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1. Introduction

1.1 Welcome

Thank you for your interest in Nebraska's Home and Community-Based (HCBS) Aged and Disabled (AD) and Traumatic Brain Injury (TBI) waiver services. The Nebraska Department of Health and Human Services (DHHS) Division of Disability and Aging (DDA) strives to enhance the quality of life for participants by promoting independence and community integration.

DDA supports the choices of aged adults and individuals with physical disabilities by promoting flexible, high-quality, participant-directed services and support for participants who require the same level of care that would otherwise be provided in a Nursing Facility (NF).

1.2 Purpose of the HCBS Provider Policy Manual

This manual outlines the requirements and procedures for Medicaid Home and Community-Based (HCBS) AD and TBI waiver services.

A. All providers of AD and TBI waiver services must comply with this policy manual.
B. This manual is a supplement to:

1. Federal law, including the Social Security Act;
2. The Code of Federal Regulations (CFR);
3. The Medicaid HCBS Waiver applications;
4. Nebraska Revised State Statutes (Neb. Rev. Stat. §); and
5. The Nebraska Administrative Code (NAC) of Regulations.

1.3 Organization of the HCBS Provider Policy Manual

A. **Organization of Content:** A table of contents is followed by an introduction and 12 chapters, each of which describes expectations and requirements related to a particular component of service delivery. Following the body of the manual, the appendices present information referenced in the manual. Appendix A lists commonly used abbreviations. Appendix B is the glossary, which lists terms and phrases used throughout the manual. Appendix C is a Glossary. Appendix D is a list of contacts and references.
B. **Numbering System:** A simple numbering system is used to ensure readability and ease in referencing sections and pages within chapters. The numbering system in the manual is as follows:

1. Each chapter is numbered 1, 2, 3, etc.
2. Each chapter has sections numbered 1.1., 1.2., etc.
3. Subsections are lettered A, B, C, etc.
4. Lists within sections and subsections are numbered 1, 2, 3, etc.
5. Appendices have letters: Appendix A, Appendix B, etc.
6. Pages are numbered sequentially throughout the entire manual.

1.4 Distribution and Update of the HCBS Provider Policy Manual

A. **Distribution:** This manual is available on the DDA website. When you need accommodation to view the manual, call DDA at (877) 667-6266.

B. **Update:** DDA updates the manual when there are changes in policy and requirements. This Policy Manual supersedes all previous policy manuals. When changes to the manual are needed:

1. DDA will make a reasonable effort to provide notification to stakeholders about the changes.
    a. Subscribers to the DDA webpage will get an automated email.

1.5 Participant Driven Collaboration

In this policy manual, "participant" means the person receiving Medicaid HCBS AD and TBI waiver services and any person legally authorized to act on behalf of the participant.

A. Participants are the most important stakeholders in the Medicaid HCBS AD/TBI waiver programs. It is essential that providers and AD and TBI service coordination develop and maintain effective working relationships with participants and any advocates who may assist the participant to exercise their rights.

B. Information in the manual outlines requirements and resources intended to promote respectful, effective relationships between participants, service coordination, and providers.

1.6 Description of AD and TBI Program

A. The AD waiver provides services for people over the age of 65 and people aged 0-64 who have disabilities. Waiver services are intended to help people live safely in their own homes instead of a nursing home or other institutional setting.

1. AD Waiver services include:
    a. Adult Day Health
    b. Assisted Living Services
    c. Assistive Technology
    d. Chore
    e. Companion
    f. Extra Care for Children with Disabilities
    g. Home Again
    h. Home and Vehicle Modifications
    i. Home Delivered Meals
    j. Independence Skills Building
    k. LRI Personal Care
    l. Non- Medical Transportation
    m. Personal Care
    n. Personal Emergency Response System (PERS)
    o. Respite
2. To be eligible for the AD waiver, a participant must have a physical disability or be over the age of 65, be eligible for Medicaid, meet the level of care for a nursing facility, and have a need for waiver services.

B. The TBI waiver provides specialized services to people ages 18 and older who are diagnosed with traumatic brain injury, are nursing facility eligible, and want to receive services in the community. Waiver services are intended to reteach skills and abilities lost due to their TBI.

1. TBI waiver services include:
   a. TBI Adult Day Health
   b. Assistive Technology
   c. Caregiver Training
   d. Chore
   e. Community Connections
   f. TBI Companion
   g. Home Modifications
   h. Home-Delivered Meals
   i. Non-Medical Transportation
   j. TBI Personal Care
   k. Personal Emergency Response System (PERS)
   l. TBI Respite Care
   m. Supported Employment – Follow Along
   n. Supported Employment – Individual
   o. Supported Residential Living
   p. Vehicle Modifications
2. To be eligible for the TBI waiver, a participant must be 18 or older, be eligible for Nebraska Medicaid, have a diagnosis of TBI, meet the level of care for a nursing facility, and have a need for waiver services.

2. Eligibility and Entry into Services

This chapter describes the process the Division of Disability and Aging (DDA) uses to determine eligibility for Medicaid Home and Community-Based Services (HCBS) Aged and Disabled (AD) and Traumatic Brain Injury (TBI) Waivers, and how a person who meets all waiver qualifications is assessed and connected for services. All points of eligibility must be met before connecting and authorizing a service provider. In the AD and TBI HCBS Provider Policy Manual, "participant" means the person receiving Medicaid HCBS AD and TBI Waiver services and any person legally authorized to act on behalf of the participant.

In this chapter, "applicant" means the person applying for AD or TBI Waiver services and any person legally authorized to act on behalf of the applicant.

2.1 Eligibility Requirements

The following eligibility requirements must be met to receive Medicaid HCBS AD Waiver services:

A. Be a citizen or legal resident of the United States;
B. Be a legal resident of the State of Nebraska;
C. Be eligible for Nebraska Medicaid;
D. Have a disability or be over the age of 65;
E. Meet Nursing Facility Level of Care (Title 475);
F. Need waiver services;
G. Meet with Service Coordinator and develop a Person-Centered Plan; and
H. Sign all appropriate paperwork.

The following eligibility requirements must be met to receive Medicaid HCBS TBI Waiver services:

A. Be a citizen or legal resident of the United States;
B. Be a legal resident of the State of Nebraska;
C. Be eligible for Nebraska Medicaid;
D. Be aged 18 through 64;
E. Have a diagnosis of Traumatic Brain Injury (such as a blow to the head);
F. Meet Nursing Facility Level of Care (Title 471);
G. Meet with Service Coordinator and develop a Person-Centered Plan; and
H. Sign all appropriate paperwork.

2.2 Medicaid Eligibility

All people who are eligible for the Medicaid HCBS AD and TBI Waiver program must also enroll in Medicaid.

A. To be eligible for Medicaid, an applicant must apply for Medicaid.
B. For application and eligibility information regarding Medicaid:

    1. Apply online at https://iserve.nebraska.gov;

2. Call Medicaid's toll-free number (855) 632-7633; or
3. Visit a local DHHS office. *For DHHS office locations, see Policy Manual Appendix D: Contacts and Resources.*

2.3 Nursing Facility Level of Care

A. AD and TBI waiver Level of Care (LOC) is based on the level of care needed to live in a nursing facility.
B. LOC is determined by assessing a person's Activities of Daily Living, Risk Factors, Medical Treatment, and Cognition Factors.
C. LOC for Children:

1. Children Ages 0-47 Months: To be eligible, the child must have needs related to a minimum of one defined medical condition or treatment per Title 471.
2. Children ages 48 months through 17 years: NFLOC eligibility can be met in one of three ways:
    a. At least one medical condition or treatment need;
    b. Limitations in at least six Activities of Daily Living (ADL); or
    c. Limitations in at least four ADL and the presence of at least two other considerations.

D. LOC for Adults
1. An adult must satisfy one of the following four categories to meet NFLOC eligibility:
    a. A limitation in at least three ADL and one or more risk factors;
    b. A limitation in at least three ADL and one or more medical conditions and treatments;
    c. A limitation in at least three ADL and one more area of cognitive limitations; or
    d. A limitation in at least one ADL, at least one risk factor, and at least one area of cognitive limitation.

E. CMS has approved the following level of care assessments for use on the AD & TBI waivers:
1. Age 0-47 months: Assessor gathers information related to a minimum of one defined medical condition or treatment per Nebraska regulations;
2. Age 48 months to 17 years: interRAI Pediatric Home Care (PEDS-HC) for Children; and
3. Age 18 and over: interRAI Home Care (HC) for Adults.

2.4 Referral for AD and TBI Services

The Aged and Disability Resource Center, Medicaid, family, or friends may be the first point of contact for people who have a need for services. When this happens, they may send a referral for the person to DHHS. A referral for services is accepted from any source. The individual will decide if they want services. If this happens, they will be asked to fill out an application.

2.5 Process of Eligibility Determination

DDA reviews points of eligibility, such as Medicaid and Disability Determination, prior to assessing for the LOC. If they do not have a disability determination through Social Security, they are referred to SRT before proceeding with LOC. If the points of eligibility are met, the LOC is completed. If NF LOC is met, they are referred to an SC for the final points of eligibility.

If the child is under 48 months, a referral to EDN or Service Coordination is completed for the LOC. When DDA receives a referral or an application, DDA assigns a member of the Eligibility and Enrollment team (E&E) to determine whether the applicant meets LOC eligibility requirements.

A. The E&E team makes initial contact with the applicant by phone or e-mail.

1. E&E will:

    a. Verify the applicant meant to apply for AD or TBI services;

        i. When the applicant did not intend to apply for AD or TBI services, they can withdraw their application by email, letter, or verbally.
        ii. The applicant does not have to wait to reapply after an application is withdrawn.

    b. Explain the AD or TBI eligibility process;
    c. Determine if the applicant has applied for SSI, is currently receiving SSI, or has been denied SSI, when applicable; and
    d. Review the information on the application to ensure it is correct and complete, including who to contact for supporting documents.

2. When the applicant does not respond to at least three attempts by E&E to make contact, they will be denied due to failure to respond to the request for additional information. DDA sends a NOD to the applicant.

B. E&E collects the following necessary documentation:

1. The participant, authorized representative, or caregiver is responsible for the collection of information from the school, medical practitioners, and others listed by the applicant.
2. The information about the applicant's disability diagnosis from the Social Security Administration, when necessary.

C. E&E will determine if the applicant meets Medicaid eligibility, disability determination, and LOC. They will complete the LOC assessment with the participants and others who are close to the participant, as needed.

D. SC will develop the PCP, confirm service need, and get the appropriate signatures.

E. When a participant meets LOC and is between the ages of 0-47 months, the participant will choose between Early Development Network (EDN) or DHHS. If EDN is chosen, they will serve as the SC coordinator. If DHHS is chosen, an SC from DHHS will be assigned. Participants will be assigned a Service Coordinator (SC) to help them set up their Person-Centered Plan (PCP) and select services. If the participant is 48 months to 64 years of age, they will be assigned an SC from DHHS. If a participant is over 65 years of age, they will have the option to remain with the SC within DHHS or be assigned to AAA to provide service coordination and select services.

2.6 Waiver Participation Requirements

A. To maintain waiver services, a person must meet HCBS AD or TBI Waiver eligibility requirements on an annual basis and:

1. Be enrolled in Medicaid;
2. Meet nursing facility level of care;
3. Receive services from only one Medicaid HCBS waiver at a time;
4. Not live in an institution:

    a. DHHS defines an institution as a nursing facility.
    b. The participant must choose to receive community-based services as the alternative to institutional care.

5. Be age 65 years or older or 0-64 years old with a disability to be on the Medicaid HCBS AD waiver. Be age 18 years and older with a traumatic brain injury diagnosis to be on the HCBS TBI waiver.
6. Use at least one HCBS AD or TBI Waiver service every 90 days.
7. Continue to follow the responsibilities of a participant outlined in the NORO, including regularly meeting with the SC and participating in development and minorizing of the PCP.

B. When the participant accepts waiver services, the participant must sign the waiver consent form.

1. The waiver consent form must be updated any time there is a change in the legal ability of the participant to consent to waiver services.
2. The waiver consent form is not valid until the date the participant's eligibility for Medicaid has been determined.
3. The participant's waiver services may not be authorized until:

    a. Medicaid eligibility is approved;
    b. The Person-Centered Plan is developed and approved; and
    c. The participant signs the waiver consent form.

C. The participant must meet all points of eligibility before the start of waiver services.
D. Services cannot be backdated and will not be authorized until all points of eligibility are determined and the consent form is signed.

2.7 Cost-Effectiveness Determination

A. The Cost Effectiveness Determination is completed for participants who are eligible for and receiving ongoing services through the Nebraska AD or TBI waiver:

1. The Cost Effectiveness Determination includes the completion of a Service Needs Assessment (SNA) addressing the participant's skills and abilities and determining which services are the best fit for the participant, calculating the annual cost of their waiver care needs, and ensuring it is at no more than 150% of the average NF institutional cost for home and community-based services.

    i. The SNA is used to determine appropriate hours of services to authorize waiver services to support the participant's needs. This is completed both initially and at the annual redetermination.
    ii. Nebraska conducts a cost utilization review when HCBS waiver costs exceed 150% of the average per capita spending for Nursing Facilities which is $138,657.

b. The SC will submit the Request for Exception to the DDA Clinical Team.
c. DDA Clinical Team may approve exceptions to the standard personal care service limits if both of the following conditions are met:

    i. The participant's demonstrated need for personal care services exceeds 150% of the average Nursing Facility (NF) institutional cost.

    ii. The exception is necessary to support and ensure the participant's immediate health and safety.

    iii. When the DDA Clinical Team authorizes an exception, provider reimbursement for all hours approved in excess of the 150% NF institutional cost limit shall comply with the following maximum rate caps:

(1) Agency provider rate will be no greater than the existing rate or $32.50 per hour for any hours exceeding the 150% threshold, whichever is less.

(2) The independent provider rate will be no greater than the existing rate or $17 per hour for any hours approved over the 150% threshold, whichever is less.

(3) Standard authorized rates apply to all authorized service hours provided up to the 150% NF institutional cost threshold.

B. After the Clinical Team has completed its review and made a determination, a notice will be routed to the participant.

1. The SC will update service authorizations accordingly.

2.8 Termination of Services

A. The participant, a provider, or DDA can terminate AD or TBI HCBS waiver services. Different types of services can be ended:

1. Voluntary Termination of Waiver Services
2. Involuntary Termination of Waiver Services

B. **Termination of Services:** DDA may end services, or the person receiving services may choose to end the service.

1. The person may choose to end the services.

a. The person contacts their SC and says that they no longer want the service.

2. DDA may terminate Medicaid AD or TBI Waiver services for any of the following reasons:

a. The participant has no need for waiver services;
b. The participant has not used waiver services in the last 90 days;
c. The participant's needs are being met by another source;
d. The participant or their guardian has not supplied needed information to complete the annual eligibility or person-centered plan (PCP) review process;
e. The participant fails to meet the specified eligibility criteria at re-determination;
f. A PCP cannot be developed and maintained that protects the participant's health and welfare;
g. The participant or their guardian has not signed the necessary forms consenting to waiver services;
h. The participant or their guardian voluntarily withdraws;
i. The participant moves out of Nebraska;
j. Death of the participant;
k. The agency loses contact with the participant and the participant's whereabouts are unknown;
l. The need for Assistive Technology, Home Modifications, or Vehicle Modifications has been addressed, and no other waiver services are needed;
m. The participant or their guardian cannot meet in person with their Service Coordinator (SC) at least every 90 days;
n. The participant has become a resident of a nursing facility, intermediate care facility for the developmentally disabled, or a mental health facility and is expected to remain there for more than 90 days; or

o. The participant is no longer eligible for Medicaid.
   1. When the participant is no longer eligible for Medicaid, the participant is not eligible for waiver service, and the waiver case will be closed.
   2. When the participant becomes eligible for Medicaid before the effective date of Medicaid closure, the Notice of Action can be rescinded, and the waiver case can be reopened.
   3. When the participant becomes eligible for Medicaid after the effective date of Medicaid closure, a new referral for waiver services will need to be completed.

3. DDA sends a notice of decision to the person at least 10 days before service coordination ends. When the person does not agree with the decision, they may appeal.

C. **Consultation with Supervisor:** Termination of services may be initiated by the participant or provider receiving Medicaid HCBS AD or TBI Waiver services. If a participant stops receiving AD/TBI waiver services, they may continue to receive services from other providers.

1. Services can be ended by the participant or by the provider.

   a. The participant may choose to end services with a provider at any time, for any reason.

      i. The participant should inform their SC 10 days prior to the end of services, when possible.
      ii. The participant tells their SC and the provider when they want to end services.
      iii. A participant should tell the provider ahead of time when they plan to end services.

   b. An agency provider may stop providing services for a participant.

      i. The provider must let the participant know in writing at least 30 calendar days before services end. The written notice must include the provider's reason for ending services.
      ii. When the participant does not find a new provider before services end, DDA may require the agency provider to continue services for an additional ten days to allow more time to find a provider.

   c. An independent provider may stop providing services for a participant.

      i. An independent provider is hired by a participant who chooses to self-direct services. DDA does not require an independent provider to give advance notice before ending services with a participant.
      ii. When the participant does not find a new provider before services end, DDA may request the independent provider to continue services to allow more time to find a provider.

2. Before services end with a provider, the participant's Person-Centered Plan (PCP) team develops a transition plan including:

   a. Which services are ending and when;
   b. Any changes to continuing services;
   c. Supports needed from the provider whose service is ending to meet the needs of the participant during any transition time; and

d. Support needed when a new provider begins.

3. The provider must return the participant's personal funds and property.
4. The Service Coordinator ends the service authorization effective the date services end.

3. Participant Rights and Rights Restrictions

A person who is aged or has disability has the same legal, human, and civil rights and freedoms guaranteed to all citizens. People do not give up their rights when they accept services from the Division of Disabilities and Aging (DDA) or other state programs.

In the Policy Manual, "participant" means the person receiving Medicaid Home and Community-Based Services (HCBS) waiver services and any person legally authorized to act on behalf of the participant. In this chapter, references to participant rights mean the rights of the participant, not a person legally authorized to act on behalf of the participant.

A. State constitution and law, along with the federal constitution and law, guarantee basic legal, human, and civil rights. The Nebraska Legislature says in state law:

1. All people who are aged or have a disability have a right to live, work, and do things with people who are not; and
2. All people who are aged or have a disability have the same rights, dignity, and respect as other members of society.

B. Basic legal, human, and civil rights and freedoms include, but are not limited to:

1. The right to be treated with respect and dignity as a human being;
2. The right to receive services regardless of gender, race, religion, marital status, national origin, disability, sexual orientation, ethnicity, or age;
3. The right to be free from abuse, neglect, and exploitation;
4. The right to privacy;
5. The right to have access to personal records and to have services, supports, and personal records explained so they are easily understood;
6. Freedom of movement;
7. The right to make choices and decisions for oneself;
8. Freedom of thought and speech;
9. The right to access public places;
10. The right to access and control one's own possessions and money;
11. The right to access one's own residence;
12. The right to form relationships and contact or communicate with anyone;
13. The right to receive mail that has not been opened and to use the phone and the internet without monitoring;
14. The right to live independently in the community one chooses;
15. The right to be compensated at or above minimum wage for work in the same manner as a person who is not disabled;
16. The right to seek resolution of rights violations or quality of care issues without retaliation; and
17. The right to participate in political and public life.

C. DDA is committed to ensuring participants understand their rights. Agency providers are required to inform participants of their rights when they begin services and annually thereafter.

D. Agency providers must train their employees and contractors to understand participant rights and focus on assisting participants in exercising their rights. This includes respecting the rights, lifestyle, and personal beliefs of the participant and supporting their choices.

E. In addition to honoring participant rights and assisting participants in exercising their rights, providers have a responsibility to help participants understand that rights also come with responsibilities. To participate in community life fully, participants must be taught what is expected of them when certain choices are made.

3.1 Prohibited Practices

Any kind of rights restrictions, including all prohibited practices, are not allowed on the Aged & Disabled (AD) and Traumatic Brain Injury (TBI) Waivers because rights restrictions are not permitted.

The Division of Disability and Aging (DDA) prohibits the use of any rights restriction on the Aged & Disabled (AD) and Traumatic Brain Injury (TBI) Waivers because rights restrictions are not permitted under the waiver. A provider must report unauthorized use of a rights restriction or prohibited practice to DDA in an incident report.

A. Use of the following practices are prohibited during Medicaid HCBS AD and TBI Waiver services:

1. Mechanical restraint;
2. Physical restraint, except when used as an emergency safety intervention;
3. Chemical restraint;
4. Seclusion;
5. Aversive stimuli;
6. Corporal punishment;
7. Verbal abuse;
8. Physical abuse;
9. Emotional abuse;
10. Denial of basic needs; and
11. Discipline.

B. Mechanical restraint is any device, material, object, or equipment that restricts freedom of movement or normal access to the body.

1. The following are not considered mechanical restraints:

   a. The use of acceptable and age-appropriate child safety products, such as a car seat or booster seat;
   b. Use of standard car safety systems required by law, such as seatbelts or wheelchair tie-down straps; or
   c. Equipment ordered by a physician or health care provider for the participant's safety, such as a lap belt on a wheelchair.

C. Physical restraint is any physical hold that restricts, or is meant to restrict, the voluntary movement of a participant.

1. An emergency safety intervention is the only allowed use of physical restraint. DDA prohibits physical restraint, which does not meet the definition of an emergency safety intervention.

2. DDA prohibits the use of physical restraint as a preventative intervention. A preventative intervention, such as always linking arms, is one used during times when the PCP team feels the participant may display unsafe behavior, regardless of whether unsafe behavior occurs.

D. Chemical restraint is a drug used for discipline or convenience and not required to treat medical symptoms.

E. Seclusion is confining the participant alone in an area and physically preventing them from leaving or having contact with others.

   a. Alone in an area means the participant is secluded from peers and others in the environment, even when a provider is present.
   b. Prevented from leaving or having contact with others means the provider physically prevents the participant by a provider staff person, a door, partition, or other physical barrier.

F. An aversive stimulus is a procedure used to change unwanted behavior in a way that is painful, frightening, or potentially harmful to the participant's health or safety.

G. Corporal punishment is causing pain as a consequence for undesired behavior.

H. Verbal abuse is the use of oral, written, or gestured language that intentionally uses offensive terms towards a participant.

I. Emotional abuse is humiliation, harassment, threats, or intimidation causing distress.

J. Denial of basic needs is denying access to appropriate food and clothing, a comfortable and clean shelter, and treatment for physical needs.

K. Discipline is the use of punishment to correct undesired behavior.

1. Punishment means causing an undesirable or unpleasant outcome or consequence, as a deterrent to an undesired action or behavior, or withholding something the participant has a right to have or do.
2. A provider cannot treat participants' rights as privileges and use them as reinforcement for positive behavior or withhold them due to undesired behavior. A PCP team can discuss using reinforcement items or activities, such as a reinforcement item purchased by the provider, to encourage the participant to complete a task or behave appropriately, but not what the participant has a right to do or have.
3. It is not considered discipline to withhold access to items or activities when a participant is actively engaged in unsafe behavior, when the item or activity itself poses a safety risk. DDA does not consider this discipline, as the intention is to maintain safety while the unsafe behavior is occurring, not to punish the participant for engaging in unsafe behavior.
4. DDA does not consider it a discipline to withhold access to some activities and items when the participant is a child, because children generally do not have the same rights as adults.

   a. For example, it is an adult's right to access any public place in the community, but a child is typically not allowed to go wherever they choose.

5. The team should discuss age-appropriate consequences for a child participant and review whether the consequence being discussed involves rights that other children of the same age are typically allowed to do or is likely to result in injury.

3.2 Grievance Process

A participant or their representative has the right to file a grievance with DDA when they have a concern related to any aspect of their HCBS services, settings, or planning and to have the grievance addressed by DDA.

A. Examples of types of grievances:
   1. Concerns for the safety and well-being of the participant;
   2. Suspicion of Medicaid fraud;
   3. Provider violations of any applicable laws, regulations, or policies;
   4. Issues related to other supports, such as a social worker, physician, or therapist;
   5. Issues related to a participant's Service Coordinator;
   6. Difficulty with Medicaid HCBS waiver services or providers;
   7. Issues with services in settings that do not align with participant choices, promote community integration, or uphold a participant's right to privacy, as outlined in the HCBS Final Settings Rule;
   8. Misuse of handling, using, disclosing, or processing the participant's Personal Health Information (PHI) by DDA or the participant's provider(s), as protected by HIPAA; or
   9. Any other concern to which the department should be made aware.

B. A person may make a complaint by:
   1. Visiting the DDA Public website at: https://dhhs.ne.gov/Pages/DevelopmentalDisabilities.aspx and completing the complaint form located on the right side of the webpage;
   2. Completing the form directly at: https://wkf.ms/4e6nopb
   3. Mailing a complaint or complaint form to:
      Department of Health and Human Services
      Division of Disability and Aging
      PO Box 98947
      Lincoln, NE 68509-8947
   4. Contacting DDA by phone toll-free at 1 (877) 667-6266; or
   5. Visiting any DHHS office. *For DHHS office locations, see Policy Manual Appendix D: Contacts and Resources.*

C. Once the grievance has been resolved, DDA sends a written notification to the participant and their legal guardian.

D. Resolutions to grievances may involve, but are not limited to:
   1. Follow-up by phone or email;
   2. On-site review;
   3. Referral to DHHS Public Health for licensing or certification issues; or
   4. Referral to another agency, such as DHHS Children and Family Services or Medicaid Fraud Referral Unit.

E. DDA maintains a record of all complaints received and their resolution.

F. When you receive benefits or services from DHHS and want to contact DHHS about HIPAA matters, report a violation, or file a complaint regarding a DHHS employee or contractor related to HIPAA contact:
   1. **Phone Number:**
      (402) 471-4068
   2. **Address:**
      Department of Health and Human Services
      PO Box 95026
      301 Centennial Mall South, 3rd Floor

Lincoln, NE 68509-5026

3. **Email:**
DHHS.HIPAAOffice@nebraska.gov

G. Accessibility and Language Access

1. Grievance materials will be:

   a. Available in alternative formats upon request;
   b. Provided in prevalent non-English languages; and
   c. Accessible to individuals with disabilities

2. Assistance in completing the grievance form is available at Local DHHS offices or by contacting DDA Central Office directly at (877) 667-6266.

3.3 Appeal/Fair Hearing

When a person disagrees with an action or decision made by DDA, they have the right to appeal the action or decision by requesting a fair hearing. When DDA makes a decision, DDA sends a written notice to the applicant or participant with information about how to request a fair hearing.

A. A fair hearing may be requested by the participant when:

1. An application is denied;
2. The Department failed to act on an application with reasonable promptness;
3. A change is made in the amount or type of benefits or services received;
4. A Medicaid share of cost for Medicaid HCBS AD and TBI Waiver services is assigned;
5. A determination that services are not required;
6. The participant disagrees with the AD or TBI Waiver placement;
7. A claim for benefits or services is denied; or
8. The form of payment or services is changed to be more restrictive.

B. A fair hearing may be requested by a provider when:

1. A billing claim for providing AD or TBI services is denied;
2. The provider's certification is denied; or
3. DDA imposes disciplinary action.

C. DDA does not provide appeal rights when state or federal law requires a change in AD or TBI services, which negatively affects some or all participants.

D. **Requesting a Fair Hearing:** When a participant wants to request a fair hearing:

1. The participant may request a fair hearing at any time within 90 calendar days of the decision.

   a. The 90 days start the day after the postmark of the notice of decision.
   b. When the last day of the 90 days is a weekend or state holiday, the deadline to request a fair hearing ends at 5:00 PM on the next business day.
   c. When the participant does not submit the request for a fair hearing within the 90 days, the decision is final.
   d. If ADA accommodations, translations, or interpreter services are needed, these can be requested at the time of the request for the fair hearing.

2. When the participant submits a request for a fair hearing within ten calendar days of DDA mailing a notice of decision, the appealed action does not go into effect until the fair hearing process is complete.

a. The ten days start the day after the postmark of the notice of decision.
b. When the last day of the 10-day period is a weekend or state holiday, the period ends at 5:00 PM on the next business day.
c. When the participant does not submit the request for a fair hearing after ten calendar days have passed, the appealed action goes into effect on the effective date in the notice of decision, regardless of the ongoing appeal.
d. When anyone objects to whether the appealed action does or does not go into effect, the Hearing Officer makes the final decision.
e. DDA central office notifies providers and DHHS staff affected by the decision.

3. The written request for a fair hearing may be made with the DDA form found on the DDA public website homepage, or in another written format with the following information:

a. The name, address, phone number, and signature of the person who is requesting a fair hearing;
b. The specific decision being appealed;
c. The date of the decision; and
d. Any information to review at the fair hearing.

4. When the request for a fair hearing does not include all the required information, the hearing process cannot proceed. DDA may reject the request for a fair hearing or request additional information.
5. The request for a fair hearing must be mailed, emailed, or hand-delivered to DDA.

a. A mailed request is dated by the postmark and must be sent to:

Department of Health and Human Services
Legal Services – Hearing Section
P.O. Box 98914
Lincoln, NE 68509-8914

b. An emailed request must be sent to DHHS.DDAppeals@nebraska.gov and is automatically dated when the email is sent.
c. A request can be dropped off at any DHHS office open to the public and is stamped with the date when received in the local office. *For locations of local offices, see Appendix D.*

E. **Preparing for a Fair Hearing:** When a request for a fair hearing is received:

1. DDA assigns the request to a staff person, and that person notifies the participant that their request for a fair hearing was received.

2. DHHS Legal sends the request for a fair hearing to the Hearing Office.
3. The Hearing Office assigns a Hearing Officer who is a DHHS attorney to conduct the fair hearing.

a. The Hearing Officer has the duty to:

i. Conduct an unbiased, fair hearing;
ii. Take action to avoid delay in the fair hearing process; and
iii. Maintain order during the fair hearing.

b. Before the hearing, the Hearing Officer has the authority to:

i. Subpoena witnesses and evidence;

ii. Require all evidence to be provided to all parties;
iii. Hold meetings to clarify issues or settle the appeal;
iv. Set deadlines for submitting evidence; and
v. Extend timelines at the request of any party, when appropriate.

c. Any party may request a different Hearing Officer when they believe there is a conflict of interest.

i. The party must make the request on or before the hearing date.
ii. The hearing office or DDA Director will review the request and make a decision.
iii. When the request is not reviewed and decided immediately, DHHS postpones the fair hearing until the request is resolved.

4. The Hearing Officer sets the date and time for the hearing and attempts to arrange a time that is convenient for all parties.
5. Supporting documents to be used as evidence are delivered to the person requesting the fair hearing at least five business days before the hearing.
6. The person requesting the fair hearing must also provide the Hearing Office and DHHS Legal Services with any documentary evidence to be considered at least five business days before the hearing.
7. When the fair hearing is postponed for any reason, all parties are notified of the new hearing date by mail at least five calendar days before the new hearing date.
8. To request ADA accommodations, translation, or an interpreter in advance as outlined on the hearing notice.

F. **Holding the Fair Hearing:** When the fair hearing is held:

1. The parties present evidence and any additional information.

a. The person who requested a fair hearing must prove their case by proving to the Hearing Officer that the decision made by DDA is incorrect.
b. DDA presents evidence explaining how DDA reached the appealed decision.

2. During the fair hearing, all parties have the right to:

a. At their own cost, be advised by a lawyer and by people with knowledge about the needs of people with AD or TBI;
b. Present evidence and question witnesses; and
c. Request that the Hearing Officer not allow the use of evidence that was not provided to the party at least five business days before the hearing.

3. During the fair hearing, the Hearing Officer has the authority to, for example:

a. Swear in witnesses providing testimony;
b. Review and make decisions on the evidence presented;
c. Direct and oversee the fair hearing;
d. Consider and decide on all motions; and
e. Make sure evidence is fully presented and question witnesses when needed information is not presented.

G. **Final Decision:** After the fair hearing:

1. All parties have the right to receive a transcript of the hearing at their own cost;

2. The Hearing Officer makes recommendations to the DDA Director;
3. The DDA Director makes a decision based on the recommendations from the Hearing Officer; and
4. DDA sends the final decision, also called a hearing order, to each party by certified mail.

4. Service Coordination

For individuals on a Medicaid Home and Community-Based Services (HCBS) Aged and Adults and Children with Disabilities (AD) and Traumatic Brain Injury (TBI) waivers, a Division of Disability and Aging (DDA) Service Coordinator (SC) will perform case management functions. AD/TBI SC staff are prohibited from providing both service coordination and direct services.

Service coordination involves determining what services the person needs, developing a plan to outline the services to be provided, and monitoring to ensure services are provided according to the Person-Centered Plan (PCP). Service coordination does not involve providing direct services, such as transportation, or finding a home or job. The SC ensures there is no duplication of services, no improper influence by providers of Medicaid HCBS AD/TBI Waiver Services, and no replacement of natural supports or Medicaid State Plan services.

4.1 Service Coordination for Waiver Services

DDA bases service coordination on a person-centered philosophy, encouraging independence, productivity, and community integration for participants.

A. ADTBI SC works with each participant to:

1. Provide information on services available through the Medicaid HCBS AD or TBI waivers;
2. Develop the participant's plan, known as the PCP, which is based on the participant's personal goals and their needs;
3. Monitor the implementation of the participant's PCP;
4. Help participants connect with providers, when needed;
5. Complete service authorizations for chosen providers and transition plans;
6. Start the process to enroll any preferred independent providers;
7. Help the participant identify and access resources not funded by DDA, such as community organizations, housing assistance, legal aid, medical services, Social Security, or Vocational Rehabilitation;
8. Attend the Individual Educational Plan (IEP) meeting for students, and receive a copy of the document;
9. Determine whether the participant's needs are being met; and
10. Help advocate for what the participant wants and needs from their provider, family, and community.

B. **Service Coordinator Assignment:** DHHS assigns an SC based on the age and location of the participant. SC offices are located throughout the state.

1. The SC makes regular ongoing contact with or on behalf of the participant, at least monthly.
2. Service planning begins when the final points of eligibility have been met, and the service options that best meet the participants' assessed needs have been determined.

3. When an SC is not available due to illness, vacation, or job vacancy, the Service Coordination Supervisor (SCS) will direct other SCs at the local office to ensure the participants' needs are being met.

C. **Freedom of Choice:** Freedom of choice is the participant's right to choose the services they receive and who provides those services.

1. A participant's SC provides information about the Medicaid HCBS waivers the participant is eligible for, available services, and providers.

   a. Per federal regulation, DDA must inform a participant that they have the right to choose between services provided in Medicaid HCBS Waiver services.
   b. A participant also has the right to choose which Medicaid HCBS AD or TBI Waiver services they receive based on assessed need and select any qualified provider who is available, willing, and able to provide the services chosen. The SC provides information to support the participant in making an informed choice, including:

      i. A list of AD or TBI agency providers available in the participant's area; and
      ii. Information about connecting with providers when needed and working with independent providers.

   c. When requested by the participant, the SC will assist with scheduling appointments with potential providers, completing paperwork, or attending and accompanying them to appointments with potential providers if requested and based on assessed need. Providers will come to the participants' homes in most situations.

2. When a participant has chosen the Medicaid HCBS AD or TBI Waiver services they want to receive, the SC assists the participant in beginning the service planning process. The assistance provided depends on the services and providers the participant chooses.

   a. When a participant is interested in receiving services from an agency provider, the SC:

      i. A referral is sent in Therap after the provider is chosen by the participant.
      ii. Will support the participant in working with their chosen agency.

   b. When a participant is interested in receiving services from an independent provider, the SC:

      i. Discusses responsibilities of training, supervising, monitoring, and coordinating independent providers to meet care needs; and
      ii. Starts the process for Medicaid provider enrollment for potential providers chosen by the participant.

3. Children 0-47 are referred to the EDN when eligible; if they choose not to receive EDN services or are not eligible, they will be assigned a Service Coordinator through DHHS. Participants between the ages of 0-64 will be assigned an SC from DHHS; participants aged 65 and older can choose between the Area Agency on Aging (AAA) Targeted Case Management (TCM) or a DHHS SC.

D. **Service Monitoring:** The SC is responsible for monitoring the provision of Medicaid HCBS AD/TBI Waiver services.

1. The purpose of ongoing monitoring is to:

   a. Make sure services are provided as outlined in the participant's PCP;
   b. Make sure all needs of the participant are being met;
   c. Provide feedback to improve the quality of services;
   d. Reviewing claims for services provided; and
   e. Collect information needed for reporting to the Centers for Medicare and Medicaid Services (CMS).

2. Monitoring activities include, but are not limited to:

   a. Visits with the participant;
   b. Monthly contacts with the participant and PCP team members;
   c. Review of incident reports and medication records;
   d. Review of provider attendance and billing;
   e. Monitor Medicaid eligibility and participant's Share of Cost (SOC); and
   f. Review of the participant's service authorizations.

3. A contact between the participant and the SC will occur at a minimum of once a month. Contact may be more frequent based on participant needs.

   a. Contact must be in person or over the phone.

      i. When the participant has an assessed need for assistance with communication or cognitive impairment, or when documentation shows that the participant cannot participate in a telephone call, an unpaid caregiver may replace the participant as the contact. Participants must be present during the contact and included to the full extent possible, particularly during in-person visits. In these cases, additional in-person contacts may be made.
      ii. When the authorized representative or guardian is a paid provider, an individual with knowledge about the participant's care will also be contacted to provide monitoring information.

   b. SCs may also make unbillable contacts with the paid provider for supplemental information when there is no indication that the participant is present and involved in the contact. A family member who is a paid provider is considered a provider for the purpose of a monthly contact.
   c. The SC documents all contacts made with the participant and others in case notes.

      i. Electronic responses cannot be accepted as the primary means for monthly contacts. These include, but are not limited to:

         (1) Email;
         (2) SCOMM;
         (3) Text Messages; and
         (4) Voicemails.

E. **Service Authorizations:** The SC is responsible for ensuring that service authorizations are managed correctly.

1. The SC discusses available services and costs with the participant and assists the participant in choosing services.
2. The SC completes service authorizations to assign funding to AD and TBI providers chosen by the participant.
3. The SC tracks the use of the participant's services and provider billing.
4. When the participant has a monthly share of cost (SOC) for their Medicaid benefits, the share of cost amount is obligated to the participant's Medicaid HCBS AD or TBI Waiver services.

    a. The PCP team discusses which provider is responsible for collecting the share of cost from the participant when there is more than one AD or TBI provider.
    b. When the amount paid for one provider's services is less than the participant's SOC, the SOC is obligated to more than one provider.
    c. The SC documents when there is a share of cost in the participant's PCP and indicates "deduct customer obligation" on the service authorizations.
    d. The state-mandated electronic case management system includes a monthly report, available to providers, listing the participants they serve and the participants' share of cost.
    e. DDA pays the providers for services after the share of cost has been obligated for claims. The share of the cost portion of the claim shall be collected from the waiver participant; the DD pays the remaining portion as authorized.
    f. The provider must bill the participant for the SOC portion of payment, and the participant is responsible for paying the SOC to the provider.

5. Person-Centered Planning and Implementation

In accordance with 42 CFR. § 441.540:

> "The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available…"

The person-centered service plan is developed for each participant using Medicaid Home and Community-Based Services (HCBS) Aged and Disabled (AD), and Traumatic Brain Injury (TBI) Waiver services. The Person-Centered Plan (PCP) is an individualized plan based on the participant's unique preferences and assessments to meet identified goals and needs. DDA uses the Therap Person-Centered Plan (PCP) template. The service plan describes the waiver services chosen by the participant, the provider, the projected frequency for each service, any other services (regardless of funding source, including Medicaid State plan services), and informal supports which complement waiver services to meet the participant's needs.

5.1 Person-Centered Planning

The PCP must provide guidance to help the participant achieve important person-centered outcomes to meet their needs, attain and maintain the needed skills to achieve their life goals, and live as independently as possible in their community. The PCP clearly describes the participant's needs and the services and supports required to meet them. The participant owns the PCP and is encouraged and supported to lead the person-centered planning process.

The person-centered planning process starts by creating a team. The team may include family members, friends, and professionals per the participant's discretion, as well as required team members. This team assists the participant to live the life they choose by communicating with the participant about their supports and services, the progress they have made, and any changes they want or need.

A. Person-centered planning:

1. Focuses on the participant and their strengths, needs, goals, and preferences;
2. Seeks to balance what is important to the participant with what is important for them;
3. Means the participant is in charge of defining and controlling the direction for their life;
4. Encourages self-advocacy;
5. Increases opportunities for integration in the community;
6. Honors the participant's preferences and choices;
7. Supports the participant in having satisfying and productive relationships with family, friends, and community members;
8. Supports the participant in living as independently as possible;
9. Encourages the participant to find employment meaningful to them;
10. Leads to greater belonging as valued members of both community and society;
11. Empowers the participant to design their PCP with the support of the PCP team; and

12. Outlines other resources available when the participant wants, and goals are beyond their assessed need and scope of waiver services.

B. Person-centered support means people:

1. Treat the participant with dignity and respect;
2. Listen to and respect the participant's goals, wishes, and preferences;
    a. The participant has their values and beliefs.
    b. Team members support the participant's values rather than imposing their own, as this can become a barrier to the person-centered planning process.
3. Use appropriate words and conversation:
    a. Use person-first language (such as "a person who uses a wheelchair" instead of "wheelchair confined" and "people with developmental disabilities" instead of "the developmentally disabled");
    b. Do not use slang or degrading words;
    c. Talk with the participant and not about the participant;
    d. Call the participant by the name they choose and avoid giving nicknames unless requested by the participant; and
    e. Be aware of tone and volume.
4. Respect a participant's privacy:
    a. Sensitive information is discussed privately and quietly;
    b. Information is only shared with others who need it;
    c. Personal information (such as medication schedule, weight, or doctor's appointments) is not displayed in public areas; and
    d. Other people enter personal spaces with permission (such as a bedroom or private residence).
5. Respect a participant's property and finances:
    a. Access to their belongings at any time; and
    b. Access to and choice of how to use their personal spending money and earnings.
6. Help the participant fully connect to their community as much as possible:
    a. A participant chooses where to go;
    b. They choose when to go somewhere;
    c. They can spend time with anyone they want; and
    d. A participant can join any group they want.
7. Understand and advocate for the participant's rights:
    a. The participant may need assistance to understand and exercise their rights; and
    b. Rights should not be limited.

C. The participant communicates with their PCP team to guide the development of their PCP.

1. The participant reports to the PCP team what is working and not working.
2. The participant follows through with their PCP.
3. The participant directs changes to their PCP.

D. It is important to develop a plan balancing what is important to the participant and what is important for their safety and well-being.

1. The PCP team focuses on what is most important *to* the participant when developing the plan.

   a. Things that are important to the participant may include goals for the future, activities they enjoy, opportunities or experiences they would like to have, relationships, things they would like to learn, and their likes and dislikes.
   b. The goal of person-centered planning is to develop a plan that includes community integration in supporting the participant to achieve their personal goals, maintain or build relationships, and have opportunities for activities they consider meaningful.
   c. The team listens to the participant and shares information from observations and assessments.
   d. The plan builds on the strengths and talents of the participant to achieve their goals.

2. The PCP team considers what is most important *for* the participant to be safe, healthy, and as independent as possible, including:

   a. Supports addressing the participant's medical and adaptive needs.
   b. Team members share information gathered through observations and assessments to identify what is important for the participant.
   c. Supports that would help them overcome barriers to something important to them.

E. When developing the plan, the participant chooses based on assessed need and service parameters, Medicaid Home and Community-Based Services (HCBS) AD or TBI Waiver services, and who they wish to provide these services.

1. There are two types of providers of Medicaid HCBS AD or TBI Waiver services:

   a. An agency provider, which is a company enrolled as a Medicaid provider; and

   b. An independent provider who is a person enrolled as a Medicaid provider.

2. Each Medicaid HCBS AD or TBI Waiver service has specific provider types and requirements. A participant must choose a provider who meets the requirements of the service they want to receive.
3. A participant may have both independent and agency providers.
4. The PCP includes exploring what could help the participant be more independent.

5.2 Documentation in the Person-Centered Plan

Description of what the participant's PCP must contain.

A. What is important to the participant, including:

1. What is important to and important for the participant;
2. What activities do they enjoy doing and are interested in;
3. What are the most important things in their life;
4. How they generally interact with others, such as with friends, family, or co-workers;
5. What clubs or organizations do they belong to or are a part of;

6. Are there any cultural considerations important to them;
7. Do they have any dislikes or things they do not prefer, such as activities, interactions, or foods;
8. What are their personal goals; and
9. What others need to know or understand and do when supporting the participant.

B. The services the participant will receive in the upcoming year, including:

1. All Medicaid waiver services;
2. All non-waiver services;
3. The specific providers who work with the participant; and
4. The weekly authorized limits and scope.

C. Plans to address the participant's identified risks, which must reflect the health and safety risk factors and plans in place to minimize them, including individualized back-up plans and strategies to mitigate risk.

D. The participant's medical care, including:

1. Medical diagnoses and general health status;
2. Allergies to medications, food, or the environment;
3. Adaptive equipment needed or used;
4. Physicians and therapists treating the participant;
5. When the participant was last seen by their physicians and therapists, and
6. Who is responsible for the participant's medical care.

E. The participant's finances, including when there is a Medicaid share of cost.

5.3 Person-Centered Plan Team

The PCP is developed each year through a team process. The participant chooses their PCP team. When the participant does not want a specific person at their PCP meeting, the team will make every effort to honor the request. The Service Coordinator must invite all team members to all meetings. The team holds at least one PCP meeting each year.

A. The team includes the following:

1. Participant;
2. Service Coordinator;
3. AD or TBI agency and independent providers who work with the participant;
4. Participant's guardian, family members, advocate, and friends; and
5. Other organizations that support the participant.

B. The following team members must participate in the PCP team meeting:

1. The participant;
2. Service Coordinator;
3. AD or TBI agency and independent providers who work with the participant; and
4. The participant's guardian, when there is one.

C. The PCP team may hold additional meetings when changes in services or providers occur. When there is a change in providers, both the old and new providers are invited.

D. Any team member may request an additional meeting by contacting the Service Coordinator (SC).

1. The SC may contact other team members to decide if the PCP team needs to meet or if the team can address the member's concern without a meeting.
2. When the PCP team needs to meet, the SC is responsible for scheduling and inviting all team members.

5.4 Annual Person-Centered Plan Meeting

The annual PCP is the main planning meeting. This meeting focuses on developing a plan of services based on the participant's personal goals and preferences and assessments of strengths and needs. The purpose of the annual PCP meeting is to identify waiver and non-waiver services, interventions, strategies, and supports to assist the participant in achieving their plan and personal goals.

A. The annual PCP meeting will be held before the start of a new PCP year. The SC schedules and organizes the meeting on behalf of the participant.

B. DDA expects the participant to attend their meeting.

1. Adult participants must be in attendance for their PCP meetings.
2. Minors should be in attendance for their PCP meetings when available for their strengths and needs to be considered.

C. DDA expects each team member to contribute to the PCP meeting. When the participant is unable to communicate information, the PCP team members should share information on their behalf.

1. The participant is asked to share information, including their:

    a. Goals for the future and the current PCP year;
    b. Celebrations and accomplishments from the past year;
    c. Back-up plan for services in the event they are unable to be provided;
    d. Services, providers, and schedule for the upcoming year; and
    e. Likes and dislikes.

2. The provider is asked to share information, including, but not limited to:

    a. Plans to minimize health and safety risks, including the need for any supervision;
    b. Back-up plan for Medicaid HCBS AD or TBI Waiver services for when they are unable to be provided;
    c. Employment goals and strategies for TBI waiver participants:

        i. Current employment, including place of employment, hours worked, and support needed.
        ii. Involvement in Vocational Rehabilitation services, including progress.

3. The SC conducts the Service Needs Assessment (SNA) to identify the needs of the participant and reviews assessments such as the LOC to support service plan development and completes one of the Charting the Life Course (CtLC) Tools with the team.

4. The SC shares information and leads the discussion of:

    a. The level of care assessment and plans to address identified needs;
    b. The plans to minimize identified risks;
    c. The use of community resources and natural supports; and
    d. Referrals for other services to meet identified unmet needs.

e. Health status and medical service needs, including:

i. Managed care provider; and
ii. Assignment of responsibility for medical care.

D. After the PCP meeting, each team member is responsible for completing assigned tasks to implement the PCP.

1. Providers are required to implement the PCP. Agency providers who employ direct support staff or contract with an independent contractor are required to ensure staff training of the PCP, including habilitative programs.
2. Team members are responsible for cooperating with other AD or TBI providers, therapists, and other clinical providers.

E. The PCP must be revised as necessary to add or delete services or modify the amount and frequency of services. Service plans must be reviewed at least annually or whenever necessary due to a change in the participant's needs. The SC does this through monthly contact with the participants.

5.5 Additional Person-Centered Plan Meetings

When the PCP needs changes, the team may hold additional meetings. A meeting can be a phone call or in-person and may be referred to as an addendum or special PCP meeting. These meetings review the PCP plan and make needed changes.

All requirements for the Annual Person-Centered Planning Meeting are applicable to additional PCP meetings, including participant participation.

A. When a team member wants an additional PCP meeting, they contact the SC.

1. The SC may contact other team members to decide if the team needs to meet or if the team can address the member's concern without a meeting.
2. When the team needs to meet, the SC is responsible for scheduling and inviting all team members.

B. An additional PCP meeting or a change to the plan may occur when:

1. The PCP does not meet the participant's needs due to:

a. Medical changes;
b. Increases in reportable incidents;
c. Change in needs; or
d. Changes in health and safety risks;

2. The participant changes providers.

C. After an additional PCP meeting, each team member is responsible for completing the assigned tasks outlined in the plan to implement the PCP.

1. Providers are required to deliver the action steps and tasks outlined in the PCP to implement participants' care to meet their preferences and waiver service needs. Agency providers who employ direct support staff or contract with an independent contractor are required to ensure staff training of the PCP, including habilitative programs. When there are changes to the PCP, the provider will train staff accordingly.

2. Team members are responsible for cooperating with other AD/TBI providers, therapists, and other clinical providers.

5.6 Service Authorizations

The SC creates, edits, and approves service authorizations. A service authorization is an agreement between the provider and DDA to allow the provider to bill Medicaid HCBS AD or TBI Waiver services.

A. The SC creates service authorizations for the services and providers chosen by the participant.

1. Service authorizations are approved after the annual PCP meeting, so services can start at the beginning of the new PCP year.
2. Service Coordination may change service authorizations throughout the year based on use; and
3. Service Coordination may change service authorizations when needed, such as:

    a. Changes in Share of Cost (SOC);
    b. When a participant's assessed need changes;
    c. When a participant changes providers; or
    d. Changes to the SNA

4. Service Coordination may close a service authorization when:

    a. Eligibility for the participant's waiver is terminated;
    b. Assessed needs change;
    c. Participant request (with a 10-calendar day notice);
    d. The provider is unable or unwilling to correct any service quality issues identified by the DDA Quality Team; or
    e. A provider does not follow applicable relevant policies or regulations.

B. Providers are responsible for monitoring the state-mandated web-based system to be notified of changes in services, the start and end dates of services, and applicable directions for tasks and care are outlined in addition to the PCP.

6. Independent Providers

When a participant chooses to work with an independent provider, they are responsible for managing aspects of service delivery in a person-centered planning process.

In this Policy Manual chapter, "participant" means the individual receiving Medicaid HCBS AD or TBI Waiver services and any other person legally authorized to act on behalf of the participant.

A. Benefits of using an independent provider may include, but are not limited to:

1. Giving the participant choice and control in what services are provided, when and how services are provided, and who provides services;
2. Increasing independence and self-esteem;
3. Choosing who comes into their home to work;
4. Increasing community integration;
5. Supporting the participant to maintain their lifestyle and preferences to a greater extent; and
6. Increased satisfaction with services.

B. Risks of using an independent provider may include, but are not limited to:

1. Health and safety needs are not met by a provider with limited medical knowledge or medical training;
2. Isolation or decrease in community integration;
3. Vulnerability to abuse or neglect; and
4. The possibility that the provider may quit or not show up.

C. When the participant and their team are deciding if they want to use an independent provider, the team should discuss the following questions to help the participant decide if the use of an independent provider is a good fit:

1. Can an independent provider meet the participant's medical needs?
2. Is the participant aware of whether they are receiving adequate support?
3. Will the participant be more isolated and vulnerable to abuse/neglect?
4. Does the participant understand what abuse and neglect are, and are they capable of reporting abuse or neglect?
5. Will the participant be afraid to report abuse, neglect, exploitation, or fraud because they do not want to lose an independent provider or damage a relationship?
6. How will the participant locate providers to help in their home or the community?
7. How does the participant plan to train the independent providers who work in their home or the community?
8. When the participant's regularly scheduled provider cannot work, such as calling in sick or not showing up, how will the participant get their needs met?
9. Does the participant understand they may make changes to their plan or services, and how to do so?
10. Will the participant be able to tell a provider what they like or do not like about the provider's work?

11. Does the participant understand what may happen when they choose not to share some information with the provider about their medical needs?
12. Will the participant be afraid to dismiss a provider because they do not want to lose an independent provider or damage a relationship?
13. What would the participant do when they are home alone and there is an emergency?
14. Is the participant willing to accept help from their Service Coordinator?
15. Does the participant want to appoint someone as their advocate to help with self-direction?

D. When anyone on the PCP team thinks using an independent provider may not meet the participant's needs or be in the best interest of the participant, the team can encourage the participant to:

1. Choose an advocate to assist with the management of the independent provider; or
2. Select an agency provider.

E. Independent providers are selected by and work at the direction of the participant.

1. A participant may have any person as an independent provider when the person:
    a. Meets general Medicaid HCBS AD/TBI Waiver provider requirements;
    b. Is not legally responsible for the participant without DD Central Office approval; and
    c. Meets the expectations of the participant.
2. Medicaid HCBS AD/TBI Waiver service definitions explain which services independent providers can provide.
3. Each service has specific provider requirements.

6.1 General Responsibilities when using Independent Providers

Use of Independent providers can promote personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided.

When the participant uses independent providers, they must be willing and able to accept increased responsibility for managing their Medicaid HCBS AD or TBI Waiver services. The participant must advocate for their wants and needs.

A. The participant will actively participate in the PCP meeting, which is directed by the participant with assistance as needed from their team. Through this process, the participant is identifying preferences, needs, and desired outcomes of the provision of services.
B. The participant authorizes the exchange of information for the development of the PCP with all of the participant's service providers and in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
C. The participant accepts the responsibilities for recruiting, selecting, training, or dismissing independent providers.
D. The participant will provide a safe environment in which services are to be delivered.

6.2 Conflict of Interest

It is important to avoid conflict of interest and the appearance of conflict of interest. The PCP team must help the participant monitor possible conflicts of interest.

A. When a participant's guardian or family member helps them to self-direct, the PCP team must monitor for possible conflicts of interest to ensure the participant's best interests are prioritized in decision-making.

B. When a participant chooses a family member or friend of the guardian as an independent provider, the guardian may have difficulty placing the interests of the participant ahead of the interests of others.

C. The PCP team must monitor when a team member holds multiple roles in the participant's life. For example, when a team member is a family member to the participant and guardian, as well as a paid provider.

D. When an SC agency is also a waiver provider, they are prohibited from providing service coordination services.

6.3 Finding an Independent Provider

A. Participants must find their own independent providers. A participant may have a difficult time finding providers because there is no public list of independent providers.

1. A participant may choose someone they know, including a neighbor, friend, or family member.

    a. There are benefits to having someone the participant knows:

        i. It may be easier to find a provider; and
        ii. The provider is already familiar with the participant and with their preferences.

    b. There are also risks to having someone the participant knows:

        i. It may change, damage, or end the existing relationship;
        ii. It may be more difficult for the participant to tell the provider when things are not going well or when the provider is not meeting expectations;
        iii. It may be more difficult for the participant to dismiss someone they know when the provider is not completing job duties; or
        iv. A participant may be afraid to report fraud or abuse/neglect because of the relationship.

2. When a participant does not have someone in mind to be an independent provider, their SC may assist them in identifying potential community resources, such as:

    a. Local advocacy groups;
    b. Local schools or special education programs; or
    c. Advertising in a local newspaper, jobs website, or help-wanted website. The participant is responsible for the cost of advertising.

B. The participant should meet each potential provider. The participant is responsible for deciding if the provider is a good fit to meet their needs and preferences.

1. The participant should develop a job description using their expectations, such as:

    a. The services and schedule they want;
    b. Provider requirements for the services to be provided;
    c. Description of what the participant needs help with;
    d. Their expectations regarding attendance and being on time;

e. How much notice is required when the provider is not able to work due to illness or other commitments;
f. Required physical activities, such as lifting;
g. Rules the participant has in their home; and
h. Their personal preferences, such as around smoking, cell phone use, and pets.

2. Before meeting a potential provider in person, the participant may want to speak to the provider on the phone.

   a. The participant should talk with the potential provider about their needs and their expectations of the job.
   b. The participant should ask the potential provider if there are any tasks they cannot or will not do.
   c. The participant should ask the potential provider if they meet all requirements to be an independent provider.
   d. Based on this call, the participant decides if they will do an in-person interview.

3. The participant should decide on an appropriate place to meet the potential provider.

   a. The meeting could happen at the participant's home. When this happens, the participant:

      i. May be more comfortable because their home is a familiar environment;
      ii. Can show any adaptive equipment specific to working in their home;
      iii. Should invite a friend, family member, or their SC to attend; and
      iv. Should understand the person now knows their address.

   b. The meeting could happen in a public place. When this happens, the participant:

      i. Is not inviting a stranger into their home;
      ii. May invite a friend, family member, or their SC to attend; and
      iii. Must be aware of not sharing confidential information in public.

4. The participant takes the lead when meeting potential providers.

   a. Before the participant starts to ask questions of the potential provider, they should explain the job duties, services, and schedule. It may be helpful to provide a written description of their expectations.
   b. The participant should have a list of questions to ask the potential provider about their background and experience. Possible questions include:

      i. What previous jobs have you had?
      ii. How did previous jobs prepare you for this job?
      iii. What is your experience working with people who are aged, have disabilities, or have a brain injury?
      iv. What other experiences have you had that prepared you for this job, such as volunteering or education?
      v. Is there any reason you cannot perform the job duties?
      vi. Do you have any questions about the job duties or schedule?
      vii. Is there any reason why you cannot meet my expectations?
      viii. How would you resolve any problems or disagreements? Give examples of situations you have had in other jobs.

ix. Have there been times when you were scheduled to work, but were not able to show up or were late? Why? How did you let your boss know?

x. Do you have dependable transportation to get to work? When the provider is going to provide transportation, discuss details.

c. There are some questions that a participant cannot ask during an interview because they can be considered inappropriate or discriminatory. These include:

i. National Origin/Citizenship

(1) A participant cannot ask: Are you a citizen? Where were you or your parents born? What is your native language?

(2) A participant can ask: Are you authorized to work in the United States? Are you fluent in the language I use?

ii. Age

(1) A participant cannot ask: How old are you? What is your birthday? When did you graduate from high school or college?

(2) A participant can ask: Are you age 19 or older? This is the minimum age required to be an independent provider.

iii. Marital/Family Status

(1) A participant cannot ask: Are you married? Who do you live with? Do you plan to have a family? How many children do you have? What are your childcare arrangements?

(2) A participant can ask: The schedule for this job may change and may not be the same from week to week. Would you be willing to work with a changing schedule? This question is acceptable as long as the participant asks of all applicants.

iv. Physical Abilities

(1) A participant cannot ask: How tall are you? How much do you weigh?

(2) A participant can ask: Are you able to lift 50 pounds? Can you assist with wheelchair transfers?

v. Disabilities

(1) A participant cannot ask: Do you have any disabilities or medical conditions?

(2) A participant can ask: Are you able to perform the job duties?

vi. Arrest Record

(1) A participant cannot ask: Have you been arrested?

(2) A participant does not need to ask about this history. During the Medicaid provider enrollment process, abuse/neglect registries and criminal history checks are completed.

C. The participant reviews all information and decides if they want to use the potential provider. A participant may have more than one provider, or a primary and a backup provider.

1. A participant should tell the provider that they cannot provide services until the provider enrollment is complete and a service authorization is completed.
2. The participant notifies their SC when they would like a certain independent provider.
3. When the potential provider is not already a Medicaid enrolled provider, DDA sends the participant an independent provider enrollment packet.

D. The participant gives the potential provider the enrollment packet.
E. When the provider completes the enrollment process and is approved or denied, DDA notifies the participant and the provider.

6.4 Retaining an Independent Provider

A. The participant is responsible for ensuring their provider receives adequate training to meet their needs. Training should cover the participant's expectations of the independent provider.

1. The participant should talk with their provider about what to do in the event of an emergency, such as fire, flood, or severe weather.

    a. The provider and participant should discuss emergency plans during the first week, and review these plans as needed.
    b. When the participant has a fire extinguisher, smoke detector, or other emergency equipment, ensure these items are working properly and the provider knows where emergency equipment is located and how to use these items.

2. The participant should review their medical needs with the provider, including medical conditions, medications they take, and allergies.

    a. The participant should train or arrange for the training of their provider in any medical conditions the participant has that could lead to medical emergencies, such as diabetes or epilepsy/seizure disorder.
    b. The participant should explain what action the provider should take in the event of a medical emergency.
    c. The participant should give the provider a list of emergency phone numbers.
    d. When the participant chooses not to share medical information, they cannot hold the provider accountable in a medical emergency.

3. The participant should encourage their provider to attend additional training.

    a. The participant can attend training with their provider when the participant wants to receive the training.
    b. Some training has an associated cost to attend; the provider is responsible for the cost of the training.
    c. New and ongoing training is available to independent providers online on the DDA training page.

4. The participant should keep a written record of all training the provider completes.

B. The participant is responsible for scheduling and supervising their providers.

1. The participant needs to set a schedule with the provider.

    a. The participant should give advance notice to the provider when they want the agreed-upon schedule to change; and

b. When the participant wants to cancel scheduled services, for example, due to illness or another activity, they should give the provider as much notice as possible.

2. When the participant changes their expectations for the provider, they should let the provider know.
3. When the participant is happy with the provider, they should talk with the provider about what is going well.
4. When the provider is not following the schedule, not providing services as specified in the PCP, or not meeting the participant's expectations, it is the participant's responsibility to resolve any issues.

   a. The participant should discuss any concerns with their service coordinator.
   b. The participant should talk with the provider about what is not working and remind the provider of expectations.
   c. The participant may give a warning that if things do not improve, they will dismiss the provider.

5. When the participant is unable to resolve an issue with the provider, they may dismiss the provider, but it is the participant's responsibility to find a new provider.
6. The participant should have a backup plan in case the provider is not able to provide services as scheduled or expected.

C. When the participant thinks the provider puts their health or safety at risk, the participant should talk to their service coordinator.
   1. When the SC agrees that the provider put the participant's health or safety at risk, the participant may consider dismissing the provider.
   2. When the participant thinks their provider may have abused or neglected them, they should call the abuse/neglect hotline at (800) 652-1999 or law enforcement.
   3. When a report of abuse/neglect is substantiated concerning the provider, DDA policy requires the provider's agreement to be terminated immediately.
      a. The same is true for convictions for crimes identified in state regulation.
      b. When the provider delivers respite services in the provider's home, any substantiated abuse/neglect by a household member means the provider can no longer provide respite services in their home.
      c. When, at any time, the participant becomes aware of any of these issues related to their provider, the participant must report this information to their SC so they can take appropriate action.
   4. When the provider meets expectations, but the participant no longer needs the provider, the participant may give the provider advanced notice that they will no longer be needed.

6.5 Service Coordinator Responsibilities

When a participant chooses to work with an independent provider, they are responsible for supporting aspects of Medicaid HCBS AD/TBI Waiver services. Using an independent provider gives a participant responsibility for managing aspects of service delivery in a person-centered planning process, which changes the role of the SC.

A. The SC provides information and assists the participant with connecting to natural and informal supports.

1. The participant oversees their meeting and leads the discussion. The SC assists the participant by ensuring the team discusses all needed information at the PCP meeting. The SC writes the PCP. Utilizing information in the Charting the Life Course (CtLC) Tool.

2. The SC works with the participant to create the participant's plan to manage independent providers. The SC does not perform these tasks directly, but assistance may include:

    a. Directing the participant to resources for finding providers;
    b. Attending interviews that the participant conducts with potential providers;
    c. Assisting with enrolling and authorizing independent providers;

        i. When a participant has someone in mind to be an independent provider, they tell their SC.
        ii. When the potential provider is not already enrolled as a Medicaid provider, the SC gives the provider enrollment form to the potential provider, and the potential provider submits the form to the DDA central office.
        iii. When the potential provider is enrolled as a Medicaid provider, the SC authorizes services.

    d. Making sure there is a back-up plan when a provider does not arrive when scheduled or quits.

B. The SC monitors how the use of an independent provider is going, including:

1. How often an independent provider misses work;
2. If, and how often, the participant's back-up plan is being used;
3. High turnover of independent providers;
4. Participant satisfaction with services;
5. If the participant's schedule is developed based on the participant's needs and allows flexibility when the participant chooses to adjust;
6. If the participant is involved in activities of their choosing in the community;
7. If the participant is using services in a way that supports their health and safety; and
8. If the participant has shown an inability to supervise an independent provider effectively.

C. When another team member or the SC has concerns that the participant is not self-directing services in a manner meeting their needs, the team:

1. Meets to discuss needed changes;
2. Make referrals to agency providers when appropriate; or
3. Adjust the participant's budget and service authorizations to reflect any changes in services or providers.

7. Provider Requirements

7.1 Core Requirements for All Providers

DHHS DDA provides funding and oversight of HCBS Aged and Disabled (AD) and Traumatic Brain Injury (TBI) Waiver providers.

A. There are two types of AD or TBI providers:

1. An agency provider is a company that is an enrolled Medicaid provider and certified by DHHS to provide AD/TBI services. The agency provider is responsible for hiring or contracting and supervising employees and contractors who work with the participant and for other administrative functions.
2. An independent provider is a person or vendor enrolled as a Medicaid provider and not employed by an agency. The participant is responsible for supervising their provider.

B. **General Provider Requirements:** All providers of Medicaid HCBS AD or TBI Waiver services must meet these general provider requirements:

1. Be authorized to work in the United States;
2. Not be an employee of DHHS, unless approved by DDA;
3. Enroll as a Medicaid provider;

    a. Before Medicaid HCBS AD or TBI Waiver services begin, a potential provider must complete the enrollment process using the electronic Medicaid provider enrollment system:

        i. DDA Central Office or the designated Resource Development staff completes a referral to the electronic provider enrollment system for the potential provider for the specific services the provider is indicating can be provided to participants.
        ii. The potential provider submits required documentation in the electronic provider enrollment system.
        iii. The electronic provider enrollment system contractor and DHHS Medicaid and Long-Term Care (MLTC) staff review submitted documentation to check for required background checks and approve or deny enrollment based on whether the provider meets required criteria.

    b. When a potential provider has completed the enrollment process and the electronic provider enrollment system approves them to become a Medicaid provider, they sign a Medicaid provider agreement.

        i. The Medicaid provider agreement is a contract between AD or TBI providers and MLTC to outline federal and state Medicaid requirements, which all providers must follow.
        ii. The provider must sign the Medicaid provider agreement every five years.

(1) This section is applicable to all Medicaid providers; AD or TBI waiver providers have additional processes and standards to uphold.

4. All TBI Waiver providers and their employees are required to have specialized training on traumatic brain injuries.

    a. DHHS will issue a certificate of completion, which must be uploaded into Maximus by the provider.

    b. Employees must complete training and have their certificate of completion before providing services.

    c. Files will be reviewed by DHHS at annual renewal meetings and by request.

5. Effective January 1, 2025, all HCBS Providers, PAS Providers, direct care workers, caregiver employees, and contracted care staff hired by an agency are required to obtain a National Provider Identifier (NPI) number to enroll or maintain a Nebraska Medicaid Service Provider Agreement.

    i. Independent providers and agency providers' direct care staff must have a Type 1 individual provider NPI.
    ii. Agencies must have a Type 2 organization NPI.

6. Work drug-free and maintain a drug-free workplace;
7. Follow all statutes, regulations, and policies governing:

    a. Providers of Medicaid services; and
    b. Providers of AD or TBI services.

8. Follow Health Insurance Portability and Accountability Act (HIPAA) rules;
9. Have access to and the ability to use the state-mandated web-based case management system;
10. Comply with billing requirements, including submitting thorough and accurate claims through the state-mandated web-based case management system;
11. Be able to meet the participant's needs:

    a. Follow and implement the participant's person-centered plan (PCP);
    b. Be physically able to provide services to participants;
    c. Know what to do in emergencies;
    d. Be responsible for a participant's safety and property; and
    e. Take steps to prevent incidents of abuse, neglect, and exploitation.

12. Not be legally responsible for the participant when providing direct services, except for a parent to a minor child or spouse providing LRI Personal Care service.
13. All guardians enrolling as providers to deliver direct services and supports must comply with NE Rev. Stat 30-2627.
    a. Specific to Adult Day services, relatives or legal guardians may serve as employees of agencies or as the owner of an agency, but they must not provide direct care to the participant, as it would need to be provided by other employees.
14. Avoid all conflicts of interest and any appearance of conflicts of interest. A provider must immediately notify DDA of any conflicts of interest so the PCP team can make other arrangements for services to be provided.

a. When a participant has a family member or friend as an independent provider or a family member or friend works for an agency provider, it may be difficult to prioritize the interests of the participant ahead of the interests of the provider. The team should work to ensure the autonomy of the participant through choice and best interest of the participant. Examples of conflict of interest:

   i. A financial interest separate from the participant, such as when a provider owns property that a participant pays to live in.
   ii. A family member provides both natural and paid supports at the same location.
   iii. A participant may be afraid to report fraud or abuse/neglect because a provider is a friend or family member.

b. The PCP team must monitor for possible conflicts of interest to ensure decision making prioritizes the participant's best interests are prioritized in decision-making. Examples of situations the PCP team must monitor:

   i. A team member holds multiple roles in the participant's life, such as when a participant's family member is a paid provider.
   ii. One provider holds two official roles, such as when the owner of an agency provider works as an employee, provider of personal care, or live-in caregiver.

C. **Natural and Community Support providers defined**

1. Natural Supports: Unpaid friends and family who have a long-standing, pre-existing relationship with the participant, often based on mutual interests. Fictive kin are considered natural supports.
2. Community Supports: Unpaid individuals from the community who have developed a supportive relationship with the participant through regular contact and are willing to assist based on this connection.
3. Back-up Staff: A paid Medicaid provider who is trained and authorized to provide coverage for the host home or shared living service provider in accordance with the participant's person-centered plan (PCP). Back-up staff must be enrolled in Maximus as a provider. Back-up staffing delivering direct services must meet all provider requirements and standards.

D. **Using Natural Supports vs. Back-Up Staff**

1. The use of natural or community support is identified during the person-centered planning process. This support does not provide coverage for the provider staff and should only be used to broaden and enhance a participant's ability to participate in various community experiences. If a provider needs coverage, the provider will use a Medicaid approved provider for back-up staff as outlined in the PCP. Providers are responsible for providing services in accordance with the PCP.
2. The agency is responsible for conducting background checks and providing training for anyone assisting with the participant during the provision of waiver services. Background screening is required for all provider staff and members of the provider's household when providing extra care for children with disabilities services who have contact with the participant, except for minor children. This does not apply to natural or community supports who engage with the participant as a friend or relative with shopping, transportation, recreation, or other community activities.

3. When a participant chooses to engage in natural or community support, the paid provider must document the participant as "absent" from their services. The provider must only bill for the services rendered. Natural and community support are required to notify the provider agency of any critical incidents or other reportable incidents. The provider is responsible for reporting any incidents to the assigned SC. The SC is responsible for completing the GER. Information regarding GERs and critical Incident reporting can be found in Chapter 12, Appendix A of this manual.

E. **Maintaining Confidentiality:** A provider cannot share participant records with anyone outside DHHS without written authorization, as participant records are confidential. The provider can share records and information with a person who is legally responsible for the participant.

1. When there is a breach of confidential information, the following should be notified:

   a. The participant whose confidentiality has been breached;
   b. DDA Director; and
   c. Federal Health and Human Services.

2. Failure to maintain confidentiality of participant records may result in termination of the Medicaid provider agreement or other penalties as required by law.

F. **Assistance with Health Services:** All providers must observe and respond to the participant's health needs and physical condition, as outlined in the PCP.

1. When a participant uses assistive and adaptive devices, all providers must support the participant in the use of the devices, as needed.
2. A provider assigned responsibility for action steps surrounding medical care or reports to the participant or their family in the PCP must arrange for repair or replacement of a device when needed.
3. A provider not assigned responsibility for medical care must report a need for repair or replacement of a device to the person assigned responsibility for medical care.

G. **Transportation:** A participant may be authorized for Non-Medical Transportation when they have an identified need outlined in the PCP that qualifies them for this waiver service. This service is billed as a separate service under the Medicaid HCBS AD or TBI Waivers and cannot be billed when transportation is included in the rate of another Medicaid HCBS AD or TBI Waiver service. Transportation requirements in this section must be met whenever a provider drives a participant.

1. The provider must ensure:

   a. The vehicle meets the participant's needs;
   b. The vehicle being used is in good working order;
   c. Seatbelts and other safety devices work; and
   d. Adaptive items necessary for the participant are available and working. Adaptive items would be noted in the participant's PCP. This may include:

      i. Wheelchair lift;
      ii. Running boards; or
      iii. Grab bars.

2. A provider cannot charge the participant an additional transportation fee when:

   a. Transportation can be billed as a Medicaid HCBS AD or TBI Waiver service;

b. Transportation is included in the rate of a Medicaid HCBS AD/TBI Waiver service; or
c. Transportation for non-emergency medical needs is available through Medicaid.

H. **State-Mandated Web-Based Case Management System:** DDA uses the state-mandated web-based case management system for service planning, documentation, reporting, secure communication (SComm), and billing. Providers can use the state-mandated web-based case management system for the following:

1. Medication administration record (MAR);

a. A MAR is required when an agency provider staff:

i. Administers routine or as needed (PRN) medications; or
ii. Assists with any steps of medication administration.

b. A MAR is not required when an independent provider administers medication under the direction of the participant.
c. A MAR is not required when a participant self-administers their medication. In order for a participant to self-medicate, they must:

i. Take or apply medication as prescribed, including at the right time, the right amount, the right route, and the right medication;
ii. Monitor for desired effect and side effects, and take appropriate actions;
iii. Receive no assistance with any activity related to medication administration; and
iv. Competency of all medication administration steps is documented in their file.

2. Review and acknowledgement of service authorizations;
3. Communication with SC;
4. Documentation of participant information (TLogs)

I. **Electronic Visit Verification:** In 2016, Congress passed the 21st Century Cures Act, with provisions mandating that states implement Electronic Visit Verification (EVV) for some Medicaid-funded in-home services to reduce fraud, waste, and abuse. Because most AD/TBI waiver services include personal care and some are provided to participants in their homes, EVV must be implemented for AD/TBI services that meet the description in the 21st Century Cures Act. Effective January 2021, a provider must use EVV when providing personal care services primarily in a participant's private or family home.

1. Services that require EVV:

a. Companion Care;
b. Personal Care;
c. Extra Care for Children with Disabilities (In-home);
d. LRI Personal Care;
e. Respite Care In-Home; and
f. Community Connections.

2. A provider can choose who to contract with for EVV:

a. When a provider chooses Therap with a module for EVV, EVV can interact with other modules. The provider knows the state-mandated web-based case

management system, which is the preferred option for AD/TBI providers. DHHS pays the cost of the state-mandated web-based case management system.

b. A provider may choose the state-contracted EVV vendor who is responsible for statewide EVV. This vendor will interface with other state systems and train providers and participants. The state-contracted EVV vendor will compile information regardless of being the chosen vendor.

c. A provider may choose any other vendor, but the vendor must meet minimum requirements for third-party vendors established by DHHS. When a provider chooses another vendor, the provider is responsible for any costs and ensuring their EVV vendor meets requirements.

3. A provider's chosen an alternate EVV vendor will gather and verify the following information for each delivery of services:

   a. The service provided;
   b. The participant receiving the service;
   c. The participant's or guardian's signature;
   d. The location where the service is provided;
   e. The date the service is provided; and
   f. The start and end times of the service.

4. The 21st Century Cures Act requires that there be a solution to capture the needed information, even when Wi-Fi or cellular data isn't available.

   a. If a Provider has no availability to a smartphone or tablet to capture GPS, then Interactive Voice Response (IVR) can be used as a last resort to capture the start and end of a visit. IVR is a conditional method of collecting EVV data and requires Nebraska DHHS approval prior to using it. Alternative EVV vendors will be required to send an IVR Phone number and PIN when the IVR mento his used to start and/or end a visit.
      i. Note: Only primary or secondary addresses and phone numbers listed under the recipient screen in Mobile Caregiver* Provider Portal that matches what's requested for IVR will be approved.
      ii. This information must match the waiver participants' information iServe for the IVR request to be configured.
      iii. Provider makes IVR approval request to the DHHS by email at DHHS.IVR@nebraska.gov or by completing the IVR Attestation form and IVR request form. If the participant's phone number changes the provider must submit new forms.
   b. All claims for EVV services must be released from the state-contracted EVV vendor after visit data is transferred or collected in the provider's choice of EVV system.

J. **Record Keeping:** A provider must maintain accurate, current, and complete participant and business records. Agency and independent providers must keep several types of records. The following requirements apply to all providers:

1. DDA expects providers to complete and maintain all records in compliance with applicable regulations, the HIPAA, the DHHS Medicaid provider agreement, and a participant's PCP.

a. Participant records must not be given, copied, or viewed without a signed release. Records requiring a signed release include:

   i. Photographs, including those used for incident documentation, social media sites, or provider publications; and
   ii. Electronic records.

b. The provider must make records available to DHHS upon request.

2. A provider must use the state-mandated web-based case management system for maintaining some records. The provider may keep all records in the state-mandated web-based case management system or develop a system for maintaining records not required in the state-mandated system.

   a. Participant records must be readily available when providing services.
   b. Providers must keep records to support billing claims for services provided.
   c. Providers must keep records for six years, or longer when there are any issues related to an audit, litigation, or other actions DHHS must resolve.

3. When a participant discontinues services with one provider and starts services with a new provider:

   a. The previous provider is required to maintain all records related to the participant as described above for the required length of time, even though they are no longer providing services to the participant; and
   b. The previous provider should supply copies of any relevant records requested by the participant's new provider, with appropriate authorization.

K. **Billing for Services:** A provider bills by submitting a claim for Medicaid HCBS AD/TBI Waiver services that the provider delivered.

1. To bill for services:

   a. There must be a service authorization in the state mandated web based case management system before provision of the service; and
   b. The provider must acknowledge service authorizations in the state mandated web based case management system.
   c. It is the responsibility of the provider to ensure the service authorization is correct when acknowledging.

2. The provider submits claims electronically. Claims must:

   a. Be submitted after the service occurs and within six months of the date of service;
   b. Be within the service amount assigned to the provider according to the service authorization;
   c. For participants who use multiple providers, coordination will need to occur to ensure service limitations are not exceeded; and
   d. Meet the requirements outlined in the definition of the service provided.

      i. If tasks are required, only the tasks that are completed by the caregiver are selected.

3. When a claim is submitted, DHHS:

a. Pays the provider (no money goes to the participant); and
b. May review claims for accuracy:

i. Based on a sample for routine review; or
ii. When there is a question about the accuracy of the claim.
(1) These claims may be referred to for additional review by the Program Integrity team if applicable.

4. Failure to keep required records may result in disciplinary action or funds being taken back for claims not supported by available records. Required records to support billing claims include, but are not limited to:

a. Start and end times of services provided; and
b. Location of service provided when service requires community integration.
i. Tasks actually performed are documented accordingly for the visit or claim.

L. **Reporting Incidents:** When a situation occurs that may negatively affect a participant, such as alleged or suspected abuse, neglect, exploitation, mistreatment, or use of emergency safety interventions, the provider must notify the Service Coordinator, who will submit an incident report in the state-mandated web-based case management system. The state-mandated web-based case management system calls incident reports General Event Reports (GERs).

1. Providers must report the following types of reportable incidents to DDA:

a. Allegation, suspicion, or actual events of verbal, physical, sexual, psychological, emotional abuse, neglect, or exploitation of a child or vulnerable adult.
b. Allegation or suspicion of financial exploitation.
c. Misuse or unauthorized use of restrictive interventions or seclusion.
d. A medication error resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death.
e. Unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

2. Providers must also report the following incidents:

a. Actual or Potential Airway Obstruction
b. Allegation, Suspicion, or Actual Events of Verbal, Physical, Sexual, Psychological, or Emotional Abuse, Neglect, or Exploitation of a Child or a Vulnerable Adult
c. Allegation or Suspicion of Financial Exploitation
d. Communicable Disease
e. Death of a Participant
f. Emergency Situations
g. Fall with Significant Injury
h. Fatal 5
i. Incidents Involving Emergency Personnel/Requiring Emergent Response.
j. Infestations
k. Injuries of Unknown Origin Raising Suspicion
l. Injury requiring medical or Nursing Interventions beyond First Aid
m. Medication Errors
n. Misconduct not involving Law Enforcement

o. Missing Person(s)
p. Misuse or Unauthorized use of Restrictive Interventions or Seclusion
q. PRN Psychotropic Medication Usage
r. Property Damage
s. Suicide Attempts
t. Swallowing Inedible Items
u. Unplanned Hospital/Emergency Room/Urgent Care Visit
v. Use of Emergency Safety Interventions
w. Use of Restraint or Prohibited Practices
x. Vehicle Accident

3. The assigned SC must submit a written incident report in the state-mandated web-based case management system within 24 hours of the provider becoming aware of the incident.

   a. The provider must verbally report to the SC as soon as possible, but no more than four hours after becoming aware of the incident.

      i. Verbal report must be made as soon as possible and safe to do so; and
      ii. Verbal report may be a voicemail, not a text message, to the Service Coordinator.

   b. The provider should verbally report the incident within 24 hours of the provider reporting the incident to the SC to:

      i. The guardian when the participant has a guardian;
      ii. A family member when the participant has requested a family member be notified; and
      iii. The participant, when the participant is not aware that a reportable incident has occurred.

4. Incidents meeting the criteria for a Root Cause Analysis will be triaged into two categories:

   a. High-Level Root Cause Analyses

      i. Maintain the existing timeframe of 12 business days with two business days to return the document request.
      ii. Be completed for incidents involving substantiated abuse, neglect, and exploitation; incidents that identify other-to-be at risk; incidents involving a participant who is missing for 24 hours or more; and incidents that are initiated by a mortality review.
      iii. Five business days to return an action plan for all Root Cause Analyses (previously two business days).

   b. Routine-Level Root Cause Analyses

      i. Have extended time frames.
      ii. Be completed for incidents involving prohibited practices; incidents involving participant or provider trending; and incidents involving high-level medication errors.
      iii. Five business days to return document requests.

iv. Provider-related activities such as interviews and onsite reviews will be extended up to 28 business days, resulting in more time for the provider to set up and participate in interviews, and prepare for an onsite review.
v. Five business days to return an action plan for all Root Cause Analyses (previously two business days).

5. Agency providers have additional responsibilities to investigate incidents and submit reports to DDA.
6. For further information on how to write a GER see Appendix A.

M. **Reporting Abuse, Neglect, and Exploitation:** Any suspected abuse, neglect, or exploitation must be reported to local law enforcement or the 24-hour toll-free DHHS abuse and neglect hotline at 1-800-652-1999. This is in accordance with Nebraska Rev. Stat. 28-372 of the Adult Protective Services Act or, in the case of a child, in accordance with Nebraska Rev. Stat. 28-711 of the Child Protective Services Act.

1. Providers must report when there is a deliberate action to the participant or when the injury required more than basic first aid to treat abuse and neglect, or exploitation following the DDA incident reporting requirements.
2. Providers of waiver services are required to have training on the identification of abuse, neglect, and exploitation, and reporting requirements.

a. Training on this topic is available at no cost to the provider on the DHHS website and can be found here.

N. **Death of a Participant:** Providers are responsible for reporting the death of a participant to DDA.

1. When a participant dies, the provider must verbally report to the SC as soon as possible, but not more than 4 hours after becoming aware of the death.

2. When the death of a participant occurs during a time when they are not receiving services, the death must be reported as soon as the provider is made aware.

a. Promptly submit any additional relevant information as it becomes available to the above email inbox.
b. Respond promptly to any requests from the DDA or their designee for additional information.

7.2 Service Provider Enrollment

Each provider must be properly enrolled before services can be authorized. The enrollment is effective for up to 12 months, cannot be backdated, and the agreement must be signed bythe provider on or before the effective date.

Referral is Received

A. The enrollment process starts when the provider is referred to the RD.
B. The RD checks for any previous NFOCUS organizations and the organization's status.
1. When the provider is closed, determine why the organization was closed. (Any questions the RD should direct to their supervisor.)
C. Each referral must be screened for any outstanding overpayments related to a Medicaid

refund request.

1. The potential provider may not be enrolled until the refund is paid or a specific payment plan is in place.
    a. Questions regarding overpayments should be sent to Program Integrity.

D. The potential provider's demographic information including the provider's email address and EIN or SSN will be needed for the provider enrollment entity, Maximus.

RD Enters the Referral

A. After all required information is gathered and the RD determines the potential provider meets all the previous criteria a referral can be entered into the Provider Data Management System (PDMS), Maximus, for the enrollment process.

B. For all providers except Assisted Living Facilities, the RD will enter the referral into Maximus ensuring all information matches the provider's tax records.

1. Doing business as" names or other changes from the official paperwork cannot be entered into Maximus. The information must match tax records.

Any entity applying to be an agency rather than an individual provider must have their Employer Identification Number (EIN), also known as a Federal Tax Identification Number, entered into Maximus.

Provider Evaluation by the RD

A. The potential provider must be evaluated according to waiver criteria which includes the following: General Provider Requirements, Provider Participation Standards outlined in the Medicaid waiver regulations, and the Provider Agreement.

B. The RD will evaluate the provider at initial enrollment, at the time of renewal before the expiration of the enrollment term, and any time there is reason to believe the provider is not fulfilling their responsibilities.

C. The RD will establish if the potential provider can recognize and respond to signs of distress in the participant and access emergency resources when needed.

D. At least annually, the RD will conduct a face-to-face interview with the provider.
    1. Out-of-state personal emergency response system (PERS) and Home Delivered Meals providers will be interviewed virtually.

E. The RD conducts an annual Final Setting Site assessment of each provider-owned or operated location where services are provided. Except when services are provided in the participant's individual or family home.

F. Quality-of-service provision will be evaluated by the RD at least once during the enrollment period.
    1. This evaluation will be carried out by observing service delivery, visiting the service facility, interviewing the provider, or interviewing a participant served by the provider.

G. The Provider Relations Team in partnership with Program Integrity will review policies and procedures of all agency providers at enrollment and the Maximus 5-year revalidation.
    1. The RD will confirm policies and procedures are maintained on an annual basis as well.

H. Provider Relations will not approve a provider until policies and procedures are provided and reviewed, regardless of other steps in the process being complete.

1. Providers have 30 days to respond to avoid delays in enrollment and will submit this information directly to Provider Relations.

I. The potential provider must be aged 19 years or older to enroll, when under 19 the referral is withdrawn.

J. When the potential provider is willing to accept additional participants, this information will be noted in the file.

Avoiding Conflict of Interest

A. Employees of the State of Nebraska, its subdivisions, or designees cannot enroll as providers.

1. For HCBS purposes, a designee would be an employee of an agency that has a contract with the Department of Health and Human Services (DHHS) to manage AD or TBI Waiver services or providers.
2. When desired, the participant may request an exception on behalf of the state employee potential provider, have the exception approved, and verify approval before enrollment is initiated.
3. The exception is documented in the comment section of the signed Nebraska Service Provider Addendum (MC-190) and the provider file.

B. To avoid any conflict of interest, the RD must ask if the potential provider is a relative of a DHHS staff person or designee responsible for approving AD or TBI Waiver providers or authorizing services.

1. In situations where a DHHS staff person's or designee's relative is the only staff, approval must be obtained from the MLTC Provider Relations; to prevent any conflict of interest or nepotism.
2. When a potential provider has a relative who is a state employee, they must disclose the identity of the relative and the department they work for to avoid any conflicts of interest.

C. When a provider has any financial or other interests, direct or indirect, with the Service Coordination office where they are seeking to enroll, the provider needs to contact the central office for an alternative RD assignment.

1. Providers cannot perform service coordination and be authorized to deliver services to the same participant.

D. The potential provider cannot enroll when they are a recipient of a similar service.

E. If the potential provider is the Legal Guardian, another Personal Representative should be identified to sign for the service delivery of EVV services.

1. If that is not possible, the participant will sign, even if that is only with a mark.
    - If the individual is a minor, the authorized Guardian will need to validation service delivery through EVV, if the authorized guardian is not present the caregiver can select "physically unable to sign".
2. Should neither the Personal Representative of the participant are able to sign, the guardian will sign for services delivered.
    - If the participant is physically unable to sign, a personal representative is necessary to sign for the participant or "physically unable to sign" must be selected when they are not present. EVV.
3. Service Coordinators will include in the PCP how service delivery will

be validated through EVV in these instances.

4. When the authorized representative or guardian becomes a paid provider, an additional individual with knowledge about the participant's care will be contacted to provide monitoring information and to participate in the person-centered planning process when needs, services, and providers are discussed with the Service Coordinator.
5. Any billing documents signed by the provider, as both the provider and participant's authorized representative/designee, will be returned. A paid provider cannot physically or digitally sign the Record of Services form on behalf of the participant. The signature of the participant or another competent representative with knowledge of the service delivery is required. (see MLTC provider bulletin 17-09).
6. Participants needing an authorized representative must complete a Designation of Authorized Representative form and submit it to their Service Coordinator before billing.

When the Potential Provider does not Meet the Waiver Criteria

A. When the potential provider does not meet waiver criteria, the RD will email Provider Relations at DHHS.MedicaidProviderEnrollment@nebraska.gov and include information regarding why the potential provider does not meet waiver criteria. The potential provider, or on-going provider who does not meet waiver criteria, the provider cannot be authorized to provide services regardless of maximus enrollment status.

Maximus and Provider Relations

A. After the referral is entered, the RD will provide instructions to the potential provider on how to enroll through the Maximus web portal and Maximus will send an email notice to the potential provider inviting them to enroll.

B. The potential provider must make any change in address or banking information directly in Maximus.

C. The potential provider will submit their part of the required information within the Maximus application.

D. The RD will ensure the potential provider has the Maximus referral number generated by the application.

E. Maximus will notify the RD via email a potential waiver agency has enrolled.

F. Provider Relations will send a letter to the potential provider agency requesting additional information. (See Provider Relations' letter to agency providers in the addendum.)

G. Provider Relations will send the Fingerprint Criminal Background Screening (FCBS) packet to providers who need to complete the fingerprint checks.

H. The RD will let the potential provider know that as part of the approval process, they will be asked to verify criminal history checks from all states where they have lived, including any APS or CPS registry information.

I. Best practice is for the potential provider to get this information from the State Patrol of any previous states.

J. Web-based checks, such as SentryLink, may be used.

K. Maximus will gather the data needed from the required screenings, except for the Fingerprint Criminal Background Check (FCBC), and send it to Provider Relations.

L. Provider Relations will not review a provider's information until everything has been received.

M. Once Provider Relations receives the data from Maximus, the additional documentation required from potential agencies, and the Fingerprint Criminal

Background Screening, when applicable, they will approve or deny the potential provider.

N. The RD cannot move forward until approval of the provider is received from Provider Relations.

Maximus

A. Maximus is the vendor that completes all screening and enrollment of providers based on the information the RD provides. Maximus, approves or denies a provider.

B. Potential provider completes enrollment process with Maximus, which includes risk-level- based background checks. (See Appendix A)

1. When the service is being provided in the potential provider's residence, the provider will include all the people who live with them on their provider enrollment form.

C. Maximus will invite the potential provider to complete the required APS or CPS check.

1. Potential providers should be encouraged to complete the APS or CPS process promptly and pay all associated fees.

a. Online APS or CPS checks are processed much faster than completing the paper form.

2. Failing to complete APS or CPS checks results in a denial.
3. When the provider uses the invite sent by Maximus the results will go directly to Maximus, when the provider does not use the invite for the request, the results will go to the provider. The provider will then need to upload the results to Maximus.

D. When the potential provider has completed and passed all the initial background checks, Maximus will notify the RD via email when the potential provider needs to complete fingerprint background checks.

1. Provider Relations will send the potential provider the fingerprint background check packet to complete.

a. Any deviations from this will likely be rejected.
b. Potential providers should be encouraged to complete the fingerprint background check process promptly and pay all associated fees.
c. Owners with 5% or more ownership of high-risk service agencies will need to complete the fingerprint background check process. Each owner receives their packet.
d. When the potential provider does not complete the fingerprint background check process within the required 30 days, they will be denied.

E. Once completed, the Nebraska State Patrol office will submit fingerprint background check results to Provider Relations.

F. Maximus then forwards the information to DHHS Provider Relations who approves or denies initial enrollment. Provider Relations also reviews existing providers and will send the information to Program Integrity for termination

when needed.

1. When approved, Provider Relations will notify Maximus that the potential provider can be successfully enrolled.
2. When denied, Provider Relations will notify Maximus that the potential provider cannot be enrolled.

    a. Provider Relations will send a denial letter informing the potential provider why they cannot be enrolled.

G. Enrollment information for approved potential providers will be sent to NFOCUS via a nightly interface.

H. Maximus will notify the RD and new provider via email once they have been successfully enrolled.

I. At any point during the screening and enrollment process, a potential provider may be denied as a provider, or from providing a specific service by Provider Relations. The denied potential provider will appear on the weekly denial list sent to RD staff. The denial letter will also be mailed to the potential provider and can be viewed in the attachments of the potential provider's profile in Maximus.

RD Initial In-Person Meeting and Final Settings Rule

A. After the provider approval is received the RD will conduct an in-person meeting to further evaluate the provider.

    1. Out-of-state PERS providers can be evaluated by virtual meeting.

B. The RD will complete the in-person meeting in the local office or other community setting when the services will be provided in the participant's home and the potential provider does not reside there.

C. The RD will complete a site visit and Final Settings Rule assessment of all care settings owned or operated by the provider to determine if the setting meets the Final Settings criteria.

D. The in-person meeting must take place in the service setting when any of the following are true:

    1. The potential provider and participant live in the same place but are not related.
    2. The services will be provided in the potential provider's residence.
    3. The service location is owned or operated by a provider, not the participant.
    4. The service provided is assisted living, adult day health, independent skills management, respite, or out-of-home extra care for children with disabilities.

E. Any setting of service provision must be checked for service-specific provider requirements found in regulations 480 NAC.

Assisted Living

A. When the setting is an assisted living, more information is required from the provider. The RD will gather the following:

    1. Two months of activity schedules;
    2. Two months of menus;
    3. Provider hiring policies;

4. Nebraska Service Provider Addendum (MC-190);
5. ALF Service Coordinator Questionnaire (MLTC-1100);
6. Provider policies on reporting abuse, neglect, and law violations;
7. Resident counsel team meeting minutes;
8. Annual or recertification checklist;
9. Initial survey or Final Rule Checklist; and
10. Felony and/or misdemeanor statements for staff.

Service Provider Agreement

The RD will review the information provided and sign the provider agreement with the provider.

A. The Service Provider Agreement is a legally binding document.
   1. It describes the following:
      a. The service or services to be provided.
      b. The agreed-upon unit of measure for rates dependent on service-specific standards.
      c. The unit rates for each provider
         i. Any rates subject to a fee schedule, the fee schedule overrules any agreed upon rates on the MC-190.
      d. The responsibilities of the provider, DHHS, and their partners.

B. It is used for all providers, agencies, and individuals.

Completing a Provider Agreement

A. When a potential provider has met all the necessary requirements, RD staff must complete a Services Provider Agreement.

B. The following policies govern service provider agreements:
   1. Each provider must have a service provider agreement in effect before service can be authorized.
   2. RD staff will evaluate and assess all service providers located within the office's jurisdiction before referring to Maximus or Program Integrity.
   3. Service Provider Agreements are:
      a. Valid up to 12 months.
      b. Never backdated.
      c. Must be agreed upon and signed by all parties on or before the effective date.

C. Changes in service provider agreements require agreement and new signatures of the contract.
   1. Address changes that do not affect the service location must be changed in Maximus by the provider and reported to RD staff, but do not require a new agreement.

D. Renewing a provider agreement:
   1. Staff assigned to RD responsibilities must use established standards to re-evaluate each service provider before the expiration of a provider

agreement.

2. Provider agreements must be renewed based on the same procedures used for initial approval, including conducting an in-person interview and completing provider checklists.

7.3 Agency Provider Requirements

A. An agency provider is responsible for all administrative aspects related to providing AD/TBI services, such as hiring, dismissing, scheduling, training, and paying employees and contractors who work with participants.

B. An agency provider must follow all core requirements for agency providers of Medicaid HCBS AD or TBI Waiver services. AD or TBI agency provider must be a Medicaid-enrolled agency provider.

C. An agency provider must also:

1. Have written policies to describe how their business runs and procedures giving direction to employees and contractors;
2. Complete background checks on all employees and contractors working directly with participants; AD or TBI waiver service providers are prohibited from allowing employees or contractors to work with participants when charged, pending disposition, or convicted of certain crimes. A list of specific crimes is published on the Medicaid Program Integrity website under the Provider Screening Guidelines.
3. Ensure all employees and contractors meet requirements for education and experience, and other requirements;
4. Ensure contractors comply with all applicable laws, rules, regulations, policies, and procedures;
5. Maintain any licensure with DHHS Division of Public Health (DPH);
6. Maintain required certification with DPH as required by AD/TBI services provided; and
7. Maintain certification of insurance on or before the first date of service, including:

    a. Worker's Compensation as required by state law;
    b. Commercial motor vehicle liability coverage;
    c. Professional liability coverage; and
    d. General liability.

D. The following Medicaid HCBS AD/TBI Waiver services may be offered by an agency provider:

1. Adult Day Health Services;
2. Assistive Technology;
3. Chore;
4. Companion;
5. Community Connections;
6. Extra Care for Children with Disabilities;
7. Home Again;
8. Home Delivered Meals;
9. Home Modifications;
10. Independence Skills Building;
11. LRI Personal Care;
12. Non-Medical Transportation;
13. Personal Care;

14. Personal Emergency Response System (PERS);
15. Respite;
16. Supported Employment – Follow-Along;
17. Supported Employment – Individual;
18. Supported Residential Living; and
19. Vehicle Modifications.

E. Before starting a business to provide Medicaid HCBS AD/TBI Waiver services, a potential agency provider should have:

1. Knowledge or education in business administration, including organizational skills and practices to operate a business.
2. Knowledge, education, or experience in working with people who have AD/TBI; and
3. Adequate funding to operate the business. DHHS does not provide start-up funding.

F. Before accepting a referral to begin providing services to a participant, an agency provider must consider:

1. The safety of all participants served; and
2. Whether the agency provider has the resources to provide services to the participant. The agency provider must not accept a referral for a participant when they cannot meet the participant's needs based on the information provided in the referral.

G. **Required Notifications to DDA:** An agency provider must notify MLTC Provider Enrollment and the assigned RD worker in writing:

1. Within ten business days of:

   a. Change in agency provider ownership;
   b. Change in agency provider director; or
   c. Change in contact information, including physical business address, phone number, mailing address, or email address; and

2. At least 30 calendar days before adding a new service option to the Medicaid agency provider agreement.

H. **Policies and Procedures:** An agency provider must have written policies describing how their business operates and written procedures giving direction to employees. An agency provider's director is responsible for overseeing AD or TBI services, establishing policies and procedures, and making sure the agency provider complies with local, state, and federal regulations and their own policies and procedures.

1. An agency provider's written policies and procedures must:

   a. Comply with applicable regulations;
   b. Be available to all agency provider employees and contractors;
   c. Describe the agency provider's operation and how systems are set up to meet participant needs;
   d. Be reviewed at least annually by the agency provider; and
   e. Be revised by the agency provider as needed.

2. The policies and procedures must address all requirements in regulations, including the following core areas:

   a. Criminal history checks;

b. The incident reporting system;
c. Process for responding to alleged or suspected abuse, neglect, or exploitation;
d. Process for quality improvement;
e. Participant rights and restrictive measures;
f. Entry to services;
g. Employee and contractor training; and
h. Disaster preparedness.

l. **Employee Requirements:** An agency provider must hire, train, and manage employees and contractors, making sure they have the skills and qualifications needed to provide each service offered by the agency provider.

1. An agency provider must ensure all employees and contractors complete the required background checks and training.

a. The agency provider must ensure all employees and contractors meet the following qualifications:

i. Be authorized to work in the United States; and
ii. Be at least 19 years old when providing direct services to a participant.

b. The agency provider must obtain all required background checks.

i. All employees and contractors providing direct support services must have the following checks completed at the time of employment and annually thereafter:

(1) The Central Registry of Child Protection Cases and Adult Protective Services maintained by DHHS;
(2) National criminal history;
(3) The Nebraska State Patrol Sex Offender Registry; and
(4) All checks required in the Medicaid Service Agency Provider Agreement.

ii. Any costs related to required background checks are the responsibility of the provider.
iii. When the employee or contractor provides approved services in their home (extra care for children), all members of the employee or contractor's household age 13 or older must pass the Central Registry of Child Protection Cases and Adult Protective Services. When the employee or contractor provides approved services in their home, all members of the employee or contractor's household age 18 or older must pass the same background and registry checks as the employee or contractor.
iv. An employee or contractor cannot provide direct support services to a participant if:

(1) They are listed on the Central Registry of Child Protection Cases and Adult Protective Services or the Nebraska State Patrol Sex Offender Registry; or
(2) They are charged and awaiting resolution or convicted of a certain crime as outlined.

v. The employee or contractor cannot provide services within their home when they or any member of their household requiring a background check are listed on the Central Registry of Child Protection Cases and Adult Protective Services or the Nebraska State Patrol Sex Offender registry, or have been convicted or charged, pending disposition, and awaiting resolution with any crime outlined under the Provider Screening Guidelines, or when convicted or charged and awaiting resolution with any crime outlined in state regulations.

vi. An employee or vendor must notify the agency provider immediately when they are charged or convicted of any crime as published on the Medicaid Program Integrity website under the Provider Screening Guidelines or when placed on any DHHS or Nebraska State Patrol Sex Offender registry.

c. The agency provider must ensure that any person providing a service requiring a license, certification, registration, or other credential has the required credential.

i. The Medication Aide Act (Nebraska Revised Statutes §§71-6718 – 71-6742) states that when employees or contractors of certified agency providers are involved in the administration of medication to participants, they must be certified as Medication Aides, and all applicable statutes and regulations must be followed.

ii. Agency employees are considered certified when their name is verifiable on the Public Health registry and not prior.

d. An agency provider must maintain enough employees and contractors to provide services, supports, and supervision to always meet the needs of each participant.

J. **Record Keeping:** An agency provider must maintain accurate, current, and complete participant, business, and employment records. Information must be factual and must not include false names, dates, data, or narratives. Records should not include abbreviations, acronyms, or symbols that the provider does not define. This keeps the record accessible to anyone reading it. It is acceptable to abbreviate participant names to maintain confidentiality. This information should be maintained in accordance with applicable policies and regulations.

1. An agency provider must use the state-mandated web-based case management system for maintaining the following records:

a. Medication administration record (MAR);
b. Billing and attendance;
c. Safety Plans and protocols; and
d. Health records.

2. For records not kept in the state-mandated web-based case management system:

a. Providers must write in ink, record information in a typed/printed format, or record in an electronic file with appropriate provisions for backup.
b. Provider must not use correction fluid or correction tape to correct errors.
c. Errors are corrected by marking through the incorrect entry with a single line and recording the date and initials of the person correcting the entry.
d. Information must be legible.

e. The person recording each entry must date and authenticate with their signature and title.

3. Participant records must be available when providing services and organized in a systematic and chronological format.
4. Records must be made available upon request to the following:

   a. The participant;
   b. Family members or others who have appropriate consent to access the records;
   c. DHHS or designees conducting monitoring or other related activities;
   d. Other state and federal agencies with authority to conduct monitoring.

5. An agency provider must keep records for six years, or longer when there are any issues related to an audit, litigation, or other actions to be resolved by DHHS.
6. An agency provider is responsible for maintaining participant records. This includes the following when applicable, but is not limited to:

   a. Attendance records;
   b. Authorization for medical treatment and consents; and
   c. Health records.

7. Measurable data must be documented daily.
8. When there are changes in ownership, the previous owner must transfer all participant records to the current owner.
9. Before an agency provider closes, the administrator must notify DDA in writing of the location and storage of participant records.

K. **Participant Rights:** An agency provider must ensure participant rights are protected.

1. An agency provider must inform participants of their rights and responsibilities.

   a. The information must be given at the time of entry to services and annually.
   b. The provider must inform the participant when there are any changes to participant rights or responsibilities. For example, changes to an agency provider-wide smoking policy.
   c. The provider must give information that the participant can easily understand verbally and in writing.

L. **Quality Improvement:** Ensuring quality in the provision of services and supports is the responsibility of all partners in the service delivery system. Agency providers are responsible for ongoing internal review of the quality of their services.

1. The provider must implement a quality improvement (QI) process on an agency provider-wide basis and must outline areas of services they are monitoring for quality improvement.
2. The QI process must:

   a. Ensure the needs of participants are met;
   b. Ensure compliance with applicable regulations;
   c. Identify problems and take corrective action in a timely manner; and
   d. Use information gathered in the QI process to improve services and revise policies and procedures.

3. An agency provider must maintain documentation of all QI activities.

4. Participants and their families must be involved in the QI process, such as satisfaction surveys or membership on QI committees.

M. **Billing:** An agency provider cannot bill DHHS for some activities related to providing services to participants.

1. DHHS is not responsible for the following costs:

   a. Agency provider startup costs; or
   b. Services provided to a participant under age 21 during any time when the participant is to be attending school or could be receiving services provided through the educational system.

2. An agency provider cannot bill separately for time spent on the following activities, because they are included in the rates for Medicaid HCBS AD/TBI Waiver services:

   a. Direct labor cost for employees and contractors providing services;
   b. Employee-related expenses, such as retirement benefits, health insurance, paid time off, and overtime;
   c. Non-billable employee or contractor activities, such as training, recordkeeping, employee meetings, PCP meetings, habilitation program development, maintenance, or shopping for supplies and cleaning when the participant is not present.
   d. Program support, such as clinical supports, nursing care, and rent/maintenance for buildings where services are provided; and
   e. Administrative expenses, such as salaries and benefits for employees or contractors not in direct support roles like human resources or quality improvement.

N. **Participant Complaints:** An agency provider must have a process to promptly address complaints submitted by, or on behalf of, a participant. The complaint process must include time frames and procedures for reviewing complaints and providing a response.

1. The process for submitting a complaint must be reviewed with each participant when entering services and annually thereafter.

   a. The process must be available at all times to anyone who may want to make a complaint.
   b. The process must include an option to submit an anonymous complaint.

2. A participant can submit a complaint to the agency provider or choose to submit a complaint elsewhere, such as with DDA or with law enforcement.

   a. The DDA grievance process can be found in Chapter 3.3 of this manual.
   b. The DDA complaint process can be found in Chapter 7.5 of this manual.

3. An agency provider must maintain documentation of all complaints submitted through the agency provider's complaint process and the responses.

O. **Investigations and Follow-up to Reported Incidents:** When an agency provider reports an incident, the agency provider is responsible for completing an investigation and additional reporting.

1. An agency provider must investigate each reportable incident.

2. The investigation reviews agency provider employees and contractors to ensure they follow:

    a. Applicable laws and regulations;
    b. Agency provider policies and procedures; and
    c. The participant's PCP and any related plans or protocols, such as a safety plan, behavior support plan, or seizure protocol.

3. The investigation must determine what action the provider will take to prevent similar incidents in the future.

P. **Disaster Preparedness:** An agency provider must have written disaster plans to ensure they meet all participants' needs during and after an emergency or disaster, such as flood, fire, tornado, utilities outage, or loss of water supply. An agency provider must be prepared to:

1. Maintain proper identification of a participant;
2. Move a participant to a safe place or provide protection; and
3. Provide for the basic needs of a participant, including food, water, and medical supplies.

Q. **Terminating Agency Provider License:** DPH may terminate an agency provider's license as outlined in 175 NAC.

7.4 Independent Provider Requirements

A. An independent provider must follow all core requirements for providers of Medicaid HCBS AD or TBI Waiver services, as well as the requirements specific to independent providers. An independent provider is a person or company that is an independent contractor of Medicaid HCBS AD or TBI Waiver services.

B. Each provider must be properly enrolled before services can be authorized. The enrollment is effective for up to 12 months, cannot be backdated, and the agreement must be signed by the provider on or before the effective date.

1. An independent provider is not an employee of an agency.
2. An independent provider:

    a. Must become enrolled as a Medicaid independent provider;
    b. Must meet requirements and have an authorization to provide each Medicaid HCBS AD/TBI Waiver service; and
    c. Can not live with a participant when providing respite, homemaker, or home modifications.

3. The following services may be provided by an independent provider:

    a. Chore
    b. Companion
    c. Extra Care for Children with Disabilities
    d. Home Again
    e. Home Delivered Meals
    f. Independence Skills Building
    g. LRI Personal Care
    h. Non-Medical Transportation
    i. Personal Care
    j. Respite

4. Legally Responsible Individuals (LRIs) may only be Independent Providers when approved by DDA Central Office.

C. **Considerations for a Potential Independent Provider:** Before becoming an independent provider of Medicaid HCBS AD/TBI waiver services, a potential independent provider should have:

1. Knowledge, education, or experience in working with people who are aged, or have a physical disability or traumatic brain injury; and
2. The ability to keep electronic records in the state-mandated web-based case management system.

D. **Record Keeping:** An independent provider must maintain accurate, current, and complete participant and business records.

1. An independent provider must use the state-mandated web-based case management system for maintaining some records. The independent provider may keep all records in the state-mandated web-based case management system or develop a system for maintaining records not required in the state-mandated system. The following records must be maintained in the state-mandated system:

    a. Attendance records
    b. Financial records

2. Measurable data must be documented daily.
3. Participant records must be available when providing services.
4. The provider must keep records for six years, or longer when there are any issues related to an audit, litigation, or other actions to be resolved by DHHS.

E. **Billing:** An independent provider cannot bill DHHS for some costs associated with becoming an independent provider for participants.

1. DHHS is not responsible for the following costs:

    a. Costs associated with training, both for training required before independent provider enrollment and training after independent provider enrollment.
    b. Services provided to a participant under 21 years old during times the participant is attending school or can be receiving services provided through the educational system.

2. An independent provider cannot bill separately for time spent on the following activities, because they are included in the rates for Medicaid HCBS Waiver services:

    a. Training;
    b. Recordkeeping;
    c. PCP team meetings; or
    d. Shopping for supplies, maintenance, and cleaning when the participant is not present.

7.5 Complaints

Any person has the right to make a complaint to DDA when they have a concern and to have the complaint addressed by DDA. Complaints can be submitted by advocates, community members, stakeholders, etc. For participant concerns, refer to the grievance section.

A. Possible examples of types of complaints:

1. Concerns for the safety and well-being of a participant;
2. Suspicion of Medicaid fraud;
3. Provider violations of any applicable laws, regulations, or policies;
4. Issues related to other supports, such as a social worker, physician, or therapist;
5. Issues related to a participant's Service Coordinator;
6. Difficulty with Medicaid HCBS DD Waiver services or providers;
7. Issues with services in settings that do not align with participant choices, promote community integration, or uphold a participant's right to privacy, as outlined in the HCBS Final Settings Rule;
8. Misuse of handling, using, disclosing, or processing the participant's Personal Health Information (PHI) by DDA or the participant's provider(s), as protected by HIPAA; or
9. Any other concern to which the department should be made aware.

B. Any person may file a complaint by:

1. Visiting the DDA Public website at https://dhhs.ne.gov/Pages/Developmental-Disabilities.aspx and completing the complaint form located on the right side of the webpage;
2. Mailing a complaint or complaint form to:

   Department of Health and Human Services
   Division of Disability and Aging
   PO Box 98947
   Lincoln, NE 68509-8947;

3. Emailing a complaint or complaint form to: DHHS.DDDCommunityBasedServices@nebraska.gov;
4. Contacting DDA by phone toll-free at 1 (877) 667-6266; or
5. Visiting any DHHS office. *For DHHS office locations, see Policy Manual Appendix D: Contacts and Resources.*

C. Once the complaint has been resolved, DDA sends a written notification to the person who submitted the complaint if requested.

D. Possible resolutions to complaints may involve, but are not limited to:

1. Follow-up by phone or email;
2. On-site review;
3. Referral to DHHS Division of Public Health for licensing or certification issues;
4. Referral to another agency, such as DHHS Children and Family Services or Medicaid Fraud Referral Unit.

E. DDA maintains a record of all complaints received and their resolution.

F. When you receive benefits or services from DHHS and want to contact DHHS about HIPAA matters, report a violation, or file a complaint regarding a DHHS employee or contractor, contact:

1. **Phone Number**:
   (402) 471-4068
2. **Address:**
   Department of Health and Human Services
   P.O. Box 95026

301 Centennial Mall South, 3rd Floor
Lincoln, NE 68509

3. **Email:** DHHS.HIPPAOffice@nebraska.gov

8. Partnership with Vocational Rehabilitation

Nebraska's Assistive Technology Partnership (ATP) provides a range of services to enable individuals with disabilities to obtain assistive technology, home modifications, and vehicle modifications to meet their needs.

ATP and the Division of Disability and Aging (DDA) work together to make it possible to provide Nebraskans with disabilities with the necessary means to help them succeed at home, school, and work with assistive technology and modifications.

ATP will adhere to the agreement between ATP and DHHS.

A participant who needs assistive technology, home modification, or a vehicle modification will need to speak with their Service Coordinator to fill out an ATP Referral.

8.1 ATP Assessments

An assessment must be completed so that the participant can make an informed decision before setting their priorities. This prevents modifications or assistive devices from being recommended based on inaccurate or incomplete information.

A. ATP will assess the participant's home environment or vehicle, including disabling conditions, functional skills, and limitations. ATP shall provide an evaluator's recommendations via the Environmental Assessment Modification (EMA) and justifications for the equipment or modification need(s) identified and requested.

B. The ATP Technology Specialist will verify ownership of the property, and if it is a property that is a rental, the Technology Specialist will send this information to the property owner with a permission form for them to review, sign, and return to ATP to proceed with a home modification.

C. After an assessment is completed by the Technology Specialist, the approved project plan and specifications are sent out to available qualified direct project providers (vendors/contractors) in ATP's provider pool for the specific type of modification or assistive technology. Cost quotes are requested in a certain timeframe.

8.2 DDA Role

A. The SC confirms that there is a need before making a referral.
   1. The need should be clearly stated on the referral form through a statement indicating the participant's limitation(s) and the accessibility concerns or needs this creates.
      a. This information should be outlined and supported by the following:
         i. interRAI assessment
         ii. Service Needs Assessment
         iii. PCP
         iv. Medical documentation (if applicable)

2. When the referral meets the criteria, and the explanation of limitations is clear, ATP will complete the EMA to determine possible solutions.

B. Refrain from making recommendations for a specific solution before the assessment is completed by ATP.
   1. Making a recommendation before an assessment often creates expectations for the participant that they will receive a specific piece of equipment or modification.

C. The SC shall submit a referral through ATP.
   1. A referral form has been developed for specific use by representatives for the AD and TBI waivers.
   2. This referral form will be used for participants determined to be eligible for services under the waiver.

8.3 Conditions of Provision

A. The need for Assistive Technology Supports, Home Modifications, or Vehicle Modifications must be identified during participant's initial or annual assessment and included in the person-centered plan (PCP) as necessary to enable the participant to be more independent in daily skills, integrate more fully into the community, and to ensure the health, welfare, and safety of the participant.

B. Services include:
   1. Environmental Modification Assessments to identify the type of technology, modifications, or adaptations necessary to aid the participant;
   2. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the assistive technology device;
   3. Evaluation, purchase, and month-to-month rental of assistive technology; and
   4. Any training or technical assistance needed for the participant and family members, guardians, and other interested parties.

C. Support or modifications must be a direct medical or physical benefit to the participant.

D. Funds may be authorized to assist with adaptations of direct medical or remedial benefits (such as ramps, grab bars, widening doorways, or bathroom modifications) for a recently purchased home.

E. When modifications are needed for a home under construction that requires special adaptation to the plan (such as a roll-in shower), the funds may be used to cover the difference between the standard fixture and the modification required to accommodate the participant’s need. All items and assistive equipment must meet applicable standards of manufacture, design, and installation.

F. All general contractors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications.

G. Home modifications will be provided in accordance with applicable local and state building codes.

8.4 Limitations

A. Assistive Technology Supports and Home Modifications, are not available to provider-owned, leased, or operated locations. Vehicle Modifications are not available to provider-owned, leased, or operated vehicles.

B. Items excluded from Assistive Technology Supports:
   1. Long-term leasing of equipment;
   2. Supports not directly benefiting the participant medically or physically; and
   3. Durable medical equipment is required to be provided under the Medicaid State Plan.

C. Items excluded from eligibility for Home Modifications:
   1. Modifications that are considered general utility and home repairs;
   2. Standard housing obligations;
   3. Carpeting;
   4. Roof repair;
   5. Sidewalks;
   6. Storage and organizers;
   7. Hot tubs;
   8. Whirlpool tubs;
   9. Landscaping or Fences;
   10. General construction costs in a new home or additions to a home purchased after enrollment in the waiver;
   11. Adaptations that add to the total square footage of the home, except when necessary to complete an adaptation, such as to improve entrance or egress to a residence or to configure a bathroom to accommodate a wheelchair;
   12. Improvements exclusively required to meet local building codes;
   13. Adaptations to assisted living apartments; and
   14. Modifications to facility provider settings.

D. Items excluded from eligibility for Vehicle Modifications:
   1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
   2. Purchase or lease of a vehicle;
   3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications; and
   4. Modifications of facility provider vehicles.

E. If Assistive Technology is damaged, stolen, or lost **and** not covered by insurance or warranty, it may only be replaced once every two years.

8.5 Funding Exceptions

DDA Central Office approval is required for participants to receive home or vehicle modifications that exceed $10,000 every five years.

A. When a modification request is approved but the quote exceeds $10,000 and the participant, family, or guardian is unable to cover the remaining cost, the designated person at ATP will route the information and exception request to the DDA Central Office for review.

B. Exceptions for home and vehicle modifications will not exceed $20,000.

9. Partnership with Vocational Rehabilitation (VR)

DHHS DDA Nebraska Vocational Rehabilitation (Nebraska VR) and the Nebraska Commission for the Blind and Visually Impaired (NCBVI) collaborate to provide employment opportunities. In this chapter, "VR" means the vocational rehabilitation agency, which is either Nebraska VR or NCBVI.

DDA, Nebraska VR, and NCBVI work together to:

A. Focus on competitive integrated employment for participants;
B. Build provider expertise on vocational rehabilitation services and employment;
C. Provide participants with the opportunity to be educated about employment opportunities in their community; and
D. Coordinate services between DDA and Vocational Rehabilitation providers to avoid duplication of services.

A participant who wants employment services must use any vocational rehabilitation services they qualify for, because Medicaid HCBS TBI Waiver services can only be used after all other available resources.

9.2 Competitive Integrated Employment

A. Competitive integrated employment means being gainfully employed at a job in an integrated community setting where the participant receives a competitive wage.

   1. Competitive wage is at or above the minimum wage, but no less than the standard wage and level of employee benefits paid for the same or similar work performed by a person without a disability. Any limitations in work hours or level of pay must result directly from the participant's disability, which the participant cannot overcome.
   2. Employee benefits include workers' compensation, paid holidays, paid vacations, paid sick time, and health insurance.
   3. An integrated community setting is a job in the community where people with disabilities interact with and work alongside co-workers without disabilities.
   4. Being gainfully employed looks different for each participant, as it depends on their ability to work independently or with support. The PCP documents support needs.

B. There are two types of competitive integrated employment:

   1. Supported Employment is ongoing support necessary for success in a working environment, based on the unique strengths, abilities, interests, and the choice of the participant.
   2. Customized Employment matches the strengths and interests of a participant and an identified business need where the employer modifies an existing job by containing one or more, but not all, of the tasks from the original job description.

9.3 Referrals for Vocational Rehabilitation Services

To receive vocational rehabilitation services, a referral must be completed.

A. To qualify for vocational rehabilitation services, a participant must:

1. Have a disability, including physical, mental, emotional, learning disabilities, or visual impairment;
2. Have a barrier to employment caused by a disability or a visual impairment; and
3. Could benefit from vocational rehabilitation services by successfully finding competitive integrated employment.

B. DDA requires a referral to VR when the participant:

1. Wants competitive integrated employment;
2. Wants a different job;
3. Wants to get another part-time, competitive integrated job; or
4. Loses their job.

C. To complete a referral to VR:

1. A participant, their SC, or another PCP team member can contact their local VR office.
2. Once contact is made, a VR counselor schedules a meeting with the participant and anyone else the participant invites, such as the SC and a provider, to discuss:

    a. The participant's current situation;
    b. Employment interest, concerns, goals; and
    c. Complete an application for vocational rehabilitation services.

3. VR has 60 days to respond to the referral or make a determination.

    a. When a participant is referred to VR and is notified by VR that they will not move forward with VR services, this information will be communicated to the SC by the participant and/or the PCP team.
    b. The PCP team should use the information in the letter for service planning.

D. When a participant is receiving waiver services to support their current employment and wants to work more hours at the same position, there does not need to be a referral to VR. If a participant would like some assistance in determining the impact of working more hours, they may benefit from utilizing the benefits counseling service.

9.4 Services Provided by Nebraska VR and NCBVI

DDA expects participants aged 18 to 64 years old and interested in competitive integrated employment to seek services from Nebraska VR or NCBVI.

A. VR works with students as young as 14 in Pre-Employment Transition Services (Pre-ETS). Students learn about career opportunities through job exploration, work-based learning experiences, workplace readiness, exploring options after high school, and teaching self-advocacy with a goal of being prepared for competitive integrated employment after leaving the school system.

B. VR provides:

1. Eligibility determination for vocational rehabilitation services;
2. Career counseling;
3. Benefits orientation when discussing possible employment;

4. An individual plan for employment, which includes the job goal, when the participant expects to reach the goal, what services are needed, and who will provide those services;
5. Planning long-term supports for maintaining employment when vocational rehabilitation services end. Supports may include Medicaid waiver services, community resources, or natural supports; and
6. Benefits management assistance when the participant is employed.

C. VR contracts with a provider to support a participant in finding and maintaining competitive integrated employment.

1. TBI provider can become a vocational rehabilitation provider.
2. The TBI provider signs a service agreement with VR to provide services through the milestone process.
3. VR makes milestone payments to a VR provider when the participant completes steps towards gaining competitive integrated employment.

D. When a participant is involved with vocational rehabilitation:

1. The VR counselor should attend the participant's PCP meetings or provide information to the participant's team to assist with service planning.
2. The Service Coordinator should attend the participant's VR meetings to assist or provide information as needed.

9.5 Workforce Innovation and Opportunity Act (WIOA)

Section 511 of the federal WIOA ensures each person has access to information and services to help them achieve competitive integrated employment.

A. WIOA limits the use of subminimum wage.
B. AD/TBI provider may use subminimum wage to pay a participant, following requirements in WIOA.

1. WIOA does not allow an employer to pay a subminimum wage to a participant under section 14(c), unless Nebraska VR or NCBVI has provided career counseling, information, and referral (CCIR).

a. The CCIR provides a participant with career counseling, information, and referrals to other resources in the community.
b. VR completes a CCIR in order for the provider to pay or continue to pay a participant subminimum wage and to hear about opportunities for competitive integrated employment. A CCIR is completed:

i. Upon the initial request;
ii. Six months after the initial request; and
iii. Yearly thereafter.

c. The TBI provider is responsible for tracking the completion of the CCIR and providing information to the Department of Labor's Wage and Hour Division when requested.
d. The participant's Service Coordinator receives documentation after completion of a CCIR.

2. TBI provider cannot hire a participant under the age of 25 at subminimum wage, unless the provider documents the participant has:

    a. Received a CCIR; and
    b. Applied for vocational rehabilitation services and was found:

        i. Ineligible; or
        ii. Eligible, but worked toward employment goal without success, resulting in closure of the vocational rehabilitation case.

3. When an employer pays a participant at or above minimum wage, WIOA requirements do not apply.

9.6 DDA Role

A. The Service Coordinator makes sure the school has connected the student with VR before they transition from high school, when the student is interested in competitive integrated employment.

    1. When a student transitions from school to the TBI waiver without a referral to VR, the Service Coordinator or a designated team member makes a referral to VR.
    2. When a student graduates before they are 21 years old, they can apply and work with vocational rehabilitation services.

B. When a participant is using vocational rehabilitation services, their VR counselor should participate in service planning with the PCP team. The participant's PCP must document their involvement with VR.

    1. When the VR counselor is unable to attend PCP team meetings, the Service Coordinator may get an update from the VR counselor before the PCP meeting to share with team members.
    2. The PCP documents VR involvement, which may include referral date, determination of eligibility or ineligibility, the start of vocational rehabilitation services, what milestone they are on, and any other relevant information.

C. The PCP documents any attempts at competitive integrated employment and the outcomes. When the participant has not been successful at competitive integrated employment, the PCP team must discuss and document what the team is doing to assist the participant to be more successful in the future.

9.7 Availability of Services

The availability of employment-related TBI waiver services may be limited, based on the participant's use of vocational rehabilitation services, eligibility for vocational rehabilitation services, refusal to use vocational rehabilitation services, and completion of vocational rehabilitation services.

A. A participant using vocational rehabilitation can use other TBI services:

    1. TBI Adult Day Health Services
    2. TBI Personal Care
    3. TBI Respite Care
    4. Assistive Technology
    5. Caregiver Training
    6. Chore

7. Community Connections
8. Home Delivered Meals
9. Home Modifications
10. Non-Medical Transportation
11. Personal Emergency Response System (PERS)
12. TBI Companion
13. TBI Supported Residential Living
14. Vehicle Modifications

B. When a participant has Supported Employment (Individual or Follow-Along) to maintain their competitive integrated employment and wants another part-time job:

1. TBI waiver services can continue to help the participant maintain their current job; and
2. Vocational rehabilitation services support the participant in getting a second job.

C. Once the participant has completed the VR process by obtaining desired competitive integrated employment, completed the VR process, their case is closed.

1. A vocational rehabilitation service is not a Medicaid HCBS waiver service, so it does not meet the requirement for a participant to use a waiver service every 90 days to stay on the waiver.

10. Central Office Approval

This section outlines the services that need additional Central Office approvals. Providers work with the participant's SC to obtain the appropriate Central Office approval.

A. Respite serving individuals 18 years and older and children 13 years or younger;
B. LRI Personal Care provided by an independent provider;
C. Home and Vehicle modifications above $10,000;
D. Relative Legal Guardian requesting to become an Independent Provider

10.1 Respite Serving Individuals 18 Years and Older with Children 13 Years and Younger at the same time

DDA Central Office approval is required for settings where Respite services are being provided for individuals aged 18 and older and children aged 13 and younger. Respite providers or provider staff must not provide respite to individuals 18 years and older and children 13 and younger at the same time and location, unless approved by DDA Central Office. When Respite is provided to a child and adult at the same time and location, there must be documented approval in the person-centered service plan.

A. Individual PCP teams can approve requests when:

   1. The age gap between the minor and all adults in the setting is five years or less;
   2. The PCP team has met and agrees that the participant's needs can safely be met within the setting; and
   3. The PCP has been updated to document the discussion and agreement of the team.

B. When the age gap is greater than five years, the request will be sent to DDA Central Office for final approval.
C. DDA requires that all minor children and adult participants receiving waiver services within the same setting have a documented team discussion and approval in their PCP prior to receiving services in the setting.

10.2 Home and Vehicle Modifications Above $10,000 and Prior to Five Years

DDA Central Office approval is required for participants to receive home or vehicle modifications that exceed $10,000.

A. When a modification request is approved, but the quote exceeds $10,000, ATP will route a request to DDA Central Office for final approval.
B. Exceptions for home and vehicle modifications will not exceed $20,000.

10.3 Legally Responsible Individual Requesting to Become an Independent Provider

DDA Central Office approval is required for Legally Responsible Individuals to provide the LRI Personal Care service as an Independent Provider.

A. The SC will complete the DDA Central Office Approval Form for LRI Independent Provider. The SC will discuss the request with their SCS, who will route the request to DDA Central Office for final approval.
B. When DDA Central Office approves a request for an LRI to become an Independent Provider, the SC will complete referrals to all area agency providers prior to annual renewals.
C. When an agency provider is able to provide a comparable service to meet the participant's needs, the LRI will not be reauthorized to provide LRI Personal Care.
D. Renewals will be completed when the current exception request expires.

10.4 Relative Legal Guardians Requesting to Become an Independent Provider

DDA Central Office approval is required for a relative Legal Guardian to become an Independent Provider.

A. The SC will complete the DDA Central Office Approval Form for Relative Legal Guardian Independent Provider.
B. The SC will discuss the request with their SCS, who will route the request to DDA Central Office for final approval.
C. When DDA Central Office approves a request for a relative Legal Guardian to become an Independent Provider, the SC will complete referrals to all agency providers prior to annual renewals.
D. When an agency provider can provide a comparable service to meet the participant's needs, the relative Legal Guardian will not be reauthorized to provide services.
E. Renewals will be completed every 12 months but will be due at the time of the participant's annual PCP meeting.

11. Final Setting Rule

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under section 1915(c) of the Act. The rule shifts the definition of home and community-based settings to maximize opportunity for individuals to have access to community living and participation, as well as choice, dignity, and privacy.

11.1 Heightened Scrutiny Oversight

A. Final setting rule identifies settings that require heightened scrutiny (HS) as settings that are institutional and settings that are presumed to be institutional in nature. According to the final rule, settings presumed to be institutional include:

1. Any setting that is in a building that is a publicly or privately operated facility that provides inpatient institutional treatment;
2. Settings on the grounds of, or directly next to, a public institution; or
3. Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

B. The Heightened Scrutiny (HS) process is initiated when noncompliance is identified through:

a. Nebraska's routine data reviews;
b. Stakeholder complaints; or
c. On-site audits.

C. A formally written notification is issued to the provider explaining the need for an HS review, along with the request for an evidence packet.

D. The provider must submit an evidence packet that includes, at a minimum, a statement and supporting documents that show compliance with the Heightened Scrutiny Evidence Worksheet Instructions

a. Community Integration
b. Individual Rights
c. Choice and Autonomy
d. Provider-Owned or Controlled Settings Requirements
e. Staff Training

E. The oversight team will review the submitted Heightened Scrutiny Evidence Worksheet Packet to make sure it is complete and accurate.

F. **Initial Assessment:** The Quality Assurance Team reviews an initial evaluation to determine if the documentation meets Nebraska's HCBS quality standards.

G. A comprehensive review is performed in accordance with Nebraska's systemic assessment guidelines.

1. Any identified deficiencies or gaps will trigger a request for a Corrective Action Plan from the provider.

H. **On-Site Inspection:** After the internal review, the oversight team will schedule and conduct an on-site inspection of the providers' facility.

1. This visit is used to:

   a. Validate the accuracy of the submitted documentation.
   b. Observe service delivery, staff training, and physical environment conditions.
   c. Confirm that operational practices align with both documented procedures and Nebraska HCBS standards.

2. Completion of the site visit, along with a positive evaluation is required before moving forward.

I. **Public Comment**: Initial findings, including the internal review and site visit are published for a designated public comment period to enable stakeholder review.

J. CMS Notification and Final Approval: CMS will review the report and send a notification and final approval through the process of:

1. Final Report Preparation: A comprehensive final report is compiled. It integrates the internal review data (including site visit findings) and the public commentary feedback.
2. CMS Submission: The CMS Liaison submits the final report to CMS for review. Billing authorization cannot commence until documented CMS approval is received.

K. **Billing Authorization Milestone:** Once CMS sends their final approval, then billing authorization can start:

1. Final Authorization: Once CMS approval is secured and all documentation is finalized, the provider attains the billing authorization milestone.
2. Billing Commencement: The facility is then authorized to begin billing under its HCBS waiver.

L. **Documentation and Record-Keeping**: Documentation process will begin once CMS has given final approval and the billing process has begun:

1. Records Management: All documentation- including notifications, Evidence packets, internal review memos, site visit reports, public comments, and CMS correspondence must be maintained in accordance with Nebraska DHHS record retention policies.
2. Audit Trail: Detailed audit trails must clearly document each of the internal assessments, including the site visit and stakeholder engagement.

M. **Compliance Monitoring and Quality Assurance**: In this stage of the process, compliance monitoring will be used in the continuous process of assessing whether an organization adheres to legal regulations, standards, and internal policies to avoid penalties and reputational damage.

1. Regular Monitoring: Periodic audits and quality reviews shall be conducted to ensure ongoing compliance with Nebraska HCBS STP requirements and applicable federal regulations,

2. Procedure Updates: This SOP will be reviewed and updated as necessary to reflect any changes in Nebraska's STP guidelines, CMS regulatory updates, or applicable Nebraska Administrative codes. Additional state regulatory detail may be reviewed at the Nebraska DHHS regulations and waivers for DDA page here.

11.2 Federal Requirements for HCBS Final Settings Rule

A. AD and TBI Providers will have an assessment completed by their Resource Development worker when they enroll as a new provider and then again during their annual review. After this information has been submitted initially and then annually thereafter, DDA may require that they complete the heightened scrutiny worksheet. HCBS Final Setting Rule is a federal regulation aimed at improving Home and Community-Based Services by:

1. Enhancing the quality of services and person-centered planning;
2. Adding protections for participants in waiver services;
3. Increasing participant integration in their communities; and
4. Ensuring settings where services are delivered do not have institutional features.

B. Final settings rule requirements include:

1. The setting is integrated in and supports full access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is selected by the individual from among options, including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and resources.
3. The setting ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
4. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.
5. The setting facilitates individual choice regarding services and supports, and who provides them.
6. The setting provides for a legally enforceable agreement between the provider and the consumer that allows the consumer to own, rent, or occupy the residence and provides protection against eviction.
7. The setting provides for privacy in units, including lockable doors, choice of roommates/housemates, and freedom to furnish and decorate the sleeping or living units within the lease or other agreement.
8. The setting provides options for individuals to control their own schedules, including access to food at any time.
9. The setting provides individuals with the freedom to have visitors at any time.
10. The setting is physically accessible.

C. HCBS services are required to comply with the final setting rule. To ensure that complaints are directed appropriately, information regarding the online complaint form requirement can be found here. The grievance process is included as an option for participants, with further information on submitting grievances available in the Grievance System Resource document.

D. For additional resources, please refer to HCBS Final Settings Rule Resources and Training.

12. Appendices

Appendix A: Incident Reporting and GER's

Introduction

The Division of Disability and Aging (DDA) requires incident reporting for **services on Medicaid Home and Community-Based Services Waivers (HCBS), including the Aged and Disabled (AD) Waiver and the Traumatic Brain Injury Waiver (TBI).** The instructions in this guide are specific to the AD and TBI unless otherwise stated.

Currently, AD and TBI Service Coordinators are responsible for documenting reported incidents within Therap using the General Event Reports.

This guide outlines who is responsible for reporting incidents, timelines for required reporting, reportable incident definitions, and how incident information should be entered in Therap. Assisted living, independent, and agency providers are responsible for reporting all reportable incidents to the Service Coordinator per the timelines outlined within this guide.

This guide only covers incidents that must be reported to the DDA in Therap via a General Event Report (GER).

- A Service Coordinator may choose to document or track other incidents not reportable to the DDA in Therap using GERs with low notification levels for internal use, but this is not required.

This guide outlines the DDA expectations for submission of GERs but does not give instructions for access and use of the GER module in Therap. Therap user guides and training courses are available on the Therap Help and Support site.

In this guide, "provider" means an Independent Provider or an employee or contractor of an Agency Provider unless otherwise specified.

Responsibility for Reporting Incidents

The Service Coordinator is responsible for completing all reporting requirements.

- When a provider discovers that a reportable incident occurred during a time services are delivered, the provider must notify the Service Coordinator so the Service Coordinator may complete the GER.
    - When a case of abuse, neglect, or exploitation is reported to have occurred with another provider, the discovering party will contact the Service Coordinator and Adult Protective Services, and not the other provider.
    - **AD and TBI Waivers– Suspected incidents of abuse, neglect, or exploitation, unplanned hospitalization, and death occurring outside of waiver services will require the Service Coordinator to enter a GER.**

When an incident occurs at a time when **no services** are being delivered to the participant, it is **not required to be reported by the provider to service coordination,** and a General Event Report is not needed.

- When a provider learns a serious incident has occurred during a time when no services were being delivered, the provider should notify the participant's Service Coordinator, so any follow-up needed by the Service Coordinator can be arranged, but a General Event Report should be completed, which is best practice.
- When a provider learns that abuse, neglect, or exploitation of a participant may have occurred during a time when the provider was not delivering services, the provider must report the suspected abuse/neglect/exploitation, unplanned hospitalization, or death to the Department of Health and Human Services Abuse and Neglect Hotline or law enforcement (see contact information on page 3) and report to the Service Coordinator and a General Event Report is required to be completed.

Reporting and Notification Requirements

It is required that **all** reportable incidents listed in this guide be reported to the Division of Disability and Aging, and other people outlined in this chart be notified when an incident occurs, as the incidents identified have a risk or potential risk of causing harm to waiver participants. The chart below lists the required reports and notifications, required timelines, and how the reports and notifications must be made.

Required Notification/ Report	How Notification/Report is Completed	Required Timeframe for Notification/Report
A verbal report made to the participant's Service Coordinator (SC)	Phone call/voicemail. ***When unable to reach the Service Coordinator by phone **and** unable to leave a voicemail, notification can be made by secure email, fax, or SComm in Therap.* ***Do **not** use text messages, as it is not a secure communication.*	As soon as possible, but no more than 4 hours after observing or discovering the reportable incident.
Verbal notification to the legal representatives(s) ***Not applicable when a participant has no guardian.* ***When there are multiple guardians, at least one guardian must be notified, and the provider must attempt to notify all guardians.* ***No legal representative/Guardian notification when the legal representative is the alleged perpetrator of abuse, neglect, or exploitation.*	Phone call/voicemail. ***When the service coordinator cannot reach the guardian, voicemail is sufficient to meet notification requirements.* ***When the service coordinator cannot reach/leave a voicemail for the guardian, all attempts are recorded in the General Event Report.*	*Preferred:* As soon as possible upon observing/discovering the incident. *Required:* Within 24 hours of the verbal report to the Service Coordinator.
Verbal notification to the participant ***Not applicable when the participant was present or is aware of the incident.*	In-person. **Document any contact/non-contact within the General Event Report.	*Preferred:* As soon as possible upon observing/discovering the incident. *Required:* Within 24 hours of the verbal report to the Service Coordinator.
Written report to the Division of Developmental Disabilities – All incidents identified in this guide	General Event Report **submitted** in Therap,	Within 24 hours of the verbal report to the Service Coordinator.
	Submitted General Event Report **approved** in Therap,	Within 72 hours of the General Event Report submission,

When making the verbal report to the participant's Service Coordinator, the provider must give **all** the following information available:

- Name of the person making the verbal report and the provider agency they work for (when applicable);
- Participant's name;
- Type of incident being reported;
- A summary of the incident; and
- A summary of any action taken immediately to ensure the safety of the participant and others.

Defining Reportable Incidents

DDA defines **reportable incidents** as any event, injury, or illness in the following categories:

- Actual or Potential Airway Obstruction
- Allegation or Suspicion, of Verbal, Physical, Sexual, Psychological, or Emotional Abuse, or Neglect, or Exploitation of a Child or a Vulnerable Adult
- Allegation or Suspicion of Financial Exploitation
- Communicable Disease
- Explained or Unexplained Death of a Participant
- Emergency Situations
- Fall Requiring More than First Aid
- Fall without significant injury
- Fatal 5+
- Incidents Involving Emergency Personnel Requiring Emergency Response
- Infestations
- Injuries of Unknown Origin Raising Suspicion
- Injury Requiring Medical or Nursing Interventions beyond First Aid
- Medication Errors
- Misconduct Not Involving Law Enforcement
- Missing Person(s)
- Misuse or Unauthorized Use of Restrictive Interventions or Seclusion
- PRN Psychotropic Medication Usage*
- Property Damage*
- Suicide Attempts
- Swallowing Inedible Items*
- Unplanned Hospital/Emergency Room/Urgent Care Visit
- Use of Restraint or Prohibited Practices*
- Vehicle Accident

Unsure of whether an incident is reportable?
It is appropriate to err on the side of caution and **submit a General Event Report for Service Coordination, agency provider management, or the Division of Disability and Aging staff to review and make a determination.**

When an incident involves suspected or alleged **abuse, neglect, or exploitation**, the Service Coordinator or provider must **immediately report** the incident to **law enforcement** or the **DHHS Children and Family Services Abuse and Neglect Hotline** at:

1-800-652-1999

The hotline is toll-free and is available 24 hours a day, 7 days a week.

All Service Coordinators and providers of HCBS services are *mandatory* reporters of abuse, neglect, and exploitation.

*These incidents are not typical on the AD and TBI waivers.

In this section, each incident category is further defined, and types of reportable illness/injury/incidents within these categories are specified.

For some incident categories related to illness and injury, there are specific illnesses, injuries, or changes in condition that the Division of Disability and Aging requires to be reported, regardless of whether medical treatment is received or other circumstances. **These criteria are only given as directions for incident reporting.** The *Division of Disability and Aging does not make any recommendation for when a participant should or should not be supported to seek medical attention for an injury, illness, or change in condition.*

Actual or Potential Airway Obstruction

A reportable incident in this category is any event in which any emergency intervention is provided to a participant in response to choking or experiencing an airway obstruction. Interventions may include, but are not limited to, performing the Heimlich maneuver/abdominal thrusts, back blows, or requiring medical attention.

Allegation or Suspicion of Verbal, Physical, Sexual, Psychological, Emotional Abuse, or Neglect, or Exploitation of a Child or Vulnerable Adult

A reportable incident in this category is any allegation or suspicion of abuse, neglect, or exploitation committed by a provider, peer of the participant, family member, or anyone else in which a participant is a **victim.** This report will also be used when the participant neglects him or herself.

Any behavior by a participant toward another participant that meets the definition of abuse, neglect, or exploitation must be reported as such.

- When it is suspected that a participant has committed abuse, neglect, or exploitation against another participant, the abuse, neglect, or exploitation is reportable for the **victim** in this category.
- The actions of a participant who may have committed abuse, neglect, or exploitation are **not** reportable in this category. This is reportable in other categories, such as misconduct or law enforcement contact.

The definitions of abuse, neglect, and exploitation should be carefully reviewed to ensure the incident being reported meets the definitions of abuse, neglect, or exploitation. Incidents that clearly do not meet these definitions must not be reported in this category.

Abuse, neglect, and exploitation must be coded as High Notification regardless of the participant's history of fabricating stories.

Definitions of abuse, neglect, and exploitation are in the Incident Guide Definitions.

Allegation or Suspicion of Financial Exploitation

A reportable incident in the category is any allegation or suspicion of financial exploitation by a provider, peer of the participant, family member, or anyone else in which a participant is the victim.

Financial exploitation, also known as financial abuse, occurs when someone misuses or steals another person's money, assets, or personal information.

Communicable Disease

A reportable incident in this category is a participant who is diagnosed by a medical practitioner with an illness such as COVID-19, Influenza, Tuberculosis (TB), etc. A communicable disease is an illness carried by microorganisms and transferred through people, animals, surfaces, foods, or air.

Although a cold or upper respiratory infection could be transferred from one person to another, this would not be a reportable incident in this category.

Death of a Participant

A reportable incident in this category is the death of a participant, regardless of cause.

Emergency Situations

A reportable incident in this category is:

- Any injury or medical emergency **caused by** a fire, flood, tornado, severe weather, or other emergency or natural disaster, regardless of severity.
    - This does *not* include injuries occurring ***during*** an emergency or natural disaster, only injuries ***caused by*** the emergency or natural disaster.
    - For example, when a participant is hit by flying debris or struck by lightning, their injury is *caused by* severe weather, so it would be reported in this category.
    - However, when a participant is running to the tornado shelter during severe weather, falls, and is injured, this is *not* reported in this category.
- Any displacement of a participant from a site where Home and Community-Based Services are usually provided when displacement is caused by a fire, flood, severe weather, or other emergency or natural disaster for 24 hours or longer.
    - This does *not* include situations in which a participant cannot go to a site due to weather conditions or other unsafe circumstances, but the site itself is not unsafe/damaged in any way.

Definitions of injury and displacement are in the Incident Guide Definitions.

Falls Requiring More than First Aid

A reportable incident in this category is when a participant comes to rest unintentionally on the ground or lower level, for any reason, and requires more than first aid. “More than first aid” refers to any medical assessment, treatment, or intervention that goes beyond basic, immediate, non-invasive care intended to stabilize a minor injury or condition. It includes any medical evaluation or treatment performed or directed by a licensed medical professional when that care exceeds simple first-aid measures.

Definitions of fall and injury are in the Incident Guide Definitions.

Falls without Significant Injury

A reportable incident in this category is when a participant comes to rest unintentionally on the ground or lower level, for any reason, and does not require treatment greater than first aid or additional follow-up by a medical professional.

Fatal 5

The term “Fatal 5” refers to the top conditions linked to preventable death of people in congregate care settings or community-based residential settings.

A reportable incident in this category is any change in medical condition of sufficient severity to require assessment or treatment from a physician, regardless of whether medical attention was received.

The following illnesses/changes in condition must **always** be reported, as they are considered to be of sufficient severity, which would likely require assessment or treatment from a physician:

- Aspiration
- Dehydration
- GERD (Gastroesophageal Reflux Disease)
    - When the participant has a new diagnosis of or experiences an adverse event due to a diagnosis of GERD.
- Severe Constipation/Bowel Obstruction
- Sepsis

- Seizure
    - When the participant has a seizure for the first time in recorded personal history, or
    - The seizure lasts longer than five minutes or the timeframe set by the participant's physician.
    - When the provider does not observe the beginning of a seizure and cannot accurately determine how long the seizure lasts, or the participant is unable to report the length of the seizure.

Definitions of types of change in condition are in the Incident Guide Definitions.

Incidents Involving Emergency Personnel Requiring Emergent Response

A reportable incident in this category is any event directly related to the participant involved that results in the activation of law enforcement, ambulance, fire department or other emergency response departments.

Law Enforcement Involvement: The purpose of law enforcement involvement is to capture those events when law enforcement is activated due to behavior by the participant that is not or cannot be remediated by provider staff. When police respond to an ambulance call but are not directly needed, a law enforcement event is not required.

Ambulance: The purpose of an ambulance is to capture those events when assistance is needed from emergency medical personnel, regardless of whether the participant or guardian chooses to receive care upon the ambulance dispatch or if a person is transported to a higher level of care.

Fire Department: The purpose of fire department reporting is to capture those events when assistance is needed from the fire department for care or response to emergent situations, such as gas leaks, fire, and smoke. This is reportable regardless of additional transport or false alarm situations.

Infestations

A reportable incident in this category is any incident in which a participant has the presence of insects or animals in a location where HCBS services are received, typically to cause damage or disease.

The presence of an infestation may include bites or rashes caused by the infestation. It could also include other signs of infestation, such as live or dead parasites or parasite eggs, animal droppings, or evidence of dwelling (nests).

This category does *not* include all insect or arachnid bites. Bites and stings occurring during exposure to insects or arachnids in an outdoor environment, or due to contact with insects or arachnids which do not cause infestation (such as bees or mosquitoes), are not reportable in this category.

Injury of Unknown Origin Raising Suspicion

A reportable incident in this category is any injury in which:

- The origin of the injury is unknown, ***and***
- The injury raises suspicion of abuse or neglect due to the size, type, location, placement, pattern, or circumstances of the injury.

Even minor injuries (such as bruises, scrapes, or minor cuts) requiring no medical treatment must be reported when the origin of the injury is unknown, *and* the injury raises any suspicion.

Injuries that raise suspicion may include, but are not limited to:

- Injuries that were not observed and cannot be explained by the participant;
- Injuries where the explanation (from the participant or other people) is inconsistent with the size, type, location, pattern, or severity of the injury;
- Injuries to a participant not consistent with their means of mobility;
- Bruises in areas less likely to be accidentally bruised, such as the face (except for the forehead), neck, back, abdomen, arms, buttocks, ears, and hands;
- Multiple bruises of uniform shape or appearing in clusters;

- Injuries carrying a clear imprint of a hand or implement;
- Human bite marks in areas that could not have been caused by self-injurious behavior or by a participant with no history of biting themself as self-injurious behavior;
- Cuts or abrasions on areas typically protected by clothing (such as the back, chest, abdomen, and genitals);
- Injury to genitals or anus with no related medical cause; and
- Patterns of similar injuries over time for which a cause cannot be determined.

When the cause of an injury can be reasonably determined, it will not be reported in this category. (For example, John was sitting outside; later, he was found to have several small, raised areas consistent with mosquito bites.)

The definition of injury is in the Incident Guide Definitions.

Injury Requiring Medical or Nursing Intervention Beyond First Aid

A reportable incident in this category is any injury of **sufficient severity** that would likely require assessment or treatment from a physician, regardless of whether medical attention was sought or where medical attention was received.

Providers must assess whether the severity of an injury meets this criterion, based on whether an objectively reasonable person, not receiving Home and Community-Based Services, would seek assessment or treatment from a physician. When in doubt, it is appropriate to err on the side of caution and report the incident.

The following injuries must ***always*** be reported, as they are of sufficient severity and likely require assessment or treatment from a physician:

- Concussion;
- Dislocation;
- Fracture;
- Poisoning;
- Pressure sores/ulcers – newly discovered or untreated; and
- Burns – third degree.

A definition of injury is in the Incident Guide Definitions.

Medication Errors

A reportable incident in this category is any administration of medication/treatment/procedure in a manner inconsistent with instruction from the prescribing physician (wrong dose, time, person, route, or medication), failing to administer necessary medication/treatment/procedure, administration of prescribed PRN (as needed) or over the counter (OTC) medication causing adverse interaction with prescribed medications.

Medication Errors will be classified by severity.

Notification levels for medication errors are in Incident/Event Type Chart.

Misconduct Not Involving Law Enforcement

A reportable incident in this category is any event that involves possible criminal activity where law enforcement is not involved. Examples include, but are not limited to, exposing oneself in public, possession of drug paraphernalia, and cruelty to animals.

The Service Coordinator or Provider must assess whether the severity of the event meets this criterion, based on whether an objectively reasonable person, not receiving Home and Community-Based Services, would potentially receive criminal charges. When in doubt, it is appropriate to err on the side of caution and report the incident.

Missing Persons

A reportable incident in this category is when a participant is not at a location or service, unexpectedly.

- Example: When a person who lives in an assisted living facility leaves the facility without staff knowledge and cannot be located, this is a reportable incident.
- Example: When a person who lives in a community setting/their own home is assumed missing and cannot be located, this is a reportable incident.

Misuse or Unauthorized Use of Restrictive Interventions or Seclusion

A reportable incident in this category is when a provider uses a restrictive intervention or seclusion.

The use of a restrictive intervention is not allowed on the AD or TBI waivers.

PRN Psychotropic Medication

A reportable incident in this category is any administration of ***prescribed*** psychotropic medication on a PRN (as needed) basis.

The use of restrictive interventions, including the use of PRN psychotropic medications as behavioral interventions by a provider and not directed by the participant, is not allowed on the AD or TBI waivers.

A definition of psychotropic medication is in the Incident Guide Definitions.

Property Damage

A reportable incident in this category is any physical destruction or damage to items, furniture, or the physical structure of a building or damage to property of a total estimated value of $150 inflicted by a participant regardless of the participant's ability to understand the value of the damage.

Suicide Attempts

A reportable incident in this category is any event in which the participant harms themselves with the intent and means to end their life. Incidents of self-harm without the intent or means of suicide are not captured in this event type.

Swallowing Inedible Items

A reportable incident in this category is any incident in which a participant swallows an item that is not fit or suitable for eating. Inedible items are items such as coins, batteries, and plastic.

Unplanned Hospitalization, Emergency Room, or Urgent Care Facility

A reportable incident in this category is when a participant is admitted to a hospital or seen at an emergency room or urgent care facility for any medical or psychiatric reason.

When a participant is admitted to a hospital, and then transferred and admitted to another hospital, the second hospital admission does not need to be reported in an additional incident report. The transfer should be documented in the follow-up section of the original incident report.

Use of Restraint or Prohibited Practices

A reportable incident in this category is **any** use of a prohibited practice.

Prohibited practices are:

- Mechanical restraint;
- Physical restraint,
- Chemical restraint;
- Aversive stimuli;
- Corporal punishment;
- Discipline;

- Seclusion;
- Denial of basic needs; and
- Implementation of an intervention by a participant.
- Human rights violation

Definitions of all prohibited practices are in the Incident Guide Definitions.

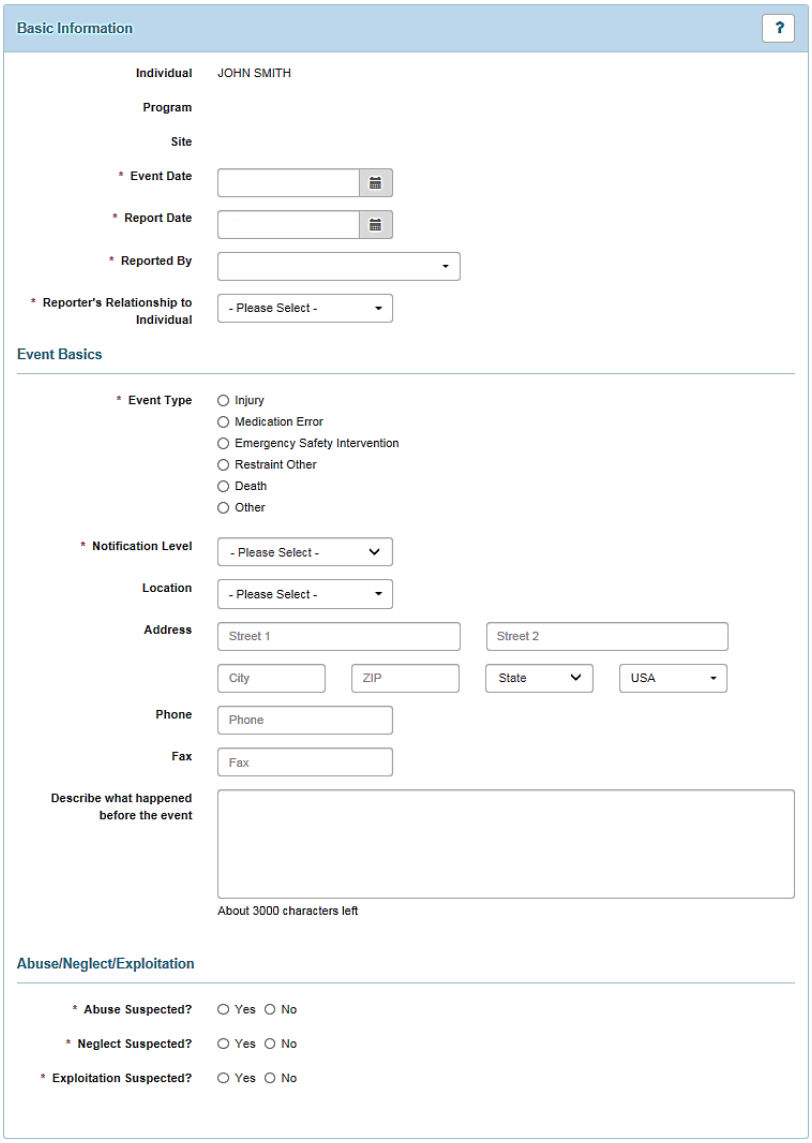
Vehicle Accident

A reportable incident in this category is any vehicular accident that results in an adverse outcome to the participant or that involves media attention or criminal activity on behalf of the provider staff.

A definition of a vehicle accident is in the Incident Guide Definitions.

Guidelines for Completing General Event Reports

Basic Information



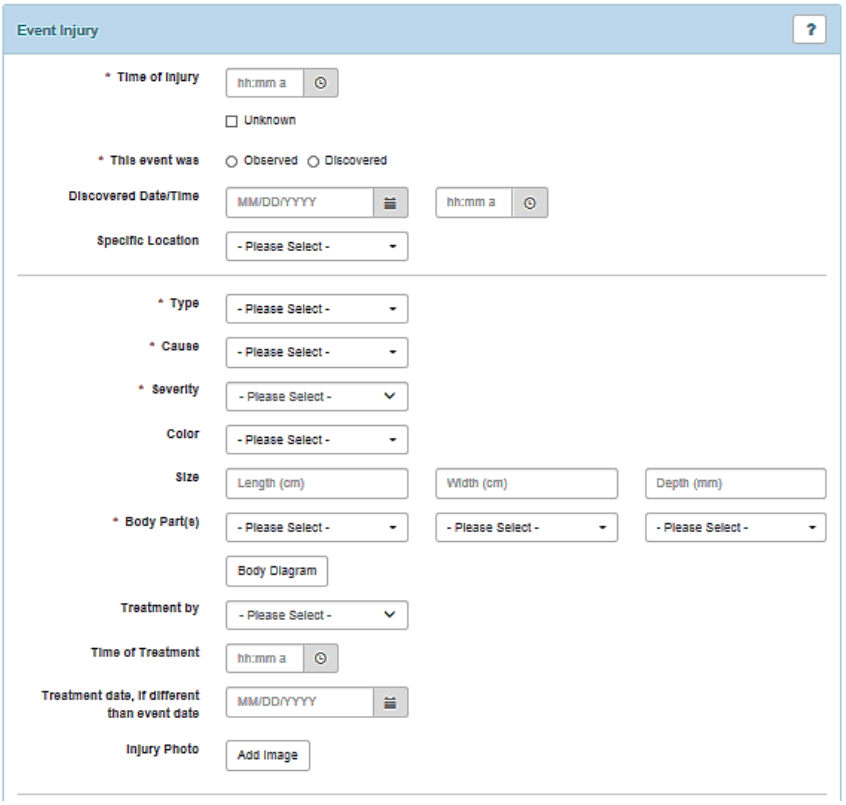
- *Event Date* is the date the incident **occurred**.
    - Event date will auto-fill; ensure the correct event date is documented.
    - When the incident involves a medication error resulting in serious illness or injury, and the illness/injury was caused by a series of medication errors over two or more days, the Event Date is the date the participant became ill/injured, *not* the first date of the error.
- *Report Date* will auto-fill with the date the General Event Report is entered. This must not be changed. The Report Date and submission date for the General Event Report must match.
- *Reported By* must be changed to the primary person witnessing the event when not completed by the same person. When the person who witnesses the event does not complete the General Event Report, a written, signed statement from the witness must be uploaded to the General Event Report.
- *Event Type* is determined based on the category of the incident being reported, according to the chart in the Incident/Event Type Chart.
- **The *Notification Level* must match the chart in the Incident/Event Type Chart for all incidents reportable to the Division of Developmental Disabilities.**
- The *Location* must be filled out. When the physical address where the incident occurred is known, it should be filled out.
    - For a death General Event Report, ensure the place of death is exact and indicates a hospital name and location when that is where they were pronounced.
- Phone information for the location should be filled out when known.
- Fax information for the location is not required.
- *Describe What Happened Before the Event* must include a summary of what the participant, staff, and any other peers (if peers are known) involved in the incident were doing before the start of the incident.

- For a death General Event Report, information on advanced directives and hospice care status, including the name of the hospice agency, must be included. It is important to add information concerning the person's health status leading up to death.
- **This section cannot contain the same information as the event summary.**

- *Abuse/Neglect/Exploitation Suspected* questions must always be completed. When reporting an allegation or suspicion of abuse, neglect, or exploitation, one of these must be marked **Yes**.
  - Exception: *When reporting an Abuse/Neglect/Exploitation event that meets the Quality Reporting definition but does not meet state statute, the provider would enter this area with a no answer and then clearly dictate that the event does not meet state statute in the Abuse/Neglect/Exploitation event summary.*

Event Information

There is a different *Event Information* form for each event type (Injury, Medication Error, Emergency Safety Intervention, Restraint Other, Death, and Other). There are different instructions for completing each type of form.



Event Injury Information

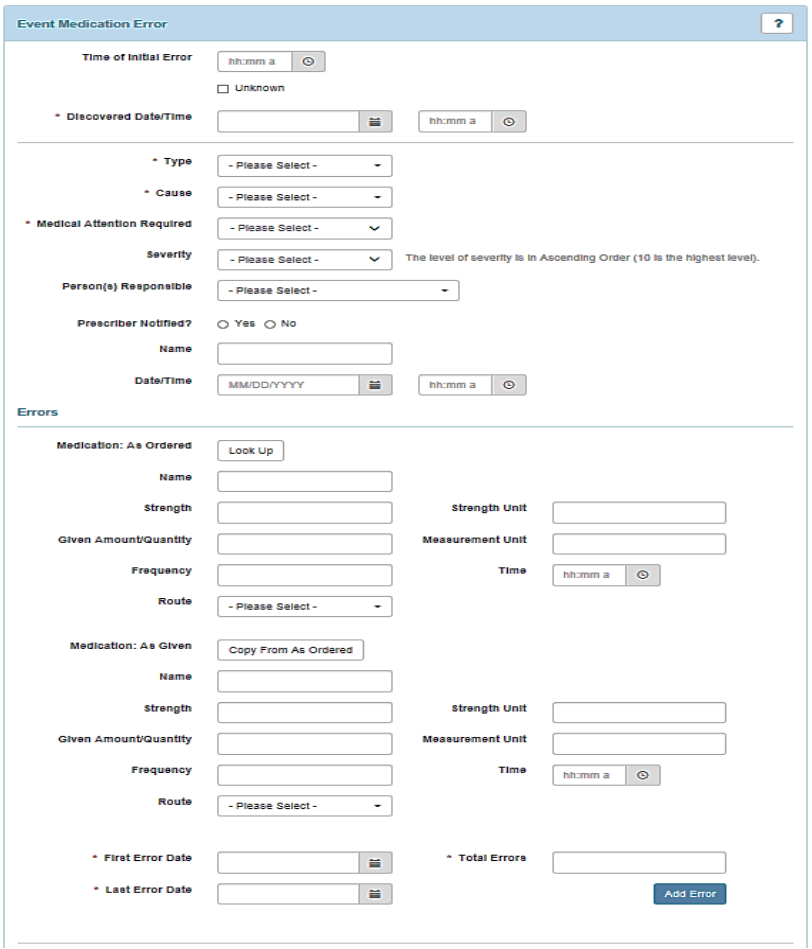
- *Time of Injury* is the time the injury occurred. When the injury was not observed, Unknown should be marked.
- The General Event Report must document whether the injury was observed or discovered.
  - Observed means the provider directly witnessed the participant being injured.
  - Discovered means the injury was not witnessed at the time it happened and was found at a later time or reported by the participant or another third party (such as parent/guardian, community member, peer).
- *Discovered Date/Time* is the time the provider discovered the injury when it was not observed. When the injury was discovered, the Discovered Date/Time **must** be completed.
- *Type* is the type of injury, such as a bruise, cut, or fracture.
- *Cause* is the cause of the injury to the participant.
  - Some incidents **must** be entered with a specific Cause. When a specific Cause is required, it is specified in the chart in the Incident/Event Type Chart.
  - When no Cause is specified for a category, select the Cause that most closely matches the injury.
- *Severity* documents the severity of the injury, based on the care required to address the injury. The following criteria must be used to document the severity of the injury:
  - Very Minor – No care needed

- Minor – First aid or nursing care
- Moderate – Assessment/treatment from a physician
- Severe – Emergency room treatment or hospitalization
- Death – Injury results in the participant's death

- *Treatment By*, *Time of Treatment*, and *Treatment Date* must be completed when **any** treatment is provided. Mark the highest level of treatment the participant received.

Event Medication Error Information

- *Discovered Date/Time* is when the medication error was discovered.
- *Type* is the type of error. Only the following types should be used:
  - Omission (medication was forgotten or refused)
  - Wrong Dose
  - Wrong Individual
  - Wrong Medication
  - Wrong Route
  - Wrong Time



- *Cause* is the reason the medication error occurred. Mark the option that most closely fits the circumstances of the error. When Other is marked, a box for further description appears and must be completed.

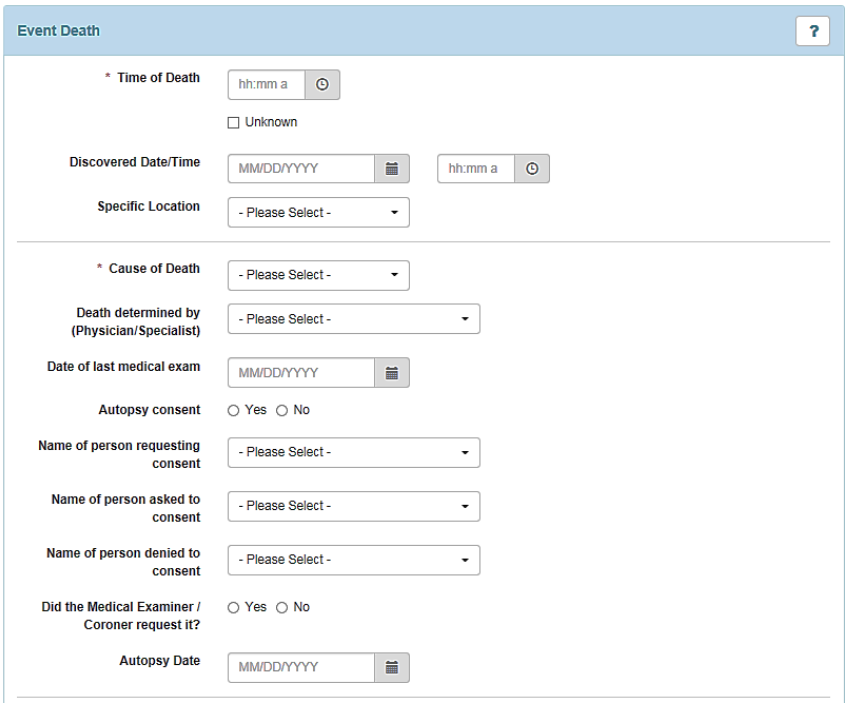
- *Medical Attention Required* is how the medication error was addressed. Only the following medical attention types should be used the medication error is reportable in a **high** General Event Report.
  - Immediate Physician Visit
  - Immediate Emergency Room Visit

- *Person(s) Responsible* must be completed and should list all staff responsible for the medication error. When the participant is responsible for the medication error, mark Other and enter the participant's name.
- The *Errors* section must be completed in its entirety.
  - For example, when the wrong dose of medication was given, the *Strength*, *Strength Unit*, or *Given Amount/Quantity* in *As Ordered* is different from *As Given*.
  - Do not include errors that led to illness in the past. Each episode of illness due to medication error is documented independently.

Event Death Information

- *Time of Death* is the specific time of death determined by a medical professional.
  - Unknown should be marked when the exact time of death is not known at the time of the General Event Report submission/approval. When an approximate time of death is known, this should be included in the Summary section.

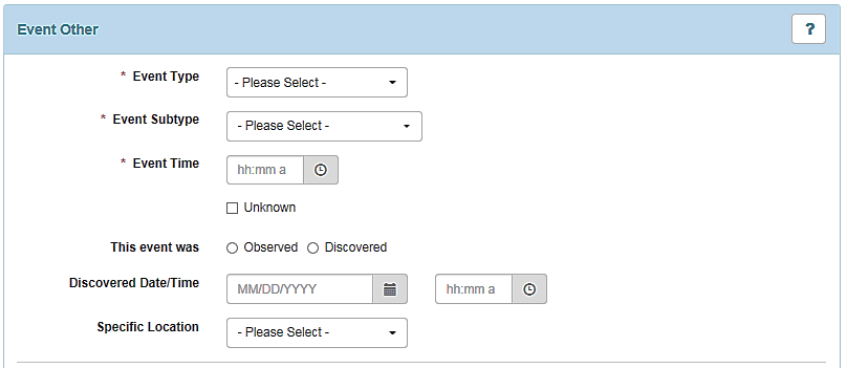
- *Discovered Date/Time* is the date and time the provider learned of the participant's death.
- *Cause of Death* is the cause of the participant's death as determined by a medical professional.
    - The option that most closely matches the cause of death should be marked.
    - When Other is marked, a box for further description appears and must be completed.
    - *Unknown* should be marked when the cause of death is unknown at the time of General Event Report submission.
    - General Event Report submission should not be delayed waiting for information about the cause of death.



- *Death Determined By* must be completed. When Other is marked, a box for further description appears and must be completed.
- *The date of Last Medical Exam* is completed when the date of the participant's last medical exam is known.
    - This field must be completed when the provider submitting the General Event Report is also responsible for the participant's medical care.
- *Autopsy Date* can be completed when known.
    - The autopsy fields may be left blank when the provider does not have information at the time the General Event Report is submitted/approved.

Event Other Information

- *Event Type* is the type of event that occurred. This must be marked exactly as specified in the chart in the Incident/Event Type Chart. Event types not specified in the chart cannot be used in a high/medium General Event Report.
    - When some Event Types are marked, an *Event Subtype* field appears.
    - Event Subtype must also be marked as specified in the chart in the Incident/Event Type Chart, when applicable.
    - When no Event Subtype is specified, choose the option that most closely matches the incident being reported.

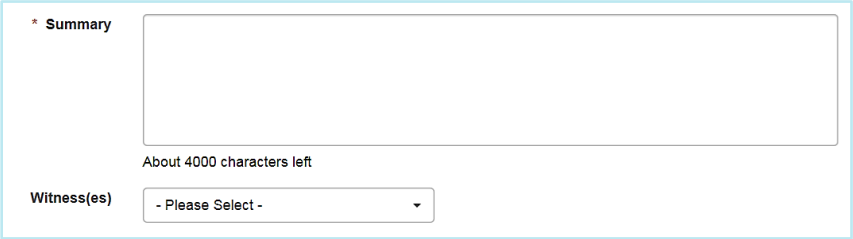


- *Event Time* is the time the incident occurred. When the incident was not observed, Unknown should be marked.

- The General Event Report must document whether the incident was observed or discovered.
    - Observed means the provider directly witnessed the incident.
    - Discovered means the incident was not witnessed at the time it happened and was discovered later.
- *Discovered Date/Time* is the time the provider discovered the incident when it was not observed. When the incident was discovered, the Discovered Date/Time must be completed.

Summary and Witness Sections

- All Event Information forms have *Summary* and *Witness* sections. Instructions for these sections apply to all event types.
- The *Summary* must contain a comprehensive description of the reportable incident.

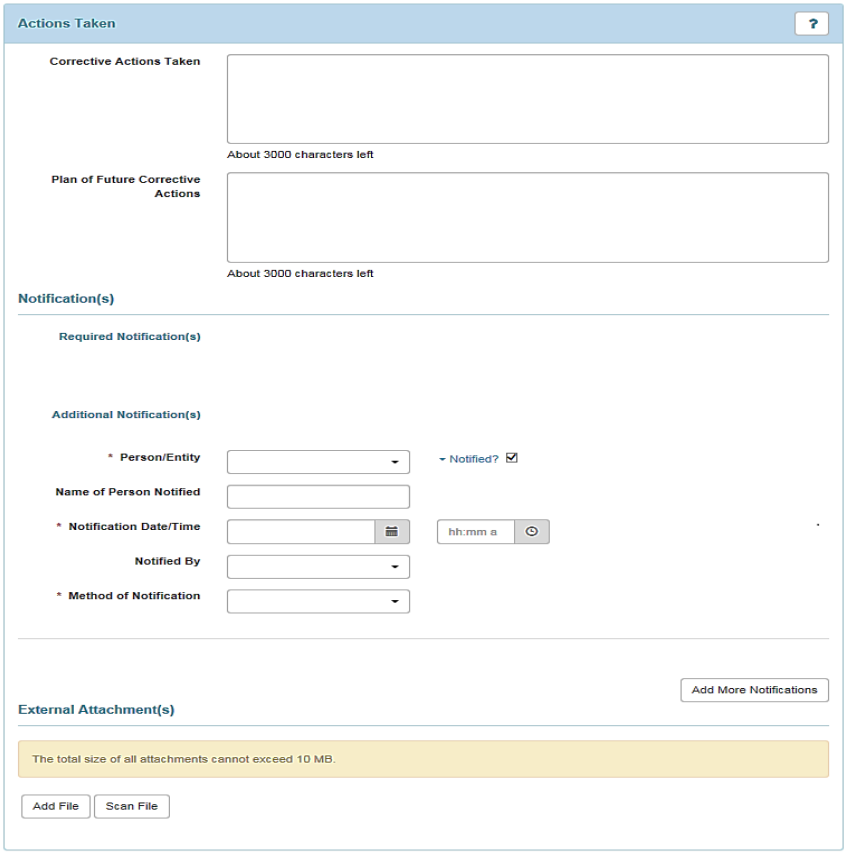


    - There may be more than one event in a single General Event Report, so the summary of the entire incident may be documented across several Summary sections.
    - Instructions for how to name the participant, peers, and staff are provided in the *General Event Report Instructions and Frequently Asked Questions* section.
    - For death events, add information on who was present at the time of death and with whom they resided at the time of death.
- *Witness(es)* may be used to list all witnesses to the incident, but this section is not required.
    - When witnesses are not listed in this section, the summary must identify all independent providers, agency provider staff, and contractors involved in or witnessing the incident.

Actions Taken

- *Corrective Actions Taken* outlines actions taken immediately following the incident to address any issues that may have contributed to the incident, ensure the safety of the participant and others, and minimize the risk of additional incidents while any required follow-up is completed.
    - When no corrective action was needed at the time of the incident, document that no action was taken.
    - Most incidents require some type of action taken at the time of the incident to ensure safety. The rationale when no action is taken is documented here.
    - When reporting requirements, including timelines, are not met, it should be documented in this section with the reason or circumstance(s) and action to address the issue.
- *Plan of Future Corrective Actions* outlines any planned actions to prevent or reduce the risk of similar incidents in the future.
    - When no plans for corrective action have been identified at the time the General Event Report is submitted/approved, document that no action is planned.
    - Most incidents require some type of action taken to prevent incidents in the future. The rationale when no action is taken should be documented here.
- *Notification(s)* must document all notifications required in this guide. The name of the person notified and the person completing the notification must always be completed. The following notifications must be documented in the General Event Report:
    - Participant, when not already aware of the incident;

- Guardian or Legal Representative, when applicable;
- Service Coordinator;
- Law enforcement or DHHS Children and Family Services (CFS) Abuse and Neglect Hotline for any allegations or suspicion of abuse, neglect, or exploitation *that meets state statute*; and
- Any other notifications required by the provider agency's policies and procedures (not applicable for independent providers).



- *External Attachments* may include photographs, documents, or other materials providing relevant information related to the incident.
  - External attachments cannot be uploaded as opposed to providing the required information in the General Event Report form.
  - For example, when documents from a hospitalization are uploaded, the incident summary cannot say "see attached" instead of including a required summary of the incident on the General Event Report.

General Instructions and Frequently Asked Questions

How should a provider complete section fields in the GER form not mentioned in these instructions?

All fields required by the Division of Disability and Aging or having specific instructions for how they should be completed are enclosed in this guide. When a field is not required and is not discussed in the guide, it is optional and can be used for additional information that the provider decides is appropriate or helpful.

How should the participant, peers, and providers/staff be named in a General Event Report event summary?

The participant for whom the General Event Report is being written must be referred to by their legal first name.

Any peers (participants other than the one for whom the General Event Report is written) involved in the incident must be referred to by their initials so a person authorized to review or investigate the incident can identify other involved participants when there is a need to do so.

Agency staff or providers must be referred to by either their full name or first initial and last name, and they must be designated as agency staff or providers when referenced.

Acronyms for personnel titles must be avoided, as these may vary from one provider to the next and lead to confusion about a person's role in the reportable incident.
Examples of identifying/naming other people in a participant's General Event Report:

- "Provider A. Smith saw Susan begin to have a seizure." (A. Smith is clearly identified as a provider, and the participant is referred to as Susan, even though she typically goes by Sue.)
- "Staff C. Columbus saw Thomas strike his housemate DE in the face with a closed fist." (C. Columbus is clearly identified as a staff member, the housemate involved in the incident is referenced by initials, and the participant is referred to as Thomas even though he typically goes by Tom.)

What does an agency staff or provider do when two or more participants are involved in a reportable incident?

When more than one participant is involved in a reportable incident and the circumstances of the incident meet the criteria to be reportable for both/all participants, a General Event Report must be completed for each participant.

For example:

- It is discovered that a participant has been intimidating/threatening another participant in the same home to give them money. This constitutes exploitation for the participant making the threats and taking the money. It also constitutes exploitation against the participant being threatened and having their money taken. A General Event Report must be completed for both participants.

There may be situations where more than one participant is involved in an incident, but is only reportable for one of the participants. In these cases, a General Event Report is not required for all participants involved.

For example:

- A participant has a behavioral episode and destroys the property of another participant with the value of the destroyed property being greater than $150. The behavioral incident resulting in property destruction constitutes a reportable incident for the participant who had the behavioral episode. However, nothing happened to the other participant that meets the criteria for a reportable incident. Therefore, only the General Event Report is required for the participant who had the behavioral episode.

- When a participant residing with other participant(s) has missing items, but the other participant(s) items are not missing, a General Event Report is only required to be completed for the participant whose items are missing.
- A participant is displaying aggressive behavior that results in harm to another participant physically, emotionally, or psychologically, the incident must be reported in two ways. The victim would receive a GER with the event category of Abuse/Neglect/Exploitation. If the victim sustained an injury, the event category of Injury would also be included. The participant who was the aggressor receives a GER with the event category of Misconduct/Possible Criminal Activity.

How should a provider document an incident with many different parts/events throughout the course of the entire episode/incident?

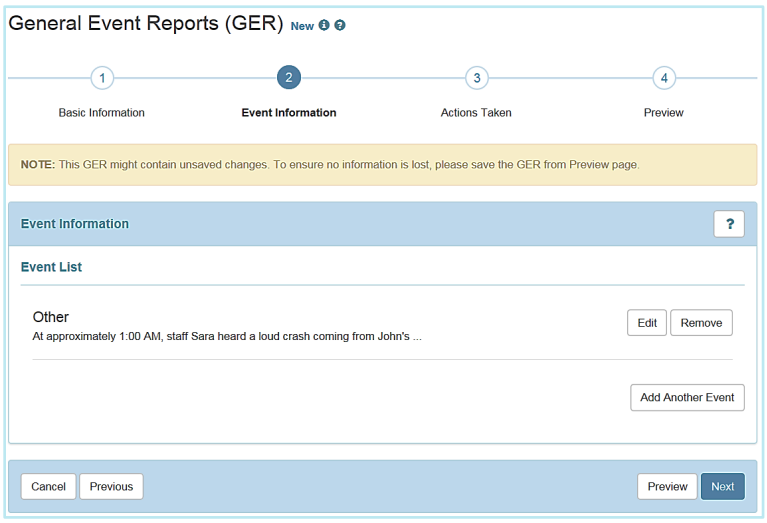
There must be a separate Event Information form for each part of an incident that meets the definition of a reportable incident outlined in this guide.

- The **only** exception to this is when an incident falls into both the Injury Requiring Medical Attention category **AND** one of the following: Injury of Unknown Origin Raising Suspicion or Injury Due to Fire, Flood, or Other Emergency/Natural Disaster.
- When an incident meets the criteria for both Injury Requiring Medical Attention and one of the others listed, this should be documented in only one Event Information form. All classification criteria for both types of incidents outlined in the chart in the Incident/Event Type Chart must be included.
- When there are additional reportable parts of the same incident aside from the two injury categories, these must be documented in separate Event Information forms.

When there is a part of an incident that is related to the reportable incident but is not reportable by itself and does not meet the criteria for a General Event Report or is at a different notification level, it will be documented in a separate Event Information form in the General Event Report, and the General Event Report Notification level will be at the level of the highest event reported.

- For example, if a participant is physically abused by a caretaker, causing them to fall and have an ambulance called, resulting in a **high-level** General Event Report to be entered for Abuse, Neglect, and Exploitation, Fall with Significant Injury, and Emergency Services Involvement. Although the latter two incidents are at a medium level, this would be reported as a high level with three events.

To add multiple Event Information forms to a General Event Report:



- Complete Basic Information, select the Event Type for the first event to be entered, and click Next.
- Complete the Event Information for the first event in the General Event Report and click Next.
- The Event List page will appear. Click Add Another Event to add more Event Information forms to the General Event Report.
- Complete Event Information for the second event.
- Repeat these steps until all reportable parts of the incident are shown as separate events in the Event List.
- When finished adding events to the General Event Report, click Next.

What if a Service Coordinator needs to correct an error, add additional information, or add another event to a General Event Report that has already been approved?

The Service Coordinator should send a SComm to their Service Coordination Supervisor or the Department of Health and Human Services DDA Quality Team, or send a secure email to NeGERHelp@libertyhealth.com requesting the removal of the approval and a brief description of the corrections/additions the provider is making.

When the Service Coordinator is adding an additional event to an approved General Event Report, the new event must have occurred on the same day as the original incident.

Once the approval of the General Event Report has been removed, the Service Coordinator will have two (2) business days from the requested removal of approval date to make the adjustments and reapprove the General Event Report.

What if an additional event related to a previous incident occurs on a different day?

The Service Coordinator must complete a new General Event Report with any reportable events of the original incident that did not occur on the same day.

- For example, a participant goes to an emergency room due to a serious injury and is admitted to the hospital. A General Event Report is completed with Event Information forms reflecting the injury requiring care from a physician, the use of an emergency room, and a hospital admission. After the General Event Report has been approved, the participant dies from the injury for which they were hospitalized. The death arises from the same incident on which a General Event Report has already been completed but cannot be added to an approved General Event Report; so, a new General Event Report reporting the participant's death must be completed.

How should threatened or attempted behaviors be documented?

There are times when a participant threatens or attempts to do something that, if the participant were successful, would require an incident to be reported. In general, attempted or threatened behaviors should not be documented as reportable incidents, even when the incident would have been reportable had the participant's actions been successful. **An exception to this rule is attempted suicide. A suicide attempt must always be reported.**

- For example, a participant pushes a television valued at more than $150 off a table during a behavioral episode. However, in the aftermath of the incident, it was determined that the television was not damaged, despite the participant's attempt to do so. Because the participant did not cause damage to the property, this behavioral episode is not reportable.

Is a General Event Report necessary if the incident is documented in some other way?

Yes, it is required that any incident that meets any of the criteria described in this guide be reported through a General Event Report to the Division of Disability and Aging, regardless of whether the information is documented elsewhere.

- For example, a participant has a seizure requiring physician intervention. Although the provider may report this in an internal reporting process or a seizure tracker, Service Coordination notification and the completion of a General Event Report is still required.

Is the provider always required to contact the CFS abuse/neglect hotline or law enforcement?

The provider will not be required to contact the CFS abuse/neglect hotline or law enforcement if the incident does not meet state statute requirements.

- State Statute requires the presence of a physical injury to consider an incident to be physical abuse.

- When the incident did not result in a physical injury as defined by the state of Nebraska, the provider may mark the Abuse/Neglect/Exploitation section of the Basic Information tab as “No”.
- An abuse/neglect/exploitation event is still required, and the provider should ensure that the summary of that event indicates that it does not meet state statute.

The provider should ensure that employees entering and approving GERs are knowledgeable about the state statute and definitions. If a provider is unsure whether an event meets the state statute, it should err on the side of caution and enter the GER as meeting the statute.

The definition of Injury can be found in the Incident Guide Definitions.

When there is an incident of alleged or suspected abuse, neglect, or exploitation, does it matter whether the provider contacts the CFS abuse/neglect hotline or law enforcement?

State law requires reporting to the CFS abuse/neglect hotline **or** local law enforcement, so contacting either will meet the statutory reporting requirement.

When a participant’s health or safety is at immediate risk due to the abuse, neglect, or exploitation is reported, law enforcement should be contacted (via 911) so that they can intervene immediately to maintain the participant’s safety.

Regardless of whether a provider chooses to call the CFS hotline or law enforcement to report alleged or suspected abuse, neglect, or exploitation, the incident must also be reported to the Division of Disability and Aging in a General Event Report.

How can a prohibited practice be discovered, rather than observed?

When a prohibited practice is used by a provider/staff but is not identified as a prohibited practice by the provider/staff using the intervention or observing the incident, such as the use of a restraint, but is later identified as the use of a prohibited practice by agency management or other agency employees, a participant’s guardian, or the Department of Health and Human Services staff, the incident (use of the restraint) would be considered discovered.

The time of discovery is at the time it is identified that the use of a prohibited practice occurred.

Is the provider required to notify a Power of Attorney (POA) if the participant does not have a guardian?

When the participant does not have a guardian but does have a POA in place, the SC, participant, and individuals selected by the participant will need to meet and determine the scope of the POA.

- For example, a participant may have a Financial POA in place, which would not have the ability to be notified of the incident information outside of the possible exploitation or other monetary incidents. The determination of the participant will be reflected in the person-centered plan.

Incident/Event Type Chart

Reportable Incident Category	Notification Level	Event Type	Subcategory	Other Categorization
Alleged or Suspicion Verbal, Physical, Sexual, Psychological, or Emotional Abuse, Neglect, or Exploitation of a Child or Vulnerable Adult	HIGH	Other	*Event Type:* Abuse/Neglect/Exploitation	*Basic Information:* Must designate which is suspected (abuse, neglect, or exploitation).
Allegation or Suspicion of Financial Exploitation	HIGH	Other	*Event Type:* *Abuse/Neglect/Exploitation*	*Basic Information:* Must designate which is suspected (abuse, neglect, or exploitation).
Death of a Participant	HIGH	Death	*N/A*	*Cause:* Determined based on available information.
Vehicle Accident	Medium *__HIGH__ - *accident is due to staff criminal activity or results in media attention*.	Other	*Event Type:* Vehicular Accident	*Basic information: for this to be reportable, an adverse outcome to the participant - usage of this event would always result in additional events to the GER.*
Events that Result in Injury or Illness				
Unplanned Hospital Admission/Emergency Room/Urgent Care Visit	Medium	Other	*Event Type: Unplanned Hospitalization*	*Sub Event: Admission/Emergency Room without Admission/Urgent Care as appropriate.*
Injury Requiring Medical or Nursing Interventions Beyond First Aid	Medium	Injury	*Event Type:* Determined based on the type of injury	*Cause:* Determined based on the cause of the Injury. *Severity:* Must always be moderate or higher.
Injuries of Unknown Origin Raising Suspicion	Medium	Injury	*Event Type:* Determined based on the type of injury	*Cause:* Undetermined.

Reportable Incident Category	Notification Level	Event Type	Subcategory	Other Categorization
Falls				
Fall Requiring More than First Aid	Medium	Other	*Event Type:* Fall with Significant Injury	*Severity:* Must always be moderate or higher. *Will require an additional event.
Fall without Significant Injury	Medium	Other	*Event Type: Fall without Significant Injury*	*N/A*
Actual or Potential Airway Obstruction	Medium	Other	*Event Type:* Choking/Potential Choking	N/A
Change of Condition/Medical Decline				
Seizure	Medium	Other	*Event Type: Fatal 5+*	*Cause:* Seizure.
Dehydration	Medium	Other	*Event Type: Fatal 5+*	*Cause:* Dehydration.
Bowel Obstruction/Severe Constipation	Medium	Other	*Event Type: Fatal 5+*	*Cause: Bowel Obstruction/Severe Constipation.*
Sepsis	Medium	Other	*Event Type: Fatal 5+*	*Cause: Sepsis.*
Aspiration	Medium	Other	*Event Type: Fatal 5+*	*Cause: Aspiration.*
GERD	Medium	Other	*Event Type: Fatal 5+*	*Cause: GERD.*

Reportable Incident Category	Notification Level	Event Type	Subcategory	Other Categorization
Restraint/ Prohibited Practices				
Misuse or Unauthorized use of Restrictive Intervention or Seclusion	HIGH	Other	*Type: Prohibited Practices*	Subtype-determined by the Unauthorized use of Restrictive Intervention or Seclusion.
Prohibited Practices: **Mechanical Restraint** **Physical Restraint** **Chemical Restraint** **Aversive Stimuli** **Corporal Punishment** **Discipline** **Seclusion** **Denial of basic needs** **Intervention by a participant** **Human rights violation**	HIGH	Other	*Type:* Prohibited Practices	*Subtype* – determined by the type of prohibited practice used.
PRN Psychotropic Medication Usage – **Must be prescribed**	Medium	Other	*Event Type:* PRN Psychotropic Medication	N/A
Injury or Displacement due to Fire, Flood, Tornado, or similar emergency				
Injury	Medium	Injury	*Type:* Determined based on the type of injury	*Cause:* Determined based on the cause of injury. *Severity:* Must always be moderate or higher.
Displacement	Medium	Other	*Event Type:* Displacement due to Emergency/Natural Disaster	N/A

Reportable Incident Category	Notification Level	Event Type	Subcategory	Other Categorization
Incidents involving possible criminal activity or Emergency Response Services				
Misconduct – Possible criminal activity not involving law enforcement	Medium	Other	*Event Type:* Misconduct/Possible Criminal Activity	*By Whom:* Individual.
Incidents involving Emergency Personnel	Medium **HIGH - When Criminal charges are brought against a participant.*	Other	*Event Type:* Emergency Services Involvement	*Event Subtype:* Choose Ambulance/Fire Department/Police Accordingly.
Medication Errors				
Medication Errors resulting in the need for immediate medical care from a hospital/physician (including urgent care) or contact with Poison Control	HIGH	Medication Error	*Type:* Determined based on error	*Cause:* Determined based on the cause. *Medical Attention Required:* This must always be an immediate physician's visit or immediate emergency room visit.
Medication Error due to an error in the Rights and Med Administration – person, time, medication, dose, route	Medium	Medication Error	*Type:* Determined based on error	*Cause:* Determined based on the cause *Medical Attention. Required:* Must never be an immediate physician visit or immediate emergency room visit.

Reportable Incident Category	Notification Level	Event Type	Subcategory	Other Categorization
Other Concerns				
Communicable Disease – such as COVID-19, Influenza, Tuberculosis, etc.	Medium	Other	*Event Type:* Communicable Disease	*Subtype:* Determined based on the diagnosis of a physician.
Swallowing Inedible Items	Medium *__HIGH__ – *when results in hospitalization*	Other	*Event Type:* Swallowing Inedible	
Property Damage *$150 or more*	Medium	Other	*Event Type: Property Damage*	
Infestations	Medium	Other	*Event Type: Infestation*	
Missing Persons	Medium	Other	*Event Type:* AWOL/Missing Person	N/A
Suicide Attempts	Medium	Other	*Event Type:* Suicide Attempt	

Incident Guide Definitions

Allegation: A claim made by any person that a participant has been abused, neglected, or exploited, and there is no evidence that the claim may be false.

- Evidence that a claim may be false is objective information or documentation that disproves the claim that abuse/neglect/exploitation occurred.
- For example, a participant has a history of making false allegations of abuse against staff members at his home. The participant claims that a specific staff member hit him and further elaborates that it happened two days ago in the evening.
- Evidence that this is not a reportable allegation could include staffing records that show the accused staff was not working on the date in question or information from other staff on duty that the accused staff was working with a different participant at the time in question.

The fact that the participant has made false allegations of abuse in the past is *not*, in and of itself, sufficient evidence to determine that a participant's statement is not a reportable allegation. When there is a belief that the allegation is spurious, the provider will have four hours from observation/discovery of the event to have the event reviewed by a trained investigator. When the trained investigator can identify that the allegation is blatantly spurious, the rationale for the decision will be documented in the *Future Plan of Corrective Actions* section of the General Event Report.

Aspiration: The act of drawing something, such as liquid or a foreign object, into the respiratory tract when taking a breath. Must be diagnosed by a physician to be considered a reportable event.

Aversive Stimuli: Procedures that are punishing, physically painful, emotionally frightening, or that have the potential to be a health or safety risk to participants when they are used to modify behavior.

Bowel Obstruction/ Severe Constipation: Bowel obstruction is a blockage that keeps food or liquid from passing through the small intestine or large intestine (colon). Constipation is the infrequent, irregular, or difficult evacuation of the bowels. Multiple drugs have constipating side effects; drugs intended to improve constipation often cause a higher risk of impaired bowel function. An incident would be determined as reportable as bowel obstruction/ severe constipation when diagnosed by a medical practitioner.

*Failure to track constipation and/or administer PRN bowel medications as indicated per the bowel protocol will be reported as neglect.

Chemical Restraint: A drug or medication used for discipline or convenience and not required to treat medical conditions.

Corporal Punishment: Infliction of bodily pain as a penalty for disapproved behavior.

Dehydration: Dehydration is an abnormal depletion of body fluids. It is common with people who do not swallow well, refuse fluids, or indicate fear when fluids are introduced. Dehydration is likely when fluids are restricted to prevent incontinence (which can lead to constipation and increased seizure activity). An incident would be determined reportable as dehydration when dehydration is a diagnosis received by a medical practitioner.

Denial of Basic Needs: Withholding access to appropriate food and clothing, comfortable and clean shelter, and treatment for physical needs.

Discipline: Use of punishment to correct undesired behavior.

Fall: A sudden, unintentional drop to the ground or floor under the force of gravity, for example, due to loss of balance, lack of support, tripping over environmental obstacles, or the actions of another person (being pushed).

Financial exploitation or theft of property or funds: Exploitation means the wrongful or unauthorized taking, withholding, appropriation, conversion, control, or use of money, funds, securities, assets, or any other property of a participant by any person utilizing undue influence, breach of a fiduciary relationship, deception, extortion, intimidation, force or threat of force, isolation, or any unlawful means or by the breach of fiduciary duty by the guardian, conservator, agent under a power of attorney, trustee, or any other fiduciary of the participant. Includes theft of items considered to have significant sentimental value, such as picture albums, keepsakes, collections, etc.

Human rights violation: Any support or practice imposed without due process, intentionally or unintentionally, limiting a participant's basic rights and freedoms to which everyone is entitled.

Illness: A condition that negatively affects the normal function of a person's body due to an internal cause, including both infectious diseases (caused by bacteria or viruses) and non-infectious diseases (such as genetic diseases or cancer).

Implementation of an Intervention by a Participant: When a behavioral or safety intervention is implemented or used by a participant on another participant at the direction of the provider.

Injury: Harm, pain, illness, impairment of physical function, or damage to body tissue.

- An external force or cause may include sources of trauma in which skin is torn, cut, or punctured (an open wound) or where blunt force causes an injury such as a bruise or fracture (a closed wound).
- An external source or cause could also include movement causing strains/sprains, exposure to poison/toxins, burns, or frostbite.
- The external force can be accidental, caused by another person, or caused by the participant (such as self-injurious behavior or attempted suicide).

Mechanical Restraint: Any device, material, object, or equipment attached to or adjacent to a participant's body that restricts freedom of movement or normal access to the body. Mechanical restraint is not:

- The use of acceptable child safety products;
- Use of car safety systems; or
- Safeguarding equipment, when ordered by a physician or health care provider.

Physical Abuse: Any allegation or suspicion of abuse committed by a provider, peer of the participant, family member, or anyone else in which a participant is the victim. Any knowing or intentional act on the part of a caregiver or any other person that results in physical injury.

Physical Neglect: The failure to provide proper care, supervision, or attention to a person or the person's health, safety, or well-being; failure to provide necessities such as food, clothing, essential medical treatment, or adequate supervision as described in the person-centered plan, shelter, or a safe environment. The failure to exercise one's duty to intercede on behalf of the person also constitutes neglect.

Physical Restraint: Any use of physical contact that restricts, or is meant to restrict, the movement or normal functioning of a participant.

Physician: A medical doctor or similar medical professional who can direct/provide medical treatment and prescribe medication within their scope of practice. This includes physician assistants (PAs) and advanced practice registered nurses (APRNs). This does not include registered or licensed practical nurses, therapists, or other types of doctors and medical professionals (dentists, clinical psychologists, etc.).

PRN Medication: Medication is prescribed to be given as needed, such as when specific symptoms or circumstances occur.

Psychological Abuse: Any allegation or suspicion of abuse, neglect, or exploitation committed by a provider, peer of the participant, family member, or anyone else in which a participant is the victim. Actions include but are not limited to humiliation, harassment, threats of punishment, or derogatory communication (vocal, written, or gestures).

Psychotropic Medication: Medication that acts primarily on the brain, resulting in changes to perception, mood, consciousness, or behavior used to alter a person's behavior or mood. PRN pain medications are not counted in this category as long as they are used for pain.

Punishment: Withholding something the participant has a right to have or do, such as their personal property or access to the community, based on their behavior, completion of a task, or success in a habilitation program.

Reportable Critical Incident: Critical events or incidents are those events that bring harm or risk of harm to participants, including abuse, neglect, exploitation, or licensing violations. These events must be reported to the appropriate authorities to conduct follow-up action.

Seclusion: Involuntary confinement of a participant alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

- Separation of a participant to a safe room or area *as part of emergency safety intervention* is not seclusion.
- Alone in a room or area means that the participant is removed from peers and others in the environment, even when a provider is present.
- Preventing from leaving or having contact with others means that the participant is physically prevented by a provider or a door, partition, or other physical barrier.

Seizure: A sudden, uncontrolled electrical disturbance in the brain, which can cause changes to behavior, movements, feelings, or consciousness.

Sepsis: Sepsis is an infection of the bloodstream and the body's response to that infection, resulting in a cluster of symptoms such as a drop in blood pressure, an increase in heart rate, and fever. An incident would be determined as reportable as sepsis when diagnosed by a medical practitioner.

Sexual Abuse: Sexual assault as described in section §28-319 or §28-320, or incest as described in section §28-703. Sexual exploitation includes but is not limited to a violation of section §28- 311.08 and causing, allowing, permitting, inflicting, or encouraging a participant to engage in voyeurism, exhibitionism, prostitution, or the lewd, obscene, or pornographic photographing, filming, or depiction of the participant.

Suspicion: Any belief, perception, or indication that a participant has been abused, neglected, or exploited.

Vehicle Accident: The unintended collision of one motor vehicle with another, a stationary object, or a person , impacting a person receiving Medicaid Home and Community Based Services either as a result of riding in the vehicle or being hit by a vehicle.

Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to individuals served. (404 NAC 2)

Vulnerable Adult: Any person 18 years of age or older who has a substantial mental or functional impairment or for whom a guardian or conservator has been appointed under the Nebraska Probate Code.

- Substantial functional impairment shall mean any incapability, because of physical limitations, of living independently or providing self-care as determined through observation, diagnosis, investigation, or evaluation.
- Substantial mental impairment shall mean a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, or ability to live independently or provide self-care as revealed by observation, diagnosis, investigation, or evaluation.

Appendix B: Acronyms and Abbreviations

Acronym	Definition
AD Waiver	Aged and Disabled Waiver
APS	Adult Protective Services
ATP	Ability to Pay
ATP	Assistive Technology Partnership
BSP	Behavior Support Plan
CDD	Licensed Center for people with Developmental Disabilities
CDD	Comprehensive DD Waiver
CFS	Children and Family Services
CMS	Centers for Medicare and Medicaid Services
CPS	Child Protective Services
CST	Clinical Support Team
DD	Developmental Disabilities
DDAD	Developmental Disabilities Adult Day Waiver
DHHS	Nebraska Department of Health and Human Services
DDA	Nebraska Department of Health and Human Services Division of Disability and Aging
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESI	Emergency Safety Intervention
EVV	Electronic Visit Verification
FBA	Functional Behavioral Assessment
FSW	Family Support Waiver
GER	General Event Report (Therap) – Incident Reports

HCBS	Home and Community-Based Services
HIPAA	Health Insurance Portability and Accountability Act
HLRC	Human and Legal Rights Committee
IBA	Individual Budget Amount
ICF/IID	Intermediate Care Facility for individuals with Intellectual Disabilities
IEP	Individualized Education Plan
IFM	Individual/Family Meeting
IPE	Individual Plan for Employment
IQ	Intelligence Quotient
LOC	Level of Care assessment
LTG	Long Term Goal
MAR	Medical Administration Record (Therap)
NAC	Nebraska Administrative Code
NCBVI	Nebraska Commission for the Blind and Visually Impaired
NCDHH	Nebraska Commission for the Deaf and Hard of Hearing
NDE	Nebraska Department of Education
NF	Nursing Facility
N-FOCUS	Nebraska Family Online Client User System
NMAP	Nebraska Medical Assistance Program (Medicaid)
NRRS	Nebraska Resource Referral System
OAP	Objective Assessment Process
OG	Operational Guideline
PAS	Personal Assistance Services (Medicaid program)
PASRR	Preadmission Screening and Resident Review
PASS	Plan for Achieving Self-Support (Social Security Administration)
PCP	Person-Centered Plan
PN	Person Number

PNM	Physical/Nutritional Management
POA	Power of Attorney
POC	Plan of Correction
POI	Plan of Improvement
P&P	Policy and Procedure
QA	Quality Assurance
QI	Quality Improvement
SDA	Service District Administrator
SC	Service Coordinator
SCS	Service Coordination Supervisor
SComm	Secure Communication (Therap)
SNA	Supports Needs Assessment
SNAP	Supplemental Nutrition Assistance Program
SOC	Share of Cost
SOC	System of Care
SpED	Special Education Branch of the Nebraska Department of Education
SPMI	Severe and persistent mental illness
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income, a federal program providing direct financial assistance to the aged and disabled, available through Social Security offices
SSN	Social Security Number
SSW	Social Services Worker
TDD	Telephone Device for the Deaf
TLog	Therap Log (progress note; daily log)
TTY	Tele-typewriter for the Deaf
TTW	Ticket to Work

VR	Vocational Rehabilitation services, a Division in the Department of Education and services provided through separate Vocational Rehabilitation regions
WIOA	Workforce Innovation and Opportunity Act

Appendix C: Glossary

The following definitions are used in the HCBS Provider Policy Manual:

Ability to Pay (ATP)	An amount determined by the Department of Health and Human Services (DHHS) that a person must pay for developmental disabilities service coordination when they meet qualifications for developmental disabilities eligibility but are not eligible for Medicaid.
Abuse of a Vulnerable Adult	Any knowing or intentional act on the part of a caregiver or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, or sexual exploitation of a vulnerable adult. *Defined in Neb. Rev. Stat. §28-371*
Abuse or Neglect of a Child	Knowingly, intentionally, or negligently causing or permitting a minor child to be: 1. Placed in a situation that endangers his or her life or physical or mental health; 2. Cruelly confined or cruelly punished; 3. Deprived of necessary food, clothing, shelter, or care; 4. Left unattended in a motor vehicle when such minor child is six years of age or younger; 5. Sexually abused; or 6. Sexually exploited by allowing, encouraging, or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films, or depictions. *Defined in Neb. Rev. Stat.* §28-710
Activities Of Daily Living (ADLs)	Basic everyday tasks, such as eating, cooking, dressing, and bathing.
Aged and Disabled (AD) Waiver	A Medicaid Home and Community-Based Service (HCBS) Waiver administered by DHHS Division of Medicaid and Long-Term Care (MLTC) to serve elderly adults and people of all ages with physical disabilities.
Agency Provider	A company that is an enrolled Medicaid provider and certified by DHHS to provide Medicaid HCBS DD Waiver services.
Appeal	A process for a person or provider to request a fair hearing to review a decision made by DHHS.
Applicant	A person applying for Medicaid HCBS DD Waiver services.

Application Date	The date DHHS Division of Disability and Aging (DDA) receives a completed application for Medicaid HCBS DD Waiver services with all information necessary to determine eligibility.
Assessment	An evaluation to identify a participant's preferences, skills, or needs.
Assistive Technology	A device, equipment, or appliance used to increase a participant's ability to complete activities of daily living or control their environment.
Aversive Stimuli	A procedure used to change unwanted behavior that is painful, frightening, or potentially harmful to the participant's health or safety.
Back-up Staff	Back-up staff is a person present in place of the Host Home or Shared Living provider.
Behavior Support Plan (BSP)	A type of habilitation program based on a behavioral assessment, which teaches an appropriate replacement behavior and decreases problem behavior.
Behavioral Assessment	Evaluation of participant behavior and baseline used to develop a BSP.
Benefits	Public assistance, such as Medicaid, Social Security Income (SSI), Supplemental Nutritional Assistance Program (SNAP), or Assistance to the Aged, Blind, or Disabled (AABD).
Budget Year	The 12 consecutive months following the start of a participant's person-centered plan (PCP) during which their annual individual budget amount may be used to purchase Medicaid HCBS DD Waiver services. This is also called the PCP year.
Business Days	Monday through Friday, excluding state holidays.
Centers for Medicare and Medicaid Services (CMS)	A federal agency under the US Department of Health and Human Services, which approves and oversees the Medicaid HCBS Waivers.
Certification	Approval by DHHS Division of Public Health (DPH) for an agency provider to deliver Medicaid HCBS DD Waiver services to participants.
Chemical Restraint	A drug used for discipline or convenience and not required to treat medical symptoms.
Code of Federal Regulations (CFR)	Rules set by federal government agencies.

Competitive Integrated Employment	Gainful employment in a job, which takes place in an integrated community setting where the participant receives a competitive wage for their, job.
Competitive Wage	Earning at or above minimum wage, but no less than the wage and employment benefits, such as insurance, paid for the same or similar work performed by a person without a disability.
Compliance	To follow any applicable statutes, regulations, and policies.
Comprehensive DD Waiver (CDD)	A Medicaid Home and Community-Based Service (HCBS) Waiver administered by DDA which allows people of all ages with developmental disabilities to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. This waiver includes both residential and day services.
Conflict of Interest	A situation when a provider or person's own interests may be inconsistent with their responsibilities to a participant.
Contractor	A person, organization, or business not employed by the agency, with whom an agency provider enters into an agreement to provide a service.
Corporal Punishment	Causing pain as consequence for undesired behavior.
Customer Obligation	Term used by Medicaid for share of cost.
Customized Employment	Competitive integrated employment based on a match between the strengths and interests of a participant and an identified business need where an existing job is modified, containing one or more, but not all, of the tasks from the original job description.
Denial Of Basic Needs	Withholding access to food or water, clothing, shelter, and treatment for physical needs.
Developmental Disabilities Adult Day Waiver (DDAD)	A Medicaid Home and Community-Based Service (HCBS) Waiver administered by DDA which allows people ages 21 and over with developmental disabilities to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. This waiver includes day services.
Disability and Aging Court-Ordered Custody Act (DDCA or DDCOCA)	Nebraska state statute, which gives authority to a court to commit a person with a developmental disability who is age 18 or older and poses a threat of harm to others to DHHS for custody and treatment.
Disability and Aging	A severe, chronic disability, including an intellectual disability, other than mental illness, which: a. Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness; b. Is manifested before the age of twenty-two years; c. Is likely to continue indefinitely;

	d. Results in substantial functional limitations in one of each of the following areas of adaptive functioning. i. Conceptual skills, including language, literacy, money, time, number concepts, and self-direction; ii. Social skills, including interpersonal skills, social responsibility, self-esteem, gullibility, wariness, social problem solving, and the ability to follow laws and rules and to avoid being victimized; and iii. Practical skills, including activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living; and e. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth through the age of nine years inclusive who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the major life activities described in subdivision (4) of this section if the individual, without services and support, has a high probability of meeting those criteria later in life. *Defined in Neb. Rev. Stat. §83-1205*
DDA Central Office	The administrative office of DDA which includes the Director, Deputy Directors, Administrators, Financial Officer, Medical Director, Clinical Team, Policy Team, Quality Improvement Team, and Provider Relations Team.
DDA Clinical Team	The team that includes the Medical Director, psychologists, nurses, behavioral professionals, and other medical professionals.
DHHS-Mandated Electronic Medicaid Provider Enrollment System	Maximus.
Discipline	Use of punishment to correct undesired behavior.
Emergency Safety Intervention (ESI)	Use of physical restraint or separation as an immediate response to an emergency safety situation.
Emergency Safety Situation	Unexpected participant behavior that places the participant or others at significant risk of serious or life-threatening harm.
Emotional Abuse	Humiliation, harassment, threats, or intimidation causing distress.
Employee Benefits	Worker's compensation, paid holidays, paid vacations, paid sick time, health insurance, and other compensation provided by an employer.
Exploitation of a Vulnerable Adult	Wrongful or unauthorized taking, withholding, appropriation, conversion, control, or use of money, funds, securities, assets, or any other property of a vulnerable adult or senior adult by any person:

	1. By means of undue influence, breach of a fiduciary relationship, deception, extortion, intimidation, force or threat of force, isolation, or any unlawful means; or 2. By the breach of a fiduciary duty by the guardian, conservator, agent under a power of attorney, trustee, or any other fiduciary of a vulnerable adult or senior adult. *Defined in Neb. Rev. Stat. §28-358*
Family Support Waiver	A Medicaid Home and Community-Based Services (HCBS) Waiver administered by DDA which allows people ages birth to 21 years with developmental disabilities to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. This waiver includes both residential and day services.
Fair Hearing	A meeting between DHHS and a person or provider appealing a decision in which a hearing officer reviews presented evidence.
Final Settings Rule	CMS requirements for all home and community-based settings receiving Medicaid HCBS Waiver funds to offer participants opportunities for community involvement and services in the most integrated settings.
Funding Priority	Criteria used to determine the order in which eligible people receive funding for developmental disabilities services.
Gainful Employment	A job in the community where a participant receives steady work and at least minimum wage.
General Event Report (GER)	State-mandated electronic form used to report incidents in the state-mandated web-based case management system (Therap).
Habilitation Program	A structured method of teaching skills, with goals and data collection.
Habilitative Service	A developmental disabilities service, which teaches a participant through habilitation programs and provides other supports such as personal care, supervision, and medication administration.
Health Insurance Portability and Accountability Act (HIPAA)	Federal law, which governs sharing of protected health information.
Hearing Officer	A DHHS attorney assigned to hold a fair hearing.
Immediate Response	Available within moments to assist the participant.
Independent Provider	A person who is an enrolled Medicaid provider and employed by a participant.
Individual Budget Amount (IBA)	Maximum amount of funding available to a participant during their PCP year to purchase Medicaid HCBS DD Waiver services.

Individual Family Meeting (IFM)	A conversation with the participant, held before the annual PCP meeting, about how things are going, things they enjoy, things they may want to change, and what their hope is for the future.
Person-Centered Plan (PCP)	A plan of services, supports, activities, and resources based on the participant's personal goals and preferences, and assessments of strengths and needs.
Person-Centered Plan (PCP) Year	The 12 consecutive months following the start of the budget year.
Person-Centered Plan (PCP) Team	The people who support a participant to develop and carry out the PCP. Members include the participant, their guardian, Service Coordinator, developmental disabilities providers, and others chosen by the participant.
Informed Choice	A well-considered decision made when given all options or information.
Institution	In-patient hospitals, skilled nursing facilities, intermediate care facilities for individuals with Intellectual disabilities (ICF/IID), and Regional Centers.
Integrated Community Setting	A place in the community where people with and without disabilities interact, and live and work together.
Integration	Full involvement in a person's community.
Intelligence Quotient (IQ)	A score based on standardized testing to assess human intelligence. An IQ score is not a diagnosis but may be used to diagnose a developmental disability. IQ must be assessed by a qualified professional.
Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/IID)	An institution licensed by Public Health for people with developmental disabilities, which provides ongoing evaluation, planning, supervision, and habilitative services.
Inventory For Client and Agency Planning (ICAP)	An assessment tool measuring adaptive skills and behavioral needs, used as part of the objective assessment process.
Legally Responsible Individual (LRI)	A person who is the natural or adoptive parents of a minor child or spouse of the waiver participant.
Level of Care (LOC)	An assessment completed to determine if a person requires the same level of services provided in an ICF/IID.
Long-Term Goal (LTG)	The planned outcome of a habilitation program reflecting what the participant will learn. The PCP team develops the long-term goal based on the participant's personal goals and assessed needs.
Maximus	DHHS-mandated electronic Medicaid provider enrollment system
May	An action or task, which is optional.

Mechanical Restraint	Any device, material, object, or equipment that restricts freedom of movement or normal access to the body, except: 1. The use of acceptable and age-appropriate child safety products, such as a car seat or booster seat; 2. Use of car safety systems, such as seatbelts or wheelchair tie-down straps; or 3. Equipment ordered by a physician or health care provider for the participant's safety, such as a lap belt on a wheelchair.
Medicaid	Public health insurance program for people who have low-income or people with disabilities.
Medication	Any prescription or nonprescription drug intended for treatment or prevention of disease, or to affect body function.
Medication Administration Record (MAR)	Documentation of administered medications. A provider must maintain documentation in the state-mandated web-based case management system (Therap).
Monthly Spend Down	Terms used by Medicaid for share of cost.
Must	An action or task which is required by DDA.
Natural Supports	A person who has a non-paid, personal relationship with a participant, including family members, friends, neighbors, and other community members.
Nebraska Administrative Code (NAC)	Nebraska state regulations.
Neglect of Vulnerable Adult	Any knowing or intentional act or omission on the part of a caregiver to provide essential services or the failure of a vulnerable adult, due to physical or mental impairments, to perform self-care or obtain essential services to such an extent that there is actual physical injury to a vulnerable adult or imminent danger of the vulnerable adult suffering physical injury or death. *Defined in Neb. Rev. Stat. §25-361.01*
Notice of Decision (NOD)	A written notice to an applicant or participant informing them of a decision made by the Department.
Notice of Rights and Obligations	A written notice to a participant or guardian informing them of their rights and responsibilities in order to receive developmental disabilities services, which are signed by the participant or guardian.
Objective Assessment Process (OAP)	Standardized process to determine a participant's annual individual budget amount (IBA).
Obligated	The assignment of the Medicaid share of cost to a specific Medicaid provider.

Oversight	Observation, direction, and monitoring by a person or people responsible for expertise in a specified area.
Participant	The person receiving Medicaid HCBS DD Waiver services and any person legally authorized to act on behalf of the participant.
Party	All people and organizations involved in a fair hearing, which include, the DHHS Hearing Officer, DDA and DHHS Legal, the person submitting the appeal, and any other person or entity identified by the person submitting the appeal.
Person-Centered Approach	A process to ensure a participant is at the center of decisions, which relate to their life. The process involves: 1. Listening to the participant; and 2. Sharing ideas to support the participant in reaching their personal goals.
Person-First Language	Speaking or writing which places the person before the disability. For example, "person with autism" instead of "autistic person."
Physical Restraint	Any physical hold that restricts, or is meant to restrict, the voluntary movement of a participant.
Plan of Improvement (POI)	A written document outlining the provider's plan to address any areas out of compliance during a certification or service review.
Policy and Procedure (P&P)	Written policies describing how a business is run, and procedures giving direction to employees and contractors.
Power of Attorney (POA)	Legal representative appointed by a person to make decisions on their behalf, such as medical or financial decisions.
Private Home	A participant's own home, or their family's home when living with their family; not provider owned or leased, operated, or controlled.
PRN (Pro Re Nata) Medication	A medication is taken as needed rather than on a set schedule.
Provider Controlled or Operated Setting	A location where developmental disabilities services are provided by an agency provider in which the provider manages what takes place in the setting, such as schedules, staffing, activities, and services offered, and who receives services in the setting.
Provider Owned or Leased Setting	A location where developmental disabilities services are provided by an agency provider in which the provider, a provider employee, or provider contractor owns or leases the location.
Psychotropic Medication	A medication, which generally alters brain function, resulting in changes to perception, mood, consciousness, or behavior.
Punishment	Imposition of an undesirable or unpleasant outcome by an authority as a response and deterrent to an undesired action or behavior. Withholding

	something a participant has a right to have or do based on their behavior, completion of a task, or success in a habilitation program.
Quality Improvement (QI)	A continuous process of performing reviews, analyzing data, evaluating current practices, and making changes to improve services.
Risk Screen	Assessments that measure the following risks: 1. Behavior; 2. Health; 3. Spine and Gait; 4. Physical Nutrition Management; and 5. Enteral Feeding.
Room and Board	The term "room" means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day or any other full nutritional regimen. (Application for a 1915 (c) Home and Community-Based Waiver Instructions, Technical Guide and Review Criteria, January 2019).
Safety Plan	A guide for people providing direct support which includes: 1. A summary of all identified risks, triggers, and warning signs; 2. A detailed description of all supports, strategies, and equipment used to address the identified risks; and 3. Specific instructions for when and how all supports, strategies, and equipment are used.
Seclusion	Being confined alone in an area and physically prevented from leaving or having contact with others.
Self-Administration of Medication	When a participant is able to: 1. Independently take or apply medication as prescribed, including at the right time and in the right amount; 2. Independently monitor for the desired effects and side effects of the medication, and take appropriate actions; and 3. Receive no assistance with any activity related to medication administration.
Self-Directed Services	Services offered by independent providers employed by a participant.
Self-Direction	Participant management of their services when working with an independent provider. The participant is responsible for managing all aspects of service delivery, including hiring, training, scheduling, supervising, and dismissing providers.
Separation	Use of physical contact to remove a participant from a situation triggering unsafe behavior, another person, or a dangerous situation.

Service Coordinator (SC)	DDA staff assigned to help a participant find needed services and supports, facilitate the development of the ISP, and ensure the PCP is implemented as written.
Setting	A location where developmental disabilities services are provided.
Shift Staff	Employees of a developmental disabilities agency provider that work in a 24 - hour Continuous Home setting. Shift staff work in the residential setting and do not live there.
Short-Term Objective (STO)	A step towards achieving a long-term goal.
Should	An action or task which is best practice and recommended by DDA.
State General Funds	Money that pays for developmental disabilities services when a Medicaid HCBS DD Waiver service cannot be billed.
State-Contracted EVV provider	Tellus.
State-Mandated Web-Based Case Management System	Therap.
Supported Employment	Ongoing assistance necessary for success in competitive, integrated employment.
Telehealth	Contact between a participant and a health care provider for diagnosis or treatment using audio and visual technology, rather than in-person interaction.
Tellus	The state-contracted EVV provider.
Therap	State-mandated web-based case management system.
Vendor	A vendor is a company or agency enrolled as a Medicaid provider but not certified as a disability and Aging provider.
Verbal Abuse	Use of oral, written, or gestured language that intentionally uses offensive terms towards a participant.
Vocational Rehabilitation (VR)	A service that assists people with disabilities to find and maintain employment. Nebraska VR or the Nebraska Commission for the Blind and Visually Impaired (NCBVI) provide this service.
Vulnerable Adult	Any person 18 years of age or older who has substantial mental or functional impairment or for whom a guardian or conservator has been appointed under Nebraska Probate Code. 1. Substantial functional impairment shall mean any incapability, because of physical limitations, of living independently or providing self-care as determined through observation, diagnosis, investigation, or evaluation.

	2. Substantial mental impairment shall mean a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, or ability to live independently or provide self-care as revealed by observation, diagnosis, investigation, or evaluation. *Defined in Neb. Rev. Stat. §28-371*
Week	A calendar week beginning 12:00 AM Monday through 11:59 PM of the following Sunday.

Appendix D: Contacts and Resources

D.1 DDA Contacts and Office Locations

DDA Central Office Address

Nebraska Department of Health & Human Services - Division of Disability and Aging
301 Centennial Mall, South
P.O. Box 98947
Lincoln, NE 68509-8947

DDA Central Office Phone, Fax, and Email

Toll-Free: (877) 667-6266
Lincoln: (402) 471-8501
TTY (for those who are deaf or hard of hearing): (402) 471-7256
Email: DHHS.DDDCommunityBasedServices@nebraska.gov

DDA Website
http://dhhs.ne.gov/Pages/Developmental-Disabilities.aspx

DDA Staff Directory and Local Office Locations
https://dhhs.ne.gov/Pages/Developmental-Disabilities.aspx

D.2 Department of Health and Human Services Contacts

DHHS Public Website
http://dhhs.ne.gov/

Medicaid Contact Information

Toll-Free: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178
TTY (for those who are deaf or hard of hearing): (402) 471-7256
http://dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx

Reporting Abuse, Neglect, or Exploitation of Children or Vulnerable Adults
Toll-Free: (800) 652-1999

Economic Assistance
Toll-Free: (800) 383-4278
https://dhhs.ne.gov/Pages/Economic-Assistance.aspx

DHHS Public Assistance Office Locations
http://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx

Financial Services for Ability to Pay
DHHS.financialresponsibility@nebraska.gov

To Report Suspected Medicaid Fraud by a Provider or Recipient
http://dhhs.ne.gov/Pages/Program-Integrity-Reporting-Fraud.aspx

D.3 Statutes, Regulations, and Medicaid HCBS DD Waivers

Nebraska Revised Statutes – A listing of all chapters of Nebraska statute
https://nebraskalegislature.gov/laws/browse-statutes.php

Nebraska Administrative Code (NAC) – A listing of state regulations maintained by DHHS, specific to the Division of Developmental Disabilities
https://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx

Medicaid HCBS Waivers – Waiver agreement approved by the federal Department of Health and Human Services outlining services offered under the Aged and Disabled (AD) waiver and Traumatic Brain Injury (TBI) waiver.
https://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx

D.4 Application and Eligibility Resources

iServe Nebraska – Website with online application for developmental disabilities services
https://iserve.nebraska.gov/

D.5 Complaints and Appeals Resources

Appeal/Fair Hearing Request – Information and form for filing an appeal of a DHHS decision can be found here.
https://dhhs.ne.gov/Pages/DD-Notice-of-Decision.aspx

Nebraska Ombudsman's Office Website – The Office of the Ombudsman is an independent office, which handles complaints from citizens against agencies of the state government.
https://www.nebraskalegislature.gov/divisions/ombud.php

D.6 Employment Resources

Nebraska Vocational Rehabilitation (VR) Contact Information

Toll-Free: 877-637-3422
Website: http://www.vr.nebraska.gov/
Local Offices: http://www.vr.nebraska.gov/offices/

Nebraska Commission for the Blind and Visually Impaired (NCBVI) Contact Information

Toll-Free: (877) 809-2419
Website: https://ncbvi.nebraska.gov/about/statewide-offices

D.7 Provider Resources

Provider Information – Information for providing HCBS waiver services.
https://dhhs.ne.gov/Pages/Medicaid-Home-and-Community-Services-Provider-Information.aspx