TITLE 480 - HOME AND COMMUNITY-BASED SERVICES

CHAPTER 2 - PROGRAM REVIEW AND ADMINISTRATION

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) § 68-901 et seq. (the Medical Assistance Act).

002. DEFINITIONS.

002.01 ACTIVITIES OF DAILY LIVING (ADL). Refer to Title 471 Nebraska Administrative Code (NAC).

002.02 ADULT. For the purposes of Medicaid and Home and Community-Based Services, an adult is an individual age 18 or older.

002.03 AGED. For the purposes of Medicaid and Home and Community-Based Services, an aged individual is age 65 or older.

002.04 AGENCY PROVIDER. Providers who have one or more employees or will be subcontracting any one or part of the service for which they are requesting approval.

002.05 ASSESSMENT. A process which includes receiving referrals, gathering information, interviewing, and jointly determining participant strengths, needs and desired outcomes.

002.06 AUTHORIZED REPRESENTATIVE. A person appointed by the participant to sign documentation or apply for benefits on their behalf.

002.07 CAREGIVER. A provider, either formal or informal who assists, and assumes responsibility for the care of the participant.

002.08 CHILD. For the purposes of Medicaid and Home and Community-Based Services, a child is an individual age 17 or younger.

002.09 COMMON CARRIER. Any person who or which undertakes to transport passengers or household goods for the general public in intrastate commerce by motor vehicle for hire, whether over regular or irregular routes, upon the highways of this state.

002.10 DEPARTMENT. The Department of Health and Human Services as established by the Health and Human Services Act. For the purposes of these regulations, a reference to the Department also includes a reference to the designee of the Department.

002.11 DEPARTMENT STAFF. Employees of the Department or its designees.

002.12 ESCORT. A person who accompanies or personally assists a participant who is unable to travel or wait alone. This may include assistance to and from a vehicle or place of destination, supervision, or

support.

002.13 EXEMPT TRANSPORTATION PROVIDER. Transportation carriers exempted from Nebraska Public Service Commission certification as defined in Neb. Rev. Stat. §§ 75-303 to 75-303.03.

002.14 HEALTH MAINTENANCE ACTIVITIES. Noncomplex interventions which can be safely performed according to exact direction, which do not require alteration of the standard procedure, and for which the results and participant responses are predictable.

002.15 HOME AND COMMUNITY-BASED SERVICES. Services not otherwise furnished under the State's Medicaid plan which are furnished under a waiver granted under the provisions of 42 CFR Subpart G.

002.16 INDIVIDUAL PROVIDER. Providers who have no employees. Individual providers are independent contractors and not employees of the Department or the State of Nebraska. For the purpose of Federal Insurance Contribution Act (FICA) withholding, the provider is considered an employee of the participant.

002.17 INDIVIDUAL TRANSPORTATION PROVIDER. An individual carrier who meets the requirements of Neb. Rev. Stat. § 75-303 (11), (12), or (13), has an approved service provider agreement with the Department and is chosen by the participant.

002.18 INFORMAL SUPPORTS. Unpaid supports that are provided voluntarily to the individual in lieu of Waiver services and supports. Informal supports are typically provided by friends, family members, or other persons in the community and can include services such as cleaning or transportation. Informal supports may include support provided by or to another person which results in a benefit that is shared by the participant.

002.19 INSTITUTIONAL SETTING. An institutional setting is a medical facility where a person may reside on a short- or long-term basis, including a hospital, nursing facility, institution for developmental disabilities, or an institution for mental diseases. For the purposes of Home and Community-Based Services, any institution will be presumed to be an institutional setting if it has the following attributes: located in a publicly or privately operated facility that provides inpatient institutional treatment; located in a building on the grounds of, or adjacent to, a public institution; or the location has the effect of isolating individuals receiving Home and Community-Based Services from the broader community of individuals not receiving Home and Community-Based Services.

002.20 INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL). Tasks that are performed in the regular course of independent living. The tasks include the following but are not limited to:

(A) Performing essential household chores;

(B) Traveling around and participating in the community;

(C) Shopping for food, clothing and other essential items;

(D) Meal planning and preparation;

(E) Managing finances; and

(F) Communicating by phone or other media.

002.21 NOTICE OF ACTION. Written notice to the participant, legal representative, or provider, which includes a statement of what action will be taken, the reason for the intended action, and the specific policy manual reference that supports the action or the change in federal or state law that requires the action.

002.22 NURSING FACILITY. A facility licensed by the Department’s Regulation and Licensure Unit as a nursing facility.

002.23 PARTICIPANT. An individual either applying for or receiving Waiver services. For the purposes of these regulations, a reference to a participant may include the participant’s guardian, legal representative, or any person authorized to act on the participant’s behalf.

002.24 PERSON-CENTERED PLAN (PCP). An individualized, written plan for each participant documenting the provision of services and supports that takes into consideration each participant's strengths, needs, priorities, and resources. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider – formal or informal - who will furnish each.

002.25 PRIOR AUTHORIZATION. A process that is employed to control the use of covered services. When services are subject to prior authorization, payment is not made unless approval for the service is obtained in advance by Department staff.

002.26 PROVIDER IDENTIFICATION NUMBER. A nine digit federal identification (FID) number or a nine digit Social Security number (SSN).

002.27 RESIDENT SERVICE AGREEMENT (RSA). An assisted living provider must evaluate each resident and have a written service agreement negotiated with the resident and authorized representative, if applicable, to delineate the services to be provided to meet the needs identified in the evaluation, in accordance with 175 Nebraska Administrative Code (NAC) 4-006.06.

002.28 SERVICE PROVIDER AGREEMENT. A legally binding document which may include service specific agreements, description of service to be provided, and the maximum rate(s) allowed for each service. The responsibilities of the provider and of the Department are stated in the agreement. Refer to 471 NAC 2-000.

002.29 SHARE OF COST (SOC). A participant's monthly financial out-of-pocket obligation for medical services when the participant's income exceeds the program limits. When a participant has excess income resulting in a share of cost, the amount of the share of cost is deducted from the Medicaid payment to the provider. The participant is obligated to pay the share of cost amount to the provider in order to receive services.

002.30 SPECIALIZED ASSISTED LIVING (SAL). A licensed assisted living facility which delivers specialized services to residents. In order to provide Waiver services to otherwise qualified residents, the following criteria must be met:

(A) The person has completed the acute phase of rehabilitation;

(B) The person has conditions that are severe, chronic, and disabling, requiring in excess of four hours of care per day, but who do not require complex medical interventions;

(C) The person has the capacity to direct their own care as well as communicate those needs in a traditional or non-traditional manner;

(D) The person's projected costs reflect savings to the state over institutional care or services provided in the home; and

(E) The person's ultimate long-term goal is to transition to safe, independent living elsewhere in the community, when appropriate.

002.31 TARGETED CASE MANAGEMENT. An individualized, goal-oriented process, based on participant choices, which makes the best use of resources to maximize independence and attain the level of care that is consistent with the participant's level of need.

002.32 TRAUMATIC BRAIN INJURY (TBI). A non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

002.33 WAIVER. Medicaid Home and Community-Based services are commonly referred to as Waiver services. The reference comes from Section 1915(c) of the Social Security Act which allows normal Medicaid rules to be waived in order to provide additional services in the participant's residence.

002.34 WAIVER CAPACITY. A term used to describe the maximum unduplicated number of individuals who may participate in a Waiver during the year.

003. ADMINISTRATION.

003.01 APPLICABILITY. The provisions outlined in 480 NAC 2-000 apply to all services in Title 480 Chapters 2-000 to 6-000.

003.02 COST EFFECTIVENESS. The average cost of Waiver services funded by Medicaid must not exceed the average cost to Medicaid for nursing facility services. Medicaid Waiver services must be cost effective in two distinct ways:

(A) In any year that the Waiver is in effect, the average per capita expenditures under the Waiver cannot exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the specified level of care had the Waiver not been granted; and

(B) In any year that the Waiver is in effect, the actual total expenditures for Home and Community-Based Waiver and other Medicaid services, including the corresponding claim for Federal Financial Participation (FFP) in expenditures for the services provided to individuals under the Waiver, cannot exceed 100 percent of the amount that would be incurred in the absence of the Waiver by the State's Medicaid program for these individuals in the specified institutional setting.

003.03 STATEWIDE PROVISION OF SERVICES. Waiver services are provided statewide to eligible participants depending on Waiver capacity availability.

003.04 AVAILABLE WAIVER CAPACITY. If a statewide waiting list is required due to limited Waiver capacity, the Department may determine that an individual qualifies for a priority placement into an available Waiver opening. The Department retains sole discretion to determine the applicability of criteria and the need for prioritization. The next available opening is assigned based upon the following priority criteria:

(A) Needs in domains which define nursing facility level of care are so severe that the health and welfare of the participant are jeopardized, but the needs could safely be met with immediate Waiver services;

(B) Family or caregivers are in a crisis or high stress situation;

(C) No informal support network is available to meet identified needs;

(D) Inappropriate out-of-home placement is being planned;

(E) No other program is available to meet the needs identified in the referral;

(F) Support services are required to allow the participant to return home; or

(G) A participant with an identified Waiver service need of Assistive Technology Supports or Home and Vehicle Modifications lacks access to resources to meet these specific needs and Waiver eligibility is the only

method of addressing the identified needs.

003.05 WAIVER PARTICIPATION. A participant may receive services from only one Nebraska Home and Community Based Services (HCBS) Medicaid Waiver at a time.

003.06 FUNCTIONAL STABILITY. When a participant's functioning has stabilized due to the provision of Waiver services, the participant's history of risk and initial assessment will be considered and documented in determining whether level of care eligibility continues to apply.

003.07 SERVICE NEEDS FOR CHILD PARTICIPANTS. Participants who are children will always have a legally responsible caregiver; and therefore, will have differences in service needs when compared to adult participants. Service needs such as (but not limited to) meal preparation, food, shelter, access to education, and transportation should be met by the legally responsible caregiver.

003.08 PARTICIPANT SAFETY, HEALTH, AND WELFARE. Medicaid Home and Community-Based Waiver services must ensure the participant's health and welfare, including the consideration of acceptable risk with respect to participant choice, and must prevent the provision of unnecessary or inappropriate services and supports. If, despite consideration of the full range and scope of services, the participant's safety, health or welfare is in jeopardy, Waiver services may not be provided. The participant will be presented with alternate service delivery options, which are available to maintain a safe plan. The participant will be afforded notice and hearing rights in accordance with this chapter.

004. REQUIREMENTS APPLICABLE TO ALL MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER SETTINGS. In addition to the participant rights outlined in 480 NAC 3-000, and requirements outlined in each service specific section each provider must ensure that their setting affords each participant, specific person-centered opportunities.

004.01 INTEGRATION AND ACCESS. The setting must be integrated in and support full access of individuals receiving Medicaid Home and Community-Based Services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings based on services offered or available under each Waiver, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid Home and Community-Based Services (HCBS).

004.02 PARTICIPANT CHOICE. The setting must be selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The settings options must be identified and documented in the person-centered service plan and be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

004.03 PARTICIPANT RIGHT TO PRIVACY. The setting must ensure a participant's rights of privacy, dignity, respect, and freedom from coercion and restraint.

004.04 PARTICIPANT INDEPENDENCE. Each participant must have the opportunity to optimize individual initiative, autonomy, and independence. The setting must optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and interactions with individuals of the participant's choice.

004.05 FACILITATION OF CHOICE. The setting must facilitate individual choice regarding services and supports, and who provides them.

005. NOTIFICATION OF ADVERSE DECISIONS. Refer to 465 NAC 2-000 and 6-000, and title 477 NAC 3-000, 9-000, and 10-000. Persons who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to, a potential Waiver participant being denied services, a Waiver participant's services being reduced, or a Waiver participant determined ineligible for Waiver services.

005.01 MEDICAID ELIGIBILITY. If the termination of Waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

005.02 DENIAL OR TERMINATION OF ELIGIBILITY. Eligibility for Medicaid Waiver services may be denied or terminated for any of the following reasons:

(A) The unavailability of Waiver capacity;

(B) The participant has no Waiver service need;

(C) The participant has not used Waiver services in the most recent 60 calendar days;

(D) The participant's needs are being met by another source;

(E) The participant does not meet priority assessment criteria;

(F) The participant or their guardian has not supplied needed information to complete the eligibility or person-centered plan (PCP) review process;

(G) The participant fails to meet the specified eligibility criteria at the initial determination or a later re-determination;

(H) A person-centered plan (PCP) cannot be developed and maintained which protects the participant's health and welfare;

(I) The participant or their guardian has not signed necessary forms consenting to Waiver services;

(J) The participant or their guardian voluntarily withdraws;

(K) The participant moves out of Nebraska;

(L) The death of the participant;

(M) The agency loses contact with the participant and the participant's whereabouts are unknown;

(N) The need for Assistive Technology Supports (ATS), Home and Vehicle Modifications (H/VM) has been addressed and no other Waiver services are needed;

(O) The participant or their guardian is not able to meet in-person with their Services Coordinator at least every three months; or

(P) The participant has become a resident of a nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), or an institute for mental disease and is expected to remain there for more than 60 days.

005.03 PROVIDER NOTICE. Refer to 471 NAC 2-000 for specific information regarding notice of action information sent to providers. When a Waiver participant's services are being changed or terminated, the services coordinator will provide written notice to the provider of the change in service provision or termination of payment for Waiver services.

006. APPEALING DECISIONS OR ACTIONS. The Department provides opportunities for fair hearings as defined in 42 Code of Federal Regulations (CFR) 431, Subpart E, to participants or their legal representatives who are not given the choice of Medicaid Home and Community-Based Services (HCBS) as an alternative to nursing facility services or who are denied the services of their choice. Refer to 465 NAC 2-000 and 6-000, and title 477 NAC 3-000, 9-000, and 10-000.

006.01. RIGHT TO APPEAL. Medicaid Waiver participants or their guardians have the right to appeal the following decisions or actions:

(A) Refusal to accept a request for Waiver assessment;

(B) Failure to act upon a request within the mandated time period;

(C) Failure to offer the choice between Medicaid Aged and Disabled Waiver services and nursing facility services;

(D) Denial, termination, or reduction of services; and

(E) Termination of the Medicaid Waiver case.