

TITLE 480
HOME AND COMMUNITY-BASED WAIVER SERVICES
FOR AGED PERSONS OR ADULTS OR CHILDREN WITH DISABILITIES

Chapter 5 Home and Community-Based Waiver Services for Aged Persons or Adults or Children
With Disabilities

5-001 INTRODUCTION

A. GENERAL INTRODUCTION

Home and community-based waiver services offer eligible persons a choice between entering a Nursing Facility (NF) or receiving supportive services in their homes. Medicaid funding through the Nebraska Medical Assistance Program (NMAP) is used to fund either service option. The average cost of waiver services funded by Medicaid must not exceed the average cost to Medicaid for NF services.

To be eligible for support through this "Aged and Disabled Waiver," a potential client must meet the following general criteria:

1. Have care needs equal to those of Medicaid-funded residents in Nursing Facilities;
2. Be eligible for Medicaid; and
3. Work with the services coordinator to develop an outcome-based, cost effective service plan.

B. PHILOSOPHICAL BASE

Waiver services build on client/family strengths and are intended to strengthen and support informal and formal services already in place to meet the needs of the client and are not intended to replace them.

Waiver services utilize a self-directed services philosophy and vision that holds that each client has the right and responsibility to participate to the greatest extent possible in the development and implementation of his/her service plan.

The services coordinator and the client together shall identify appropriate levels of services coordination by considering risk factors or capacity to direct their own services. The services coordination levels include:

- ! Self-Directed Services Coordination
- ! Supportive Services Coordination
- ! Comprehensive Services Coordination

Elements in the following areas shall be considered to determine the level of services coordination both initially and as service levels change:

1. Determination of strengths, priorities, and resources.
2. Planning for services.
3. Connecting with needed services.
4. Advocacy.
5. Monitoring.

C. ADMINISTRATION

The Health and Human Services (HHS) System administers Nebraska's Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities. Administrative activities include -

1. Obtaining waiver approval and reapproval from the Health Care Financing Administration (HCFA);
2. Establishing policies and procedures to implement the waiver;
3. Developing and maintaining a priority process for access to the waiver;
4. Determining children's level of care eligibility for the waiver;
5. Monitoring expenditures under the waiver;
6. Developing and maintaining a quality assurance process for the waiver;
7. Performing on-site reviews to determine compliance with waiver requirements;
8. Performing case record reviews;
9. Maintaining statistics;
10. Conducting training;
11. Providing technical assistance and consultation;
12. Processing billings for services provided; and
13. Reporting required data to HCFA.

D. IMPLEMENTATION

1. Services coordination activities

Staff assigned services coordination assume the following responsibilities:

- a. Utilizing the priority process when accepting referrals;
- b. Assessing, together with the client, his/her strengths, needs, priorities, and resources;
- c. Determining a potential waiver client's eligibility for waiver services;
- d. Jointly developing a plan of services and supports with each waiver client;
- e. Determining appropriate resources to meet the client's needs and desired outcomes;

- f. Determining the estimated total monthly cost of a proposed plan of services and supports and comparing the estimated cost to the Medicaid monthly payment for care in a NF. This dollar amount is referred to as "the ongoing cap";
- g. Offering the client/legal guardian the choice of nursing facility or waiver services;
- h. Arranging for support and services identified in the plan of services and supports, while maintaining the client's freedom of choice in providers;
- i. Authorizing a plan of services and supports for each waiver client;
- j. Contacting, coordinating, and confirming the client's service provision with providers of service;
- k. Coordinating services from all available sources to ensure that client needs and desired outcomes are met;
- l. Working with the client depending upon the level of services coordination needed;
- m. Jointly reviewing needs;
- n. Jointly measuring outcome achievement;
- o. Monitoring ongoing service provision;
- p. Annually reevaluating level of care;
- q. Annually reviewing plan of services and supports;
- r. Assisting the client and the client's Medicaid eligibility staff in tracking spenddown obligation/shared cost;
- s. Monitoring ongoing Medicaid eligibility; and
- t. Providing documentation to support case decisions and actions.

2. Resource development activities

Staff assigned resource development assume the following responsibilities:

- a. Recruiting or locating providers to allow each waiver client's freedom of choice;
- b. Approving and contracting with providers;
- c. Monitoring provider service provision;
- d. Providing narrative documentation; and
- e. Conducting public information activities.

E. GLOSSARY OF TERMS

Adult: For the purposes of Medicaid and this waiver, an individual age 18 or older.

Aged: For the purposes of Medicaid and this waiver, an individual age 65 or older.

Assessment: A process which includes receiving referrals, gathering information, interviewing, and jointly determining client strengths, needs and desired outcomes.

Cap: The average Medicaid monthly expenditure for care in a NF. This dollar amount is referred to as "the cap."

Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the client. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

Child: For the purposes of Medicaid and this waiver, an individual age 17 or younger.

Cost Effective: A requirement that the expenditures reflected in the Plan of Services and Supports be within "the cap" and also reflect a service rate appropriate for the client's individualized service need.

Guardian: The biological or adoptive parent of a minor child, or an individual appointed by a court to ensure that an adult's needs are met and well-being is protected.

Institutional Setting: A hospital or a nursing facility.

Nursing Facility (NF): A facility licensed by the Department of Health and Human Services Regulation and Licensure as a nursing facility.

Plan of Services and Supports: A process for providing services and supports that takes into consideration each client's strengths, needs, priorities, and resources and results in an individualized, written plan for each client. This plan describes the full range of services to be furnished (regardless of funding source), their frequency, and the type of provider who will furnish each.

Senior Care Options: Nebraska's NF preadmission screening program for aged persons and Aged and Disabled Waiver services coordination system for eligible persons who choose to explore home care.

Services Coordination: An individualized, goal-oriented process, based on client choices, that makes the best use of resources to maximize independence and attain the level of care that is consistent with the client's level of need. Services coordination is federally referred to as case management.

Slots: Nebraska's quota of waiver clients.

Waiver: Nebraska's Home and Community-Based Waiver for Aged Persons or Adults and Children with Disabilities.

5-002 CLIENT ELIGIBILITY CRITERIA

Clients eligible for waiver services must -

1. Be eligible for the Nebraska Medical Assistance Program (NMAP);
2. Have participated in an assessment with a services coordinator;
3. Meet the Nursing Facility (NF) level of care criteria (471 NAC 12-000);
4. Have care needs which could be met through waiver services at a cost that does not exceed the cap; and
5. Have received an explanation of NF services and waiver services and elected to receive waiver services.

Waiver services are provided statewide to eligible clients for whom a slot is available.

5-003 SERVICES COORDINATION PROCESS

Services coordination is an individualized, goal-oriented process, based on client/family choices, that makes the best use of resources to maximize independence and attain the level of care that is consistent with the client's level of need. Waiver services coordination may be provided by HHS staff or, staff under contract with HHS.

A. AGED PERSONS AND ADULTS WITH DISABILITIES

1. ACCESS

PURPOSE: To allow easy entry into the health and human services system for persons who are in need of services.

To allow for multiple entry points into the health and human services system for persons via familiar professionals/sites.

Potential clients access long term care services through either the Department of Health and Human Services, Vocational Rehabilitation Services, Area Agencies on Aging, Independent Living Centers or other community agencies.

2. INTAKE/SCREENING

PURPOSE: To collect information to further identify the potential client's needs, evaluate waiver level of care eligibility, and prioritize the referral.

The services coordinator shall -

- a. Accept referrals of potential waiver clients from any source (e.g., the potential client, the potential client's relative, HHS staff, Care Management Unit staff, hospital staff, nursing facility staff, a physician, advocacy agencies).
- b. Document the date of referral and gather demographic information.
- c. Gather functional information needed to determine whether the potential client meets the NF level of care required for eligibility while interviewing the referral source and/or collateral contacts. This information is gathered in the following assessment categories:

(1) Activities of daily living -

- (a) Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.
- (b) Continence: The control of one's body to empty the bladder and/or bowel on time; the ability to change incontinence pads/briefs, cleansing, and disposing of soiled articles; ability to manage ostomy equipment; ability to self-catheterize.
- (c) Dressing/Grooming: The ability to put on and remove clothing as needed from both upper and lower body; the ability to do routine daily personal hygiene (combing hair, brushing teeth, caring for dentures, washing face and hands, and shaving).
- (d) Eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth, and does not include meal preparation.
- (e) Mobility: The ability to move from place to place indoors or outside.
- (f) Toileting: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet, management of clothing, and cleansing.
- (g) Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (It does not include toilet transfer.)

(2) Risk Factors -

- (a) Behavior: The ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially-appropriate manner.
- (b) Frailty: The ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk.
- (c) Safety: The availability of adequate housing, including the need for home modification or adaptive equipment to assure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect.

(3) Medical Treatment or Observation

- (a) A medical condition is present which requires observation and assessment to assure evaluation of the individual's need for treatment modification or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or
- (b) Due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; or
- (c) The individual requires at least one ongoing medical/nursing service. The following is a non-inclusive list of such services which may, but not necessarily, indicate need for medical or nursing supervision or care:
 - (1) Application of aseptic dressing;
 - (2) Routine catheter care;
 - (3) Respiratory therapy;
 - (4) Supervision for adequate nutrition and hydration due to clinical evidence of malnourishment or dehydration or due to a recent history of weight loss or inadequate hydration which, if unsupervised, would be expected to result in malnourishment or dehydration;
 - (5) Therapeutic exercise and positioning;
 - (6) Routine colostomy or ileostomy care or management of neurogenic bowel and bladder;
 - (7) Use of physical (side rails, poseys, locked wards) and/or chemical restraints;
 - (8) Routine skin care to prevent pressure ulcers for individuals who are immobile;
 - (9) Care of small, uncomplicated pressure ulcers and local skin rashes;
 - (10) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
 - (11) Chemotherapy;
 - (12) Radiation;
 - (13) Dialysis;
 - (14) Suctioning;
 - (15) Tracheostomy care;
 - (16) Infusion therapy;
 - (17) Oxygen;
 - (18) Open lesions other than stasis or pressure sores (e.g., cuts);
 - (19) Wound care or treatment (e.g., pressure ulcer care, surgical wound);
 - (20) Intravenous medications;
 - (21) Transfusions;
 - (22) Medication monitoring; and/or
 - (23) Other special treatment or procedure.

(4) Cognition

- (a) Memory: Ability to remember past and present events; does not need cueing;
- (b) Orientation: Fully oriented to person, place, and time.
- (c) Communication: Ability to communicate information in an intelligible manner, and the ability to understand information conveyed.
- (d) Judgment: Ability to solve problems well and make appropriate decisions.

The services coordinator may administer a standard mini-mental test, as appropriate, to further identify memory, orientation, and communication limitations. Additional exploration of judgment may also be necessary.

d. Determine NF level of care.

Services coordinators collect the above information on each individual seeking NF or waiver services to determine the functional abilities and care needs of that individual. Information may be gathered from a variety of sources (e.g., the individual, family, care providers, physicians, facility staff, case files, medical charts), using observation, documentation review, and/or interview until sufficient information is obtained to determine the individual's current functioning in each area.

Persons who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria for Nursing Facility or Aged and Disabled Home and Community-based Waiver services:

- I. Limitations in three or more Activities of Daily Living (ADL) AND Medical treatment or observation.
- II. Limitations in three or more ADLs AND one or more Risk factors.
- III. Limitations in three or more ADLs AND one or more Cognition factors.
- IV. Limitations in one or more ADLs AND one or more Cognition AND one or more Risk factors.

For those clients who meet NF level of care, the services coordinator shall then determine if the client meets priority criteria.

If the potential client does not meet the NF level of care criteria, the services coordinator shall inform the referral source of this decision and provide notice to the potential client/guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral. Notices to clients must contain -

- (1) A clear statement of the action to be taken;
- (2) A clear statement of the reason for the action;
- (3) A specific policy reference which supports such action; and
- (4) A complete statement of the client's right to appeal.

e. Determine priority.

The services coordinator shall assign priority to potential clients who have been verified as being NF level of care and who are awaiting initial assessment by obtaining sufficient information about client needs and current services using the following criteria:

- (1) Needs in domains which define NF level of care are so severe that the health and welfare of the client are jeopardized, but the needs could safely be met with immediate waiver services;
- (2) Family/caregivers are in a crisis/high stress situation;
- (3) No informal support network is available to meet identified needs;
- (4) Inappropriate out-of-home placement is being planned;
- (5) No other program is available to meet the needs identified in the referral;
- (6) Support services are required to allow the client to return home (e.g., a Medicaid-eligible recipient is ready to be discharged from a hospital);
- (7) A client with an identified waiver service need lacks access to resources to meet needs in domains which define NF level of care AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
- (8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Based upon this information, the services coordinator shall determine the priority ranking. Prioritization of need is a process that occurs throughout multiple elements of services coordination from access through determination of strengths, priorities, and resources.

Priority Criteria Met:

If the client appears to meet NF level of care criteria and is determined to be a priority referral, the services coordinator shall contact the potential client/guardian to inform him/her that the client is eligible to be assessed for waiver services and obtain an initial request. The services coordinator shall document the date of the request in the case narrative and arrange an assessment visit.

Note: If the services coordinator has not already done so, s/he shall determine whether the potential client has been determined eligible or has applied for Medicaid. If the client has not applied for Medicaid, the services coordinator shall immediately refer him/her to Medicaid intake.

Priority Criteria Not Met:

If the potential client does not meet priority criteria, the services coordinator shall inform the referral source of this decision and provide notice to the potential client/guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral.

3. DETERMINATION OF STRENGTHS, PRIORITIES, AND RESOURCES

PURPOSE: To identify the potential client's individual strengths, needs, priorities, and resources so an appropriate plan of services and supports can be developed.

The services coordinator shall meet in person with the potential client and legal guardian, if any, to confirm the NF level of care determination and to complete an assessment of the potential client's strengths, needs, priorities, and resources. This meeting must be arranged and completed within 14 days of the request date and be held on a date and time convenient to the client/guardian. In emergency situations, the assessment must be completed within 24 hours.

If the potential client has been assessed using the program's assessment instrument within the past year, the services coordinator may use the previous assessment or obtain a release from the client to request a copy of the completed form to determine whether further assessment is indicated.

If at any point during the eligibility process, the client/legal guardian chooses NF services instead of waiver services, the services coordinator shall work with appropriate HHS staff to make these arrangements.

If at any point after the assessment, the client/legal guardian voluntarily withdraws from receiving waiver services, the services coordinator shall provide written notice of ineligibility and also provide appropriate referrals.

4. PLANNING FOR SERVICES

PURPOSE: To identify specific individual services to be provided in a coordinated and organized manner.

The services coordinator shall -

- a. Together with the potential client, develop a plan of services and supports based upon assessment results. This is accomplished by identifying desired client outcomes. Outcomes should occur in one or more of the following NF assessment categories: activities of daily living; high risk factors, joint motion; locomotion; nursing observations; orientation; and medical and nursing needs.

The plan of services and supports must ensure the potential client's health and welfare, including the consideration of acceptable risk. If, despite consideration of the full range and scope of services, the client's health or welfare is in jeopardy, waiver services may not be provided.

The potential client has freedom of choice in selecting providers of waiver services. The client's choice of providers is documented in the client's case narrative.

Copies of the plan of services and supports are distributed to other persons and agencies at the directive, and with the consent of, the client/guardian.

- b. Determine the cost of serving the potential client and determine that the estimated total monthly cost, excluding the costs of Assistive Technology and Supports (ATS) and Home Modifications, does not exceed the ongoing cap. The ongoing cap may change annually.

Services included in calculating the cost of the plan of services and supports are the Medicaid non-waiver services of home health care, personal care aide, and medical transportation and all ongoing waiver services. ATS and home modifications are one-time or annually-only waiver services and are separately capitated. This separate cap may change annually.

Ongoing caps established for persons who are partially or completely ventilator dependent may not be exceeded but may change annually.

The ongoing cap for aged persons who are not partially or completely ventilator dependent may be exceeded by no more than an established average amount per month for no more than six months in a 12-month period. If the cost of the potential client's plan of services and supports does exceed the ongoing cap and does not meet this criteria, the services coordinator shall provide written notice of ineligibility to the client/guardian. The services coordinator shall also provide appropriate information and referral.

For adults with disabilities who are not partially or completely ventilator dependent, if the estimated monthly cost of the plan of services and supports exceeds the ongoing cap, the services coordinator shall contact HHS Central Office to discuss possible approval to exceed the ongoing cap. Central Office considers the following factors in making this decision and may approve or disapprove the request based upon them:

- (1) Client demographics (e.g., living situation, diagnosis, treatment plan, and prognosis);
- (2) Health and welfare concerns;
- (3) A description of the plan of services and supports;
- (4) The costs of the ongoing waiver services (i.e., plan totals aside from home health, personal care aide, ATS, home modifications, and medical transportation);
- (5) Available support systems; and
- (6) Possible funding shifts to other programs (e.g., Social Services Block Grant).

If the cost of the potential client's plan of services and supports does exceed the ongoing cap and an exception is not approved, the services coordinator shall provide written notice of ineligibility to the client/guardian. The services coordinator shall also provide appropriate information and referral.

Note: The ongoing cap for aged persons applies to adults with disabilities when they reach age 65.

- c. Offer the client or his/her guardian the option of accepting NF or waiver services as described in the plan of services and supports, after the client has been determined to meet the NF level of care criteria, an assessment completed, and a plan of services and supports developed. If the client or the guardian chooses to accept waiver services, the services coordinator shall obtain the proper signature on the waiver consent form. The consent form must be signed at initial determination only and remains valid as long as the waiver case is open.

Note: The waiver consent form is not valid and must not be signed until the client's eligibility for Medicaid has been determined or presumptive waiver eligibility has been established. The client's waiver eligibility period may begin no earlier than the date of the client/guardian's signature on the consent form.

Presumptive Waiver Eligibility: Waiver eligibility may be presumed for any potential waiver client for whom a signed Medicaid application has been received by Medicaid eligibility staff and when the applicant is willing to cooperate with its completion (e.g., is willing to provide all requested financial records; is willing to pay a spenddown/shared cost, if required). The services coordinator shall contact the Medicaid eligibility staff to determine if it is likely the client will become Medicaid eligible prior to obtaining the client's signature on the consent form. Notation must be made on the consent form indicating presumptive waiver eligibility until a final Medicaid eligibility decision has been made.

The services coordinator shall have ongoing contact with the Medicaid eligibility staff until a final Medicaid eligibility decision has been made. If the client is determined not to be Medicaid eligible, the services coordinator shall provide written notice, effective immediately, to the client/guardian and also provide appropriate information and referral. Ten-day notice is not allowed.

Services which may be presumptively authorized are ongoing waiver services and medical transportation. Presumptive authorization for ATS and home modifications is not allowed. Any authorized services shall result in the payment of the provider.

5. CONNECTING/LINKING NEEDED SERVICES

PURPOSE: To translate the plan of services and supports into action.

To locate or develop resources to address identified service gaps.

To identify and promote an effective/optimum use of community resources.

The services coordinator shall prior authorize waiver services for up to a 12-month period, based on the plan of services and supports and the results of ongoing monitoring activities. Waiver services may not be authorized until the client's Medicaid eligibility has been determined and the waiver consent form has been signed.

The services coordinator shall provide a written description to the provider, clearly defining the parameters of service delivery. This must include at least the amount and frequency of service provision, specific service components authorized, and any applicable time limitations. Any applicable conditions or limitations relate solely to the eligibility of the waiver client and program policies and do not constitute an effort to directly control contract performance by the provider.

6. ADVOCACY

PURPOSE: To ensure the client's interests and concerns are represented and protected.

To promote client self-sufficiency and self-advocacy as appropriate.

To promote community responsiveness to the needs and concerns of clients.

The services coordinator shall provide timely notices and fully inform the client/guardian of his/her rights and responsibilities. The services coordinator shall also provide encouragement and referral for training to promote client self-directed services, self-sufficiency, and self-advocacy.

7. MONITORING

PURPOSE: To continually evaluate the effectiveness of the jointly developed plan of services and supports.

To ensure quality service delivery.

The services coordinator shall:

- a. Contact the client depending upon the level of services coordination needed. For clients directing their own services and for clients needing supportive services coordination, minimum contact shall be monthly, with at least quarterly in-person visits. For clients needing comprehensive services coordination, minimum contact shall be monthly with in-person visits at least every other month. All in-person contacts shall be at a time, date, and location convenient to the client.
- b. Ensure, by both client interview and observation, that the formal and informal supports and services being provided continue to meet the client's needs, and revise the plan of services and supports accordingly.
- c. Review the client's needs monthly, including service usage and cost, and revise the plan of services and supports to meet newly identified needs.
- d. Review the client's desired outcomes regularly with the client and revise the plan of services and supports to refine action steps to meet previously identified outcomes and develop action steps to meet newly identified outcomes.
- e. Maintain regular communication with Medicaid eligibility staff, especially in regard to the client's spenddown/shared cost obligation and ongoing Medicaid eligibility.
- f. Determine whether a reassessment of the client's level of care and strengths, needs, and resources is necessary when information is received that the care needs of the client have changed. This determination shall be made within two working days of the receipt of this information. A reassessment may also be initiated based upon the services coordinator's observation of client functioning (either improvement or decline) during a routine services coordinator contact. If a reassessment is completed and the client remains NF level of care, a new plan of services and supports must be developed. The services coordinator shall document any provider change in the case narrative.
- g. Review the client's satisfaction with the services provided, reviewing the client's overall health status, and verify that the provider(s) is complying with the requirements of perspective service provision.

B. CHILDREN WITH DISABILITIES

1. ACCESS

PURPOSE: To allow easy entry into the health and human services system for children with disabilities and their families who are in need of services.

Children with disabilities and their families access home and community-based services through the Department of Health and Human Services, community agencies, or personnel who provide services for children with disabilities and their families.

2. INTAKE/SCREENING

PURPOSE: To collect information to further identify the child/family's needs and prioritize the referral.

The services coordinator shall -

- a. Accept referrals of potential waiver eligible children from any source (e.g., the child's relative, HHS staff, hospital staff, a physician, school staff, advocacy agencies).
- b. Document the date of referral and gather demographic information.
- c. Prioritize needs of children awaiting initial assessment by obtaining sufficient information about child and family needs and current services using the following criteria:
 - (1) Needs in NF domains are so severe that the health and welfare of the child are jeopardized, but the needs could safely be met with immediate waiver services;
 - (2) Family is in a crisis/high stress situation;
 - (3) No informal support network is available to meet identified needs;
 - (4) Inappropriate out-of-home placement is being planned;
 - (5) No other program is available to meet the needs identified in the referral;
 - (6) Support services are required to allow the child to return home (e.g., a Medicaid-eligible child is ready to be discharged from a hospital);
 - (7) Family of a child with an identified waiver service need lacks access to resources to meet the child's needs in NF domains AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
 - (8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications whose family lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Based on this information, the services coordinator shall determine the priority ranking.

If the potential waiver eligible child does not meet priority criteria, the services coordinator shall inform the referral source of this decision and provide notice to the child's guardian, if that contact has been made. The services coordinator shall also provide appropriate information and referral.

- d. Contact the child's guardian to inform him/her that the child is eligible to be assessed for waiver services, if the child is determined to be a priority referral, and obtain an initial request. The services coordinator shall document the date of the request in the case narrative and arrange an assessment visit.

Note: If the services coordinator has not already done so, s/he shall determine whether the child has been determined eligible or application has been made for Medicaid. If application has not been made for Medicaid, the services coordinator shall immediately refer the child's guardian to Medicaid intake.

3. DETERMINATION OF STRENGTHS, PRIORITIES, AND RESOURCES.

PURPOSE: To identify the potential waiver eligible child's and family's strengths, needs, priorities, and resources so an appropriate plan of services and supports can be developed.

The services coordinator shall -

- a. Meet in person with the child and his/her guardian to complete an assessment of the child's and family's strengths, needs, priorities, and resources. This meeting must be arranged and completed within 14 days of the request date and be held on a date and time convenient to the family. In emergency situations, the assessment must be completed within 24 hours.

During the assessment, the services coordinator, together with the child and family, shall begin to develop the plan of services and supports.

The services coordinator may conduct an initial assessment of a child with a contracted nurse as appropriate, when the child's medical condition warrants interdisciplinary assessment. Written authorization for the assessment must be provided to the nurse.

If the child has been assessed using the program's assessment instrument within the past year, the services coordinator may use the previous assessment or obtain a release from the guardian to request a copy of the completed form to determine whether further assessment is indicated.

Early Intervention Exception: If an infant or toddler is receiving services coordination through Early Intervention, assessment provided through the Individualized Family Service Plan (IFSP) process substitutes for this and any other subsequent face-to-face assessments. The waiver services coordinator may be involved as a member of the IFSP team or may only offer technical assistance and program-specific support to the Early Intervention services coordinator/family. The Early Intervention services coordinator provides ongoing services coordination and arranges periodic interagency, interdisciplinary review. (See 480 NAC Chapter 10.)

If, at any point during the eligibility process, the child's guardian chooses NF services instead of waiver services, the services coordinator shall work with appropriate HHS staff to make these arrangements.

If at any point after the assessment, the parent/guardian voluntarily withdraws from receiving waiver services, the services coordinator shall provide written notice of ineligibility and also provide appropriate referrals.

- b. Gather functional information to determine a child's NF level of care eligibility that reflects the child's developmental level and includes information in the following NF domains:
 - (1) Activities of daily living -
 - (a) Behavior: The ability to exhibit actions that are developmentally and socially appropriate in the areas of independence, maturation, learning, and social responsibility.
 - (b) General hygiene, including:
 - (1) Bathing: The ability to get to the bathing area and cleanse all parts of the body and the hair to maintain proper hygiene and prevent body odor, including tub, shower, and/or sponge bath.
 - (2) Dressing: The ability to put on and remove clothing, as needed. This includes both upper and lower body.
 - (3) Grooming: The ability to do routine daily personal hygiene (combing hair, brushing teeth, and washing face and hands).
 - (c) Feeding/eating: The ability to take nourishment. This may include the act of getting food from the plate to the mouth or self-use of mechanical feeding devices.
 - (d) Movement, including:
 - (1) Mobility: The ability to move from place to place indoors or outside.
 - (2) Transferring: The ability to move from one place to another, including bed to chair and back, and into and out of a vehicle. (Toilet transfer is not included.)

- (e) Sight: The ability to visualize or see, especially one's environment. This may include the use of glasses, contacts, prisms, or other adaptive devices.
- (f) Hearing: The ability to perceive sound, including by the use of equipment such as hearing aids, cochlear implants, etc.
- (g) Communication: The ability to make oneself understood through the use of words, sounds, signs, facial expressions, communication boards, or other adaptive devices.
- (h) Toileting, including bladder and bowel continence: The ability to get to and from the toilet, commode, bedpan, or urinal, including transfer to and from the toilet; management of clothing, and cleansing; and the ability to get to the toilet on time to empty the bladder and bowel, including changing incontinence pad/briefs, cleansing, and disposing of soiled articles.

(2) Cognition -

The ability to remember, reason, understand, and use judgment.

(3) Environment -

The ability to function in his/her living situation, including health, housing, and accessibility.

(4) Medical/health status -

Any medical or health condition that impacts the child's ability to function independently. The complexity of care and unstable medical conditions are also factors.

(5) Support network -

The ability and capacity of extended family, friends, and community resources to provide informal and formal supports. This may include in-home supports, school services, and therapies. In addition, this includes the family's and the support network's effectiveness in protecting the child from abuse and neglect.

(6) Transition -

The availability of a coordinated set of activities designed to promote independence and movement through services and developmental stages. This may include, but is not limited to, movement from early intervention services to preschool services, child to adult services, or from one type of living situation to another.

- c. Route functional information gathered during the in-person assessment and other documentation to HHS Central Office for a NF level of care determination.

The services coordinator may require medical information and/or educational material (e.g., most recent Multi-Disciplinary Team (MDT) report, most recent psychological) as a method of gathering additional functional information upon which a NF level of care determination may be based.

If the child does not meet the NF level of care criteria, the services coordinator shall provide written notice of this decision to the child's guardian. The services coordinator shall also provide appropriate information and referral.

4. PLANNING FOR SERVICES

PURPOSE: To identify specific individual services to be provided in a coordinated and organized manner.

The services coordinator shall -

- a. Together with the child and family, further develop the plan of services and supports. This is accomplished by identifying desired client outcomes. Outcomes should occur in one or more of the following NF domains: activities of daily living; cognition; environment; medical/nursing status; support network; and transition.

The plan of services and supports must ensure the child's health and welfare, including consideration of acceptable risk. If, despite consideration of the full range and scope of services, the child's health or welfare is in jeopardy, waiver services may not be provided.

The child's guardian has freedom of choice in selecting providers of waiver services. The guardian's choice of providers is documented in the child's case narrative.

Copies of the plan of services and supports are distributed to other persons and agencies at the directive, and with the consent of, the child's guardian.

Note: If a child under the age of three receives services coordination through an Early Intervention Program, the Individualized Family Service Plan (IFSP) developed for that program meets the plan of services and supports requirement for this waiver. The IFSP document must specify needed service(s) to be authorized through this waiver, with a copy maintained in the waiver case record.

- b. Determine the cost of serving the child and determine that the estimated total monthly cost, excluding the costs of Assistive Technology and Supports (ATS) and Home Modification services, does not exceed the ongoing cap. The ongoing cap may change annually.

Services included in calculating the cost of the plan of services and supports are the Medicaid non-waiver services of home health care, personal care aide, and medical transportation and all ongoing waiver services. ATS and home modifications are one-time or annually-only waiver services and are separately capitated. This separate cap may change annually.

If the estimated monthly cost of the plan of services and supports exceeds the ongoing cap for children, the services coordinator shall contact Central Office to discuss possible approval to exceed the ongoing cap. Central Office considers the following factors in making this decision and may approve or disapprove the request based upon them:

- (1) Child demographics (e.g., living situation, diagnosis, treatment plan, and prognosis);
- (2) Health and welfare concerns;
- (3) A description of the plan of services and supports;
- (4) The costs of the ongoing waiver services (i.e., plan totals aside from home health, personal care aide, ATS, home modifications, and medical transportation);
- (5) Available support systems; and
- (6) Possible funding shifts to other programs.

If the cost of the child's plan of services and supports does exceed the ongoing cap and an exception is not approved, the services coordinator shall provide written notice of ineligibility to the child's guardian. The services coordinator shall also provide appropriate information and referral.

- c. Offer the child's guardian the option of accepting NF or waiver services as described in the plan of services and supports after the child has been determined to meet the NF level of care criteria, an assessment completed, and a plan of services and supports developed. If the guardian chooses to accept waiver services, the services coordinator shall obtain his/her signature on the waiver consent form. The consent form must be signed at initial determination only, and remains valid as long as the waiver case is open.

Note: The waiver consent form is not valid and must not be signed until the child's eligibility for Medicaid has been determined or presumptive waiver eligibility has been established. The child's waiver eligibility period may begin no earlier than the date of the guardian's signature on the consent form.

Presumptive Waiver Eligibility: Waiver eligibility may be presumed for any potential waiver eligible child from whose guardian a signed Medicaid application has been received by Medicaid eligibility staff and when the guardian is willing to cooperate with its completion (e.g., is willing to provide all requested financial records; is willing to pay a spenddown/shared cost, if required). The services coordinator shall contact the Medicaid eligibility staff to determine if it is likely the child will become Medicaid eligible prior to obtaining the guardian's signature on the consent form. Notation must be made on the consent form indicating presumptive waiver eligibility until a final Medicaid eligibility decision has been made.

The services coordinator shall have ongoing contact with the Medicaid eligibility staff until a final Medicaid eligibility decision has been made. If the child is determined not to be Medicaid eligible, the services coordinator shall provide written notice, effective immediately, to the child's guardian and also provide appropriate information and referral. Ten-day notice is not allowed.

Services which may be presumptively authorized are waiver services and medical transportation. Presumptive authorization for ATS and home modifications is not allowed. Any authorized services shall result in the payment of the provider.

5. CONNECTING/LINKING NEEDED SERVICES

PURPOSE: To translate the plan of services and supports into action.

To locate or develop resources to address identified service gaps.

To promote an effective/optimum use of community resources.

The services coordinator shall prior authorize waiver services for up to a 12-month period, based on the plan of services and supports and the results of ongoing monitoring activities. Waiver services may not be authorized until the child's Medicaid eligibility has been determined and the waiver consent form has been signed.

The services coordinator shall provide a written description to the provider, clearly defining the parameters of service delivery. This must include at least the amount and frequency of service provision, specific service components authorized, and any applicable time limitations. Any applicable conditions or limitations relate solely to the eligibility of the waiver client and program policies and do not constitute an effort to directly control contract performance by the provider.

6. ADVOCACY

PURPOSE: To ensure the child/family's interests and concerns are represented and protected.

To promote child-centered, family-driven, comprehensive service delivery.

To promote community responsiveness to the needs and issues of children with disabilities and their families.

The services coordinator shall provide timely notices and fully inform the child's guardian of his/her rights and responsibilities. The services coordinator shall also provide referrals for family and community training to promote child-centered, family-driven, comprehensive service delivery.

7. MONITORING

PURPOSE: To continually evaluate the effectiveness of the jointly developed plan of services and supports.

To ensure quality service delivery.

The services coordinator shall -

- a. Contact the family depending upon the level of services coordination needed. For families coordinating/directing their own services, and for families needing supportive services coordination, minimum contact shall be monthly, with at least quarterly in-person visits. For families needing comprehensive services coordination, minimum contact shall be monthly with in-person visits at least every other month. All in-person contacts shall be at a time, date, and location convenient to the client/family.
- b. Ensure, by both child/family interview and observation, that the formal and informal supports and services being provided continue to meet the child's and family's needs, and revise the plan of services and supports accordingly.
- c. Review the child/family's needs monthly, including service usage and cost, and revise the plan of services and supports to meet newly identified needs.
- d. Review the child/family's desired outcomes regularly with the child/family and revise the plan of services and supports to refine action steps to meet previously identified outcomes and develop action steps to meet newly identified outcomes.
- e. Maintain regular communication with Medicaid eligibility staff, especially in regard to the family's spenddown/shared cost obligation, if any, and ongoing Medicaid eligibility.

- f. Determine whether a reassessment of the child's level of care and strengths, needs, and resources is necessary when the information is received that the care needs of the child have changed. This determination shall be made within two working days of the receipt of this information. A reassessment may also be initiated based upon the services coordinator's observation of the child's functioning (either improvement or decline) during a routine services coordinator contact. If a reassessment is completed and the child remains NF level of care, a new plan of services and supports must be developed. The services coordinator shall document any provider change in the case narrative.
- g. Review the family's satisfaction with the services provided, review the child's overall health status, and verify that the provider(s) is complying with the requirements of perspective service provision.

Note: A child must be reassessed as an adult when s/he reaches age 18. If the child remains NF level of care, a new plan of services and supports must be completed. A new waiver consent form must be completed when the child reaches the age of majority (age 19) if the parents are not court-appointed legal guardians.

Early Intervention Exception: If the Early Intervention services coordinator receives information that the care needs of an infant or toddler have changed, indicating a change in level of care, the waiver services coordinator shall offer assistance to the Early Intervention services coordinator to obtain a new NF level of care determination by HHS Central Office.

C. NOTIFYING OF ADVERSE DECISIONS

Persons who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to a potential waiver client being denied services, a waiver client's services being reduced, or a waiver client determined ineligible for waiver services. The services coordinator shall send written notice of denial, reduction, or termination of services to the client/guardian. Notice to clients/guardians must contain -

- (1) A clear statement of the action to be taken;
- (2) A clear statement of the reason for the action;
- (3) A specific policy reference which supports such action; and
- (4) A complete statement of the guardian's right to appeal.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. Exception: If the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility.

1. Reasons for denying or terminating eligibility

Eligibility for services under the waiver may be denied or terminated for any of the following reasons:

- a. The unavailability of a waiver slot;
- b. The client has no waiver service need;
- c. The client's needs are being met by another source;
- d. The client does not meet priority ranking;
- e. The client/guardian has not supplied needed information to complete the eligibility process;
- f. The client fails to meet the specified eligibility criteria;
- g. A plan of services and supports cannot be developed/maintained which protects the client's health and welfare;
- h. The client/guardian has not signed necessary forms consenting to waiver services;
- i. The client/guardian voluntarily withdraws;
- j. The client moves out of Nebraska;
- k. The death of the client;
- l. The agency loses contact with the client and his/her whereabouts are unknown; or
- m. The need for Assistive Technology and Supports or Home Modifications has been addressed and no other waiver services are needed.

2. Situations when notice not required

No notice need be sent to the client/guardian in the following situations:

- a. The client/guardian reports that waiver service is no longer required and requests that his/her case be closed;
- b. The services coordinator learns of a client's death;
- c. The client is committed to an institution or admitted to a nursing facility on a long-term basis;
- d. The client's whereabouts are unknown;
- e. The services coordinator has verified that waiver services are being provided in another service area to which the client has moved;
- f. An authorization period is ending and the client/guardian has not acted upon a request for a level of care and plan of services and supports review; and
- g. The limited authorization for Assistive Technology and Supports or Home Modifications is ending and no other waiver services are authorized.

3. Provider Notice

When a waiver client's services are being changed or terminated, the services coordinator shall provide written notice to the provider of the change in service provision or termination of payment for waiver services.

No provider notice is issued when service ends at the end of the service authorization period.

D. APPEALING DECISIONS/ACTIONS

The Department of Health and Human Services shall provide opportunities for fair hearings as defined in 42 CFR 431, Subpart E, to clients or their legal representatives who are not given the choice of home and community-based services as an alternative to NF services or who are denied the services of their choice (see 465 NAC 2-001.02 and 6-000).

Waiver clients/guardians have the right to appeal the following services coordination decisions/actions:

1. Refusal to accept a request for waiver assessment;
2. Failure to act upon a request within the mandated time period;
3. Failure to offer the choice between Home and Community-Based Waiver Services and NF services;
4. Denial of eligibility;
5. Denial, termination, or reduction of services; and
6. Termination of the waiver case.

5-004 SERVICES COORDINATION DOCUMENTATION

Services coordination documentation shall be maintained for each client, must be retained for four years, and may consist of either paper and/or computer data. Documentation must include:

1. Initial referral information;
2. Documentation related to waiver eligibility and authorization;
3. Determinations of NF level of care;
4. Assessment(s) and other functional information;
5. Plans of services and supports;
6. All written notices to, and other communication with, the client/guardian;
7. Interagency correspondence, including referrals;
8. Activities related to services delivery monitoring; and
9. Narrative documentation (e.g., communication with client/family/guardian and service providers; services coordinator decisions and actions; and other factual information and services coordination activity relevant to the case).

Narrative documentation must be objective and free from bias.

When a client moves from one service area to another, the services coordinator shall send to the receiving services coordinator pertinent documentation.

5-005 WAIVER SERVICES

Medicaid services available to persons eligible for this home and community-based waiver program are:

- A. Adult Day Health Care;
- B. Assisted Living Service;
- C. Assistive Technology and Supports;
- D. Child Care for Children with Disabilities;
- E. Home Care/Chore;
- F. Home-Delivered Meals;
- G. Home Modifications;
- H. Independence Skills Management;
- I. Nutrition Services;
- J. Personal Emergency Response System;
- K. Respite Care; and
- L. Transportation.

A. ADULT DAY HEALTH CARE

1. Description

Adult Day Health Care (ADHC) is a service which allows for structured social, habilitation, and health activities. It may (1) alleviate deteriorating affects of isolation; (2) aid in transition from one living arrangement to another; (3) provide a supervised environment while the regular caregiver is working or otherwise unavailable; and/or (4) provide a setting for receipt of multiple health services in a coordinated setting. ADHC is provided outside of the client's place of residence for a period of four or more hours daily, but less than 24 hours.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. ADHC definitions

Habilitation: Services which develop and/or retain capacity for independence, self-care, and social and/or economic functioning.

Licensed Nurse: LPN or RN licensed in Nebraska.

3. ADHC conditions of provision

Service Components: Providers shall offer, or make available through arrangements with community agencies or individuals, each of the services required to meet the needs identified during the client's assessment. Depending on the client's assessed needs, these services include -

- a. Personal care services to address limitations in activities of daily living (ADL) (e.g., transferring, dressing, eating, toileting, and bladder and bowel continence. Assistance with ADL's must be provided by staff and supervised by a licensed nurse.
- b. ADL training, including training the client to increase independence in performing ADL's, the use of special aids, and accident prevention. This must be provided by staff under the supervision of a licensed nurse.
- c. Health assessment/nursing service, including observation of changes in client health and notification of family/doctors, health education and counseling, and administration of medications (either by staff or by the client), and skilled nursing care.
- d. Meal services, including preparation and serving of at least one daily meal. Menus must be planned by staff or a contracted individual who has knowledge of dietetic requirements and nutrition. If a dietitian is not on staff, one staff person must be designated as responsible for food service. Each client must be provided with a noon meal if s/he attends at mealtime. This meal must include at least one-third of the daily dietary allowance required for adults. Each participant who is in attendance for a full day must also be provided with two snacks daily which are controlled for sugar, salt, and cholesterol levels, as appropriate. Special diets must be provided according to the individual participant's plan.
- e. Recreational therapy, including social and recreational activities. Center staff must provide individual and group activity. The dignity, interests, and therapeutic needs of individual participants must be considered in the development of activity programs.
- f. Counseling, including individual and group counseling provided to participants and their families in the following areas: coping skills, and personal, social, family, and adjustment problems. Counseling may be provided only by a certified social worker, a certified master social worker, or a certified professional counselor.
- g. Other activities: The provider shall ensure that the program offers a balance of activities to meet each client's needs and interests. Clients are encouraged to participate in activities, but are free to decline.

Limitations: If the client will receive both Adult Day Health Care and Independence Skills Management (ISM), the services coordinator shall not authorize any component of ISM that will be duplicated by Adult Day Health Care.

School System Services: No service which is the responsibility of the school system may be provided under the waiver.

The services coordinator shall not authorize Adult Day Health Care services for the hours the client is attending school.

Adult Day Health Care Plan: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client and services coordinator and must include the client's strengths, needs, and desired outcomes as they pertain to ADHC, a plan to meet the needs and desired outcomes, and ADHC components to be provided. The plan must also include an up-to-date listing of the client's current medications and treatments, any special dietary requirements, a description of any limitations to participate in activities, and any recommendations for special therapies. Center staff shall, together with the client and services coordinator, review and revise the plan as appropriate, but at least semiannually. A copy must be submitted to the client's services coordinator.

4. ADHC standards

The Department of Health and Human Services annually contracts with providers of Adult Day Health Care to ensure that all applicable federal, state, and local laws and regulations are met.

Provider Standards: Providers of ADHC shall obtain adequate information on the medical and personal needs of each client, if applicable; and observe and report all changes to the services coordinator.

Facility Standards: Each Adult Day Health Care facility must meet all applicable federal, state, and local fire, health, and other standards prescribed in law or regulation. This includes the following standards:

- a. Atmosphere and design: This includes -
 - (1) The facility must be architecturally designed to accommodate the needs of the clients being served;
 - (2) Furniture and equipment used by clients must be adequate;
 - (3) Toilets must be in working order and easily accessible from all program areas; and
 - (4) A telephone must be available for client use.
- b. Location and space: The facility shall ensure that the facility has sufficient space to accommodate the full range of program activities and services. This includes -
 - (1) Flexibility for large and small group and individual activities and services;
 - (2) Storage space for program and operating supplies;
 - (3) A rest area, adequate space for special therapies, and designated areas to permit privacy and isolate clients who become ill;
 - (4) Adequate table and seating space for dining;
 - (5) Outside space available for outdoor activities and accessible to clients; and
 - (6) Adequate space for outer garments and private possessions of the clients.
- c. Safety and sanitation: The facility shall ensure that -
 - (1) The facility is maintained in compliance with all applicable local, state, and federal health and safety regulations;
 - (2) If food is prepared at the center, the food preparation area must comply with HHS regulations;
 - (3) At least two well-identified exits are available;

- (4) Stairs, ramps, and interior floor have non-slip surfaces or carpet;
- (5) The facility is free of hazards (e.g., exposed electrical cords, improper storage of combustible material);
- (6) All stairs, ramps, and barrier-free bathrooms are equipped with usable handrails; and
- (7) A written plan for emergency care and transportation is documented in the client's file.

Staffing: Each center must be staffed at all times by at least one full-time trained staff person.

The center shall maintain a ratio of direct care staff member to clients sufficient to ensure that client needs are met. The center shall develop written job descriptions and qualifications for each professional, direct care, and non-direct care position.

Provider Skills and Knowledge: Direct care staff members must –

- a. Have training or one or more years' experience in working with adults in a health care/social service setting;
- b. Have knowledge of CPR and first aid;
- c. Be able to recognize distress or signs of illness in clients;
- d. Have knowledge of available medical resources;
- e. Have access to information on each client's address, telephone number, and means of transportation; and
- f. Know reasonable safety precautions to exercise when dealing with clients and their property.

The provider must have a licensed nurse on staff, or contract with a licensed nurse, who will provide the health assessment/nursing service component of ADHC and supervise ADL/personal care and ADL training component.

Counseling must be provided only by a certified social worker, a certified master social worker, or a certified professional counselor.

- 5. ADHC rates and frequency: The frequency of service is a calendar day of at least four hours. In the event that a waiver client must leave the ADHC facility due to an unplanned need and has been there less than 4 hours, this is considered a full day for reimbursement purposes. DHHS Central Office establishes a statewide rate for ADHC.
- 6. ADHC record keeping

The provider shall maintain the following in each client's file:

- a. Adult Day Health Care plan; and
- b. Phone numbers of persons to contact in case of emergency.

B. ASSISTED LIVING SERVICE

1. Description

Assisted living is an array of support services that promote client self-direction and participation in decisions which incorporate respect, independence, individuality, privacy, and dignity in a home environment. These services include assistance with or provision of personal care activities, activities of daily living, instrumental activities of daily living, and health maintenance.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and support.

2. Definitions

Resident Service Agreement: An individualized contractual agreement between the facility and client. Clients who receive waiver assisted living service shall also have an individualized Plan of Services and Supports.

3. Assisted Living Service Conditions of Provision

The need for assisted living service is jointly determined by the client and services coordinator.

Service Components: Providers shall offer and make available each of the service components required to meet the needs identified during each client's assessment, and included in the individualized Plan of Services and Supports. The need for the following services is determined on an individual basis as specified in the plan of services and supports to promote or maintain the client's level of independence. These include -

- a. Adult day care/socialization activities: Structured social, habilitative and health activities geared for the needs of the clients.
- b. Escort services: Accompanying or personally assisting a client who is unable to travel or wait alone. This may include assistance to and from a vehicle and/or place of local destination. This may also include providing, or making arrangements for supervision and support to the client while away from the assisted living facility, as determined on an individual basis, and specified in the Resident Service Agreement.
- c. Essential shopping: Obtaining clothing and personal care items for the client when the client is unable to do so for him/herself. This does not include financing the purchases of clothing and personal care items.

- d. Health Maintenance Activities: Non-complex interventions which can safely be performed according to exact directions, which do not require alterations of standard procedure, and for which the results and client's responses are predictable (e.g., recording height and weight, monitoring blood pressure, monitoring blood sugar, and providing insulin injections as long as the client is stable and predictable). The need for health maintenance activities is determined on an individual basis.
- e. Housekeeping Activities: Cleaning of public areas as well a client's private residence, such as dusting, vacuuming, cleaning floors, cleaning of bathroom and making and changing of the bed. Bed linens will be changed as soiled but at least weekly. Clean bath linens shall be made available daily.
- f. Laundry services: Washing, drying, folding and returning client's clothing to his/her room. Dry cleaning is the responsibility of the client but the facility will assist the client in arranging for this service if needed.
- g. Meal Service: Three meals per day, seven days per week, as well as access to between meal snacks. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for adults, and take into account cultural and personal preference for foods served at specific times of day. Meals will be delivered to the client's room for those experiencing temporary illness.
- h. Medication Assistance: Assistance with the administration of prescriptions and non-prescription medications.
- i. Personal Care Services: Assistance with ADL's (e.g., transferring, dressing, eating, bathing, toileting, and bladder and bowel continence). The facility shall also provide assistance with eating. Assistance with eating includes opening packages, cutting food, adding condiments, and other activities which the client is unable to perform for his/herself in preparing to eat the food. If the client is unable to eat independently, the facility shall feed the client or shall assure other arrangements are made for this care. Personal care will be provided to the client in a manner in which the individual maintains as much independence and privacy as possible. The amount and degree of personal care services is determined on an individual basis.
- j. Transportation Services: Transporting, or making arrangements for transporting a client to and from local community resources identified during client assessment and included in the Plan of Services and Supports as directly contributing to the ability of the individual to remain in an assisted living facility.

Resident Service Agreement: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client, services coordinator, and facility staff, and must include the client's strengths, needs, and desired outcomes, and the service components to be provided. The plan must also include an up-to-date listing of the client's current medications and treatments, any special dietary requirements, and a description of any limitations to participate in activities. Assisted living staff shall, together with the client and services coordinator, review and revise the resident service agreement as appropriate, but at least annually. A copy must be submitted to the client's services coordinator.

When a facility or the services coordinator determines that a client's needs are beyond the facility's capabilities or capacities to meet the client's needs, the services coordinator and the client will initiate alternative arrangements.

4. Assisted Living Standards

HHS annually contracts with waiver providers of assisted living to ensure that all applicable federal, state, and local laws and regulations are met.

Facility Standards:

- a. Each assisted living facility shall be licensed as an assisted living facility and certified as an Assisted Living Service waiver provider, as defined in 480 NAC, Chapter 5, by the HHS System.
- b. Licensed nursing facilities in the State of Nebraska may apply to the Department for funding to convert all or a portion of their operation to assisted living under provisions of the Nebraska Health Care Trust Fund Act. Nursing facilities obtaining an assisted living license after utilizing funds granted under provisions of the Nebraska Health Care Trust Fund Act will not be required to meet the provisions of an independent living unit, independent bedroom, and independent toilet facilities for a period not to exceed six months from the effective date of the assisted living license.
- c. The facility shall provide a private room with bath consisting of a toilet and sink for each client receiving waiver assisted living service. Any facility that receives funding through the Nebraska Health Care Trust Fund Act shall provide a private room with bath consisting of a toilet, sink, and tub or shower for each client receiving waiver assisted living service. Semi-private rooms shall be considered on an individual basis (e.g., couples), and require prior approval of the HHS System.

- d. Assisted living service provided in facilities also providing nursing facility care shall be separately licensed and separately located in another wing or section of the building, with separate dining and common areas. Individual facility exceptions to separate dining areas may be considered based on the facility's assisted living philosophy, and requires prior approval of the HHS central office.

For general provider standards, see 480 NAC 5-006.

5. Assisted Living Rates

The frequency of service is a month. Medicaid payment for assisted living service is through rates established by HHS Central Office. Variable rates may be utilized and may change annually.

6. Assisted Living Record Keeping

The provider shall maintain the following in each client's file:

- a. The current Resident Service Agreement;
- b. The current Plan of Services and Supports; and
- c. Phone numbers of persons to contact in case of an emergency and the client's physician's name and phone number.

For general provider record keeping, see 480 NAC 5-011.

C. ASSISTIVE TECHNOLOGY AND SUPPORTS

1. Description

Assistive technology and supports (ATS) are specialized medical equipment and supplies which include devices, controls, or appliances which enable a client to increase his/her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which s/he lives. Approvable items are limited to those which are necessary to maintain the client in his/her home.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Assistive Technology and Supports conditions of provision

The need for ATS is jointly determined by the services coordinator and the client/family.

Consultation for ATS is provided by the Nebraska Department of Education Assistive Technology Project (ATP).

3. ATS standards

Consultation provided by ATP shall meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS.

All items/assistive equipment shall meet applicable standards of manufacture, design, and installation.

4. Assistive Technology and Supports rates

A frequency of service is per device/support, not to exceed the established annual cap. The established cap may change annually.

5. ATS record keeping

ATP shall maintain the following in each client's file:

- a. The ATP Assessment Report which includes a summary of client's needs and current support, recommendations, cost estimate, cost coordination, if needed, and recommended vendor.
- b. Notice of eligibility or ineligibility of ATS services.
- c. Authorization of ATS services.
- d. Documentation of the client's orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates.
- e. Copy of signed vendor bill and signed Consumer Acceptance form.
- f. Narrative summary.

D. CHILD CARE FOR CHILDREN WITH DISABILITIES

1. Description: Child Care for Children with Disabilities (CCCD) is that portion of child care provided to children related to their medical or disability-related needs. Child care is provided to children from birth through age 17 on the average of less than 12 hours per day, but more than two hours per week on a regular basis, in lieu of caregiver supervision. Care is provided in a child's home by an approved provider or in a setting approved or licensed by the Department of Health and Human Services. The parent or primary caregiver is responsible for the basic cost of routine child care. The Aged and Disabled Medicaid Waiver is responsible for the payment of the service above the basic cost of routine child care.

The need for this service must be reflected in one or more assessment areas of the child's plan of services and supports.

2. CCCD conditions of provision: The services coordinator shall include Child Care for Children with Disabilities in the plan of services and supports only to allow the usual caregiver(s) to:

- a. Accept or maintain employment. CCCD expenditures must be cost effective in comparison to employment wages and benefits received by the usual caregiver(s). Parent(s) who receive CCCD waiver service to maintain employment and are self-employed or employed part-time may be required to submit income documentation to show cost effectiveness. The average monthly income shown must meet or exceed the projected average CCCD Medicaid costs. An exception may be granted when there are extenuating circumstances, which may include but are not limited to self-employment income verified by an annual tax return which also reflects business expenses or losses. Goods or services received in place of wages are not considered in comparison of costs. Verification of the hours/schedule of employment is required. Persons who are self-employed shall provide a statement of hours worked.
- b. Seek employment. To meet this need, CCCD may be authorized up to 12 hours per week for two consecutive months within any 12-month period. Each time a parent or usual caregiver loses employment, she/he is entitled to two months of child care to allow him/her to seek employment.
- c. Enroll in and regularly attend vocational or educational training to attain a high school or equivalent diploma or an undergraduate degree or certificate which enables the caregiver(s) to increase future or maintain current earning power. This excludes students pursuing second undergraduate degrees, second certificates, any graduate degree, or classes to maintain a professional license or certificate. Verification of class schedule is required.

School System Services: No service which is the responsibility of the school system may be provided under the waiver. The services coordinator shall not authorize Child Care for Children with Disabilities for the hours the child is attending school.

3. CCCD standards: Waiver providers of CCCD must be approved or licensed through DHHS. Waiver providers of CCCD shall obtain adequate information on the medical and personal needs of each child, if applicable; and observe and report all changes to the services coordinator.

4. Child Care for Children with Disabilities Rates

CCCD rates shall be negotiated based upon the child's needs which affect staffing requirements (i.e., provider skill level or intensity of care provision), as identified through the assessment process.

The parent or primary caregiver of the child is responsible for the cost of routine child care. That amount is determined by the provider rates published by the Child Care Subsidy Program for care provided in the provider's home or a center. For care provided in the child's home, the license-exempt family child care home rate chart applies to individual providers and the child care center chart applies to agency providers. The Department is responsible for payment of the approved cost of the service above the basic cost of routine child care.

Services may be authorized in frequencies of hours and/or days. Six or more hours of care provided outside the child's home must be paid at a day rate, if that option is offered by the provider to private pay families.

E. HOME CARE/CHORE

1. Home care/chore description

Home care/chore is a service for adults which includes general household activities necessary for maintaining and operating the individual's home when the individual is unable to perform these activities. Home care/chore activities provided are limited to those activities that are required to maintain the client in a healthy and safe environment.

Any or all home care/chore activities may be provided to the client as documented in the plan of services and supports. These include bill paying; errand service; essential shopping; food preparation; housekeeping activities; laundry service; personal care service; simple home repairs and maintenance; and supervision.

The need for home care/chore services must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Home care/chore activities and conditions

The following home care/chore activities are those which could normally be performed by the client, but which the client is presently unable to perform. The need for each activity must be identified during client assessment.

Full-Time/Live-In housekeeping: The services coordinator shall authorize full-time housekeeping only when the client is living alone or living with only minor children, or when the circumstances of eligible individuals residing together indicate this need. The housekeeper may live in. A full-time housekeeper shall -

a. Provide the following activities of home/care chore, as appropriate:

- (1) Bill Paying: Assisting clients to organize and/or pay bills.
- (2) Errand Service: Providing service in relation to needs described for escort service when not generally accompanied by the client. If the client does accompany the provider, the provider shall not bill an additional amount for transportation.

- (3) Essential Shopping: Obtaining food, clothing, housing, or personal care items.
 - (4) Food Preparation: Preparing meals necessary to maintain independence. The client shall provide necessary meal preparation supplies.
 - (5) Housekeeping Activities: In-home cleaning and care of household equipment, appliances, or furnishings. The client shall provide necessary supplies.
 - (6) Laundry Service: Washing, drying, ironing, folding, and storing laundry in the client's home; or utilizing laundromat services on behalf of the client. The client shall provide soap and machine-use fees.
 - (7) Personal Care Service: Limited to a non-legally responsible relative providing basic personal care and grooming including bathing, shaving, shampooing, assisting with dressing, ambulation, and toileting. This service is identical to what may be provided through Medicaid Personal Care Aide except that non-legally responsible relatives are allowed as waiver providers even though they are excluded as regular Medicaid Personal Care Aides (see 471 NAC 15-004.02). Natural, adoptive, and stepparents of a minor age client and the spouse of a client are prohibited as providers through both the regular Medicaid Personal Care Services and the Aged and Disabled Medicaid Waiver Personal Care Service.
 - (8) Supervision: Staying with the client for part of a day when the client would otherwise be alone, and performing non-medical activities necessary to provide for the safety and comfort of the client.
- b. Provide service to only one household;
 - c. Be available on a 24-hour basis to provide the authorized chore components; and
 - d. Bill only for the days service is actually provided.

Note: If transportation service is provided by the housekeeper, s/he may be approved and bill for additional mileage as a transportation provider. Additional payment for time is not allowed.

Simple Home Repairs and Maintenance: Providing minor repair of windows, screens, steps/ramps, furnishings, and household equipment. Mowing, raking, removing trash (to garbage pickup point), removing snow and ice, and cleaning water drains may also be provided. Mowing is limited to that necessary to meet the health and safety of the client and to meet local codes.

If the client lives in a rental property, the services coordinator shall investigate the lease agreement and determine the responsibilities of the landlord to provide repairs or maintenance.

3. Home care/chore standards

A home care/chore provider may be an individual or agency. HHS annually contracts with providers of home care/chore to ensure that all applicable federal, state, and local laws and regulations are met.

The provider shall have had training and/or experience in carrying out home care/chore services comparable to those which will be authorized.

The home care/chore provider shall obtain adequate information on the medical and personal needs of each client, if applicable, and observe and report all changes to the services coordinator.

Each home care/chore provider must be at least 19 years old and shall –

- a. Have knowledge of basic first aid skills and of available emergency medical resources, if providing supervision or full-time, live-in housekeeping, personal care, and escort services; and
- b. Exercise reasonable caution and care in the use and storage of clients' equipment, appliances, tools, and supplies.

Each agency provider shall –

- a. Employ home care/chore staff based upon their qualifications, experience, and demonstrated abilities;
- b. Provide training to ensure that home care/chore staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and
- c. Ensure adequate availability and quality of service.

4. Home care/chore rates

Home care/chore rates shall be established by HHS central office. These established rates may change annually.

Services may be authorized in frequencies of hourly, daily, or by the job.

F. HOME-DELIVERED MEALS

1. Description

Home-Delivered Meals is a service for adults which provides a meal prepared outside the client's residence and delivered to his/her residence. Each meal must consist of a variety of properly prepared foods containing at least one-third of the Minimum Daily Nutritional Requirements for Adults.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Home-Delivered Meals conditions of provision

The need for home-delivered meals is jointly determined by the services coordinator and the client.

3. Home-Delivered Meals standards

HHS annually contracts with providers of Home-Delivered Meals to ensure that all applicable federal, state, and local laws and regulations are met. In addition, providers must meet the following standards:

a. Provider health and safety standards

Food preparation facilities and areas must conform to all established local, state, or federal fire prevention, sanitation, zoning, and facility maintenance standards. Food preparation personnel must be -

- (1) In good health and free from contagious disease; and
- (2) Skilled and instructed in sanitary food handling, preparation, and serving practices.

b. Home-delivered meal standards

Home-delivered meals must -

- (1) Be delivered on an established daily schedule;
- (2) Be transported and delivered using utensils and equipment which are sanitary and maintain proper food temperatures. Thermos-type containers and disposable or sterilizable serving dishes must be used;
- (3) Reflect the general dietary needs of persons who are aged or have disabilities, as well as the specific dietary needs of each client; and
- (4) Contain one-third of the minimum daily nutrition requirement per meal for adults using a variety of foods from day to day.

Providers of Home-Delivered Meals shall obtain adequate information on the medical and personal needs of each client, if applicable; and observe and report all changes to the services coordinator.

4. Home-Delivered Meals rates

Home-Delivered Meals rates shall be established by HHS central office. This established rate may change annually. A frequency is one meal.

G. HOME MODIFICATIONS

1. Description

Home modifications are those physical adaptations to the home which enable the client to function with greater independence in the home. Approvable modifications are limited to those which are necessary to maintain the client in his/her home.

Home modifications may include, but are not limited to, the installation of ramps and grab bars; widening of doorways; modification of bathroom facilities; or installation of specialized electric and plumbing systems which are necessary to support assistive equipment.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Home Modifications conditions of provision

The need for home modifications is jointly determined by the services coordinator and the client.

The consultation for home modifications is provided by the Nebraska Department of Education Assistive Technology Project (ATP).

Approved waiver home modifications shall not include adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the client, such as carpeting or roof repair.

3. Home Modifications standards

Consultation provided by ATP shall meet the contractual obligations and terms of the proposal as agreed upon by ATP and HHS.

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and/or certifications.

Home modifications will be provided in accordance with applicable local and state building codes. All modifications must be made by or overseen by appropriately licensed/certified persons.

4. Home Modifications rates

Home modification rates shall be established through a bid process.

The frequency of the service is by the job, not to exceed the established annual cap. The established cap may change annually.

5. Home Modifications record keeping

ATP shall maintain in each client's file:

- a. The ATP Assessment Report which includes the summary of the client's needs and current supports; recommendations, cost estimate, cost coordination, if needed, and recommended contractor.
- b. Notice of the client's eligibility or ineligibility for home modifications.
- c. Authorization of home modification services.
- d. Documentation of the client's orientation and training on how to use or maintain the assistive equipment/support, which may include the delivery and/or installation dates.
- e. Copy of the signed contractor bill and signed Consumer Acceptance form.
- f. Narrative summary.

H. INDEPENDENCE SKILLS MANAGEMENT

1. Description

Independence Skills Management (ISM) is training for adults and children in activities of daily living and training to overcome or compensate for the effects of physical disabilities. Training may occur in the client's home or in the community, and may be provided individually or in a group setting. The caregiver (non-Medicaid paid provider) may be included in this training to promote independence of the waiver client.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. ISM conditions of provision

ISM training must be provided to the client or his/her caregiver as indicated in the client's plan of services and supports. ISM training must be provided in the most appropriate setting to meet the client's needs. ISM providers shall provide training that is adaptable to the client's current residence. Individuals who reside with the client shall not be authorized as ISM providers.

ISM service components include the following:

- a. Self-Care and Daily Living Skills: This includes training to increase independence in performing activities of daily living, such as dressing, grooming, personal hygiene, feeding, ambulation, and toileting;

- b. Performing Essential Care and Home Management Activities: This includes training in -
- (1) Basic home management, such as housekeeping, meal preparation, child care, cleaning, and related activities;
 - (2) Mobility, such as using public transportation;
 - (3) Shopping, including money management and meal planning;
 - (4) Hiring and supervising attendants;
 - (5) Financial management;
 - (6) Health maintenance;
 - (7) Social skills, including counseling to deal with feelings and problem solving for disability-related issues;
 - (8) Accident prevention;
 - (9) Communication, including services directed toward assisting the individual in acquiring new or improving techniques for communication; and
 - (10) Accessibility, including housing relocation.

Other training, as identified in the client's plan of services and supports, may be included in each component.

Exclusions: The services coordinator shall not authorize ISM services -

- a. When the public school system or rehabilitation services are responsible for providing training for independent living;
- b. If the client will receive Adult Day Health Care and the components of ISM would be duplicated by Adult Day Health Care. Note: The services coordinator may authorize other ISM components as needed; and
- c. When the training would fall in any of the following categories:
 - (1) Basic education or academic remedial training to acquire the general educational background, knowledge, and skills to prepare for vocational training;
 - (2) Work adjustment training to acquire work habits, work tolerance, or on-the-job behaviors essential to employment;
 - (3) Vocational training to acquire knowledge and skills essential to performing tasks involved in an occupation; or
 - (4) Training which can only be performed by licensed audiologists, hearing aid dealers, occupational therapists, optometrists, physical therapists, speech pathologists, and other related health care professionals.

ISM Plan: The provider shall ensure that there is a written plan for each client. The written plan must be jointly developed with the client and services coordinator and must include the client's strengths, needs, and desired outcomes as they pertain to ISM, a plan to meet the needs and desired outcomes, and the ISM components which will be provided. The ISM provider shall send a copy of the written plan to the client's services coordinator. Monthly progress reports must also be submitted.

Termination of ISM: ISM services must be terminated when -

- a. The outcomes identified in the client's plan of services and supports have been achieved; or
- b. The provision of services has demonstrated that the client is not benefitting from ISM services.

Related Transportation: The services coordinator shall authorize appropriate waiver transportation services for transportation related to ISM.

3. ISM standards

HHS annually contracts with providers of Independence Skills Management (ISM) to ensure that all applicable federal, state, and local laws and regulations are met.

Each provider must be age 19 or older and have three years experience in the components of independence skills management or be directly supervised by a person with three years experience. In addition, experience with formalized teaching methods is preferred.

The provider must have knowledge of any client-specific procedures as documented in the client's record. The provider must obtain adequate information on the medical and personal needs of each client. ISM providers must observe and report all changes to the services coordinator.

Any facility used in connection with the provision of ISM must meet the following environmental and fire and safety standards:

- a. Be architecturally designed to accommodate the needs of the clients being served;
- b. Have adequate equipment and furniture for use by the client;
- c. Have toilets in working order;
- d. Have a telephone available for clients' use.
- e. Have at least two well-identified exits;
- f. Have non-slip surfaces or carpets on stairs, ramps, and interior floors;
- g. Be free of hazards (e.g., exposed electrical cords, improper storage of combustible materials); and
- h. Have usable handrails for all stairs, ramps, and barrier-free bathrooms.

4. ISM rates

ISM rates shall be negotiated at the lowest possible rate. A frequency of service is hourly.

5. ISM record keeping

The provider shall maintain the following in each client's file:

- a. The ISM plan and any recommended changes;
- b. The monthly progress reports;
- c. The name of the client's physician; and
- d. Pertinent medical information (e.g., activity restrictions, medications and administration schedule, and special diets).

I. NUTRITION SERVICES

1. Description

Nutrition Services (NS) are those which measure indicators of dietary or nutrition-related factors to identify the presence, nature, extent of impaired nutritional status of any type, and to obtain the information needed for intervention, planning, and improvement of nutritional care. The service includes assessment, intervention, including education/counseling and follow-up.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Nutrition Services conditions of provision

NS Plan: The need for nutrition services is jointly determined by the services coordinator and the client. The NS provider shall send a copy of the nutrition plan to the client's physician if there are specific physician-identified needs, and to the services coordinator. Evaluation of progress will be ongoing and will be reported to the services coordinator prior to the end of the authorization period.

Termination of NS: Nutrition services must be terminated when -

- a. The outcomes identified in the client's nutrition plan have been achieved; or
- b. The provision of NS has demonstrated that the client is not benefitting from nutrition services.

3. Nutrition Services standards

HHS annually contracts with providers of nutrition services to ensure that all applicable federal, state, and local laws and regulations are met. NS providers must be a licensed medical nutrition therapist, or an individual certified in specific areas of nutritional expertise (e.g., certified diabetic educator) AND have training or experience in providing nutritional services to the population to be served.

The provider must obtain adequate information on the medical and personal needs of each client. NS providers must observe and report all changes to the services coordinator.

4. Nutrition Services rates

NS rates shall be established by HHS central office. This established rate may change annually. The frequency of service is hourly.

5. NS record keeping

The provider shall maintain the following in each client's file:

- a. The nutrition plan and any recommended changes;
- b. The progress reports;
- c. The name of the client's physician; and
- d. Any pertinent medical information (e.g., medications, special diets, medical restrictions).

J. PERSONAL EMERGENCY RESPONSE SYSTEMS

1. Description

Personal Emergency Response Systems (PERS) provides adults immediate access to emergency help at any time through communication connection systems.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. PERS conditions of provision

The need for PERS is jointly determined by the services coordinator and the client.

3. PERS standards

HHS annually contracts with providers of Personal Emergency Response Systems (PERS) to ensure that all applicable federal, state, and local laws and regulations are met. In addition, providers must -

- a. Instruct the client about how to use the PERS device;
- b. Obtain a client/client representative signature verifying receipt of the PERS unit;
- c. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days a week;
- d. Furnish a replacement PERS unit to the client within 24 hours of notification of malfunction of the original unit while it is being repaired;
- e. Update list of responder and contact names at a minimum of semi-annually to ensure accurate and current information;
- f. Ensure monthly testing of the PERS unit; and
- g. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct clients in the use of PERS devices, as well as to provide for system performance checks.

4. PERS rates

A frequency of service is a monthly rental fee. Installation fees shall be authorized separately.

5. PERS record keeping

The provider shall maintain the following in each client's file:

- a. Documentation of service delivery including client orientation to the system and installation of PERS device;
- b. List of responder and contact names;
- c. Case log documenting client and responder contacts; and
- d. Record of monthly testing of the PERS unit.

K. RESPITE CARE

1. Description

Respite Care is temporary care of an aged adult or adult or child with disabilities to relieve the usual caregiver from continuous support and care responsibilities. Components of respite care service are supervision, tasks related to the individual's physical needs, tasks related to the individual's psychological needs, and social/recreational activities.

Respite care may be provided in the individual's home or out of the home. If respite is provided by a hospital or other facility, the individual is not considered a facility resident.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Respite Care definitions

In-Home Care or Services: Care or services provided in the client's home.

Out-of-Home Care or Service: Care or services provided in a home or facility where the client does not reside.

Usual Caregiver: A person who resides with the client and is available on a 24-hour per day basis to assume responsibility for the care and supervision of the client. This may include a caregiver who is employed outside the home if s/he retains "on-call" responsibility while away from the client.

3. Respite Care conditions of provision

Respite Care may be authorized for one or more of the following situations:

- a. An emergency or crisis arises which -
 - (1) Requires the usual caregiver's absence; or
 - (2) Places an unusual amount of stress on the usual caregiver;
- b. The usual caregiver requires health services (e.g., dental care, doctor appointments, hospitalization, temporary incapacity of caregiver);
- c. The usual caregiver needs relief for regular, prescheduled, personal activities (e.g., religious services, grocery shopping, or club meetings);
- d. The usual caregiver requires irregular periods of "time out" for rest and relaxation; or
- e. Usual caregiver vacations.

Respite care may not be used to allow the usual caregiver to accept or maintain employment or pursue a course of study designed to fit him/her for paid employment or professional advancement. (See instead Child Care for Children with Disabilities, 480 NAC 5-005.B.)

Respite Care for a Live-in Housekeeper: Respite care may be used to relieve a live-in housekeeper. However, if respite care is provided for a full day, no live-in housekeeper payment may be approved for that day. Respite care paid for a portion of a day will not change that day's live-in housekeeper rate.

4. Respite Care standards

A provider may be an individual or agency. HHS annually contracts with providers of respite care to ensure that all applicable federal, state, and local laws and regulations are met.

Respite providers must agree never to leave the client alone while providing the service.

Respite providers shall obtain adequate information on the medical and personal needs of each client. The provider shall observe and report all changes to the services coordinator.

Agency provider standards

Each agency provider shall –

- a. Employ respite care staff based upon their qualifications, experience, and demonstrated abilities;
- b. Provide training to ensure that respite staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and
- c. Ensure adequate availability and quality of service.

Out-of home provider standards

If respite care is to be provided outside of the client's home, the provider must -

- a. Ensure that the facility or home is architecturally designed to accommodate the needs of the clients being served;
- b. Have available an operable telephone;
- c. Post emergency phone numbers by the telephone;
- d. Ensure that the home/facility is accessible to the client, clean, in good repair, free from hazards, and free of rodents and insects;
- e. Ensure that the facility or home is equipped to provide comfortable temperature and ventilation conditions;
- f. Ensure that toilet facilities are clean and in working order;
- g. Ensure that the eating areas and equipment are clean and in good repair;
- h. Ensure that the home/facility is free from fire hazards;
- i. Ensure that the furnace and water heater and any firearms, medications, and poisons are inaccessible to the client; and
- j. Ensure that any household pets have all necessary vaccinations.

5. Respite Care rates

Respite Care rates shall be established by HHS central office. This established rate may change annually. Frequency of service is hourly and/or daily.

The rate for Respite Care may include the cost of three full meals per day only when respite care is provided on a 24-hour basis in a facility that is not a private residence.

L. TRANSPORTATION

1. Description

Transportation service is transporting a client to and from community resources identified during client assessment as directly contributing to the ability of the individual to remain at home. Service may be provided by an individual, agency (exempt provider), or by common carrier.

The need for this service must be reflected in one or more assessment areas of the client's plan of services and supports.

2. Transportation definitions

Common Carrier: Any person who transports passengers by motor vehicle for hire and is licensed as such with the Public Service Commission (PSC).

Escort: A person who accompanies or personally assists a client who is unable to travel or wait alone. This may include assistance to and from a vehicle and/or place of destination, supervision, or support.

Exempt Provider: Carriers exempted from PSC licensure by law including those which -

- a. Transport persons who are aged and their spouses and dependents under a contract with a municipality or county;
- b. Are owned and operated by a nonprofit organization which has been exempted from the payment of federal income taxes as provided by Section 501(c)(4), Internal Revenue Code, and transporting solely those persons over age 60, their spouses and dependents and persons experiencing disabilities;
- c. Are operated by a municipality or county as authorized by law in the transportation of persons who are aged;
- d. Are operated by a governmental subdivision or a qualified public purpose organization having motor vehicles with a seating capacity of 20 or less and are engaged in the transportation of passengers in the state; or
- e. Are engaged in the transportation of passengers and are operated by a transit authority created under and acting pursuant to the laws of the State of Nebraska.

3. Transportation conditions of provision

Non-medical transportation is covered by this waiver program for the following assessed needs:

1. Apply for Benefits: To allow the client to apply or be recertified for benefits and services from programs when a face-to-face interview is required for:
 - a. Nebraska Department of Health and Human Services;
 - b. Social Security Administration; or
 - c. Veteran's Administration.
2. Shop for Food and Essential Items: To allow a client to shop for food and essential items a maximum of one round trip per calendar week.
3. Obtain Legal Services: To allow the client to receive legal counsel from legal aid societies, private attorneys, county attorneys and other professional legal sources for non-criminal matters a maximum of one round trip per calendar month.
4. Obtain Financial Services: To allow the client to take care of financial matters at a banking institution a maximum of one round trip per calendar month.
5. Access Waiver Services: To allow the client transportation to and from Adult Day Health Services or Independence Skills Building.
6. Secure Housing: To allow a client to tour and secure adequate housing or an independent living arrangement. Authorization is allowed for a maximum of five round trips in any twelve-month period. Additional trips may be authorized if the client's health and safety is jeopardized.

Exclusion: Transportation may not be authorized to obtain educational services for children.

5. Transportation rates

Transportation rates shall be negotiated according to statutory limits.

Frequency of service is by mileage or trip or hourly for escort service.

6. Authorization of individual transportation providers

Staff shall contract with and authorize payments for individual providers only if -

- a. The proposed provider is the individual who will personally drive the vehicle;
- b. There is no common carrier serving the area in which the client needs transportation; or the common carrier is incapable of providing the specific service in question. (An individual cannot be authorized unless the carrier(s) serving the area provides a written statement that they are incapable. If the provider refuses to provide such a statement, the staff shall contact Central Office for possible intervention by the Public Service Commission.); and
- c. The provider is registered with the PSC, certifying that all provider requirements are met.

5-005.M Home Again (HA) Service

1. Description: HA Service is available to support and enable Medicaid-eligible nursing facility residents to move to a more independent living situation of their choice. Items and services covered include but are not limited to:

1. Furniture, furnishings, and household supplies;
2. Security deposits, utility installation fees or deposits; and
3. Moving expenses.

2. Need for Service: All items and services covered must be essential to:

1. Ensure that the person is able to transition from the current NF; and
2. Remove identified barriers or risks to the success of the transition to a more independent living situation.

3. Persons Eligible: To receive this service, a person aged 18 or older must be a current NF resident whose NF services have been paid by Medicaid for at least six months. Persons whose NF stay is rehabilitative are not eligible for this service.

4. Items and Services Covered: The Services Coordinator and client must jointly determine the need for specific Home Again Services. Services must be identified in one or more assessment areas and reflected in the client's Plan of Services and Supports. The Services Coordinator may authorize services in one or more of the following areas:

1. Essential furniture, appliances, furnishings, and household supplies;
2. Security deposits and utility installation fees and deposits;
3. Moving expenses;
4. Assistance from a Home Again Sponsor; and
5. Expenses for other services or items related to the move which are essential to remove barriers to the transition or its success.

Once purchased, all items become the property of the client. Any prior-authorized transition expenses incurred in good faith will be covered by the program even if the transition does not ultimately occur (for example, the client has a medical emergency).

5. Items and Services Not Covered: Medicaid funds may not be used to pay rent. In addition, the Services Coordinator must not authorize items and services which:

1. Are not essential to supporting the move or ensuring its success;
2. Are available through the Medicaid state plan or through another service of this Waiver program;

3. Are available at no cost from relatives, friends, or any other source; or
4. Relate to a move to an assisted living facility and are the responsibility of the AL facility or included in the client's public assistance budget. Examples are a rental deposit, monthly payment, utilities provided for all residents, or basic furniture.

6. Service Duration: HA services may be authorized only once during a twelve month period. The authorization period for HA Services may begin as soon as the client, Services Coordinator, and NF staff agree that a discharge plan indicates a move to a more independent setting. The Services Coordinator may authorize expenditures made up to 60 days in advance of the planned move date and for 30 days after the actual move date.

7. Home Again Sponsor: Each client eligible for Home Again Service must have a designated HA Sponsor. The role of the Sponsor includes but is not limited to:

1. Assisting the client as necessary to locate and procure accessible, affordable housing;
2. Providing support in dealing with the changes related to the transition move; and
3. Providing the up-front funding to obtain the essential items and services included in the Plan of Services and Supports.

If the client has no family or friend available to fill the Sponsor role at no cost, the Services Coordinator may authorize the payment to a paid Sponsor. A relative or friend assuming the role of Sponsor must also meet provider standards to receive reimbursement of actual transition expenditures made on behalf of the client.

8. HA Sponsor Standards: A HA Sponsor may be an individual, a business, an organization or an agency. In addition to the general standards for all waiver providers, a HA Sponsor must:

1. Be age 19 or older;
2. Recognize and support the client choice in selection of items and services provided through this service;
3. Have experience in carrying out activities related to locating housing and setting up a household;
4. Be free of communicable disease;
5. Be able to recognize distress and/or signs of illness in clients;
6. Observe and report all changes in client functioning to the services coordinator and/or to the NF staff; and
7. Assure that any vehicle and driver transporting a client to look for housing or other transition need meets applicable licensing and safety laws and regulations.

9. Home Again Rates: The Home Again rate consists of payment for the actual cost of items and services necessary for the client's move and any payment to the sponsor. The maximum amount allowed for the Home Again service is a one-time payment of \$1500, of which up to \$300 may be allowed for the payment to the sponsor. This amount may be subject to annual adjustment as allowed by the Legislature (see 480-000-209). Payment for the Home Again service is not counted in the client's monthly cost for waiver services.

10. Home Again Services Provider Billing: HA Sponsors must bill for services by:

1. Totaling and submitting dated receipts for purchases made on behalf of the client;
2. Totaling and submitting receipts or other written documentation of the financial obligation incurred by the Sponsor on behalf of the client for security deposits, utility installation, and/or fees;
3. Providing a detailed listing of the dates and activities performed if payment for the Sponsor's time is authorized; and
4. Submitting a billing request for the total amount of expenses incurred.

5-006 GENERAL PROVIDER STANDARDS

GENERAL STANDARDS FOR ALL WAIVER PROVIDERS: All home and community-based services (HCBS) waiver providers are Medicaid providers (see 471 NAC 2-000). All HCBS waiver providers shall meet the following general provider standards:

1. Follow all applicable Nebraska Health and Human Services policies and procedures (Nebraska Administrative Code Titles 465, 471, 473, 474, and 480).
 - a. Bill only for services which are authorized and actually provided.
 - b. Submit billing documents after service is provided and within 90 days.
2. Accept payment as payment in full for the agreed upon service(s) unless the client has been assigned a portion of the cost. Provider will not charge clients any difference between the agreed upon rate and private pay rate.
3. Agrees not to provide services, if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
4. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
5. Retain financial and statistical records for four years from date of service provision to support and document all claims.
6. Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 - 74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site.
7. Keep current any state or local license/certification required for service provision.
8. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
9. Agree and assure that any false claims (including claims submitted electronically), statements, documents, or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
10. Respect every client's right to confidentiality and safeguard confidential information.
11. Understand and accept responsibility for the client's safety and property.
12. Not transfer this agreement to any other entity or person.
13. Operate a drug-free workplace.
14. Not use any federal funds received to influence agency or congressional staff.
15. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect.
16. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place.
17. Have the knowledge, experience, and/or skills necessary to perform the task(s).
18. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
19. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate HHS staff.
20. Be age 19 or older if an individual provider; or assure that agency staff who assume the following roles are age 19 or older: director, administrator, agency representative for signing legal documents, or provider of in-home client services.

Reports of Abuse or Neglect: If the provider is an agency, HHS staff shall review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse or neglect are in place.

If the provider is an individual, HHS staff shall check the Central Registries to determine if any substantiated reports of abuse or neglect by the provider exist. If the provider provides services in his/her own home, HHS staff shall also check the Central Registries to determine if any substantiated reports of abuse or neglect by household members exist. If a report of abuse or neglect has been substantiated, HHS staff shall not contract with the individual provider.

If a report of abuse or neglect concerning a current waiver provider (or household member) as perpetrator is substantiated, staff shall immediately terminate the provider contract and notify the services coordinator.

Reports of Convictions, Unacceptable Behaviors: Before approval, the provider shall provide a statement to HHS staff, giving information concerning any felony and/or misdemeanor arrests and convictions and pending criminal charges. Any other adult regularly present in the home must also provide such a statement if services will be provided in the provider's home. These statements must be signed and dated.

If additional information is needed to determine whether the provider meets this standard (e.g., the statement shows a questionable history or the staff has reason to question the validity of the statement), HHS staff shall obtain a release of information and request information available from law enforcement. Releases must also be obtained from household members, as applicable. Refusal to sign a release of information is grounds for immediate denial or termination of provider approval.

No provider approval will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the client.

5-007 PROVIDER APPROVAL PROCESS

Designated HHS staff use the following policies and procedures when evaluating and approving providers of waiver services.

A. DEFINITIONS

Agency Provider: Providers who have one or more employees or will be subcontracting any one or part of the service(s) for which they are requesting approval.

Individual Provider: Providers who have no employees and will not normally be subcontracting any service(s) for which they are requesting approval. Individual providers are independent contractors and not employees of HHS or the State of Nebraska. (For the purpose of FICA withholding, the provider is considered an employee of the client.)

Provider Identification Number: A nine-digit federal identification (FID) number or a nine-digit Social Security number (SSN).

Service Provider Agreement: A legally binding document which may include an addendum and all applicable provider checklists, describing the service(s) to be provided, and the maximum rate(s) allowed for each provider. The responsibilities of the provider and of HHS are stated in the agreement.

Subcontracting: Occurs when a service provider pays someone other than an employee to provide the contracted service.

B. EVALUATING A POTENTIAL PROVIDER

HHS staff shall conduct an in-person interview with each potential provider.

If the provider does not meet standards at the time of the initial visit or interview, but is willing to correct the deficiency within a reasonable period of time, staff shall continue the evaluation process when proof of compliance is received.

All waiver providers must have a Social Security number or FID number, whichever is appropriate, and provide it to HHS before contracting.

Conflict of Interest: No employee of HHS or its subdivisions may be approved as a service provider if s/he is in a position to influence his/her own approval or utilization.

HHS Staff Relatives as Providers: HHS staff shall not approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related. In situations where a HHS staff person's relative is the only resource, staff shall obtain approval from the Service Area Administrator or designee.

Client Relatives as Providers: Legally responsible relatives (i.e., spouses of clients or parents of minor children who are clients) shall not be approved as service providers for their relatives.

C. DENYING A POTENTIAL PROVIDER

Denial of Application: If HHS staff determine that the potential provider does not comply with all the provider standards for the service(s) to be provided, s/he shall -

1. Document the regulation(s) on which the denial is based and the reason(s) why the potential provider does not comply with the cited regulations; and
2. Send a letter of notice to the potential provider including -
 - a. Explanation of the reasons for HHS's determination that the potential provider does not comply with the cited regulations, or that HHS and the potential provider have failed to agree on contracting issues;
 - b. Citation of the regulations on which the denial was based; and
 - c. Notification of the potential provider's right to appeal HHS's decision/action.

Voluntary Withdrawal: Written notice to the potential provider is not required if s/he voluntarily withdraws from the evaluation process.

D. COMPLETING A PROVIDER AGREEMENT

When a potential provider has met all necessary requirements, HHS staff shall complete a Services Provider Agreement. Staff shall explain that monitoring visits will occur.

If the provider is a non-emancipated minor, the signature of his/her parent or legal guardian must be obtained on the provider agreement.

Agreement Policies: The following policies govern service provider agreements:

1. Each provider must have a service provider agreement in effect before service can be authorized for purchased;
2. Resource development staff shall evaluate and approve or disapprove all service providers located within the office's jurisdiction;
3. Service provider agreements are effective up to 12 months, are never back-dated, and must be agreed upon and signed by all parties on or before the effective date; and
4. Changes in service provider agreements require agreement and new signatures of the contract. Address changes which do not affect the service location must be reported to HHS staff and do not require a new agreement.

Monitoring: Staff assigned services coordination or resource development responsibilities shall provide ongoing monitoring of the quality of services provision. Staff monitoring must also be done any time there is reason to believe a provider is not fulfilling his/her responsibilities. Staff shall report any suspected abuse or neglect to law enforcement and/or the appropriate HHS staff.

E. NOTIFYING OF PROVIDER TERMINATION

Either HHS or the provider may terminate an agreement by giving at least 30 days advance written notice. The 30-day requirement may be waived in case of emergencies such as illness, death, injury, or fire. If the provider violates or breaches any of the provisions of the Service Provider Agreement, then the agreement may be terminated immediately at the election of HHS.

When an agreement is to be terminated by HHS, staff shall -

1. Document the reason(s) for the termination and provide written notice.
2. Provide written notice which includes:
 - a. Explanation of the reasons for the termination;
 - b. Citation of the regulations on which the termination was based; and
 - c. Notification of the provider's right to appeal HHS's decision/action.

Resource development staff shall notify services coordination staff of the provider termination.

F. APPEALING DECISION/ACTIONS

A provider of waiver services has the right to appeal any decision/action that has a direct adverse effect on the provider (see 471 NAC 2-003). Hearings are scheduled and conducted according to the procedure in 465 NAC 2-001.02 and 6-000.

5-008 PROVIDER AGREEMENT RENEWAL

HHS staff shall use established standards to re-evaluate each service provider before the expiration of a provider agreement. Provider agreements must be renewed based on the same procedures used for initial approval, including conducting an in-person interview and completing provider checklists.

5-009 RESOURCE DEVELOPMENT DOCUMENTATION

Resource development documentation shall be maintained for each provider, and retained for four years. Documentation must include:

1. Provider agreements, addendums, and checklists;
2. Verification of Central Registry checks;
3. Felony and/or misdemeanor statements;
4. Written notices to, and other communication with, the provider;
5. Activities related to services delivery monitoring;
6. Narrative documentation (e.g., resource development staff decisions and actions; and other factual, relevant information); and
7. Billing and payment records.

5-010 PROVIDER SOCIAL SECURITY TAX WITHHOLDING

Affected Providers: In some situations, HHS withholds Social Security taxes (Federal Insurance Contribution Act, FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. HHS, upon receiving a signed "Employer Appointment of Agent," acts on behalf of clients who receive in-home services to withhold mandatory FICA taxes from individual providers and pays the client's matching tax share to the Internal Revenue Service (IRS).

Earnings Taxed for Social Security: Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one client. (For example, for calendar year 1995 the base amount was \$1,000 paid for FICA-covered services per client.) HHS shall withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for FICA services per client, the amount withheld for that year is refunded.

Social Security Tax Rates: HHS remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by HHS on behalf of the client employer.

5-011 PROVIDER RECORD KEEPING

Providers of waiver services must retain for four years the following material:

1. Documentation which supports provision of services to each client served under the waiver;
2. Any other documentation determined necessary by HHS to support selection and provision of services under a plan of services and supports;
3. Financial information necessary to allow for an independent audit under the waiver;
4. Documentation which supports requests for payment under the waiver; and
5. Provider agreements with HHS.