MAABD MEDICAL CATEGORIES

B-300 OVERVIEW

Eligibility for medical assistance is categorized in groups based on budgeting methodologies associated to the eligibility determination.

Family Medical Groups - cover individuals, families and children in Nevada Check Up using the MAGI budget methodologies. These groups have no resource test.

Specialized Medical Groups - cover individuals in specialized groups such as Aged Out, Rite of Passage and Breast and Cervical and allows for exemptions from income and resource determinations.

MAABD Groups - cover aged, blind and disabled individuals using SSI budgeting methodologies. These groups have a resource test.

Individuals requesting medical assistance must be evaluated under all potential medical groups including Nevada Check Up prior to being referred to the exchange. Individuals determined ineligible due to excess income will be referred to the Nevada Health Link to apply for advanced premium tax credits and shop for insurance. LPRs, who are ineligible because they are serving the 5-year bar, may be eligible to purchase insurance through the exchange and receive advance premium tax credit.

If an applicant is pending an SSI decision, evaluate eligibility for all Medicaid categories, including the new childless adult group, until a decision is made by SSA.

If the individual is determined to be eligible in another category:

- Approve eligibility in the appropriate month; and
- Deny the MAABD pending SSI case effective the same month of approval; and
- Keep SSI pending for months which are not covered by another category, until an SSI decision is received.

A new application is not required to move between a MAGI group and non-MAGI groups. Additional information may be required to process the conversion. See Conversions section in D-500 for more information.

B-305 AGED BLIND AND DISABLED

Medicaid eligibility under the Aged, Blind and Disabled groups are determined using Social Security Income (SSI) budget methodologies and are exempt from the MAGI methodology.

SSI budgeting methodologies include a resource determination.

Individuals 65 years of age or older, blind or disabled, should be evaluated for eligibility under the MAABD groups.

Aged Individuals -must be 65 years or older.

Blind – determined blind according to Social Security Administration criteria.

Disabled Individuals – individual must meet the disability criteria established by the Social Security Administration (SSA). The determination can be made by Social Security or the Division of Health Care Financing and Policy (DHCFP).

B-310 MEDICARE BENEFICIARIES

The Medicare Beneficiary program provides qualified Medicare eligible individuals with coverage of their Medicare premiums, as well as co-pays and deductibles for some qualified beneficiaries. Individuals enrolled in the Medicare Beneficiary program are also entitled to have reduced Part D prescription drug premiums through Social Security's Low-Income Subsidy program.

Individuals eligible under the QMB and SLMB Medicare Beneficiary groups may also be eligible for full Medicaid benefits under the AM, SSI, Institutional and Home-Based Waiver categories. These individuals are referred to as dual eligible.

When an applicant is enrolled in Medicare Part A but is not enrolled in Part B, do not make them apply for Part B. Part B can be initiated by accretion to the Buy-In. Add the MEDI screen, and post eligibility. This will generate an accretion request by the system and allow enrollment at no cost to the recipient. If an open enrollment start date is reflected in the SOLQ, Medicare Beneficiary eligibility will override the open enrollment start date.

Note: For ongoing full Medicaid recipients who are enrolled in Part A only, see Section C-605.1.

When an applicant is already enrolled in Part B, but is not enrolled in Part A, do not make them apply for Part A. Add MEDI screens and post eligibility to cover their Part B premium. If they are QMB, the system will generate an accretion request to initiate Part A at no cost to the recipient.

When an applicant is aged and has met the 5-year bar citizenship requirement but has never enrolled into Medicare and does not qualify for full Medicaid - add MEDI screens based on their entitlement to enroll, then post eligibility. Complete a Public Welfare Accretion (PWA) letter and advise the client to present the completed form to Social Security when they apply for Medicare. The PWA form allows enrollment at no cost to the recipient. Allow the individual 10 days from their first day of eligibility to provide verification of enrollment. Terminate the case for noncooperation if they do not enroll.

Conditional Part A – If an aged applicant appears to have **not** worked the 40 quarters (10 years) necessary for free Part A and appears to be eligible for **QMB only**, pend for enrollment into Conditional Part A and Part B. Complete the Conditional Part A Enrollment Form (2776-EM) and advise the client to take the form to SSA to enroll into Conditional Part A and Part B. Allow 20 days in which to provide proof of enrollment. Once proof of enrollment is received, post QMB eligibility and send an email to the DHCFP Buy-In Inbox (buyin@dhcfp.nv.gov) requesting accretion for both Part A and Part B effective the first month of QMB. DHCFP will alert SSA that the client's premiums are being paid by the State and the "conditional" piece of their Part A will be removed allowing the client to be enrolled into premium-free Part A and Part B Medicare and Buy-In. If the client does not return proof of enrollment into Medicare within 20 days, deny MAABD due to non-cooperation.

Note: Coverage of Part A premiums is available only to QMB recipients. SLMB and QI covers Part B only. If a client appears to be eligible for SLMB or QI, do not send them to enroll into Conditional Part A.

If the aged applicant appears to have worked the 40 quarters (10 years) necessary for free Part A, either by working or deemed from a spouse, pend for enrollment into free Part A only. **Do not** send them with the Conditional Part A Enrollment form, as Conditional Enrollment into Part A is only necessary for individuals who do not have free Part A. Allow 20 days in which to provide proof of enrollment. Once received, DWSS will initiate Part B from the first month of approval by a manual accretion performed by DHCFP, thereby avoiding any billing to the client for Part B. Send an email to the Buy-In Inbox (buyin@dhcfp.nv.gov) once QMB, SLMB, or QI is approved, requesting the accretion to Part B. If the client does not return proof of enrollment into Medicare within 20 days, deny MAABD due to non-cooperation.

Note: For ongoing full Medicaid recipients who become entitled to Medicare see section C-605.1.

Note: Individuals eligible for Medicare are not eligible to receive benefits under the NCU, CH1, AM1 or CA groups.

B-310.1 Low Income Subsidy (LIS) Referrals

Individuals eligible for Social Security's LIS program receive reduced premium payments for their Part D prescription drug program. The Social Security Administration transmits

applicant information from LIS applicants to DWSS. DWSS must treat this data as an application for the Medicare Beneficiary programs.

Application processing timeframes are determined by the date the file is received by DWSS. The eligibility determination is established based on the date the LIS application was received by Social Security. QMB effective dates remain the same when processing LIS referral applications.

Example: LIS file is received by DWSS on January 29, 2010. Application effective date (date LIS application is received at Social Security) is December 2, 2009. Applicant meets all eligibility requirements for QI eligibility, decision date is February 20, 2010, first month of eligibility would be December 2009.

If the same applicant was determined eligible for QMB, first month of eligibility would be March 2010.

B-310.2 Qualified Medicare Beneficiaries (QMB)

Covers *only* Medicare co-pays, premium and deductible charges for individuals who:

a. Are currently enrolled or eligible to enroll in Medicare Part A; and

b. Have net countable income at or below 100% of FPL; and

c. Have countable resources at or below $9,090 for individuals and $13,630 for married couples.

Note: Individuals with QMB coverage receive a Medicaid card for billing Medicare co-pays and deductibles only. QMB coverage includes having their Part A and Part B premiums paid for by the Division, and payment for deductibles and co-insurance for services covered by Medicare but not normally covered by Medicaid.

This category of assistance is different from all other categories. In addition to not receiving full Medicaid benefits:

a. They do not have to pay patient liability if they are institutionalized, unless the case is converted to a state institutional case.

b. They are eligible beginning the month immediately following the month the eligibility decision is made (they are not eligible for prior medical coverage).

   Note: If it is found QMB coverage was denied in error, use the denial decision date and approve benefits the month following this date. If QMB is terminated in error, reinstate coverage so there is no break in benefits.

c. Individuals applying for QMB are not required to apply for benefits which may be available to them.

Note: If a QMB eligible woman reports she is pregnant, evaluate Medicaid under the pregnant woman group.

B-310.3 Special Low-Income Medicare Beneficiaries (SLMB)

Covers *only* the Part B Medicare premium payment for aged and disabled individuals who:

a. Are currently enrolled or eligible to enroll in Medicare Part A; and

b. Have net countable income 100% - 120% of FPL; and

c. Have countable resources at or below $9,090 for individuals and $13,630 for married couples.

Note: SLMB does not pay for co-payments or deductibles. A Medicaid card will not be issued.

Coverage begins with the application month, and prior medical coverage is available for up to three months prior to the application month to cover the Medicare premiums. The Medicare premium is considered proof of service for prior medical requests.

Note: If a SLMB eligible woman reports she is pregnant, evaluate Medicaid under the pregnant woman group.

B-310.4 Qualified Individuals (QI)

Covers *only* the Part B Medicare premium payment for aged and disabled individuals who:

a. Are currently enrolled in or eligible to enroll in Medicare Part A; and

b. Have net countable income 120% - 135% of FPL; and

c. Have countable resources at or below $9,090 for individuals and $13,630 for married couples; and

d. Are not eligible under any other Medicaid category

Note: A Medicaid card is not issued for this program. This individual cannot be eligible for Medicaid under another category and be eligible as a qualified individual.

Coverage begins with the application month, and prior medical coverage is available for up to three months prior to the application month. The Medicare premium is considered proof of service for prior medical requests.

Note: If a QI eligible woman reports she is pregnant, evaluate Medicaid under the pregnant woman group.

B-310.5 Qualified Disabled Working Individuals (QDWI)

Covers ONLY special Medicare Part A hospital insurance premiums for disabled individuals who lose their free hospital coverage due solely to earnings which exceed the Substantial Gainful Activity (SGA) limits established by the Social Security Administration (SSA). These individuals must:

a. Be under age 65; and

b. Continue to meet Social Security's disability criteria; and

c. Not be otherwise entitled to Medicare hospital coverage.

Medicaid coverage of the Medicare hospital insurance premium is limited to individuals who:

a. Have enrolled in the special Medicare hospital insurance at the SSA office; and

b. Have net countable income below 200% of FPL; and

c. Have countable resources which do not exceed $4,000 for individuals and $6,000 for married couples; and

d. Are not eligible for medical assistance under another Medicaid category.

Note: A Medicaid card is not issued for this program.

At the time premium-free Medicare coverage ends, SSA will mail a notice informing individuals of their right to enroll in the special Medicare hospital insurance (now at a cost) and their potential eligibility to have the premium paid by Medicaid. They will have a seven-month period to enroll, beginning with the month of notice. If they do not enroll during this time, they may still enroll during the annual general enrollment period (January through March) if they continue to meet the special requirements. Entitlement to this special Medicare hospital insurance can begin no earlier than July 1, 1990.

Coverage of the special Medicare premium can begin the month of application (including three months prior to the month of application) if ALL eligibility criteria is met (but no earlier than July 1, 1990).

Example: if an applicant applies for benefits on October 5th and is already enrolled in the special Medicare hospital insurance, eligibility can begin effective October (including three months prior). However, if in this example, the applicant's enrollment is not effective until November 1st, the applicant is not eligible any earlier than November.

If the client appears to be eligible under another category of assistance, pursue eligibility under that category first. If the client is not eligible under any other Medicaid category, determine eligibility as a Qualified Disabled Working Individual.

B-315 SUPPLEMENTAL SECURITY INCOME (SSI)

Provides medical assistance to individuals who are:

a. Verified SSI recipients; or

b. Recipients of presumptive SSI payments; or

c. In CO1 pay status per SOLQ/SDX but without monetary payment, due to an overpayment collection; or

d. In EO2 status per SOLQ/SDX the month(s) prior to CO1 status; AND

Apply for Medicaid and meet the requirements under Cooperation, Residency, and Insurance Coverage.

SSI Recipients could be living:

a. Independently in the community;

b. In an Adult Group Care Facility (AGCF) or in appropriate settings as determined by Medicaid; or

c. In a medical facility when countable income is less than $30 a month.

B-315.1 Eligibility Exceptions

a. Individuals determined by SSI to have received SSI payments for which they were not eligible, are eligible for Medicaid for the period in which SSI payments were made on their behalf.

b. Individuals under 22 receiving inpatient psychiatric services in a residential treatment center (RTC) are eligible for Medicaid when SSI eligible.

c. Individuals under 65 who are residing in an institution for mental disease (IMD) i.e., a free-standing psychiatric hospital, **are not** eligible for Medicaid.

An institution for individuals with intellectual disabilities IS NOT an institution for mental disease.

B-315.2 SSI Resources

All resources must be reported. All resources will be evaluated by the Social Security Administration.

a. **Transfer of Resources**

If an SSI recipient has an inpatient stay in a medical facility, see Transfer of Assets policy (F-405).

b. **Resource Limits**

Resource limits are $2,000 for an individual and $3,000 for a couple. When countable resources exceed the limit do not terminate eligibility. Notify the Social Security Administration of the assets using Form 3911.

B-320 PUBLIC LAW CASES

Certain individuals who have lost SSI eligibility, but would still be eligible for SSI if some of their income was disregarded, may be Medicaid eligible if all other eligibility requirements are met. Public law dictates what income is disregarded for each group.

Special attention is required for these individuals so they do not have their Medicaid eligibility interrupted.

Countable net income (after disregards) must be less than the applicable SSI payment amounts (SPA). Resource limits are the same as for SSI cases.

B-320.1 Pickle Amendment - Public Law 94-566 Section 503

Clients are eligible for continued Medicaid assistance if:

a. They currently receive RSDI, and

b. After April 1977 they were **eligible for and receiving** SSI and **entitled to** RSDI in the same month, and

c. They became ineligible for SSI for any reason, and

d. They would now be eligible for SSI if their RSDI cost-of-living increases received after they were last **eligible for and received** SSI and **entitled to** RSDI in the same month are excluded from their countable income, and

e. All other eligibility factors are met.

Entitlement to RSDI benefits can be determined by:

a. Being "eligible for and receiving" the RSDI benefit; or

b. Being eligible for the RSDI benefit without receiving the benefit due to the "windfall off-set" requirements of Social Security.

The purpose of the "windfall off–set" is to ensure the individual who is currently eligible for either SSI or RSDI **and** subsequently becomes retroactively eligible for the other benefit does not receive more benefits than he/she would have received if payments for both benefits (SSI & RSDI) had been paid when regularly due.

Example: A client is currently applying for Medicaid. **If**:

a. The client was **eligible for and receiving** SSI and **entitled to** RSDI in April 1982; and

b. Excess resources caused him to become ineligible for SSI in May 1982; and

c. The client's resources are now within the current resource limitations; and

d. If all RSDI cost-of-living increases made after May 1982 are excluded from his countable income, the client would be eligible for SSI.

Then, the client is categorically eligible for Medicaid under the Pickle Amendment.

When a client applies for Medicaid and does not receive SSI or reside in a medical facility, use the above criteria to determine if they may be eligible under the Pickle Amendment.

Verification: When an RSDI cost-of-living increase occurs, a special SDX will be produced for ongoing SSI recipients who may become eligible under this Public Law. These cases are identified in the SDX Public Law column by Alpha Code "B."

If a client resides with his/her spouse and spousal deeming applies, deduct the RSDI cost–of–living increases from the spouse's RSDI income which were received after the client last received SSI. The last RSDI amount the client was **entitled to** can be obtained through the Social Security Administration.

Use Form 2022–EM, Pickle Amendment Certification or the RSDI Computation Worksheet Form 2654–EE. Disabled persons must continue to meet disability criteria. Verification used to support "Pickle" status must remain in the permanent section of the case file.

When re–evaluating eligibility because of changes in income, if the client would now be eligible for SSI (using SSI rules) before disregarding cost–of–living increases, they no longer meet the criteria for Medicaid eligibility under Public Law 94–566 (Pickle Amendment).

Note: To be eligible for Medicaid under the Pickle Amendment, the Center for Medicare and Medicaid Services (CMS) has always interpreted SSI eligibility to mean receipt of an actual cash benefit, not just eligible to receive a benefit.

SSA considers eligibility under these circumstances to be a benefit under the Social Security Law and qualifies an individual for eligibility under the Pickle Amendment, provided all other requirements for eligibility under the Pickle Amendment are met.

B-320.2 Adult Disabled Child - Public Law 99-643

Continues medical assistance for certain blind/disabled individuals age 18 years or older if:

a. They received SSI benefits which were based upon a disability or blindness which began prior to the individual turning age 22; and

b. They lost SSI eligibility on or after July 1, 1987 solely because they became eligible for SSA benefits as an "adult disabled child" or because of an increase in their "adult disabled child" SSA benefits; and

c. They would now be eligible for SSI if the Social Security "adult disabled child" benefit or the increase in their "adult disabled child" benefits received after July 1, 1987 was excluded from their countable income; and

d. All other eligibility factors are met.

Note: The SSI benefits did not have to begin prior to age 22; only the disability or blindness on which the SSI was based had to begin before age 22.

Verification: Social Security identifies individuals who are possibly eligible under this category with a "D" in the SDX Public Law column. Individuals must still meet all other eligibility criteria.

If a subsequent SDX is received and the Alpha Code “D” has disappeared, it is the responsibility of the case manager to determine if the individual continues to meet the above criteria and document the case accordingly.

The case manager shall document the case to show what amount of benefit is being disregarded. If the case manager cannot tell from the SDX what amount should be disregarded, Social Security should be contacted to verify. Use Form 2022-EM (Public Law Certification).

For example, if a client does not have enough quarters to receive a social security payment under his/her own record and receives only a payment on a parent’s record,

the case worker can determine that all income received from the parent's record should be disregarded. If the client receives a payment from his/her own record as well as a parent's record and the case worker is unable to determine what amount is being received from the parent's record, Social Security should be contacted using Form 2022.

B-320.3 Widow/Widowers - Public Law 100-203

Provides medical assistance to widows and widower's who are:

a. At least 60 years of age but not yet 65; and

b. Eligible for SSA Widow's or Widower's benefits or are eligible for SSA Widow's or Widower's benefits in combination with another SSA Benefit(s); and

c. Losing SSI eligibility because of the receipt of the SSA Widow/Widower's benefits or combination of Widow/Widower's benefits and other SSA Benefits; and

d. **Not** entitled to Medicare Part A; and

e. Would now be eligible for SSI if the Widow/Widower's benefits, and other SSA benefits were disregarded (SSA Disability benefits are not disregarded); and

f. All other eligibility criteria are met.

When an individual who is a widow/widower is terminated from SSI, their termination letter will inform them of possible eligibility for Medicaid. The following verifications from Social Security must be in file to determine eligibility under this category:

a. The date and reason SSI was terminated. If SSI was terminated more than a year from the date of the Medicaid application, an DHCFP disability determination must be done to verify the person is still disabled, **unless** they are currently receiving SSA Disability benefits.

b. What type of Social Security benefits the person is receiving.

c. The amount of each Social Security benefit.

d. Proof the individual is entitled to Medicare Part A.

Note: Individuals eligible for Medicaid under this provision will lose Medicaid eligibility at the time they reach age 65 or become eligible for Medicare, whichever comes first, **unless** they are found to be eligible for Medicaid under another category.

B-320.4 Widows, Widowers and Surviving Divorced Spouses – Public Law 101–508

Provides medical assistance to disabled widows, widowers and surviving divorced spouses who lose SSI because of receipt of Title II (RSDI) benefits from the changed disability criteria. These individuals are deemed to be receiving SSI if:

a. They were receiving SSI for the month prior to the month they began receiving Title II benefits; and

b. They would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

c. They are NOT entitled to Medicare Part A hospital insurance.

Verification: Social Security identifies individuals who are possibly eligible under this category with an "S" in the SDX Public Law column. If an SDX is received identifying an individual as such, it is the responsibility of the case manager to determine if the individual meets the above criteria.

Note: Individuals eligible for medical assistance under this provision will lose Medicaid eligibility at the time they reach age 65 or become eligible for Medicare, whichever comes first, **unless** they are found to be eligible for Medicaid under another category.

The case manager shall document the case to show what amount of benefit is being disregarded. If the case manager cannot tell from the SDX what amount should be disregarded, Social Security should be contacted to verify.

B-320.5 Suspension of SSI Due to Income – Public Law 96-265

Provides extended medical assistance for certain disabled/blind persons whose SSI is suspended due to excess earned income.

Verification: Social Security determines this Public Law status and identifies these cases via the SDX. When the Payment status code is NO1 or PO1 and SSA has determined the case to be one which falls under Public Law 96-265, Alpha Code "I" will appear in the SDX Public Law column.

If a subsequent SDX is received and Alpha Code "I" has disappeared, it is the responsibility of the case manager to determine if the individual continues to meet the above criteria. The case manager must document the case and Social Security should be contacted to verify ongoing eligibility status.

Disabled individuals who work can continue to receive SSI, and categorical Medicaid, even if their earned income exceeds the Substantial Gainful Activity (SGA) limits. SSA pays no cash benefit in these situations but individuals remain eligible for Medicaid as if they were still receiving an SSI payment.

B-320.6 Persons Ineligible for SSI Due to Alien Sponsor Deeming (CFR 416.1160)

Aged and disabled individuals who are ineligible for SSI due to alien sponsor deeming are considered SSI eligible, and therefore, Medicaid eligible IF they meet all other eligibility requirements.

Verification: Obtain verification of SSI ineligibility due to sponsor deeming.

a. Persons under age 65 require a disability decision from Nevada Medicaid Office (DHCFP).

b. Parent and spouse deeming requirements still apply. Determine any contributions which may be provided by the sponsor(s) to the client.

Future action the case file for when sponsor deeming no longer applies, then refer the client to apply for SSI. SSA considers sponsor income for 3 years after the individual is admitted to the United States. If SSI eligible, convert to a MAABD SSI case. If not SSI eligible, terminate Medicaid benefits unless the client is eligible under another medical assistance group.

B-325 INSTITUTIONALIZED INDIVIDUALS

B-325.1 Persons Institutionalized Less Than 30 Consecutive Days

Provides medical assistance to individuals who:

a. Meet the definition of aged, blind or disabled; and

b. Have countable income below the SSI payment level; and

c. Have countable resources less than $2,000 for an individual and $3,000 for a married couple; and

d. Have an inpatient stay at a skilled nursing facility (SNF), intermediate care facility (ICF or ICF/MR), or hospital less than 30 consecutive days.

An 'outpatient' stay is less than a 24-hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

B-325.2 Persons Institutionalized at Least 30 Consecutive Days

Provides medical assistance to individuals who:

a. Meet the definition of aged, blind or disabled; and

b. Have countable income at or below 300% of the SSI payment level; and

c. Have countable resources no more than $2,000 for an individual and $3,000 for a married couple (spousal resource assessment required); and

d. Have an inpatient stay at a skilled nursing facility (SNF), intermediate care facility (ICF or ICF/MR), or hospital for at least 30 consecutive days.

Time spent in an institution for mental disease (IMD) is considered when determining institutionalization for 30 consecutive days when going to or from the IMD. If, when going from the IMD to a SNF, ICF or hospital, the client was only temporarily transferred and not actually discharged, the time in the IMD cannot be counted toward length of time institutionalized.

The individual must be in the institution at least 30 consecutive days. In determining the number of days in a medical institution for eligibility purposes, include the day of admission, but not the day of discharge/death. Applications may be processed under this category prior to the 30th day based on a licensed physician's statement the client is likely to be in the institution at least 30 days. Eligibility will begin the first day of the month in which the client entered the medical facility, provided application is made and all other eligibility requirements are met.

See Long Term Care Services for more information regarding processing eligibility for this category.

B-330 HOME AND COMMUNITY BASED SERVICES

Provi**d**es medical assistance to aged, blind or disabled individuals who require a level of care provided in a medical facility but who can appropriately be cared for at home or in a community setting for less cost.

Individuals must meet the following eligibility criteria:

a. Meet the definition of aged, blind or disabled; and

b. Have countable income at or below 300% of the SSI payment level; and

c. Have countable resources no more than $2,000 for an individual and $3,000 for a married couple (spousal resource assessment required); and

d. Require a level of care provided in a nursing facility (determined by DHCFP or agency administering the waiver services).

See Long Term Care Services for more information regarding processing eligibility for this category.

B-335 KATIE BECKETT

Provides medical assistance to disabled children who require a level of care provided in a medical facility, but can be appropriately cared for at home for less cost, and are not eligible for SSI due to their parent's income and/or resources.

Children in this category must meet each of the following:

a. Disability criteria (determined by SSA or DHCFP); and

   Note: Do not delay sending the DHCFP disability decision while waiting for an SSI decision. The DHCFP decision can be pursued at same time as SSI for Katie Beckett. If the child previously received SSI and was denied for income, use the SSA disability determination.

b. Be under age 19; and

c. Be living at home; and

d. Require a level of care provided in a nursing facility (determined by DHCFP); and

e. Have medical costs for home care which are less than if the client were institutionalized (determined by DHCFP); and

f. Child's countable income at or below 300% of SSI payments level;

g. Child's countable resources no more than $2,000.

Send Form NMO-3010 to the appropriate DHCFP district office requesting a Katie Beckett determination, and if necessary, a disability determination.

B-335.1 Division of Health Care Finance and Policy (DHCFP) Determination

The DHCFP Central Office processes disability determinations and DHCFP district offices complete level of care assessments.

After all other eligibility requirements are met, the DHCFP Central Office will determine disability, level of care, medical costs, and if home care is appropriate. DHCFP determinations are made per the Medicaid Operations Manual. The case manager or, if appropriate, the Title XIX Social Worker will send Form NMO-3010 to DHCFP.

DHCFP will notify the district office of the review board's decision of disability and/or final eligibility under 1902(e)(3) on Form NMO-3010.

B-340 PRIOR MEDICAL

This category, under the MAABD program, is used only after all other eligibility categories have been considered. If the client is not eligible in another MAABD category, determine if they would have been eligible for SSI had SSA made a determination.

Provides medical assistance to individuals who:

a. Meet the definition of aged, blind or disabled; DHCFP makes the disability determination if SSA determination is unavailable due to death or lack of SSI application for a particular month.

b. Have countable income less than the SSI payment amount;

c. Have countable resources less than $2,000;

d. Would have been eligible for SSI had they applied, regardless of whether the individual is alive when the application for Medicaid is received.

B-345 HEALTH INSURANCE FOR WORK ADVANCEMENT (HIWA)

Allows employed people with disabilities the opportunity to obtain/maintain healthcare coverage.

Provides medical coverage to individuals who:

a. Are at least age 16 but less than 65 years of age;

b. Meet the Social Security criteria for disability;

c. Are employed;

d. Have less than $699 per month unearned income;

e. Have gross earned income (prior to income disregard) of less than 450% of FPL;

f. Have total net income (net earned plus net unearned) of less than 250% of FPL

g. Have countable resources less than $15,000.

Clients must be employed and are required to pay an insurance premium to be eligible under this category.

Individuals receiving assistance under the HIWA program who are no longer employed due to hospitalization, an inability to work that is directly related to the individual's disability, a worksite closure, or a loss of current transportation with no other alternative means of transportation available, will continue eligibility for an additional 3 months after the month in which eligibility ended, as long as premiums are paid by the due date.

B-350 AGED, BLIND AND DISABLED SPECIALIZED MEDICAL GROUPS

B-350.1 CONTINUATION OF 'PREGNANCY RELATED' MEDICAL COVERAGE

Once a MAABD-eligible individual has been converted to the pregnant woman coverage group, she is covered through the postpartum period, which ends the last day of the second month immediately following the month the pregnancy ends. **Example:** If the pregnancy ends on June 22nd, the postpartum period will end the last day of August.

See B-115 for additional information.

B-350.2 EMERGENCY MEDICAL FOR INELIGIBLE NON-CITIZENS (Public Law 99-509 Section 9406)

Authorizes Medicaid coverage for emergency medical situations to individuals who do not meet the criteria of a qualified non-citizen, but who otherwise meet eligibility criteria of a MAABD group. These cases are only entitled to coverage for emergency services.

Some non-citizens may be lawfully admitted, but only for a temporary or specified time period. These individuals do not meet Nevada residency requirements. They are:

– Foreign government representatives on official business, and their families and servants;

– Visitors for business or pleasure, including exchange visitors;

– Aliens in travel status while traveling directly through the U.S.;

– Crewman on shore leave;

– Treaty traders and investors, and their families;

– Foreign students;

– International organization representation and personnel, and their families and servants;

– Temporary workers including agricultural contract workers; and

– Members of foreign press, radio, film, or other information media and their families.

Individuals who request assistance under this category must meet the following:

a. Meet all eligibility criteria except the citizenship requirements. Residency requirements must be met; and

b. Be aged, blind, or disabled **and** would qualify for Medicaid as a state institutional case, or would be eligible for SSI, except for the fact they are ineligible non-citizens.

In determining whether an applicant is eligible as a state institutional case, eligibility is determined the same as a state institutional case except for meeting the citizenship requirements.

If the client does not qualify as a state institutional case, the case manager must make a determination of whether the applicant would be eligible for SSI except for meeting the citizenship requirements.

If the client is or becomes pregnant, evaluate eligibility using the pregnant woman criteria rather than institutional or SSI criteria.

The case can remain ongoing provided the individual continues to meet all the requirements of an emergency Medicaid case.