Waiver Process Guide

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DEFINITIONS:

Eligibility and Enrollment (E&E) - A unit within the Division of Developmental Disabilities that receives referrals for waiver services, reviews and requests supporting documentation and determines if an individual meets the level of care (LOC) assessment criteria per regulatory requirements for the respective waiver program or institutional placement. E&E adds narratives and/or alerts in a case providing information on the status of waiver assessments and sends referrals to Service Coordination, as necessary.

Home and Community Based Waiver Services (HCBS) or Waiver - Descriptions of Aged and Disabled Waiver (AD), Comprehensive Developmental Disabilities (CDD) Waiver, and Traumatic Brain Injury (TBI) Waiver eligibility and services can be found at: Eligibility For Medicaid HCBS Waiver Services.

Programs such as AD, CDD, Developmental Disabilities Adult Day (DDAD), Family Support Waiver (FSW), and TBI work in conjunction with Medicaid to promote independence by offering services, skills and equipment which allow an individual to receive comprehensive long-term care in settings such as the individuals home or assisted living facility. Waiver was designed as a cost effective alternative to institutional care and promotes independence in the community. Each waiver program has its own eligibility criteria, and offers a variety of benefits which may include Adult Day Health Services (ADHS), Assisted Living Service (AL), Assistive Technology and Supports, and Home and Vehicle Modifications (ATS, H/VM), Chore; Extra Care for Children with Disabilities, Home Again; Home-Delivered Meals, Independence Skills Building, Non-Medical Transportation, Personal Emergency Response System (PERS), and Respite Care.

See: Medicaid HCBS Waiver for Eligible Nebraskans, Services On The Aged And Disabled Waiver and Aged and Disabled (AD) Waiver Services and Eligibility Pamphlet for additional information about specific services.

Service Coordinator (SC) - Worker that assists waiver eligible individuals in obtaining access to the services needed, as identified at assessment. This includes but is not limited to: identifying and making referrals to providers, scheduling appointments, facilitating and monitoring the delivery of services, and

sending waiver eligibility notices. The SC may be a DHHS staff (AD-children, CDD, FSW or DDAD), or a staff at a county Agency on Aging or League of Human Dignity office (AD-adults or TBI Waiver) or Early Development Network (EDN). The SC sends a request to Medicaid via change report, alert, phone call, or email asking to open or close a waiver case. The SC must be assigned to only the waiver case in NFOCUS.

WAIVER REQUEST

Prior to receiving waiver services an individual must be eligible for Medicaid (with or without SOC). In addition, the individual must be age 65 or over **OR** have a disability determination (SSA or SRT), **OR** a diagnosis of traumatic brain injury.

Except when:

- An assessment is needed to determine a level of care in order to impose a deprivation (the referral email should specifically state this); **OR**
- A request for spousal impoverishment (SIMP) has been received (the referral email should specifically state this).

Individuals in a QI-1 or SLMB budget must be assessed for eligibility in a SOC/MN budget. Waiver cannot be activated until all waiver criteria are met. The Medicaid SSW must NOT pend or activate a waiver program case until requested to do so by the SC.

Medicaid staff can make referrals for waiver to: DHHS.HCBSWaiverapp@nebraska.gov . Upon receipt of the referral the E&E unit will schedule a meeting with the Medicaid beneficiary (or Authorized Representative/POA/Guardian) for a level of care assessment and may request the DD-10 form as part of that process. Although this form is part of the waiver process, it is **not** a Medicaid eligibility requirement.

If the DD-10 form or additional waiver documents are received by Medicaid staff, this information must be forwarded to DHHS.HCBSWaiverapp@nebraska.gov.

When the individual meets waiver eligibility review the 60 month look back period.

- If the individual has a deprivation of resources there is no waiver **OR** Medicaid eligibility until the period of ineligibility has been satisfied.
  - This includes no eligibility for ALL Medicaid programs such as SLMB, QI1, etc.
  - Waiver will not be activated until a Deprivation of Resources review is completed and there is no period of ineligibility determined.
- If the individual does not have a deprivation of resources, proceed with the waiver approval process.
- The worker must use the Deprivation of Resources Process Guide while reviewing the 60-month look back period for an individual.

If personal assistance services (PAS) is requested on the application, refer to the PAS Process guide / PAS Worker Guide.

OPENING A WAIVER PROGRAM CASE

It is the responsibility of MLTC staff to run Medicaid budgets in order to activate waiver. Each waiver participant is activated in their own waiver program case. Special budgeting procedures for spouses are found at 477 NAC 24-001.02.

Certain Medicaid cases are assigned, see the Medicaid Position Numbers for Case Assignments document for details. In the instance of an assigned Medicaid case, the assigned Medicaid worker will review for the 60-month look back period, open the waiver program case after the deprivation review is complete, and set the LTC indicator in the case as applicable.

1. When pending a waiver case, it will be effective for the month the individual was approved for waiver. The waiver begin date cannot be prior to the Medicaid eligibility date in NFOCUS. However, the waiver program case may need to be added for the current or the previous month, as requested by the SC.

   Example: An application for Medicaid is received on 5/1/2023 requesting waiver and the individual was approved for Medicaid effective 5/1/2023. On 8/1/2023 the worker reviews a change report submitted by the Office on Aging stating the individual was approved for waiver services effective 7/13/2023. The AD program case would be pended in the mainframe or the expert system of NFOCUS for 7/1/2023. The case will need to be checked out, and Medicaid budgets run from 7/2023 through 9/2023 to activate the AD program case.

2. To add or reopen a waiver program case:
   a. Check out the case to the expert system.
   b. Double click on **case actions** for the month waiver was approved.
      a. If the change report does not indicate the begin date, contact the SC for the date.
   c. Select **add** (or **reopen**) and add the appropriate waiver program case for the participant.
   d. The begin date is the date provided by the SC (or the reopen date).

3. If the living arrangement requires an update to assisted living with waiver (AL/W), this should be made for the next month, following the notice requirements if there is adverse action. This will ensure that when the budget is processed to activate the waiver, there will not be adverse action taken in the current (and previous, if applicable) month.

4. To activate the waiver, process Medicaid budgets beginning with the month of waiver approval through the come up month.
   a. If the participant is not eligible for ABD/Med or MIWD and the budget goes into a SOC, the Medically Needy (MN) budget should be set to **ACTIVE** for the waiver eligible individual. The SOC is obligated to be paid to the provider for services.
   b. If the participant is in a SLMB or QI-1 budget, the worker must take the following actions to move the case to MN/SOC.
      1) On the Medicaid Participants pop-up screen during budgeting, select MN.
      2) Authorize the budget.
      3) On the Spenddown screen, select **ACTIVE**.

NOTE: Waiver eligibility will not appear in the budget summary. When the case is checked in, the waiver program case will show as "active" on the NFOCUS mainframe.

4) See 477 NAC 27-004.04 through 004.04(D) for additional information on special considerations when moving a budget from QI-1 to SOC.

6. After checking the case in, assign the waiver program case to the SC and add a narrative.

7. The resources must be reviewed in the 60-month look back period (if not previously completed). The Medicaid case may need to be assigned to the applicable position number found in Medicaid Position Numbers for Case Assignments. The deprivation review must be done prior to activating the waiver case.

CLOSING THE WAIVER PROGRAM CASE

1. If a request is received (from the SC) to close the waiver case, action must be taken by the Medicaid worker.
   a. To close a waiver program case:
      1) Check out the case to the expert system.
      2) Double click on **case actions** for the month waiver was requested to close.
         i. The closure date should be the last day of the month requested by the SC, providing for 10-day notice. A closure reason will need to be selected.
   b. Update the living arrangement as applicable.
   c. Process the SOC or living arrangement change in the Medicaid budget, allowing for adequate and timely notice.
   d. When the case is checked in, the waiver case will no longer show as active in the mainframe, and the action taken on the case will generate an alert for the assigned SC. The SC will send notices for waiver.

2. If the Medicaid case is closed, this action will also close the waiver program case.
   a. If an individual loses Medicaid eligibility they no longer meet waiver eligibility.
   b. A notice of action must be sent.
      1) The notice must include the Medicaid closure reason and effective date, include any applicable policy references, and indicate that waiver services have also closed.
   c. This action will also generate an alert for the assigned SC. The SC will send specific notices for waiver.

REOPENING A WAIVER PROGRAM CASE FROM A MEDICAID CLOSED STATUS

After the waiver has been activated, any action taken to close the Medicaid program case will also close the waiver program case. Therefore, reopening a Medicaid case that was recently closed may require the worker to also reopen the waiver case.

When reopening, use the prior waiver case (reopen) rather than creating a new waiver program case for the individual.

1. Review the waiver closure date and determine if Medicaid eligibility actions closed the waiver.
   a. If the AD waiver case was in a closed status, a new referral to AD Waiver and LOC assessment are required.

      Example: Action taken on 5/16/23 to close Medicaid effective 6/1/23 for renewal not completed. On 6/3/23 the individual completes the renewal, and Medicaid is reopened effective 6/1/23. Since the AD Waiver case was in closed status effective 6/1/23, a new referral and assessment are required before the AD Waiver case is reopened.

      Example: Action taken on 5/16/23 to close Medicaid 6/1/23 for renewal not completed. On 5/26/23 the individual completes the renewal, and Medicaid is reopened effective 6/1/23. Since the AD Waiver cases never went into a closed status, no referral or assessment are needed. Proceed to step 2 unless it is documented the SC requested waiver be closed.

   - For all other waiver types (CDD, DDAD, or FSW) contact the Services Coordinator to determine if the waiver case should be reopened or remain closed.

2. If waiver was closed for a Medicaid reason (such as renewal not completed) the Medicaid program case must be reopened prior to reopening the waiver program case.
   a. See *Opening a Waiver Program Case* above for detailed steps on reactivating the waiver.
   b. This action will generate an alert for the assigned SC.
   c. The waiver program case may need to be reassigned to the SC after checking the case in.

RENEWAL / CHANGE MANAGEMENT ACTIONS FOR WAIVER INDIVIDUALS

The individual must remain eligible for ABD, MIWD, or MN/SOC to remain eligible for waiver.

- If a renewal form/verifications have not been received from the individual and it is due:
  a. Attempt to contact the individual, SC, POA or authorized representative and remind them to submit the renewal/verifications by phone, paper, or online.
  b. If the renewal form/verifications have not been received, the case will be closed allowing for 10-day notice.

- Considerations for change in Medicaid category:
  a. The Medicaid worker should attempt to contact the individual, SC, POA or authorized representative with the outcome of the renewal/change if there is a new Medicaid category or SOC amount that will impact waiver services. This ensures that both the individual and SC are aware of the impact for current service providers.
     i. The above step should be completed prior to sending out a Notice of Action (NOA) prior to authorizing the budget/making the Medicaid category change.
  b. Waiver is considered an institutional level of care living arrangement and will follow existing MLTC renewal processes.

- If an In-Home waiver individual moves into a LTC facility, the worker will assign the Medicaid case to position number 42651130 (Position Number Assignments). The assigned worker will:
  a. Update the budget for the next possible month taking into account adverse action.
  b. Review for the 60 month look back period, as necessary. (This may only pertain to new instances we are being made aware of that appear to be a deprivation. It likely will not be the first deprivation review).

- If the worker becomes aware of concerns regarding abuse, neglect, or financial exploitation, make a referral to Adult Protective Services (APS).
  a. A referral may also be needed when an individual is no longer able to manage their own affairs (self-neglect).

NOTE: The date for a Medicaid annual renewal and the date of the waiver renewal may not always align.

If personal assistance services (PAS) is requested on the application, refer to the PAS Process Guide / PAS Worker Guide.

SPOUSAL IMPOVERISHMENT (SIMP) REQUEST FOR WAIVER

Either spouse may request a SIMP assessment of resources which is completed for the first month that a spouse is institutionalized, or when it's been verified they likely require thirty (30) days of institutionalized level of care, see SIMP 30 Day Criteria Guide.

If SIMP is requested while Medicaid is active, pending, or in SOC status, assign the case to position number 42651130, follow the Position Number Assignments document for cases that are not active or pending.