NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

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Pursuant to
Neb. Rev. Stat. § 84-901.03

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Date Approved: November 3, 2022

Medically Handicapped Children's Program (MHCP)

Legal Basis:

Title V Services for the Medically Handicapped Children's Program is administered under Public Law 97-35, Subtitle D, 42 United States Code (U.S.C.) §§ 701-713, "Title V Maternal and Child Health Services Block Grant", and Nebraska Revised Statute (Neb. Rev. Stat.) §§ 43-522, 68-309, and 68-717. The Genetically Handicapped Persons Program is a program for adults with cystic fibrosis, hemophilia, and sickle cell disease established by Neb. Rev. Stat. §§ 68-1401 to 68-1406. The Disabled Children's Program is administered by the Department as part of the Title V Maternal and Child Health Services Block Grant.

The Medically Handicapped Children's Program and Disabled Children's Program are funded by a federal block grant and state funds appropriated by the legislature. The Genetically Handicapped Persons Program is funded by state funds appropriated by the legislature. The Department has the authority to set priorities of services and service components based on available funding. Donations may be accepted.

MHCP's Definitions:

- Active Treatment means treatment which is directed immediately to the cure, maintenance, or improvement of the client's medical condition.
- Acute Condition means a medical condition having a sudden onset, sharp rise, and a short course.
- Certification means a process in which the client is approved for a specific individual medical treatment plan and is determined financially eligible; authorization for specific care is then approved.
- Chronic Condition means a medical condition that is slow in its progress and long in duration which can be improved or maintained through active medical treatment or stabilized.
- Clinic means a process in which MHCP contracted or approved medical specialists, including the family evaluate the client and formulate the individual medical treatment plan (IMPT) in a MHCP designated setting.
- Deductions mean those items that are directly subtracted from the family's countable income and resources before comparison to the MHCP financial guidelines to determine financial eligibility.

- Eligibility means a process in which the client is approved for a specific individual medical treatment plan and is determined financially eligible; authorization for specific care is then approved.
- Emancipated Minor means when determining financial eligibility, a child 18 or younger who is considered an adult because s/he:
    1. Married; or
    2. Moved Away from parent/s home and is not receiving support from the parent/s.
- Family means a unit consisting of one or more adults (individuals aged 19 or older) and one or more children related by blood, marriage, or adoption who are considered members of the household unit. An unborn child may be included if proof of pregnancy is obtained. The following are considered separate families:
    1. Related Adults other than spouses and unrelated adults who reside together,
    2. Children living with non-legally responsible relatives; and
    3. Emancipated minor.

    An individual age 19 or older living at home is considered a separate family unit. The services coordinator must consider only the individual's income and resources. Family support is considered contributions.
- Financial Margin means twenty-five percent of the amount by which the family's countable income and resources exceed the MHCP financial guidelines minus the disregard and financial margin deductions.
- Financial Margin Deductions means those items that are subtracted from the financial margin to determine any amount that the client, parents, or guardian must obligate on the client's medical care.
- Individual Medical Treatment Plan (IMTP) means a written individualized plan developed by an MHCP-contracted physician specialist or a clinic team which prescribes specific treatment and/or diagnostic evaluation.
- Medically Handicapped (Children with Special Health Care Needs) means children under twenty-one years of age who experience an orthopedic condition, cerebral palsy, cystic fibrosis, heart disease, an eye problem amenable to surgery, an oral plastic handicap, mid-line birth defect, hearing problem, neoplasm, or any other major illness which is disabling or will lead to a disability and for which an active treatment plan is indicated. Care for acute conditions, such as infectious disease, appendectomy, or simple fractures, is not covered under this program.
- Recipient means an individual who has been referred to, has applied for or is certified for MHCP.

- Referral means an action by which a family or individual desires to receive services for children with special health care needs is made known to an office of the Department of Health and Human Services.
- Review a complete re-examination of all documents and other available information on the case and, if requested by the aggrieved party may include a meeting for an informal discussion of the matter between the aggrieved party, and his/her representative (if any), and MHCP administrative staff conducting the review.
- Provider means an individual or agency selected by a family or caregiver to provide.
- Valid Driver's License is a current license issued by the State or local office authorized to license individuals for the operation of motor vehicles.
- Vehicle Registration is the registration of a motor vehicle with a government authority, either compulsory or otherwise.

- Emergency Referral:
  - A hospital emergency department that wishes to refer potential applicants must make the referral within five days of admission to the hospital.

- Applications:
  - The Department must receive the completed application and signed release from the applicant within 30 days after the Department mails the forms.

- Income Exclusions:
  - Child support or spousal support are excluded as sources of income.

- Resource Limits:
  - There are no resource limits for MHCP programs.

- Services Provided outside of Nebraska:
  - Emergency situations that arise while the recipient is visiting in another state and the recipient's health would be jeopardized if care was postponed until the recipient returned to Nebraska. Medical services are covered as if they were provided in Nebraska. Emergency services may be reviewed by the medical consultant. Emergency services will be covered for up to five days.

- Medical Eligibility Determination:
  - The department will determine the medical eligibility for diabetes diagnosis. The medical consultant does not determine medical eligibility.

- Medical Eligibility Determination:
  - The department determined the medical eligibility for heart diagnosis. The Medical consultant will only determine eligibility for heart conditions that fall under the “other diagnoses may be considered” category.

- Hemophilia Diagnosis and Services:
  - This service provides treatment for hemophilia and certain bleeding disorders.

- Specialized Medical Care:
  - Specialized medical care is covered, according to each diagnoses’ service component, for eligible recipients aged 21 years and older. The medical care must be outlined in the individual medical treatment plan that is developed and signed by a health care professional. The specialized medical care must be directly related to the medically eligible diagnosis. Routine, general health care is not a covered service.

- Provider Enrollment:
  - The provider must maintain records on services provided for a minimum of six years after the date of service.

- Timely Filing:
  - Medical providers must bill within six months from the date of the service for payment to be considered by the Department. Claims received beyond six months from the date of the service will be denied.

- Payment Rates for Medical Services:
  - Pharmacy rates are as billed. Durable Medical Equipment, Physician rates, Hospital rates, and Dental rates follow the Medicaid fee schedules.

- Applications:
  - Upon receiving a referral, the Department verifies Supplemental Security Income's current pay status prior to applications being mailed to potential applicants. The Department must receive the completed application within 30 days after the Department mails the application. A legally responsible adult age 19 or older must complete the application. A referral is not a requirement for completing an application.

- Needs Assessment:

- Once the applicant or recipient is determined eligible, a needs assessment is completed to identify the disability-related needs of the family.

- Medical Mileage:
  - Medical mileage reimbursement is a covered service for families who transport recipients to disability-related medical care or treatment. Mileage for routine, general health care is not a covered service. The reimbursement rate for medical mileage follows the annual Internal Revenue Service standard mileage rate per mile driven for medical purposes.
  - All Mileage Reimbursement billing will be required to show proof of valid driver's license and current vehicle registration.
    - Mileage reimbursement will be denied to unlicensed drivers.
    - If the vehicle is not registered in the parent/guardian's name, prior approval will need to be submitted to Program Coordinator.
- Lodging:
  - Lodging is a covered service for families who travel long distances for disability-related care or treatment for the recipient. If lodging is available through another program at no cost or minimal cost, this service may not be available. The reimbursement rate for lodging follows the annual United States General Services Administration Per Diem Rates based on the location of the lodging. Additional lodging for leisure is optional and not covered.

- Respite Care:
  - Respite care is a covered service to provide caregivers a short break from taking care of the recipient with special health care needs. The Department determines the maximum dollar amount of respite care for each recipient based on the needs of the family and available funds, not to exceed $125 per month, which is then included in the individual service plan. Respite care may not be used as child care when a caregiver is working or going to school.

- Respite Providers:
  - Parents and legal guardians of recipients are responsible for locating respite providers to care for the recipients. The following are required of all respite providers:
    - (1)The provider must undergo a child and an adult registry check at least once every twelve (12) months to be enrolled as a provider. The Department may require additional registry checks when the circumstances warrant further investigation. The Department may at its discretion accept a child and an adult registry check completed by another Department program within the previous twelve (12) months.

Funds cannot be used to pay providers identified on the Department's child or adult registries as a substantiated perpetrator of abuse or neglect.

- (2)The provider must be age 19 years or older.
- (3)The provider must not reside in the household with the recipient.
- (4) Non-relative providers are encouraged. The Department has the discretion to deny payment for relative providers so long as providers are available in the recipient's residing area.

- Payments to the Recipient's Parents or Legal Guardian:
  - Payments are made as a reimbursement to the parent or legal guardian of the recipient for medical mileage and lodging services. Billing documents must be completed accurately and received by the Department timely, within 60 days from the date of service, in order to be considered for payment. Billings received by the Department after 60 days from the date of service will be denied payment. One billing document must be completed each month for each type of service authorized. Inaccurate or incomplete billing claims may be denied.