What do I need to know about Medicaid?

Medicaid is a public health insurance program that covers a low-income population, including seniors, children, and people with disabilities.

- Began in 1965 under the Social Security Act.
- Administered by states with oversight from the Centers for Medicare & Medicaid Services (CMS).
- Funding is a joint effort between the federal and state governments.
- Eligibility and benefits vary from state to state.
    - The Federal Social Security Act requires certain services to be offered by all states.
    - Nebraska offers some additional services.
- **Home and Community-Based Services (HCBS) Waivers are funded by Medicaid and provide services in addition to the state's Medicaid plan.**

Medicaid Eligibility Looks at:

- Application;
- US citizen or qualifying alien status;
- Nebraska residency status;
- Social Security determined disability status;
- Parent/Legal Guardian responsible;
- Living arrangement;
- Other health insurance;
- Income and resources within established limits for certain categories; and
- Other category requirements, such as age.

Disability Determination and the State Review Team (SRT)

Sometimes, a person seeking Medicaid coverage or waiver services must prove they have a disability in order to qualify for coverage or services. If the individual does not have a disability determination from the Social Security Administration (SSA), Medicaid's State Review Team (SRT) can make the disability determination.

- The State Review Team (SRT) is a group made up of medical professionals in the Division of Medicaid and Long-Term Care. The SRT reviews medical records submitted by the applicant.
- The SRT makes a disability determination based on the Social Security Administration's disability guidelines. For more information on these SSA disability guidelines, visit Social Security's website.

Aged, Blind, & Disabled (ABD)

There are different Medicaid categories. Most people who are eligible for HCBS Waivers are eligible for Medicaid under the Aged, Blind, & Disabled (ABD) category. It may be possible to qualify for Waiver services in another Medicaid eligibility category.

- Aged 65 years or older.
- Blind or disabled people age 64 and younger who are determined disabled by the Social Security Administration or by the State Review Team.
- Income limit is 100% of the federal poverty level (FPL).
- Resource limits of $4,000 for one person or $6,000 for two people.
- Parental income and resources considered for people under the age of 19 years.
- Private health insurance expenses are an allowable income deduction with some restrictions.

Katie Beckett Program

This program can provide Medicaid coverage for children who live in their parent's home and have high medical or care needs.

- Age 19 years or younger
- Not eligible for Medicaid in any other category
- Determined disabled by Social Security or the State Review Team
- Determined to meet the level of care to live in a:
    - Hospital;
    - Nursing Facility (NF); or
    - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
- Coverage is determined as cost-effective
- Only the child's income and resources are used to determine Medicaid eligibility.
- Medicaid covered services only, no additional supportive services

Medicaid Insurance for Workers with Disabilities (MIWD)

- MIWD is a Medicaid category that may be available for a person who meets disability criteria and is receiving earned income through employment.
- When someone is going to lose Medicaid due to earned income, this may be an option.
- There are two eligibility groups within MIWD. To be eligible for the MIWD Basic Coverage Group, a person must:
    - Qualify for Medicaid except for income;
    - Meet Social Security or State Review Team definition of disability;
    - Be working;
    - Have income within MIWD income guidelines:
        - 200% federal poverty level (FPL) or
        - 250% of FPL with premium;
    - Meet Medicaid resource limits; and
    - Pay a premium, if required.
- To be eligible for the MIWD Medical Improvement Group, a person must:
    - Meet all criteria in the Basic Coverage Group;
    - Earn the federal minimum wage and work more than 40 hours per month; and
    - Have lost Medicaid coverage from the Basic Coverage Group due to a medically improved disability. This applies if the loss of Medicaid could result in the person's inability to continue working or cause their health to regress to the point they would meet the Social Security or State Review Team's definition of disability.
- Additional requirements and information can be found in the Medicaid Regulation 477 NAC Appendix.
- A Medicaid worker will determine if a person qualifies.

Share of Cost (SOC) for People with High Medical Needs

- Share of cost is for a person with medical needs who meets all Medicaid eligibility requirements but has income exceeding the Medicaid guideline.
- Share of cost may vary based on income, deductions, and the person's living arrangement.
- Income is compared to the Medically Needy Income Level (MNIL) or a Personal Needs amount to determine the share of cost.
- The person is responsible for paying the determined share of the cost amount.
- Share of cost is a monthly amount, which can vary from month to month.
- When a person is receiving services from an HCBS Waiver, the share of the cost is automatically obligated to a Medicaid provider, usually the provider of the costliest waiver service.
- Medicaid may close if the share of the cost amount exceeds the person's monthly need.