NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

"This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document."

Pursuant to
Neb. Rev. Stat. § 84-901.03

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NEBRASKA
Good Life. Great Mission.

August 19, 2025

Share of Cost

If an applicant or recipient of Nebraska Medicaid does not meet the requirements for Nebraska Medicaid due to excess income, but can demonstrate a medical need, then a medically needy budget may be approved. Countable income for the month is reduced to the Medically Needy Income Level (MNIL) by spending the excess income on medical services or supplies. The amount that needs to be incurred is referred to as the Share of Cost (SOC). Nebraska Medicaid becomes active for the month after an individual has reduced their income below the MNIL. Each month is determined separately.

An applicant may be determined eligible for medical assistance with a Share of Cost (SOC) if:

1. The applicant's income and resources have been verified. The applicant must meet a category of eligibility except for excess income;
2. A medical need exists or can reasonably be anticipated which meets or exceeds the SOC amount;
3. The applicant has paid or obligated the SOC for medical care or services for anyone in the medical assistance unit. If the income of a parent in the home but not in the unit has been considered in the budget, the parent's medical expenses (including insurance premiums) may be applied to meet the child's SOC obligation; and
4. Obligations or expenditures are substantiated on the Record of Health Cost – Share of Cost – Medicaid Program form.

The medical need will be re-evaluated at renewal. If it is determined that a medical need continues to exist, and the applicant remains eligible, then a SOC benefit may continue. If it is determined that a medical need no longer exists or the SOC has not been met in the prior months, then the benefit will end.

Meeting the SOC Obligation

When it is necessary to obligate income to meet the SOC, a form will be mailed each month. The beneficiary will take the monthly SOC form to medical providers and medical services received for the month will be recorded on the form. The medical provider that provides the last service necessary to meet the SOC will submit the completed SOC form as directed on the form. Nebraska Medicaid coverage for medical bills not used to meet the SOC obligation is effective at the first of the month.

If the beneficiary does not meet the obligation, no medical bills are paid by Nebraska Medicaid for that month.

Allowable Share of Cost Obligations

Medical Service or Supply:

Any medically necessary service or supply is an allowable obligation of the SOC amount, whether or not the service or supply would be covered by Nebraska Medicaid. This includes the cost of:

- Transportation to obtain necessary medical care. Mileage is allowed if the person travels by car. The actual cost of other forms of transportation is allowed.
- Meals and lodging when necessary to obtain approved health services and only if the client is away from home for 12 hours or more per day. The allowance for cost of meals is $12 per day. The cost of lodging

will be allowed if reasonable and the cost is verified. The allowance for meals and lodging may be allowed for an attendant if one is needed to accompany the recipient.

- Actual fees for case management services provided by an Area Agency on Aging or a Nebraska Medicaid provider who is approved to provide case management services. Prior approval may be necessary if case management services are provided by another source.
- The amount of medical premiums, including Medicare premiums, paid by a beneficiary can be used as an obligation to the SOC amount. In most cases, this amount will be deducted before the SOC amount is calculated.
- Remedial care services are an allowable obligation, whether or not they are covered by Nebraska Medicaid. Remedial care services are those services which assist in curing, alleviating, or easing a medical condition. This includes medically necessary over the counter drugs.
- Medical expenses paid by another state, county, or city program may be used toward the beneficiary's obligation if no federal funds are used to pay the medical expense. This would include programs such as county general assistance, the Renal Disease Program or the Medically Handicapped Children's Program (MHCP).
- Deductibles and co-pays from another insurance policy (including Medicare) may be used to meet an beneficiary's SOC.
- Room and board expenses may NOT be used to meet the SOC obligation.

Any expense incurred to meet the SOC obligation will not be paid by Nebraska Medicaid.

Coordination of Benefits

When a beneficiary with a SOC obligation has medical insurance (including Medicare, worker's compensation, etc.), the following procedures apply:

1. A claim for payment is submitted to the insurance company before consideration of the SOC obligation;
2. The amount of the claim which is allowed or disallowed by the insurance company is verified (i.e., Medicare Explanation of Benefits (EOB's), or other insurance benefit explanation forms);
3. The amount that the insurance company allowed must not be counted toward the beneficiary's SOC obligation; and
4. The amount of the claim which the beneficiary incurs is counted toward the SOC obligation.

This procedure applies to all persons whose medical expenses are being used to meet the SOC obligation.

Procedures for Institutionalized Individuals

Medicaid recipients in medical institutions and certain recipients of Home and Community Based Services Waivers are considered institutionalized individuals. These recipients owe a portion of their income to the provider each month. This amount is also referred to as a SOC but is handled differently than for non-institutionalized individuals.

- No form is sent each month because the need for ongoing medical services has been established in determining their eligibility for long-term care.
- The amount that the recipient is responsible for is paid directly to the provider.
- The amount of expected institutional expenses for the month are projected in order to establish that the person has a medical need.
- An institutionalized individual may use additional medical expenses not covered by Medicaid (e.g., health insurance premiums, incontinence supplies not provided by the facility) in order to meet their SOC obligation for the month. These expenses are the same as listed above.

Change in Facilities

If the Nebraska Medicaid beneficiary moves from one facility into another during the same month, the SOC is applied to the care received in the first facility. If the SOC amount is greater than the cost of care provided in the first facility, the SOC is split, and any remaining amount is applied to care in the second facility.