

## The Basics of Nevada Medicaid Waivers

You must be financially eligible for the Nevada Medicaid program. The rules for assessing your income and assets vary from Medicaid category to category and are complex. A Division of Welfare and Supportive Services caseworker will work with you to evaluate financial eligibility and the programs for which you may be eligible.

### Waiver Programs

Individuals with special needs may qualify for Nevada Medicaid through special waiver programs. Persons who qualify may receive enhanced benefits. Waivers allow Nevada Medicaid to pay for supports and services to help people, who would otherwise be in a nursing facility or other institution, to live safely in their own homes or community. These programs serve a limited number of persons who meet the program criteria for eligibility.

Nevada Medicaid Waiver programs include the Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities, Waiver for Individuals with Intellectual Disabilities and Related Conditions, the Katie Beckett Waiver (aka Section 134), and the Home and Community Based Waiver (HCBW) for the Frail and Elderly. For the purposes of this document, we will discuss HCBW for Persons with Physical Disabilities, the Waiver for Individuals with Intellectual Disabilities and Related Conditions, and the Katie Beckett Waiver.

### Waiver for Individuals with Intellectual Disabilities and Related Conditions

The delivery of waiver services is based on the identified needs of the waiver recipient. Nevada's Waiver for Individuals with Intellectual Disabilities and Related Conditions waives certain statutory requirements and offers Home and Community-Based Services (HCBS) to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with intellectual disabilities or a related condition and who have been found eligible and have an open case with an Aging and Disability Services Division (ADSD) Regional Center.

Individuals are eligible if they meet Medicaid's eligibility requirements and are either in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or are at risk for ICF/IID placement without the provision of HCBS and support services.

Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources. However, waiver services are available to supplement those support systems so the individual is able to remain in their home. Special consideration may be given in individual circumstances when there is no other Legally Responsible Individual (LRI) residing in the home and an able and/or capable parent's employment requirements result in prolonged or unexpected absences from the home, when such employment requires the able and/or capable parent or LRI to work uninterrupted at home in order to satisfy the employment commitments, or when employment requirements include unconventional work weeks or work hours. The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury; or unavailable, due to hours of employment and school attendance, to provide the requested waiver services.

Under this waiver, the following services are available for individuals who have been assessed to be at risk for ICF/IID placement without the delivery of enhanced supports as identified in their Individual Support Plan (ISP): a) Day Habilitation; b) Prevocational Services; c) Supported Employment; d) Behavioral Consultation, Training and Intervention; e) Residential Habilitation and Residential Support Services; f) Residential Habilitation and Residential Support Management; g) Counseling (Individual and Group); h) Non-Medical Transportation; i) Nursing Services; j) Nutrition Counseling Services, and/or k) Career Planning.

## Katie Beckett

Under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), States are allowed the option to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of the parents' income or resources. Section 134 is also known as the "Katie Beckett" Option in reference to the child whose disability prompted this change.

Under the Katie Beckett Eligibility Option Medicaid eligibility category, a State is allowed to waive the deeming of parental income and resources for a disabled child under 19 years of age who would be eligible for Medicaid if the child were in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution.

The child must require a Level of Care (LOC) that would make him or her eligible for placement in a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR). A physician must sign a statement indicating that it is appropriate for the child to receive services in the home. The eligibility criteria are re-determined on an annual basis or in the case of a Pediatric Specialty Care level, every six (6) months.

For children who become eligible for Medicaid under the Katie Beckett Eligibility Option, Medicaid covers medically necessary services as defined by the Medicaid State Plan. There is a monetary limit to the Medicaid medical coverage costs. The cost of the child's care in the home must be no greater than the amount Medicaid would pay if the child was institutionalized. And there may be a cost-sharing participation needed by the parent or LRI. The Parental Financial Responsibility (PFR) is based on evaluation of parental/LRI's income and resources by the Department of Welfare and Supportive Services (DWSS) with the PFR amount determined based upon a sliding fee schedule.

## Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities

The HCBW for Persons with Physical Disabilities waiver is designed to provide to eligible Medicaid waiver recipients State Plan Services and certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

The recipient's Level of Care (LOC), functional status and needs addressed by the Plan of Care (POC) must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in their condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit. The individual with physical disability must require delivery of at least one ongoing waiver service monthly to be eligible for waiver services as documented in the POC.

Home and community based services are not a substitute for natural and informal supports provided by family, friends or other available community resources. Waiver services alone may not address all of the individual's identified needs. Under the waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization: a) Case Management; b) Homemaker Services; c) Chore Services; d) Respite; e) Environmental Accessibility Adaptations; f) Specialized Medical Equipment and Supplies; g) Personal Emergency Response System (PERS); h) Assisted Living Services; i) Home Delivered Meals, and/or j) Attendant Care Services.

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