TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 3 PARTICIPANT ACCESS AND REQUIREMENTS

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. PARTICIPANT RIGHTS AND RESPONSIBILITIES.

002.01 PARTICIPANT RIGHTS. In addition to the rights afforded to all persons, a participant enrolled in the Department's Division of Medicaid and Long-Term Care (MLTC) program has the right to:

(A) Be treated with dignity and respect;
(B) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being;
(C) Appoint an authorized representative to act on their behalf as a paid provider cannot sign their own claim on behalf of the participant; the signature of another competent representative of the participant, with the knowledge of the service delivery is required;
(D) Participate with the services coordinator in the service plan development process, and receive services in a person-centered manner that is in accordance with the approved service plan. Lead the process of service plan development when possible; and, include a representative that the individual has freely chosen, as well as other individuals chosen by the participant to contribute to the process. Person-centered services are delivered in a manner that is attentive to the participant's needs and maximizes personal independence;
(E) Have the services coordinator explain what services are available, how those services will assist the participant and what the participant's rights and responsibilities are;
(F) Request assistance with finding appropriate providers;
(G) Confirm that services were received in the manner authorized in the person-centered plan (PCP) according to Department procedures;
(H) Openly communicate with the services coordinator and receive information in a manner that is easy to understand;
(I) Meet privately with the services coordinator;
(J) Receive ongoing assistance from the services coordinator;
(K) Choose the participant's services coordinator among approved and willing services coordination options. Request changes of services coordination in accordance with availability in the service area;

(L) Make informed choices regarding the services and supports outlined in the person-centered plan (PCP), and the provider from which the participant will receive the services and supports. Access files, records or other information related to enrollment in and delivery of services under the Medicaid Home and Community-Based Services (HCBS) Waiver Program;
(M) Be assured of confidentiality of personal and sensitive health care information pursuant to relevant confidentiality and information disclosure laws;
(N) Request assistance with problems, concerns and issues, and suggest changes without fear of repercussion;
(O) Be fully informed about how to contact the services coordinator with problems, concerns, issues or inquiries;
(P) Be informed of the right to appeal decisions made by the Department about Waiver eligibility or services; and
(Q) Be informed of the right to file a formal complaint with the Department.

002.02 PARTICIPANT RESPONSIBILITIES. Participants of Waiver services have the following responsibilities:
(A) Upon enrollment, the participant must sign a Waiver consent form;
(B) Participate in determinations of eligibility and enrollment in the Waiver and development and implementation of the person-centered plan (PCP), and any back-up service plans. Cooperation includes providing accurate and complete information and medical history. The participant must continue to cooperate with any re-determination of eligibility or services. Lack of cooperation during the determination process may lead to denial of eligibility and enrollment;
(C) Decide who, besides the services coordinator, will participate in the service planning process;
(D) Participate in the recruitment, selection, and dismissal of providers;
(E) It is the participant's responsibility to ensure that the provider is properly trained. The participant will work with the services coordinator and their physician to ensure that the provider is properly trained to deliver Waiver services that meet the participant's specific needs. When appropriate, the participant will personally train the provider;
(F) Not direct the service provider to provide a service, perform a function, or take any action that is not permitted under Medicaid rules and regulations and all other applicable laws, rules, regulations, or that has not been authorized by the Department or the contracted agency;
(G) Notify the services coordinator within 10 calendar days when a change in provider or services is desired. Notification must include the proposed end date of the former provider or service, and the proposed start date of the new provider or service;
(H) Authorize the exchange of information for development of the service plan with all of the participant's service providers, and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations set forth in 45 Code of Federal Regulations (CFR) parts 160 and 164 and the Medicaid safeguarding information requirements set forth in 42 CFR 431.000 to 431.306 along with Neb. Rev. Stat. § 68-312 to 68-314;
(I) Communicate to the provider personal preferences about the duties, tasks and procedures to be performed, and when appropriate, about provider performance concerns;

(J) Report to, and work with, the services coordinator to resolve problems and concerns with any service delivery issues including, but not limited to, service disruption, complaints and concerns about the provider, or health and safety issues;
(K) Keep scheduled appointments and notify the provider and Services Coordinator if a scheduled visit or service is going to be missed;
(L) Treat the services coordinator and providers with respect;
(M) Provide a safe environment in which services can be delivered;
(N) Report to the services coordinator within 10 calendar days, any significant changes in the participant's condition, living arrangements, or circumstances;
(O) Refuse to participate in dishonest or illegal activities involving providers. Report dishonest or illegal activities to the services coordinator; and
(P) Validate service delivery in accordance with Department procedures, including but not limited to, the date and location of service delivery, arrival and departure times of the provider, and verification of service delivery by both the provider and the participant, or their authorized representative.

003. PARTICIPANT ELIGIBILITY.

003.01 ELIGIBILITY CRITERIA. Participants eligible for Waiver services must:
(A) Be eligible for Nebraska Medicaid in a category authorized to receive services from the Waiver under which services are being requested;
(B) Have conditions which place the individual in the target populations identified in the Waiver under which services are being requested;
(C) Have participated in an assessment, including any reassessments, with a services coordinator in accordance with this chapter;
(D) Meet the nursing facility level of care criteria outlined in Title 471 Nebraska Administrative Code (NAC);
(E) Be determined that meeting the care needs of the participant would not result in Nebraska violating the cost effectiveness requirements outlined in this chapter;
(F) Receive an explanation of nursing facility services and Waiver services and choose to receive Waiver services; and
(G) Use Waiver services at least every 60 days. Exceptions apply for cases that are Assistive Technology Supports (ATS) or Home and Vehicle Modification (H/VM) requests only, or in the event there is a delay in enrollment of the preferred provider.

003.02 ELIGIBILITY DETERMINATION. All participants must have an eligibility determination in order to be able to access Waiver services. Eligibility determinations include:

003.02(A) ASSESSMENT. An in-person assessment will be completed by the services coordinator, participant, and legal guardian when applicable. A child must be reassessed as an adult when they reach age 18. The following steps are included within the intake process:
(i) A referral for services will be accepted from any source;
(ii) Each participant must be determined Medicaid eligible, or under consideration for Medicaid eligibility; and
(iii) The services coordinator will contact the participant and schedule an in-person meeting to evaluate nursing facility level of care, within 14 calendar days of the referral date. Assessments are scheduled at a time and date convenient to the

participant and their guardian, when applicable this may result in scheduling outside the 14 calendar day window.

003.02(B) PRIORITY CRITERIA FOR ASSESSMENT. 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 of an assessment. Criteria to be considered to expedite the assessment include, but are not limited to:

(i) Needs that are so severe the health and welfare of the participant are jeopardized, but the needs could safely be met with immediate Waiver services;
(ii) Family or caregivers are in a crisis situation;
(iii) No informal support network is available to meet identified needs;
(iv) Inappropriate out-of-home placement is being planned;
(v) No other program is available to meet the needs identified in the referral;
(vi) Support services are required to allow the participant to return home such as, a Medicaid-eligible recipient is ready to be discharged from a hospital or nursing facility; and
(vii) A participant with an identified Waiver service need of Assistive Technology Supports or Home and Vehicle Modifications (ATS, H/VM) lacks access to resources to meet these specific needs AND Waiver eligibility is the only method of addressing the identified needs.

003.02(C) ONGOING ASSESSMENTS. An in-person re-evaluation of nursing facility level of care and needs assessment are required at least annually to ensure the participant continues to meet criteria identified in 471 NAC to be eligible for Waiver services. When there is a change in the participant's condition, an in-person functional assessment is completed to ensure the person-centered plan reflects the participant's clinical and support needs.

003.02(D) DETERMINATION OF NURSING FACILITY LEVEL OF CARE. The Department will determine nursing facility level of care in accordance with Title 471 NAC.

003.02(E) PERSON-CENTERED PLAN (PCP). A Person-Centered Plan (PCP) must be developed for each participant. For children aged 0-3 years old that are also utilizing early intervention services, the Individual Family Service Plan (IFSP) is the person-centered plan (PCP). The service planning process should be directed by the participant and any applicable representative. Steps included in the person-centered planning process are:

(i) PLAN DEVELOPMENT. The participant, together with the services coordinator, develops a person-centered plan (PCP) based upon assessment results of the potential participant's strengths, needs, priorities, preferences and resources.
(ii) PLAN REQUIREMENTS. The person-centered plan (PCP) must meet the following requirements:
    (1) Reflect that the setting in which the participant resides is chosen by the individual;
    (2) Reflect the participant's strengths and preferences;
    (3) Reflect clinical and support needs;

(4) Include individually identified goals and desired outcomes;
(5) Reflect the services and supports (paid and unpaid) that will assist the client to achieve identified goals, and the providers of services and supports, including informal supports;
(6) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies;
(7) Identify the individual and entity responsible for monitoring the plan;
(8) Document that any modification is supported by a specific assessed need and justified. The following requirements must be documented in the person-centered plan (PCP):
(a) Identify a specific and individualized assessed need;
(b) Document the positive interventions and supports used prior to any modifications to the person-centered plan (PCP);
(c) Document less intrusive methods of meeting the need that have been tried but did not work;
(d) Include a clear description of the condition that is directly proportionate to the specific assessed need;
(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
(g) Include informed consent of the participant.

(iii) PLAN IMPLEMENTATION. The person-centered plan (PCP) must be finalized and agreed to, with the informed consent of the participant, and the participant's legal representative when applicable.

004. TARGETED CASE MANAGEMENT. Targeted case management will be provided by Department staff or a designee. Regulatory references addressing participation by the services coordinator are also intended to allow participation by the services coordinator's supervisor, if necessary.

004.01 WAIVER CONSENT. If the participant accepts Waiver services, the participant or legal guardian must sign the Waiver consent form. The Waiver consent form must be updated any time there is a change in the legal ability of the participant or legal guardian to consent to Waiver services. The Waiver consent form is not valid until the date the participant's eligibility for Medicaid has been determined. The participant's Waiver services may not be authorized until the participant signs the Waiver consent form and Medicaid eligibility is approved.

004.02 MONITORING. Monitoring of Waiver services includes:

(A) Monthly contact between the participant and the services coordinator. Contact may be more frequent based on participant need. In-person visits must occur at least quarterly, and may occur more often if determined to be necessary by the services coordinator. All in-person contacts will be at a time, date, and location convenient to the participant. Each participant contact includes the following:
(i) Confirmation services being provided by both formal and informal supports and services continue to meet the participant's needs based on participant interview and observation;
(ii) Review of service usage and cost;

(iii) Review of the participant's desired outcomes;
(iv) Review the participant's satisfaction with the services provided;
(v) Review of the participant's overall health status;
(vi) Review of medical information; and
(vii) Verification that providers comply with the requirements of service provision.

(B) Revisions to the person-centered plan (PCP) as necessary to account for changes identified in (A)(i)-(vii) after each monthly contact; and

(C) Notice to the Department within two working days that the participant has had a significant change in health or needs, the services coordinator will determine whether a reassessment of the participant's level of care, strengths, needs, and resources is necessary. A reassessment may be initiated based upon the services coordinator's observation of any improvement or decline in functioning during the participant contact.

004.03 COST EFFECTIVENESS DETERMINATION. To ensure ongoing cost effectiveness of the Waiver Program in accordance with 480 NAC 2-000, the Department will determine the estimated cost effectiveness for each participant.