

# Frequently Asked Questions: Residential Habilitation – Shared Living

## Background

**Q. Why did the state need to change the Extended Family Home (EFH) model?**

- A.** With the approval of our Medicaid Home and Community-Based Services (HCBS) Comprehensive Developmental Disabilities Waiver in 2017, the Centers for Medicare and Medicaid Services (CMS) issued a corrective action plan. The plan required the state to address the issue of agency providers subcontracting with EFHs as service providers. DHHS-DD had to submit a waiver amendment to 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 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 or S-Corp) 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 agency providers and other stakeholders and research into how services are 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 and limit 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 called the Shared Living provider) to provide the direct support portion of the service. The agency provider has oversight and responsibility for 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 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 called a subcontractor, contracts with an agency provider to provide a portion of the Medicaid HCBS waiver service. An independent contractor must meet the U.S. Department of Labor economic realities tests to be considered an independent contractor, rather than an employee of the agency provider. 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 provider, and may only provide self-directed services. Shared Living is not a self-directed service, therefore an independent provider cannot provide the Shared Living service. A person may be enrolled as both a Shared Living provider and an independent provider for self-directed services.

**Q. How does an agency provider know who is an approved subcontractor?**

**A.** Agency providers are required to ensure 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. Agency providers may use their discretion to determine when to accept training from another entity. Agency providers cannot mandate the independent contractor receive training from their agency. They must ensure 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 provider 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 Staff and Support Staff

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

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

**Q. How is back-up staffing 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 individual service plan (ISP), and 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. Use of back-up staff 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.** The following apply to back-up staff hours:

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

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

**A.** This depends on the supervision needs and alone time for the participant. When a Shared Living provider needs more than 360 hours of back-up staff:

1. The home could be changed to the Continuous Home model with staff who are employees so the participant can 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 to assist; or
3. The Shared Living provider and the participant's team can assess whether the Shared Living service and setting are right for the participant.

**Q. Can the Shared Living provider use support staff?**

**A.** Yes. The Shared Living provider can use support staff to assist with providing services to a participant when:

1. The Shared Living provider is in the home the entire time and also providing support; and
2. The support staff is not used for a continuous 24-hour time frame.

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

**A.** The following are examples related to back-up staff:

1. When the Shared Living provider leaves the home for a few hours, such as for an appointment or to go bowling, and the participant does not have alone time or chooses not to use alone time, a back-up staff is required while they are out of the home.
2. When the Shared Living provider is traveling and doesn't take the participant with them, a back-up staff is required to stay with the participant until the Shared Living provider returns.

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

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

**Q. How can a Shared Living provider handle a situation when they are hospitalized or have an emergency?**

**A.** When a Shared Living provider is hospitalized for an extended period or has an emergency situation, it is possible for the agency provider who contracts with the Shared Living provider to temporarily make the home a continuous residential home and use agency provider staff for participants in the house. In this situation none of the 360 hours is used and Shared Living is not billed.

## Leases:

**Q. Can an agency provider own or lease the property where 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 on their relationship with the agency provider 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 live in the same Shared Living home?**

**A.** A Shared Living home may serve one or two participants. Groups of three must be approved by DHHS-DD.