

CHAPTER 3

PRIMARY HEALTH CARE NETWORK

Eligibility Factors

Purpose: To furnish medical services for the poor and medically indigent of Douglas County.

3:100 **Eligibility Criteria:** In order to be eligible for enrollment in the Primary Health Care Network, the applicant/recipient must qualify for General Assistance as a continuous case, except as otherwise provided herein, and/or meet the following criteria:

3:101 **Residency:** An applicant/recipient must reside within the geographic boundaries of Douglas County in order to make application through the Douglas County office. Individuals residing outside of Douglas County should be referred to the appropriate county office for application and assistance. If an individual is not residing in Nebraska and/or Douglas County, temporary assistance may be provided if:

- a) all other eligibility criteria are met; and
- b) medical care is not the only reason the applicant entered Douglas County; for example, family ties, employment, etc.
- c) the illness or injury for which medical assistance is requested arose in Douglas County, Nebraska; and
- d) the medical care is provided for a life threatening/life trauma condition.

3:102 **Citizenship Requirements:** An applicant for medical assistance must attest that:

- a) he or she is a United States citizen, or
- b) he or she is a qualified alien under the federal Immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and is lawfully present in the United States.

If the applicant attests that he or she is a lawfully present qualified alien under the federal Immigration and Nationality Act, the political subdivision (Douglas County) must then verify the applicants eligibility through the Systematic Alien Verification for Entitlements Program (“SAVE Program”). The SAVE Program is operated by the United States Department of Homeland Security and is an intergovernmental, information-sharing initiative, which is designed to aid federal, state and local benefit-issuing

agencies and licensing bureaus to verify an applicant's immigration status to ensure that only eligible persons receive public benefits and licenses.

The income of a federally recognized sponsor will be considered in determining eligibility, as specified in federal legislation.

Resources

3:200 **Resources**: The equity value of all resources (as defined in Sections 2:104 and 2:105) herein in the immediate possession or control of the applicant/recipient, unless otherwise exempt, will be considered for purposes of eligibility. Such resources include, but are not limited to:

- a) bank accounts, stocks, bonds, time certificates, mutual funds, trust funds, revocable burial funds, net proceeds available from the surrender/liquidation of stocks, 401(k) and/or any other type of retirement accounts, etc;
- b) personal property such as automobiles, boats, campers, motorcycles, jewelry, etc;
- c) real estate;
- d) business equipment including all business property, fixtures and machinery, including farm machinery;
- e) livestock, poultry and crops;
- f) royalties received by registered tribal members from land developed and operated as a casino;
- g) life insurance with a cash/surrender value exceeding the maximum expenses permitted for an adult county burial as specified in Chapter 6, herein.
- h) Gaming/gambling proceeds.

3:201 **Resource Limits**: To be eligible, an applicant may have resources whose combined equity values are:

- a) \$1,500.00 or less for a family size of one.
- b) \$2,500.00 or less for a family size of two or more.

3:202 **Exempt Resources**: The following resources shall not be considered in determining an applicant's eligibility for Primary Health Care Network benefits:

- a) \$35,000.00 of equity in a primary residence owned by the applicant/recipient;
- b) household furnishings necessary to maintain a home;
- c) one vehicle which is presently being used to meet the applicant's

transportation needs and which has an equity value not to exceed \$5,000.00.

In the case of a married couple, two (2) vehicles which are operable and presently being used to meet the transportation needs of the household, which have a combined equity value not to exceed \$7,000.00;

- d) Irrevocable burial funds in effect at the time of the first request for Primary Health Care Network benefits.
- e) life insurance policies with a combined cash/surrender value equal to the maximum amount permitted for an adult county burial as specified in Chapter 6, herein;
- f) burial lots, and
- g) Indian Lease Land.

3:203 Potential Resources: All applicants/recipients will be required to seek alternative sources of income, resources, and/or medical assistance to meet current and future medical needs when applicable. Failure to comply with any of these provisions will result in the denial or termination of Primary Health Care Network benefits. In order to comply with this provision, an applicant/recipient, shall:

- a) Complete the application for and follow through with all available appeal processes for any public and/or private entity benefits to which he/she may be entitled and/or eligible for, including but not limited to: Social Security, Supplemental Security Income, Veterans Benefits, Aid to The Aged, Blind or Disabled (Medicaid), Temporary Assistance to Needy Families, Unemployment Compensation, Worker's Compensation, Crime Victim's Reparations, and any other federal or state programs, etc;
- b) if employable, make good faith efforts to seek employment through participation in the Job Training/Community Service Programs as specified in Chapter 4, herein; and/or
- c) make reasonable efforts to obtain possession and control of resources and/or income in which the applicant has a legal interest.
- d) Any person who is, or becomes ineligible for other general assistance and/or medical assistance programs, due to his/her own actions or inactions shall also be ineligible in accordance with Nebraska Revised Statutes, Section 68-104 and 68-131 (as amended).

3:204 Verification: For purposes of complying with the provisions of Section 3:203 herein,

the applicant/recipient must:

- a) provide verification from the appropriate agency that an application for benefits has been completed; or,
- b) provide verification of participation with the Job Training/Community Service Program, as required; or
- c) provide verification that the applicant/recipient has made every effort within his/her means to secure possession and control of income, resources and medical assistance in which he/she has a legal interest.
- d) Provide verification as required. Provide work history and consent to the release of interagency earnings data from other governmental agency sources.

3:205 Ownership of Resources: Real and/or personal property which appears on record in the name of the applicant/recipient and/or persons included in the household will be considered in determining eligibility unless sufficient evidence is presented to the contrary. In cases of jointly owned property in the name of the applicant/recipient and an individual not included in the household, it shall be presumed that the applicant's/recipient's interest in such property is proportionate to all other joint owners, unless sufficient evidence is presented to the contrary.

3:206 Disposal of Resources: An individual having knowledge of the Primary Health Care Network (PHCN) resource limits is ineligible if he/she disposes of, or deprives himself/herself of, resources by transfer or sale of the resources for less than fair market value. The worker shall investigate any resource the applicant/recipient may have owned but has disposed of before or following application for benefits. The worker shall verify the fair market value of the resource at the time it was disposed of and determine the equity value of the resource. To determine the countable value disposed of, the worker shall:

- a) Subtract the compensation, if any, the client received from the equity value. The result is the countable value (i.e., equity value \$3,000.00 - amount received at transfer \$1,000.00 = \$2,000.00).
- b) Divide the countable value by the Federal Income Poverty Guidelines (monthly figure) for the household size to determine the number of months that the applicant/recipient is ineligible.

Income Criteria

3:301 Financial Eligibility/Federal Income Poverty Guidelines:

- a) The guidelines in effect at the time of application shall govern initial eligibility determinations. Retroactive eligibility determinations will utilize the Federal Income Poverty Guidelines in effect on the date of hospital admission.
- b) If the applicant's/recipient's gross income for a six (6) month period exceeds the current annual Federal Income Poverty Guidelines for household size, the applicant shall be ineligible for medical assistance benefits.
- c) Federal Income Poverty Guidelines, as issued yearly by the Office of Management and Budget, shall become effective on the first day of the month following the month of publication in the Federal Register.

3:304 Excluded Income: The following items are not considered as income in determining eligibility:

- a) Energy Assistance payments, the value of food stamps, General Assistance benefits, the value of any Title XX services, and certain relocation assistance payments.
- b) Contributions as specified in Chapter 1, Section 1:028, herein.
- c) Stipends and Pell Grant balances as outlined in Chapter 2, Section 2:110, herein.
- d) Fifty (50) percent of a newly employed recipient's gross earned income may be disregarded for a period not to exceed three (3) consecutive months of full pay, provided that the recipient has been employed less than fulltime and has received shelter or medical assistance during any of the three (3) most recent months.
- e) Payroll deductions for, or payments made on behalf of the applicant/recipient to purchase private health insurance.

3:305 Projecting Income:

In order to determine eligibility, the caseworker shall consider the former and potential earning capacity of the client and/or spouse. For purposes of projecting income, the caseworker shall, unless specific reasons are provided which would justify use of a different method:

- a) When there has been no significant change in income during the three (3) months immediately preceding the application or hospitalization, whichever

occurs first, determine the average monthly gross income based upon the three (3) months immediately preceding the month of application or hospitalization, whichever occurs first. The monthly average is then multiplied by six (6) to determine initial eligibility.

- b) When the client and/or spouse declares seasonal or self-employment, the worker shall consider the most recent income history of the applicant/recipient together with the adjusted gross income as reported on IRS Form 1040, together with any unemployment benefits received in the year prior to application or hospitalization to determine average monthly income and multiply by six (6).
- c) When there has been a significant change in income in the month of application or during the three (3) months preceding the month of application or hospitalization, whichever occurs first, use the period beginning with the month the change occurred to determine the average monthly income. Such changes may include recent employment, termination, promotion, job change, reduced hours, change in amount of unearned income, etc.
- d) Use the monthly gross income received immediately prior to the month of significant change as calculated in paragraph (a) above, if the applicant has suffered a loss or reduction of income prior to the request for assistance and such loss or reduction was a result of the voluntary actions or inactions of the client and/or spouse. Such actions or inactions include but are not limited to:
 - 1. Failure to cooperate with any state, federal, municipal, or county agency, or private entity providing benefits to the applicant and which non-cooperation results in the loss or reduction of benefits.
 - 2. Failure to work when employment is or was available within ninety (90) calendar days prior to the request for assistance, or has been offered to the applicant, and it is or was within the applicant's physical and mental ability to perform the type of work involved.
 - 3. The applicant/recipient has been denied or suffered a reduction of benefits due to fraud or misrepresentation in applying for or receiving benefits from a federal, state, local agency or private entity.

Dates of Eligibility

3:400 **Certification Period:** All qualified applicants for Primary Health Care Network benefits will be certified for coverage for a period of six (6) calendar months, from the date that the client is notified in writing.

3:401 **Certified Cases: Monthly Reporting:** Applicants who have been certified for Primary Health Care Network will remain certified for a period of six (6) calendar months from the date that the client was notified in writing provided the applicant:

- a) In all cases completes the monthly reporting requirements to confirm his/her living situation and income; and
- b) in cases where the applicant has earned income, submits documentation of current earnings with the monthly reporting form; and
- c) in cases where the applicant is required to comply with any aspect of Section 3:203, as mandated herein, the applicant submits the required documentation within the specified reporting period.

Failure to comply with the provisions of this section will result in termination of the client's case and the denial of benefits for the month following the reporting period.

3:402 **Action on Client Applications:** All applications for Primary Health Care Network shall be acted upon within thirty (30) days from the date the application is completed as defined in Chapter 1, Section 1:008, herein, unless circumstances beyond the control of the client and/or County necessitate a delay. In all such cases, the reason for the delay shall be documented in the case file.

3:403 **Presumptive Eligibility:** If an application for Primary Health Care Network benefits has been signed but cannot be acted upon because all verification and documentation have not been obtained, and in the opinion of a PHCN medical provider, the applicant is in immediate need of a medical service, prescription drugs or durable medical supplies, the caseworker shall presume that the applicant's declarations of income and resources are true and accurate and shall:

- a) determine eligibility based on the client's declarations; and
- b) if the applicant is eligible based upon such declarations, notify the appropriate medical provider that the required services, as described above, can be authorized and issued; and
- c) inform the applicant that he/she will become financially responsible for the

cost of such health care if it is subsequently determined that he/she does not qualify for Primary Health Care Network coverage.

The authorization to receive health care based upon presumptive eligibility shall not exceed a period of thirty (30) calendar days. However, an individual shall not be granted presumptive eligibility for purposes of this section if:

d) his/her previous application for benefits was rejected or his/her benefits were terminated, for failure to submit requested documentation and/or information, and such rejection/termination occurred within six months prior to the month of the current application; or,

e) the current application does not appear to be meritorious for the same or similar reason(s) that the previous application was rejected, denied or terminated.

3:404 Retroactive Eligibility for Medical Assistance: Retroactive eligibility may be considered for a period of inpatient hospitalization, if the following conditions are met:

- a) A request for medical assistance was made by the applicant or someone on his/her behalf within thirty (30) days of the date of hospital discharge.
- b) The applicant received medical services for a life threatening/life trauma condition.
- c) The provider complied with program requirements in the delivery of care.
- d) The client met all other eligibility requirements for the retroactive period under consideration.

3:405 Notice of Finding: After an application for Primary Health Care Network benefits has been completed and eligibility has been determined, a Notice of Finding will be sent to the applicant/authorized representative within thirty (30) days from the date the application is completed, as defined in Chapter 1, Section 1:008, herein, unless circumstances beyond the control of the client and/or County necessitate a delay. In all such cases, the delay shall be documented in the case file. The Notice of Finding will indicate one of the following findings:

- a) Approval.
- b) Payment(s) denied or other third party determination pending.
- c) Denial.

The Department shall provide a monthly list to the County Board of Commissioners of those applications pending sixty (60) days or longer by date of application.

3:410 Reconsideration of a Denial Pending the Outcome of Other Third Party Eligibility:

Any applicant/recipient or authorized representative who has received a Notice of Finding indicating that payment(s) are denied pending a determination of third party eligibility as specified in Section 3:405, may submit a written request for a reconsideration if eligibility for the other medical assistance program(s)/benefits(s) specified on the Notice of Finding has/have been denied and all required appeal/reconsideration processes have been exhausted. The written request for reconsideration must be received by PHCN within ninety (90) days of the date that written notice of ineligibility for the other medical assistance program(s)/benefits(s) was/were received. A copy of any pertinent denials must accompany the written request. If it is determined that PHCN is the payer of last resort for the retroactive period for which the Notice of Finding denying payment was issued, and all other financial eligibility requirements remain met for this same period, payment will be issued in accordance with the provisions of Chapter 5, herein. However, under no circumstances will a Notice of Finding be rescinded (withdrawn) and payment issued if the applicant/recipient or authorized agent failed to make a good faith effort to fully pursue any benefit or claim or failed to cooperate with the application or appeal requirements of any program/benefit to which he/she may be entitled. A final Notice of Finding will be issued upon completion of the review of the request for a reconsideration of eligibility.

Disqualification from Program Participation

3:600 Ineligible Applicants: An applicant who meets the financial eligibility criteria may still be denied Primary Health Care Network benefits if he/she:

- a) is receiving or is eligible to receive Medicare, Medicaid (including Medicaid with an excess income obligation), Veterans Health Care benefits and any other governmental health care benefits or, has been awarded charitable medical care;
- b) fails to comply with federal and/or state entitlement program guidelines which results in a denial of benefits;
- c) has a health insurance policy in effect, unless there is no coverage for a

particular life threatening/life trauma situation and documentation of non-coverage is provided and the applicant agrees to assign his/her rights under the policy to Douglas County;

- d) refuses to use any resources (unless otherwise exempt) which are available to meet his/her medical needs, or fail to comply with any aspect of Section 3:203, herein, as required;
- e) lacks income and/or resources to meet their medical needs as a result of his/her own actions or inactions, or the actions/inactions of the household as defined in Chapter 1, herein.
 - 1) For the purpose of this provision, fulltime students will be presumed to lack income and/or resources as a result of their own actions in restricting their ability to engage in fulltime employment, unless sufficient evidence is presented to the contrary.
 - 2) The provisions of 3:600(e) (1) shall not apply if the applicant/recipient is enrolled in a county approved job training program as specified in Chapter 4:100, herein.
- f) The applicant has obtained/attempted to obtain General Assistance (including Primary Health Care Network) benefits to which he/she was not entitled through fraud or misrepresentation and/or has not fully made restitution to the County.

Scope of Medical Services

3:700 Medical Coverage for Program Participants: Individuals enrolled in the Primary Health Care Network (PHCN) Program may be eligible for the following services:

- a) Primary medical care and related health care services certified as medically necessary, through the Primary Health Care Network Clinic. Clinic hours will be from 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays observed by Douglas County.
- b) Emergency medical care is not available at the Primary Health Care Network Clinic. Any Primary Health Care Network patient who suspects that he/she is having a life threatening/life trauma medical emergency, as defined in

Chapters 1 and 5, herein, must call 911 or go to the closest hospital emergency room. If the emergency is during regular Primary Health Care Network Clinic hours a patient may contact the Clinic first if uncertain as to how to proceed. If the emergency is after regular clinic hours the patient must either call 911 or go to the closest emergency room. A contracting hospital may receive payment for emergency services as specified in Chapter 5, herein.

- c) Specialty physician services and hospital outpatient/inpatient care when certified as medically necessary and prior authorized by the Medical Consultant or designee, who shall also determine the physician and/or medical facility to be utilized and the scope of medical services to be provided.

- d) Inpatient and outpatient mental health care is administered by and available through the Douglas County Community Mental Health Center.
- e) A maximum of three (3) days of psychiatric inpatient care provided by a contracting hospital if all of the following conditions are met:
 - 1) If the patient was admitted to the hospital for treatment because he/she presented a danger to himself/herself or others; and
 - 2) the admitting physician certifies that the patient was a danger to himself/herself or others at the time of admission; and
 - 3) The patient cannot be transferred to a psychiatric facility or psychiatric bed because of unavailability of space, and no other funding is available.
- f) Psychiatric inpatient care in excess of three (3) days provided by a contracting hospital only if the following conditions are met:
 - 1) The patient was admitted to the hospital for treatment because he/she presented a danger to himself/herself or others; and,
 - 2) the admitting physician has initiated action to obtain a Board of Mental Health commitment; and,
 - 3) the other conditions specified in paragraph (e), above, are met. Refusal by the admitting physician to seek a Board of Mental Health commitment, for any reason, will result in the denial of payment of hospital and related costs in excess of three (3) days.

3:701 Special Cases/Prisoners:

Prisoners in the custody of Douglas County Corrections and/or any other law enforcement agency, whether incarcerated, on work release, on house arrest, or participating in any other community diversion program, shall receive medical care as designated by correctional system officials.

3:702 Benefits Obtained Through Fraud or Misrepresentation:

In the event that a person receives Primary Health Care Network benefits through fraud or misrepresentation, the Department shall notify the individual in writing to repay the amount of fraudulently obtained benefits within thirty (30) calendar days of the date of notification or contact the Department to arrange a repayment plan. If the benefit amount that was fraudulently obtained exceeds \$1,500.00 and full restitution has not

been made within thirty (30) calendar days of the notification, the Director will refer the matter to the Douglas County Sheriff's Office for investigation and subsequent prosecution. If the amount owed is less than \$1500.00, the Director will determine whether to refer the matter to the Sheriff's Office or arrange a suitable payment plan with the individual.

3:703 Right to Appeal: An individual who has suffered a loss or reduction of benefits based upon the provisions of this chapter shall have the right to appeal such adverse action as provided for in Section 1:300 through 1:303 of these regulations.