than 185% of the Federal Poverty Level (FPL), it is eligible for TMA.

27-006.07B1 Report Requirement: The gross monthly earnings and child care costs for employment (as billed or paid) for each three-month period of months 7 through 12 must be provided.

1. The second report is due no later than the 21st of the seventh month.
2. The third report is due no later than the 21st of the tenth month.

27-006.07B2 Income Eligibility: The household's earned income for the three-month report period is averaged to determine income eligibility.

27-006.07B3 Premium Due: Beginning with month 7, the household is subject to payment of a monthly premium if its countable income is between 100% and 185% percent of the FPL. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

27-006.07B4 Causes for Closure: The household is ineligible for the remaining months of TMA (months 7 through 12) if it:

1. Fails, without good cause, to submit required verification of earnings and child care costs for employment;
2. No longer includes a dependent child;
3. Has gross monthly earnings and child care deductions for employment in excess of 185% of the FPL during the preceding three-month period; or
4. The household moves out of the state.

Note: A TMA case shall not be closed for failing to provide if the needed information from the applicable months was received.

27-006.07B4a Good Cause for Failing to Submit Required Information:

1. Death of the parent/caretaker relative;
2. Hospitalization of a household member during the scheduled receipt period for required information (the client is responsible for providing verification of hospitalization); or
3. Natural disaster (Central Office will issue instructions when these situations occur).

27-006.07C After Month 12: When a client has exhausted his/her months of TMA, a redetermination of eligibility for another Medicaid program must be completed.

27-007 EMERGENCY MEDICAL SERVICES ASSISTANCE (EMSA)

27-007.01 Emergency Medical Services Assistance for Undocumented and Ineligible Aliens: An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably result in

1. Serious jeopardy to the patient’s health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

27-007.02 Eligibility for EMSA for Undocumented and Ineligible Aliens:

27-007.02A Restricted Medical Assistance: To be considered eligible for EMSA, the State Review Team shall determine that the individual has an emergency medical condition.

The alien shall be determined eligible under the appropriate Medicaid category by meeting all eligibility criteria except citizenship or qualified alien status.

Note: The provision at 477 NAC 4-001 regarding the Effective Date of Medicaid Eligibility does not apply to EMSA.

27-008 KATIE BECKETT

27-008.01 Katie Beckett: Provides Medicaid coverage to children age 18 or younger with severe disabilities who live in their parent(s)'s household, but who otherwise would require hospitalization or institutionalization due to their high level of health care needs.

27-008.01A Eligibility Requirements: In order to receive Katie Beckett Medicaid, a child must

1. Not be eligible for Medicaid based on parental income or an SSI determination;
2. Be age 18 or younger;
3. Reside at home with a parent or legal guardian;
4. Be certified by the Department's Central Office designee as having hospital level of care needs; and
5. Not incur in-home service costs to be funded by Medicaid that would exceed the costs Medicaid would pay if the child were in a hospital setting.

Note: A child who is SSI eligible cannot be approved for Katie Beckett Medicaid.

27-008.01B Income and Resources: Parental income and resources are not deemed for a child determined eligible for Katie Beckett Medicaid. See 477 NAC 24-001.01A1 and 477 NAC 24-001.01G2b(1). Financial eligibility is based solely upon any income or resources belonging to the child.

27-008.01C Referrals: Medicaid accepts referrals for Katie Beckett eligibility determinations in the following situations:

1. It is anticipated that a child will be discharged from a hospital to his/her home and the child is not currently eligible for Medicaid;
2. Notice has been received from SSI that a child's benefits are being discontinued;
3. The medical need of a child currently eligible for Home and Community-Based Waiver has been determined to have increased beyond the level applicable to the waiver program; or
4. A child is not financially eligible for Medicaid based on family income.

27-008.01D Hospital Level of Care: Hospital level of care means that a child requires an extensive array of health care services throughout the day. This level of care may only be provided by highly skilled medical professionals in amounts normally available in a hospital but not in a skilled nursing facility. Lack of these services would be expected to result in hospitalization of the child.

27-008.01D1 Certification of Hospital Level of Care: Department certification for hospital level of care shall be provided based upon the following criteria:

1. A child needs frequent and complex medical care (defined below at 477 NAC 27-009.01D1) that requires the use of equipment to prevent life-threatening situations;
2. A child's complex skilled medical interventions are expected to persist for a specific duration of time (defined below at 477 NAC 27-009.01D3; and
3. A child's overall health condition must require continuous assessment of a medical condition to prevent a life-threatening situation.

27-008.01D2 Frequent and Complex Medical Care: A child shall need frequent and complex skilled medical interventions that require the use of medical equipment to prevent life-threatening situations. The child's health status must require both of the following:

1. Provision of skilled medical assessment and interventions multiple times every 24-hour period; and
2. At least one of the following complex skilled medical interventions:
    a. Tracheostomy care requiring regular bronchial tree suctioning.
    b. Tracheostomy care with a dependency on a ventilator, for which the average use must be equal to or greater than ten hours per day.
    c. Intravenous (IV) therapy involving central lines (including peripherally inserted central catheters [PICCs]) for daily fluids or parenteral nutrition, for which the average use must be equal to or greater than ten hours per day.
    d. Oxygen use that includes only skilled tasks requiring daily continuous oxygen, daily continuous assessments with titrations according to oxygen saturation levels, and daily bronchial tree suctioning.

Note: Tasks that are performed only when necessary (PRN) and are not continuously required do not meet the criteria for frequent and complex medical care. SiteCare is not considered a skilled medical task for the purpose of these requirements.

27-008.01D3 Duration: To meet hospital level of care, a child's qualifying frequent and complex medical care need shall be expected to be required for at least six months.

27-008.01E Disability and Level of Care Review: The Department shall review a child's Katie Beckett Medicaid eligibility on an annual basis.