Frequently Asked Questions: Shared Living

BACKGROUND:

Q **Why does the state need to change the Extended Family Home (EFH) model as we know it today?**

A With the approval of our Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities Waiver in 2017, the Centers for Medicare and Medicaid Services (CMS) issued a corrective action plan. This plan required the state to address the issue of agencies subcontracting with EFH as service providers and to submit a waiver amendment that will bring the state into compliance with federal law.

Based on technical assistance from CMS, it was determined that the Medicaid Organized Health Care Delivery System (OHCDS) model most closely fit Nebraska's current model.

Q **What is an Organized Health Care Delivery System (OHCDS)?**

A The OHCDS model was created to allow subcontracting under a medical care delivery model administered through a county or region-based service delivery system. In Nebraska, because the counties and regions do not manage Medicaid services, agency providers would be designated to fulfill the OHCDS requirements in order to provide subcontracted services.

Under this model, the OHCDS delivery of EFH services would be uniform across all agencies. For example, agencies would be required to pass through the entire service payment to subcontracted EFH providers and bill separately for a flat administrative rate. The level of administrative support would be required to be consistent from agency to agency. The amount of federal funds the State may claim for administrative services is a 50-50 match, which is less than the service match.

It would also be required that the EFH be able to contract directly with the state to provide the EFH service, rather than contract with an agency. To do so in Nebraska, the EFH would also need to become a legal entity (such as LLC, S-Corp, etc.) and go through the agency provider certification and enrollment process.

Q **Why did the state choose not to use the OHCDS model?**

A The state determined, based on feedback from providers and other stakeholders and as research into how services are being delivered in Nebraska and other states, that the OHCDS model would not be the best option for Nebraska. Through this research, the state discovered another model: the Shared Living model. The state determined this model would best meet the needs of participants receiving services, and limit the service disruption.

Q **What is the Shared Living model?**

A The Shared Living model of service delivery allows an agency provider to subcontract with a Shared Living independent contractor (also referred to as the Shared Living provider) to provide the direct support portion of the service. The agency provider has oversight and responsibility for the service delivery. The agency provider also has the discretion to determine what portion of the service rate will be retained for administrative functions and the portion of the rate, or stipend, to give to the Shared Living provider.

SHARED LIVING INDEPENDENT CONTRACTORS:

Q **What is the difference between an independent contractor and an independent provider?**

A An independent contractor, often referred to as a subcontractor, contracts with an agency provider to provide a portion of a Medicaid HCBS waiver service. Independent contractors must meet the U.S. Department of Labor economic realities tests to be considered independent contractor, rather than an employee of the agency. An independent contractor must contract with an agency provider in order to provide the Shared Living service. In contrast, an independent provider is a Medicaid-enrolled provider, not affiliated with an agency, and may only provide self-directed services. Shared Living is not a self-directed service, therefore Independent Providers cannot

provide the Shared Living service. A person may be both enrolled as Shared Living provider and enrolled as an independent provider for self-directed services for the same participant, or for different participants.

Q **How will agencies know who the approved subcontractors are?**

A Agencies will be required to ensure that their subcontractors meet Shared Living provider qualifications. They can do this by providing the training necessary for the subcontractor to meet the qualifications or by verifying the training requirements have been met by another entity. Agencies may use their discretion in determining when to accept training from another entity. Agencies can't mandate that the Independent Contractor receive training from their agency. They must, however, ensure that the Independent Contractor has completed all required training necessary to perform the duties specified within their contract. Once a contract is executed between the agency and the Shared Living provider, the Shared Living provider must sign a Nebraska Medicaid Service Provider Agreement and enroll through Maximus as an affiliate with the agency provider.

Q **Does the stipend have to be the same for every Shared Living provider or does the agency have discretion depending on the participant's tier?**

A The agency has discretion over how it structures the stipends offered to its Shared Living providers, compensates the Shared Living provider and covers administrative costs.

BACK-UP STAFFING AND SUPPORT STAFFING:

Q **What is the definition of back-up staff?**

A Back-up staffing is a staff that is present in place of the Shared Living provider.

Q **How can back-up staffing be provided?**

A Shared Living may be billed for the time a back-up staff is present in place of the Shared Living provider. Back-up staff must deliver the same habilitative services to the participant as the Shared Living provider. Back-up staff must be chosen by the participant, documented in participant's service plan, and must meet all the same provider qualifications as the Shared Living provider. The back-up staff may be compensated by the Shared Living provider or may be an employee of the agency provider. Back-up staff use is limited to no more than 360 hours per annual budget year.

Q **How does the 360 hour back-up staff cap apply to Shared Living?**

A

1. If the Shared Living provider was out of the home, and the back-up staff was providing the Shared Living service for 10 or more hours per day, 10 hours (not 24 hours) would be taken out of the 360 (because the daily rate is 10 hours).
2. If the provider was out of the home for less than 10 hours, the actual number of hours the back-up staff was providing the Shared Living service would be taken out of the 360.

Q **What if a Shared Living provider needs more than 360 hours of back-up staffing?**

A This would depend on the supervision/alone time needs of the participants living in the home. For example, if a Shared Living provider needs more than 360 hours of back-up:

1. The home could be changed to the Continuous Home model. All providers would be employees, and the participant could get continuous staffing, as needed;
2. The Shared Living provider could have a second person (living in the home and listed on the contract) available for assistance; or
3. The Shared Living provider and the participant's team should assess whether the shared living service and setting are right for the participant.

Q **Can the Shared Living provider use support staffing?**

A Yes, the Shared Living provider can use support staffing to assist with providing services to the participant(s) if:

1. The Shared Living provider is in the home the entire time and also providing support to the participant(s), and
2. The support staffing is not used for a continuous 24 hour time frame.

Q **What are some examples of when the staff are considered back-up staff and when they are not?**
A

1. If the Shared Living provider left the home for a few hours for an appointment, to go bowling, etc., and the participant does not have alone time or chooses not to use their alone time, a back-up staff would be used in place of the provider while they are out of the home.
2. The Shared Living provider was traveling and didn't take their participant with them, a back-up staff would be used to stay with the participant until the Shared Living provider returned.

Depending on the supervision needs and tier levels of the participants living in the Shared Living home:

1. If a second person lives in the home, is on the contract, and is trained to work with the participant(s), the second person would not be considered back-up staff and none of the 360 hours would be used.
2. If the participant has alone time and chooses to use their alone time, a back-up staff would not be needed.

Q **How could a Shared Living provider handle a situation in which they are hospitalized or have an emergency?**

A If a Shared Living provider is hospitalized for an extended period of time or has an extended emergency situation, it would be possible for the agency that contracts with the Shared Living provider to temporarily make the home a continuous residential home and use agency staff to support the participant(s). In this situation none of the 360 hours would be used and Shared Living would not be billed.

LEASES:

Q **Can agencies own or lease the property in which Shared Living providers live?**

A No. Allowing this would have HCBS Final Settings Rule implications. It could limit provider choice and family autonomy by making the Shared Living providers' residency dependent upon their relationship with the agency who owns or leases the home.

Q **Does the Shared Living provider need to have a lease agreement with the participant?**

A Yes. Per the HCBS Final Settings Rule, the participant has the right to a lease or rental agreement that affords the participant all the rights and responsibilities required by Nebraska tenant/landlord law.

HOME COMPOSITION:

Q **How many participants can be in the same Shared Living home?**

A A Shared Living home may serve up to two participants. Groups of three must be approved by the state.

Updated: 4-23-2019 New information is highlighted