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1. Introduction

1.1 Welcome

Thank you for your participation or interest in Nebraska's community-based developmental disabilities (DD) services. The Nebraska Department of Health and Human Services (DHHS) Division of Disability and Aging (DDA) aims to improve the quality of life by promoting independence and community integration for participants.

We support the choices of people with developmental disabilities by promoting flexible, quality, participant-directed services and supports in Nebraska communities for individuals who require the same level of care that would otherwise be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

1.2 Purpose of the DD HCBS Provider Policy Manual

This manual outlines the requirements and procedures for Medicaid Home and Community-Based (HCBS) DD Waiver services.

A. When you are a person with a developmental disability, a family member, a guardian, or an advocate, this manual will help you understand the system.
B. When you are a DD Service Coordinator, this manual will help you effectively facilitate person-centered planning and services, provide resources and referral information, and monitor the delivery of Medicaid HCBS DD Waiver services.
C. When you are a DD services provider, this manual will help you deliver quality habilitative services and supports and ensure the health and safety of those you serve. All providers of DD services must comply with this policy manual.
D. 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 9 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 C lists commonly used abbreviations. Appendix D is the glossary, which lists terms and phrases used throughout the manual. Appendix E 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 accommodations to view the manual, call DDA at 1 (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.
    b. DDA will email a link to DD provider lists and those signed up to receive stakeholder emails.
    c. DDA will publish a Provider Bulletin to alert participants, providers, and stakeholders.

1.5 Participant Driven Collaboration

In the Policy Manual, “participant” means the person receiving Medicaid HCBS DD 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 DD Waiver programs. It is essential that providers and DD service coordination develop and maintain effective working relationships with participants and any advocates who may assist participants in exercising 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 DD Programs

The federal Centers for Medicare and Medicaid Services (CMS) developed the Medicaid HCBS waiver program as an alternative to services provided in an institutional setting, such as an ICF/IID. CMS approved Nebraska’s first Medicaid HCBS waiver for people with developmental disabilities in 1987.

A. DDA oversees three Medicaid HCBS DD waivers:

1. Comprehensive Developmental Disabilities (CDD) Waiver;
2. Developmental Disabilities Adult Day (DDAD) Waiver; and
3. The Family Support Waiver (FSW).

B. A person may meet eligibility requirements for more than one waiver but may only receive services under one waiver at a time.

C. Each waiver outlines the populations served under the waiver program, the services offered, and safeguards for waiver participants.

a. The SC updates the participant's PCP as needed to meet the participant's needs while staying within their IBA.

2. When the participant has a monthly share of cost for their Medicaid benefits, the share of cost amount is typically obligated to the participant's Medicaid HCBS DD Waiver services. This could include the Medicaid DD provider(s). When the participant chooses to obligate their share of cost to the DD services, the following process should be followed:

a. The PCP team discusses which provider is responsible for collecting the share of the cost from the participant when there is more than one DD provider.
b. When the amount paid for one provider's services is less than the participant's share of cost, the share of cost 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, the participants' share of cost, and the total amount withheld from the providers' payments.
e. DDA pays the provider for services billed minus the participant's share of cost.
f. The provider must bill the participant for the share of cost portion of payment, and the participant is responsible for paying the share of cost to the provider.

D. Information on specific services can be found in the service summaries on the DHHS DDA public website.

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) Developmental Disabilities (DD) Waivers and how an eligible person receives funding. A determination of eligibility does not guarantee funding for services will be immediately available.

In the HCBS Provider Policy Manual, "participant" means the person receiving Medicaid HCBS DD Waiver services and any person legally authorized to act on behalf of the participant.

In this chapter, "applicant" means the person applying for developmental disabilities (DD) 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 DD Waiver services:

A. Meet Medicaid eligibility requirements;
B. Meet DD eligibility requirements outlined in Nebraska Revised Statute §83-1205 and the Developmental Disabilities Services Act; and
C. Meet the institutional level of care requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

2.2 Medicaid Eligibility

All people who are eligible for the Medicaid HCBS DD 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 E: Contacts and Resources.*

2.3 Statutory Requirements for Developmental Disability

In addition to being Medicaid eligible, an applicant must have an intellectual and developmental disability as defined in Neb. Rev. Stat. §83-1205 and §83.1206.01 and the Developmental Disabilities Services Act.

A. Neb. Rev. Stat. §83-1205:

    1. Developmental disability shall mean a severe, chronic disability, including an intellectual disability, other than mental illness.
    2. The applicant must demonstrate substantial limitations in each of the following three areas of adaptive skills:

a. Conceptual skills, which include language, literacy, money, time, number concepts, and self-direction;
b. Social skills, which include interpersonal skills, social responsibility, self-esteem, gullibility, wariness, social problem-solving, the ability to follow laws and rules, and avoiding victimization; and
c. Practical skills, which include activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living.

3. A developmental disability must begin in the developmental period, which ends at age 22.
4. A developmental disability is expected to be lifelong.

B. Neb. Rev. Stat §83-1206.01:

1. Intellectual disability means significant subaverage general intellectual functioning, which is associated with significant impairments in adaptive functioning manifested before the age of twenty-two years. Significant subaverage general intellectual functioning shall refer to a score of seventy or below on a properly administered and valid intelligence quotient test.

2.4 Institutional Level of Care Requirements

DDA completes an assessment to determine if a person requires the same level of care provided in an ICF/IID.

A. The ICF/IID institutional level of care assessment is completed during the initial eligibility review and annually for participants receiving Medicaid HCBS DD Waiver services.
B. The level of care assessment is completed by DDA staff.
C. DDA staff reviews the most recently completed ICF/IID institutional level of care assessment and compares the results to services and supports similar to what is provided in an ICF/IID.
D. When a person does not meet ICF/IID institutional level of care requirements:

1. DDA staff may compare the level of care assessment with other assessments or documentation to determine whether the results of the level of care assessment are accurate or need revision.

a. DDA staff may get help comparing documents from those who are familiar with the participant, such as family and friends, and providers of services.
b. Information may be reviewed at the individual family meeting or a PCP meeting.

2. Based on a review of the level of care through information and team discussion, DDA staff may revise the level of care assessment.

a. When the revised assessment shows the person does meet ICF/IID institutional level of care, services may begin or continue.
b. When the revised assessment shows the person does not meet the ICF/IID institutional level of care, they cannot receive Medicaid HCBS DD Waiver services.

2.5 Application for Developmental Disabilities Services

DD providers are not involved in the determination of eligibility for services, but may be a first point of contact for people who want to apply for services. When this happens, the provider must refer the

person to DHHS to apply. To receive funding for services through DDA, a person must submit an application and be determined eligible.

A. A person may apply for DD services at any age.
B. A person may submit their application for DD services online, in person, by mail, fax, or email.

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

a. Information in this account is secure and is only accessible with the username and password.
b. When the applicant does not finish the application in one sitting, they can save it and come back to it by logging in to their account.
c. DDA cannot access an application until the applicant submits it.

2. Apply at any local DHHS office.

a. When an applicant does not have internet access, they can go to any public DHHS office and ask to use a computer to apply for services on iServe Nebraska; and
b. An applicant will receive access to a computer and assistance when needed.
c. When a paper application is needed, a paper application can be printed from https://iserve.nebraska.gov/ or requested from your local DHHS office. A paper application can be submitted by mail, email, or in person.

C. An applicant who needs general help with the application process may:

1. Receive application assistance from a community partner. An online directory of community partners is available on the DDA website.
2. Receive application assistance and use a computer to complete an online application at a local DHHS office.

a. Translation, including sign language, is available for an applicant with limited English proficiency. Written applications are available in several different languages and can be requested from the DDA Central Office.
b. Locations are accessible to persons with physical disabilities, and the applicant can request other accommodations.
c. When someone is not available to provide immediate assistance, the DHHS local office may set up an appointment.

D. A valid application includes:

1. Name and mailing address of the applicant;
2. Signature of applicant;
3. Documentation of disability, such as educational or medical records and reports, and adaptive testing, or contact information for obtaining these records; and
4. Consent to release information so DDA can contact medical, educational, and other professionals listed in the application.

a. When completing the application online, the release of information is included in the online application form.
b. When submitting a paper application, the applicant must attach the release of information form.

E. When DDA receives the application, they request documentation as indicated by the applicant. This may include, but is not limited to:

1. Medical records showing a diagnosis of developmental disability from a medical or mental health professional operating in their scope of practice:

   a. A licensed psychologist or a medical physician operating within the scope of their practice must diagnose a developmental disability (most school psychologists are not licensed psychologists);
   b. Family doctors, geneticists, and other medical professionals will know the types of diagnoses they can make.

2. School records showing the person's needs.

   a. School records may not be available through the school after a person has graduated or moved to another school district. Parents are encouraged to keep copies of school records.
   b. Records requested include, but are not limited to:

      i. The most recent Individual Education Plan (IEP), which shows the student's needs and what is/was being taught; and
      ii. All Multi-Disciplinary Team (MDT) assessments.

         (1) Schools must review MDT assessments every three years and either determine that the MDT is still accurate or complete a new one;
         (2) An MDT cannot serve as a diagnosis;
         (3) An MDT may show that needs exist in the three adaptive skill areas, conceptual, social, and practical, required by Neb. Rev. Stat. §83-1205.
         (4) MDTs give a history of needs and help show that needs will likely continue; and
         (5) An MDT may include an IQ score, which DDA considers in determining eligibility.

F. When an applicant is determined not eligible for services, they may reapply with updated information not submitted in the previous application.

G. When an applicant is determined not eligible and appeals the decision, they cannot submit a new application during the fair hearing process.

1. DDA does not consider an application for DD services submitted during the fair hearing process valid.
2. Only one application can be valid at any time, and DHHS does not close the original application until the fair hearing process is complete.

2.6 Process of Eligibility Determination

DDA makes eligibility determinations upon receipt of information. An applicant may correct information or submit additional information at any time before the date of decision.

A. When DDA receives an application, DDA assigns a member of the Eligibility and Enrollment team (E&E) to determine whether the applicant meets statutory and level of care eligibility requirements.

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

1. E&E will:

a. Verify the applicant meant to apply for DD services;

i. What is the need or service being sought (i.e., need someone to pay rent, electricity, or heating, which would not be something waiver can pay for)
ii. When the applicant did not intend to apply for DD services, they can withdraw their application by email, letter, or verbally.
iii. DDA does not send a notice of decision when an application is withdrawn.
iv. The applicant does not have to wait to reapply after an application is withdrawn.

b. Explain the DD eligibility process;

c. Determine if the applicant has applied for SSI, is currently receiving SSI, or has been denied SSI, when applicable;
d. Review the information on the application to ensure it is correct and complete, including who to contact for supporting documents; and
e. Verify that the person with the disability or their guardian signed the application.

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

C. E&E collects the following necessary documentation:

1. The release of information from the school, medical and behavioral practitioners, and others listed by the applicant.
2. The information about the applicant's disability diagnosis from the Social Security Administration, when necessary.

D. E&E determines whether the applicant meets statutory eligibility criteria as defined in state law and federal regulations, based on review of documentation received. For eligibility to be determined:

1. Documentation received supports the presence of a developmental disability diagnosis as well as the required skill limitations; and
2. The DDA Clinical Team may assist in determining eligibility by consulting about diagnoses, adaptive skills, or testing results.

E. E&E will then determine if the applicant meets the remaining eligibility criteria, including Medicaid eligibility and the Level of Care (LOC). They will complete the LOC assessment with the participant and others who are close to the participant, as needed.

F. When a participant meets statutory requirements and LOC, the participant will be assigned a Service Coordinator (SC) to help them set up their Person-Centered Plan (PCP) and select services.

2.7 Prioritization for Medicaid HCBS DD Services

The Medicaid HCBS DD Waivers provides entrance to all eligible people. Funding is authorized according to a participant's assessed need.

2.8 Waiver Participation Requirements

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

1. Receive services from only one Medicaid HCBS waiver at a time.
2. Not live in an institution.

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

3. Be age birth through 21 years for the Family Support Waiver.
4. Be age 21 years or older to be on the Medicaid HCBS DD Adult Day Services Waiver.
5. Use at least one Medicaid HCBS DD Waiver service every 90 days.

    a. This is not applicable for the Family Support Waiver (FSW).
    b. *FSW specifies the minimum frequency for the provision of the waiver service is one waiver service per 365 days.*

2.9 Determining Individual Budget Amount

There is not a budget determination for people on the Family Support Waiver. All participants have a budget of $10,000 per Neb. Rev. Stat. §68-1530.

When a person accepts Medicaid HCBS DD Waiver services on the CDD or DDAD waivers, their annual Individual Budget Amount (IBA) must be determined. The annual IBA is the amount of money the participant may use to purchase Medicaid HCBS DD Waiver services. This money cannot be given directly to the participant or used for other purposes, such as room and board or services available under other programs.

A. **Objective Assessment Process:** DDA uses the objective assessment process to determine the annual IBA. DDA completes the objective assessment process with assistance from the participant, family members, DD service providers, and other people who know the person well. This process ensures DDA bases the person's funding on their needs.
B. The objective assessment process includes completing the interRAI assessment.

1. DDA uses the interRAI-ID (adults aged 22 and older) or interRAI ChYMH-DD (ages 4 through 21) to assess the adaptive skill level and need for support. An Adolescent Supplement may be completed for youth aged 13 – 21 years.
2. The interRAI is completed:

    a. When a waiver offer is accepted;
    b. When there is a significant change in needs;
    c. Annually; and
    d. When requested by DDA Central Office.

3. DDA completes the interRAI with input from people who know the participant best.

    a. DHHS completes assessments in person with the participant, when possible.
    b. Supplemental information may be gathered from teachers, para-educators, family members, or DD providers.
    c. The people interviewed must:

i. Know the person being evaluated; and
ii. Sees the person being evaluated regularly throughout the week.

4. DDA staff reviews documentation, such as school records, program and behavioral data, medical records, incident reports, provider-completed assessments, and any previous interRAI assessments.
5. The interRAI score determines the annual IBA, which the participant uses to purchase Medicaid HCBS DD Waiver services.

2.10 Termination of Services

A. The participant, a provider, or DDA can end DD HCBS waiver services. There are different types of services that can be ended:

1. Medicaid HCBS DD waiver services with a specific provider; or
2. All Medicaid HCBS DD waiver services.

B. **Ending Service Coordination:** DDA may end service coordination, or the person receiving service coordination may choose to end the service.

1. The person may choose to end the service coordination service.

a. The person contacts their SC and says that they no longer want the service. The SC will complete a notice of decision and end the service.

2. DDA ends the service coordination service when:

a. The person loses Medicaid eligibility, and they do not want to pay the amount assessed as an ability to pay for services.
b. The Service Coordinator is unable to contact the person.
c. The person moves out of state.
d. A review of eligibility determines that the person is no longer eligible for DD services.
e. The person passes away.

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. **Ending Services with a Provider:** A participant may stop receiving Medicaid HCBS DD Waiver services from one provider but continue to receive waiver 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 tells their SC and the provider when they want to end services.
ii. A participant is encouraged to 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 60 calendar days before services end. The written notice must include the provider's reason for ending services.
ii. For participants receiving services at the risk rate, the provider must let the participant know in writing at least 90 calendar days before services end. The written notice must include the provider's reason for ending services.
iii. 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. Supports needed when a new provider begins.

3. The participant must fulfill any housing lease agreement they hold.
4. The provider must return the participant's personal funds and property.
5. The Service Coordinator ends the service authorization effective the date services end.

D. **Ending All DD Services:** When all services end, a person is no longer on a Medicaid HCBS DD Waiver.

1. The participant or DDA may end Medicaid HCBS DD Waiver services.

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

b. DDA ends services when:

i. The participant loses Medicaid eligibility.
ii. The participant has not used a Medicaid HCBS DD Waiver service during a consecutive 90-day period.
iii. The person moves out of state.
iv. A review of eligibility determines that the participant is no longer eligible for Medicaid HCBS DD Waiver services.
v. The PCP team was unable to develop a plan for services and supports that met the person's health and safety needs in a community-based setting.
vi. The participant passes away.

2. The SC calls the provider(s) to verify the participant/guardian has notified them of closure and to communicate the last day their service authorization(s) are effective.
3. DDA sends a notice of decision to the participant at least ten days before services end. When the person does not agree with the decision, they may appeal.

E. **Temporarily Ending Services:** A participant may temporarily stop receiving services for more than 90 days.

1. A participant may request to stay on a Medicaid HCBS DD Waiver when they live in one or more of the following places for more than 90 days:

    a. A medical or inpatient hospital;
    b. A nursing facility or rehabilitation center;
    c. Jail or prison; or
    d. The crisis stabilization unit at the Beatrice State Developmental Center.

2. A participant must base their request to stay on a Medicaid HCBS DD Waiver on critical health or safety concerns and other relevant factors. The DDA central office determines whether to approve or deny the request to stay on the waiver.

    a. When DDA approves the request, the participant will not have to reapply for waiver services.
    b. When DDA denies the request, the participant's waiver services end. They will have to reapply when they wish to receive waiver services in the future.

3. Participant Rights and Rights Restrictions

A person with a developmental 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 Disability and Aging or other state programs.

In the Policy Manual, "participant" means the person receiving Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) 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 with DD have a right to live, work, and do things with people who are not disabled; and
2. All people with DD have the same rights, dignity, and respect as members of society who are not disabled.

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, creed, 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 have access to information and records relating to the use of individual budget for services provided;
12. The right to access one's own residence;
13. Freedom of religion;
14. The right to form relationships and contact or communicate with anyone;
15. The right to receive mail that has not been opened and use the phone and the internet without monitoring;
16. The right to live independently in the community one chooses;
17. The right to be compensated at or above minimum wage for work in the same manner as a person who is not disabled;
18. The right to seek and maintain competitive integrated employment when one chooses;
19. The right to seek resolution of rights violations or quality of care issues without retaliation; and

20. 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 to exercise 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 to exercise 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.

F. A participant may have difficulty maintaining their safety due to physical disability, lack of skills or knowledge, or behavioral concerns. In these situations, it may be necessary to limit a participant's rights to address an identified risk.

1. A rights restriction is any support or practice limiting a participant's rights.
2. Rights cannot be restricted without due process.

    a. Due process is a review by a committee, team, government agency, legal system, or other entity with the authority to limit a person's rights.
    b. When a rights restriction is used by a DD provider at the direction of a participant's Person-Centered Plan (PCP) team, due process requires PCP team review and approval before using a restriction and:

        i. When an agency provider uses the restriction, the provider must obtain informed consent from the participant and approval from the provider's rights review committee.
        ii. When an independent provider uses the restriction, they do not need additional approval, as the participant hires the provider, and the provider cannot use a restriction that the participant has not approved.

3. A rights restriction, other than one used by a DD provider at the direction of the PCP team, requires a different due process. Examples of a rights restriction not directed by the PCP include, but are not limited to:

    a. Guardianship – A judge puts guardianship in place through a legal proceeding.
    b. Representative Payee – The Social Security Administration appoints a representative payee.
    c. A private business may place a restriction on a participant, such as prohibiting them from entering a store because the participant has stolen from the business in the past.
    d. An agency provider may make an agency-wide policy limiting the rights of the participants in their services, such as prohibiting smoking on provider property. The provider cannot direct a policy at any single person or group, and a participant may choose a different provider when they disagree with the policy. Agency-wide policies must be compliant with all applicable federal and state laws and regulations.

3.1 Rights Restrictions Implemented by DD Providers

This section is specific to rights restrictions implemented by DD providers at the direction of the PCP team. *This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.*

A. To the greatest extent possible, a participant's rights must not be restricted.
B. Rights restrictions can play a key role in supporting participants to be safe and should be used, when necessary, when all policy guidelines and regulations are followed.
C. The PCP team must ensure the restriction is allowable, based on the following limitations:

1. A rights restriction can only be used to address a real and immediate risk to the health or safety of the participant or others, or a risk of the participant committing a crime;

    a. A rights restriction cannot be used to prevent or reduce unwanted or socially inappropriate behavior which does not pose a real and immediate risk.
    b. A rights restriction cannot be used to impose the preferences, opinions, or values of the PCP team or provider when there is no real and immediate risk.

2. A rights restriction used for a participant cannot affect another participant in the same setting, to the greatest extent possible;

    a. It may not be possible to avoid using a rights restriction, which limits the rights of another participant. When this is necessary, the provider must make reasonable efforts to decrease the impact of the restriction on other participants.
    b. For example, when a participant living in a group setting needs the kitchen cabinets locked due to a safety risk, the provider could give keys to other participants in the setting so they may freely access the cabinets.

3. A rights restriction cannot be used as punishment or discipline;

    a. A participant's rights cannot be restricted for behavior,
    b. A provider cannot withhold a participant's personal property, personal funds, or activities a participant has a right to engage in to use them as reinforcement for desired behavior.

        i. A provider may use money, food, drink, or other items as reinforcements for a participant when the provider supplies or purchases them.

    c. A participant's rights cannot be restricted due to unsuccessful completion of or refusal to participate in habilitation programming, except when refusal to participate in habilitation programming results in a health or safety risk to the participant or others.
    d. Personal property, personal funds, or activities can be restricted when there is documented evidence that access to the money, items, or activities, such as playing video games instead of eating or participating in vocational services, poses a risk to the health and safety of the participant or others.

4. A provider cannot use a rights restriction for their convenience. A provider cannot use a restrictive intervention because it is easier for the provider or a provider employee or contractor than using a non-restrictive intervention to address the same risk.
5. A provider cannot use a rights restriction due to a shortage of provider employees or contractors. A participant's rights cannot be restricted to reduce the number of

employees or contractors required to meet the needs of all participants in a setting, including arrangements for temporary shortages.

6. A rights restriction may be used with a habilitation program, but cannot be used instead of a habilitation program;

    a. A habilitation program teaches skills to reduce the risk.
    b. A rights restriction addresses a risk but does not teach skills to reduce the risk.

7. A rights restriction cannot be used as part of a positive behavior support plan;

    a. A behavior support plan is a habilitation program to help a participant learn appropriate skills or behaviors to replace a problem behavior.
    b. A rights restriction addresses a risk but does not teach skills to reduce the risk.
    c. A safety plan must document the rights restriction. The rights restriction cannot be in the behavior support plan.

8. A provider cannot use a rights restriction when there is a less restrictive option to address the risk.

    a. A restriction can only be used when there is not a less restrictive or non-restrictive option to successfully address an identified risk.
    b. It may not always be necessary to prevent a behavior or incident completely to reduce the risk.

        i. Sometimes, a provider can use a less restrictive or non-restrictive support to reduce the risk when the behavior or incident occurs, rather than using a rights restriction to prevent the incident or behavior entirely.

9. There must be a plan for reducing or eliminating a restriction;
10. Before considering a rights restriction, there must be documentation of less restrictive options used, which were not successful; and
11. A rights restriction must be safe for the participant.

    a. A provider should not use a rights restriction when it is likely that the restriction may injure the participant.
    b. Some medical conditions may increase the risk of a rights restriction resulting in injury.

3.2 Person-Centered Plan Team Review of Restrictions

This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.

When developing the Person-Centered Plan (PCP), a participant's PCP team must ensure supports are in place to address the participant's identified risks. The PCP team must review all supports to determine if they restrict the participant's rights. When the PCP team approves a rights restriction, the Service Coordinator must document it in the PCP.

A. It is important to identify when an intervention is a rights restriction, so it can be regularly reviewed by the PCP team and by the agency provider's rights review committee. This helps to ensure the restriction is necessary and is the least restrictive option to address the identified risk.

1. A review is a safeguard to ensure a rights restriction is used in compliance with applicable state regulations, DHHS policy, agency provider policy, and Medicaid HCBS DD Waiver requirements.
2. PCP team review is especially important when an independent provider uses a restriction, as a rights review committee does not review a restriction used by an independent provider.

B. The participant's PCP team must review the rights restriction at least once a year at the PCP annual meeting.

C. The PCP team must discuss and document the following when reviewing a rights restriction:

1. A description of the rights restriction, including when and how it is used. The Service Coordinator must document specific details to ensure the provider only uses the rights restriction when needed, and there are clear instructions for how the provider should use the restriction. The PCP team should consider:

    a. Specific situations, times of day, and locations the provider uses the rights restriction. For example, used whenever the participant engages in a problem behavior, used only when attending day services, or used during hours of sleep.
    b. When should the provider start and stop using the rights restriction? For example, staff start using a restriction when the participant engages in physical aggression and stop using the restriction after 30 minutes of calm behavior.
    c. A back-up plan for when safety equipment, such as an alarm, a helmet, or a lock, is unavailable or not working properly. For some items, it may be appropriate for the PCP team to specify that back-up equipment is readily available so there is no gap in needed support.

2. The reason the rights restriction is used. The PCP team should consider:

    a. What is the risk addressed by the rights restriction?
    b. How does the rights restriction address the risk?
    c. A provider cannot use a rights restriction when there is no real and immediate risk, or the restriction does not directly address the risk. The PCP team must identify non-restrictive supports, such as a habilitation program or a different type of support.

3. What supports have been used before?

    a. The PCP team should review previous interventions and the effectiveness of those interventions.
    b. In most cases, there should be documentation of less restrictive supports, which were tried but not successful in addressing the risk. When the team has tried less restrictive supports, they should carefully review whether the rights restriction is the least restrictive option.
    c. The PCP team should consider all other options to ensure the participant's needs are being met with the least restrictive option possible.
    d. The provider cannot use a rights restriction when there is a less restrictive or non-restrictive support, which could effectively address the identified risk.
    e. When a less restrictive support is tried and not successful, the PCP team should document it to assist in future service planning.

4. What are the specific criteria for reducing a rights restriction?

a. The PCP team sets criteria to determine when reducing a rights restriction may be appropriate. For example, criteria may be no incidents of property destruction for six months or less than three falls in one year. The criteria must be measurable to allow the team to determine whether the participant has met it or not.
b. When the participant meets the criteria, the PCP team should consider a reduction. When the PCP team agrees that the rights restriction continues to be necessary, the Service Coordinator documents the reason, and the team sets new criteria.
c. A restriction may be needed long-term, such as restriction in place due to a medical need or ongoing mental illness. Criteria for reducing a rights restriction is always required, even when it is unlikely the participant will meet the criteria to reduce the restriction.
d. A rights restriction for psychotropic medication requires a plan for reduction, even though the prescribing physician makes the decision to reduce medication. When the PCP team's criteria are met or the PCP team is concerned that the medication has a negative impact on the participant's quality of life, the PCP team can:

    i. Recommend to the prescribing physician to reduce medications; or
    ii. Refer the participant to another physician for a second opinion.

5. For a rights restriction, there must be habilitation or support to help the participant gain skills to reduce the identified risk and need for the rights restriction.

    a. When a rights restriction addresses a risk caused by problem behavior, there must be a behavior support plan developed using a behavioral assessment to help the participant gain skills to reduce the problem behavior.
    b. When a restriction is in place to address a risk related to a medical condition or physical disability, supports may include therapies, exercise plans, or other medical or therapeutic supports.
    c. When a restriction is related to adaptive skills, such as unsafe eating habits, the plan should include a habilitation program to teach adaptive skills to reduce the rights restriction.

3.3 Informed Consent for Rights Restrictions

This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.

An agency provider must obtain written informed consent from the participant to use a rights restriction.

A. When requesting consent, the person giving consent must be fully informed of what the restriction is and the risks and benefits of the restriction.

    1. It is important to describe the benefits and potential negative effects of the restriction so the participant or legal guardian can decide if the benefits of the restriction outweigh the risks before giving consent.
    2. Both the participant and their legal guardian must approve of the restriction.
    3. The following information is provided to the participant:

a. A complete description of the proposed rights restriction, including what it is, and how and when it will be used;
b. The reason for the restriction, including how the rights restriction addresses the identified risk. The benefit of using the restriction is summarized as part of the reason; and
c. The potential negative effects of the rights restriction, such as side effects of medication, risks of injury or discomfort, and the limitation to the participant's rights and freedoms.

B. When a restriction must be implemented immediately to maintain the participant's safety and it is not possible to receive written informed consent before using the restriction, a provider must:

1. Verbally give the same information as in a written consent;
2. Document verbal consent; and
3. Obtain written informed consent as soon as possible.

3.4 Agency Provider Human and Legal Rights Review Committee

This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.

A human and legal rights review committee HLRC is responsible for protecting participant rights by monitoring agency provider practices. An HLRC is important to ensure participant rights are not limited or restricted without an appropriate reason and due process.

A. HLR committee members must be familiar with people with disabilities and have relevant professional or personal experience, which contributes to their role as an HLR committee member. HLR committees should include people with knowledge, experience, or education in:

1. Current practices and techniques to address problem behavior;
2. Mental disorders, psychotropic medications, or medical considerations; and
3. Participant legal, human, and civil rights, what is a rights restriction, and state statutes and regulations, which outline prohibited practices, and how rights may be restricted.

B. Agency provider training for all committee members must include the following topics:

1. The legal, human, and civil rights of people with DD;
2. What constitutes a rights restriction;
3. Due process for restricting participants' rights; and
4. All state regulations, statutes, DHHS policies, and Medicaid HCBS DD Waiver requirements relevant to rights, restrictions, restraints, abuse, neglect, exploitation, and psychotropic medication use.

C. The following information must be provided to the rights review committee when they are reviewing a rights restriction, so they can make an informed decision:

1. A description of the rights restriction, including when and how it will be used;

a. This includes specific information about the use of the rights restriction so the committee can be sure the provider only uses the restriction correctly and when necessary.
b. When the description of the rights restriction and its use is unclear, the committee should not approve the restriction.

2. The reason for the rights restriction, including the identified risk being addressed and how the rights restriction addresses the risk;

    a. The committee makes sure the identified risk is a real and immediate risk as defined in this chapter, and the rights restriction reduces the risk.
    b. When the risk does not justify a rights restriction or the rights restriction does not actually address the risk, the committee should not approve the restriction.

3. A summary of what has been tried before to address the identified risk;

    a. There must be documentation of how the PCP team tried to address the risk with non-restrictive or less restrictive support, which was unsuccessful.
    b. When the team has not used other supports or strategies, the rights review committee must consider if it is appropriate for the rights restriction to be approved when the PCP team has not tried less restrictive supports.

        i. The committee may recommend the PCP team consider less restrictive support before they approve the restriction.

4. A summary of the benefits and potential negative effects of the rights restriction;

    a. Potential negative effects of a rights restriction can include, but are not limited to:

        i. Side effects of medications;
        ii. Risk of discomfort or injury;
        iii. Disruption to the participant's life;
        iv. Limiting the participant's privacy;
        v. Decreasing the participant's quality of life;
        vi. Limiting the participant's freedom; or
        vii. Limiting the participant's integration in the community.

    b. The review committee determines whether the benefit of the rights restriction outweighs the potential adverse effects.
    c. The risk addressed by the rights restriction should be serious enough to justify the rights restriction and any potential negative effects.

5. Habilitation programs and other supports to reduce the need for the rights restriction;

    a. When a rights restriction is in place, a habilitation program, behavior support plan, or other supports must be implemented to mitigate the risk, which necessitates the restriction.
    b. When there is no habilitation program or other support, the rights restriction cannot be approved.

6. Criteria set by the PCP team for reducing the rights restriction:

    a. The committee reviews the criteria and the participant's progress towards meeting the criteria.
    b. When there are no specific, measurable criteria for reduction set by the PCP team, the rights restriction cannot be approved.
    c. When the participant has met the criteria, but the PCP team decided to not reduce the rights restriction, the provider should give the rights review committee the reason for the decision and the new criteria for reduction set by the team.

7. PCP team approval for the rights restriction before use and annually thereafter, as documented in the PCP;
8. Written informed consent from the participant for the rights restriction;
9. At least six months of any relevant supporting documentation, including, but not limited to:

    a. Incident reports, daily logs, and other information showing the need for the restriction;
    b. Habilitation program data, when available;

        i. When the rights restriction addresses behavioral risk, the habilitation program data comes from the behavior support plan.
        ii. When the rights restriction addresses risk related to adaptive skills, the habilitation program data comes from the program teaching the adaptive skills.
        iii. When a habilitation program has not been in place for six months, the rights review committee must review all available data.

    c. Physician contact forms for a restriction related to psychotropic medication or medical needs; and
    d. The safety plan, which includes the rights restriction.

10. Within 10 business days of the HLRC meeting, providers will enter the meeting information in Therap in a case note questionnaire titled “Human and Legal Rights Committee.”

D. When reviewing psychotropic medications, HLRC cannot make decisions about what medications and doses the physician prescribes.

1. The rights review committee should review restrictive psychotropic medication using the same criteria as any other restriction.
2. When the rights review committee decides medications prescribed are excessive or inappropriate, the committee can request a referral to the prescribing physician for review of the participant’s medications or to another medical professional for a second opinion.

E. HLR committees will review restrictions annually and review psychotropic medications semi-annually.

F. When there is a concern with compliance with policy and regulations or case notes submitted with missing information, the case is referred to DDA Quality for further review.

1. Liberty Healthcare may refer cases after its review to the Human and Legal Rights Advisory Committee (HLRAC). Cases may be referred to the HLRAC when:

    a. Non-medication restrictions in place for five years or longer with little to no change;
    b. There are five or more restrictions in place;
    c. The reduction plan requires more than six months for measurable criteria and/or zero target behavior occurrence;
    d. Documentation of previously tried methods before implementing the restriction has three or fewer alternative methods listed; or
    e. The supports in place are not teaching the skills to reduce the restriction.

2. PCP teams can make referrals to the HLRAC for review and recommendations on how to best support a participant and reduce the use of restrictions over time. These are submitted via Therap SComm to "HLRCReferrals."

3.5 Safety Plans

This section is only used to record risks related to health conditions on the Family Support Waiver because rights restrictions are not permitted.

A safety plan addresses any identified risks, including those related to health conditions, and makes sure those who provide direct support know the participant's risks and supports. A safety plan is not a habilitation program, habilitative data is not collected, and a provider cannot use it in place of a habilitation program. When a provider uses a rights restriction to address an identified risk, they must develop a safety plan. Safety plans are to be reviewed and updated annually.

A. A safety plan must include:

1. A summary of all identified risks for the participant, including those not addressed with rights restrictions, including any known triggers or warning signs;
2. A detailed description of all supports, strategies, and equipment used to address the identified risks, including any rights restrictions and non-restrictive supports;
3. A description of supervision needs, including alone time both within and outside the residence; and
4. Specific instructions for when and how the provider uses all supports, strategies, and equipment, including descriptions of when the use of a rights restriction starts and ends.

B. The safety plan must match the PCP team's decisions about needed supports, including when and how the provider utilizes a rights restriction.

C. When the PCP team determines a participant needs a safety plan, the provider is responsible for developing the safety plan. The safety plan cannot include a support or rights restriction not agreed upon and approved by the PCP team and HRLC.

3.6 Habilitation Programs and Behavior Support Plans

A behavioral support plan can be used without rights restrictions.

When a rights restriction is used, the PCP team must take steps to reduce the need for the restriction over time. It is not acceptable to use a rights restriction to address a risk without helping the participant gain skills needed to reduce or eliminate the rights restriction.

A. When a participant has a rights restriction to address a lack of adaptive skills, there must be a habilitation program to teach the skills needed to reduce or eliminate the rights restriction.

B. When a participant has a rights restriction to address a risk related to a problem behavior, there must be a behavior support plan to teach the participant the skills needed to reduce or eliminate the rights restriction.

1. A behavior support plan must be based on a behavior assessment completed by a Licensed Psychologist, Licensed Independent Mental Health Practitioner (LIMHP), Advanced Practice Registered Nurse (APRN), or a Board-Certified Behavior Analyst (BCBA).
2. The behavioral assessment is the assessment and baseline used to develop the behavior support plan.

3.7 Psychotropic Medication

A psychotropic medication is a medication that alters brain function, resulting in changes to a person's perception, mood, consciousness, or behavior. Use of psychotropic medication may be a rights restriction. DDA does not consider vitamins and supplements, such as melatonin or St. John's Wort, to be psychotropic medications. Over-the-counter medication may be a psychotropic medication when the medication has a similar purpose or effect as prescription psychotropic medication, such as Benadryl used as a sleep aid.

A. A psychotropic medication should only be used:

1. As prescribed by a medical professional acting within their scope of practice; and
2. When there is documentation that the PCP team attempted other supports, which were not successful, to address the participant's needs, unless a physician prescribes the medication for treatment of a diagnosed mental health condition.

B. When a physician prescribes a psychotropic medication to address a current problem behavior, there must be a behavior support plan.

1. When a participant uses psychotropic medication, but does not have any current problem behaviors, the participant does not need a behavior support plan.
2. When a participant demonstrated problem behavior in the past, the PCP team must decide how long the participant must go without the identified behavior to consider it no longer requires a behavior support plan, based on the participant's history and the risk presented by the behavior.

C. A provider must not use psychotropic medication to deal with understaffing, ineffective or inappropriate supports, or environments.

D. The participant's PCP team must review all use of psychotropic medication at least once a year unless it is a rights restriction. The PCP team must review:

1. Benefits of the psychotropic medication and any side effects or other negative effects the participant experiences to determine if the benefits outweigh the negative effects; and
2. Whether the psychotropic medication is a rights restriction, based on how the psychotropic medication is administered as defined in the Medicaid HCBS DD Waivers:

    a. When self-administered by the participant, administered by an unpaid caregiver, or administered by an independent provider, it is not a rights restriction.
    b. When administered by an employee or contractor of an agency provider, the PCP team must review documentation from the prescribing physician to determine if the psychotropic medication is restrictive.
    c. When documentation from the prescribing physician meets all the following criteria, the medication is not a rights restriction:

        (1) Documentation includes the name of the psychotropic medication and the prescribed dosage;
        (2) Documentation includes a diagnosis of a clinically recognized medical condition or mental disorder being treated by the prescribed medication;
        (3) Documentation includes the reason for prescribing the medication, aside from the diagnosis, such as a description of symptoms treated; and

(4) Documentation includes any changes to the medication or dosage, or documents that the physician made no changes at the time of the medication review.

d. When documentation from the prescribing physician is not available for PCP team review, or available documentation does not meet the required criteria, the psychotropic medication is a rights restriction. The person or entity assigned responsibility for the participant's medical care is responsible for obtaining the required documentation and making it available to the PCP team.

i. The PCP team must use documentation from the prescribing physician to determine if a medication is a rights restriction.
ii. Documentation from other medical providers, medication administration records, or other sources does not meet the required criteria.

E. The PCP team reviews prescribed PRN (as needed) psychotropic medications using the same criteria as all other psychotropic medications. Additional requirements for use of PRN psychotropic medication include:

1. A provider must only give PRN psychotropic medications as prescribed and as a last resort when all other supports in the participant's plan have been exhausted.
2. Each time a PRN psychotropic medication is given, the provider must submit an incident report to DDA.
3. Each time a PRN psychotropic medication is given, it must be reviewed by the PCP team;

a. When the provider gives the PRN medication more than once per week, the PCP team must review the first administration of the PRN medication and the ongoing use of the medication.
b. The PCP team must discuss: If the PRN psychotropic medication was administered as prescribed;

i. If administration of the PRN psychotropic medication was necessary and used as a last resort;
ii. If the supports in the participant's PCP are appropriate to meet their needs, or if changes or additional supports are needed to reduce the need for use of the PRN psychotropic medication in the future.

c. The PCP must document each review.

4. The Service Coordinator may refer the use of PRN psychotropic medication to the DDA clinical team for review and recommendations, as documented in the PCP, based on frequency of administration.

F. When a psychotropic medication is a rights restriction, all requirements for a rights restriction must be met.

3.8 Emergency Safety Intervention

This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.

There may be a time when the provider must physically intervene to prevent or reduce the risk of serious harm to the participant or others. This is known as an emergency safety intervention (ESI) and

may be used when a participant's identified risks escalate to the point that the participant's routine supports cannot maintain safety.

A. An emergency safety intervention is the use of physical restraint or separation as an immediate response to an emergency safety situation. Immediate response means being available within moments to assist the participant.

   1. Physical restraint is any physical hold that restricts or is meant to restrict the movement of a participant.
   2. Separation is the use of physical contact to separate a participant from another person, a situation triggering unsafe behavior, or a dangerous situation. DDA permits separation when it does not meet the definition of seclusion in state regulation.

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

   3. An emergency safety intervention may happen when a situation places the participant or others at significant risk of serious or life-threatening harm.

B. A provider can only use ESI after all other interventions they tried were unsuccessful.

   1. When possible, staff must use all other supports specified in the participant's PCP, safety plan, and behavior support plan to address the emergency safety situation.
   2. There may be a situation when there is insufficient time to use other supports, and it is necessary to use ESI immediately to prevent serious or life-threatening harm. When this occurs, the provider must clearly describe the situation in an incident report.

C. An agency provider's policies and procedures must define DDA-approved intervention procedures and how the provider monitors use of emergency safety interventions (ESI).

   1. Providers must use The Mandt System – Relational + Conceptual + Technical level for use with all ESI.
   2. Current providers must train and maintain certification of staff in The Mandt System – Relational + Conceptual + Technical level.
   3. Agency provider staff receive training in approved safety interventions and positive behavior support techniques.

D. The provider must report all use of ESI to DDA in an incident report.

E. The participant's PCP team and agency provider HLR committee must review all use of ESIs as a rights restriction.

   1. For a participant who requires the use of an ESI on a frequent basis, the PCP team may decide to make an ESI an approved part of the participant's safety plan.

      a. When an ESI is an approved part of the participant's safety plan, this does not give team approval for use of an ESI in situations where they did not try other interventions, or the ESI is not an emergency safety situation.
      b. The PCP team determines whether the frequency of ESI use justifies including it in the safety plan. ESI should only be included in the safety plan when an ESI happens frequently.
      c. The PCP team must document use of an ESI in the participant's PCP, and the provider must list it in the safety plan as a rights restriction.
      d. When the participant receives services from an agency provider, the provider's rights review committee must review and approve the rights restriction.

e. When the use of an ESI is included in the participant's PCP as a rights restriction, it is not required for the PCP team to review each use of an ESI. The team reviews the rights restriction and all use of ESIs at least annually.

f. The provider must report each use of an ESI to DDA in an incident report.

i. The ESI must be reviewed through the incident reporting process.

ii. When a concern is identified during the incident reporting process, it may be necessary for the PCP team to review the incident.

g. When ESI is used by an agency provider, each instance must be reviewed by the rights review committee.

2. When ESI is not an approved part of the participant's safety plan:

a. The PCP team must review any use of an ESI.

i. The PCP team must discuss whether the ESI was necessary and used as a last resort.

ii. The PCP team reviews the participant's PCP to determine if changes or additional supports are needed to reduce the risk, which led to the use of an ESI.

iii. The Service Coordinator documents this review in the PCP.

b. The agency provider's rights review committee must review any use of an emergency safety intervention by provider staff.

3.9 Prohibited Practices

The Division of Disability and Aging(DDA) prohibits the use of some interventions because these interventions excessively restrict the rights of the participant and increase the risk of negative outcomes. DDA may only approve the use of a prohibited practice through the alternative compliance process. A provider must report unauthorized use of a prohibited practice to DDA in an incident report. *Prohibited Practices are not used with the Family Support Waiver because alternative compliance is not permitted.*

A. Use of the following practices are prohibited during Medicaid HCBS DD 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.

2. Safety equipment, which is not a mechanical restraint, may still be a rights restriction.

a. For example, a physician orders a lap belt in a participant's wheelchair to prevent the participant from falling out of the wheelchair when having a seizure. When the participant can stand independently, but the lap belt prevents them from standing to exit their wheelchair, the use of the lap belt is a rights restriction.

i. This is not a mechanical restraint because it is safety equipment ordered by a doctor.
ii. This is a rights restriction because it limits the participant's voluntary movement.

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.

3.10 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. Possible 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 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. 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 E: Contacts and Resources*.

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

D. Possible 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

3.11 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 DD Waiver services is assigned;
5. A determination is made that the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care is not required;
6. A determination that services are not required;
7. The participant disagrees with DD Waiver placement;
8. A claim for benefits or services is denied; or
9. 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 DD 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 DD 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 DDA mails 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.

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 DDA mails 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 Policy Manual Appendix E.*

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

1. DDA assigns the request to a staff person. The assigned person:

   a. Notifies the person that their request for a fair hearing was received;
   b. Verifies the address and telephone number of the person making the request;
   c. Makes sure the person requesting the fair hearing has the right to appeal, and verifies the guardianship status, when the participant has a guardian;
   d. Ensures the request for a fair hearing is complete and submitted within 90 days;
   e. Gathers relevant documentation to be used as evidence in the fair hearing; and
   f. Submits the request and supporting documents to DHHS Legal.

2. DHHS Legal sends the request for a fair hearing and supporting documents 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, time, and location for the hearing and attempts to arrange a time and place that is convenient for all parties.
5. DHHS Legal and assigned DDA staff prepare evidence for the hearing.
6. Supporting documents to be used as evidence are delivered to the person requesting the fair hearing at least five business days before the hearing. The person requesting the fair hearing must also provide to the hearing office and DHHS Legal any documentary evidence she/he wants the Hearing Officer to consider 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.

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 persuading 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 DD;
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 to each party by certified mail.

4. Service Coordination

For people on a Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver, a Service Coordinator will perform case management functions. DD Service Coordination 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 PCP. Service coordination does not involve providing direct services, such as transportation, or finding a home or job. The Service Coordinator ensures there is no duplication of services, no improper influence by providers of Medicaid HCBS DD 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. A DD Service Coordinator (SC) works with each participant to:

1. Provide information on services available through Medicaid HCBS DD Waivers;
2. Develop the participant's service plan, known as the Person-Centered Plan (PCP), which is based on the participant's personal life goals and their needs;
3. Monitor the implementation of the participant's PCP;
4. Complete referrals for preferred providers and arrange site visits and transition plans;
5. Start the process to enroll any preferred independent providers.
6. 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;
7. Attend the individual educational plan (IEP) meeting for students, and receive a copy of the document;
8. Determine whether the participant's needs are being met; and
9. 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 where the participant lives. 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 E&E Unit makes a referral to service coordination.
3. When an SC is not available due to illness, vacation, or job vacancy, the Service Coordination Supervisor 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 DD Waiver program, available services, and providers.

    a. Per federal regulation, DDA must inform a participant they have the right to choose between services provided in an ICF/IID or Medicaid HCBS Waiver services.
    b. A participant also has the right to choose which Medicaid HCBS DD Waiver services they receive 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 DD agency providers available in the participant's area; and
        ii. Information about self-direction and working with independent providers.

    c. When requested by the participant, the SC will assist with scheduling appointments, completing paperwork, or accompanying them to appointments.

2. When a participant has chosen the Medicaid HCBS DD Waiver services they want to receive, the SC assists the participant to begin 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. Completes an electronic referral to the agency providers chosen by the participant; and
        ii. May assist with setting up tours, contacting potential providers, and facilitating conversations with potential providers in the participant's preferred location.

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

        i. Discusses responsibilities of self-direction, including finding, interviewing, hiring, training, scheduling, supervising, monitoring, and dismissing independent providers; and
        ii. Starts the process for Medicaid provider enrollment for potential providers chosen by the participant.

D. **Service Monitoring:** The SC is responsible for monitoring the provision of Medicaid HCBS DD 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; and
    d. 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 habilitation program data;
e. Review of provider attendance and billing;
f. Review of the participant's annual individual budget amount (IBA) and service authorizations; and
g. Conducting service reviews.

3. The SC formally reviews services across all environments by completing service reviews, which are conducted unannounced.

   a. The review looks at services in the PCP to ensure the provider implements habilitation programs, delivers other supports as outlined, and identifies when revisions may be needed.
   b. The SC makes sure all the participant's needs are being met, offers feedback to providers, and may require follow-up from the provider(s).
   c. During the service review, the SC:

      i. Reviews participant records, such as program data, financial records, safety plans, incident reports, and medication records;
      ii. Observes services being provided, such as implementation of habilitation programs and interactions between agency provider staff and the participant;
      iii. Observes the physical environment to ensure it is clean and free of safety hazards;
      iv. Discusses habilitation program progress and potential changes needed to the PCP with the provider and participant;
      v. Talks with the provider about how things are going; and
      vi. Talks with the participant about how things are going and if they are happy with their services.

   d. Service reviews are unscheduled visits that occur in the setting where services are provided, when the participant is present and when services are being provided.
   e. The SC completes service reviews at least once per quarter for day and residential services when the participant receives both day and residential services.
   f. Additional service reviews may be completed at any time for reasons such as:

      i. The participant moves to a different residence;
      ii. Report of suspected abuse and neglect;
      iii. At the request of the participant, guardian, or parent;
      iv. Follow-up to previous monitoring;
      v. Concern about the number or type of incident reports;
      vi. Health and safety concerns; or
      vii. Complaints made to DHHS.

   g. When an immediate safety concern is observed:

      i. The SC will notify the participant and guardian, and appropriate people, such as agency provider administration;
      ii. The SC will not leave the participant in an unsafe situation; and
      iii. When necessary, the SC will call the Adult Protective Services Abuse and Neglect Hotline at 1-800-652-1999 or local law enforcement.

h. The SC documents service reviews on the service review form.

i. The participant and provider receive a copy of the form; and
ii. The form indicates if follow-up is needed by the provider.

(1) The form lists timelines for follow-up.
(2) When concerns are not resolved, DDA Central Office may notify DHHS Division of Public Health or the DDA Quality Team.

4. The SC completes monthly contacts with each participant to talk about how services are working for the participant, and if the participant has any unmet needs. The SC may also contact other team members on behalf of the participant.

a. Examples of contacts include, but are not limited to:

i. Face-to-face visits;
ii. Communicating with the participant and other team members by phone calls, the state-mandated web-based case management system, emails, and letters about services the participant is using or needs;
iii. Team meetings and service reviews; and
iv. Communicating with staff from other programs, such as Vocational Rehabilitation and Medicaid.

b. The SC documents all contacts made with the participant and others in case notes.
c. For the Family Support Waiver, when services are not delivered monthly, monitoring of health and welfare needs to be included in the monthly contacts.

E. **Budgeting and Service Authorizations:** The SC is responsible for ensuring a participant's annual individual budget amount (IBA) is managed correctly.

1. The SC discusses available services and costs with the participant and assists the participant in choosing services, which the participant can purchase with their annual IBA.
2. The SC completes service authorizations to assign funding to DD providers chosen by the participant.
3. The SC tracks the use of the participant's IBA during the PCP year to ensure:

a. Use of services matches the assigned funding;
b. The participant has enough funding to last all year;
c. The participant is receiving the services they need; and
d. The SC updates the participant's PCP as needed to meet the participant's needs while staying within their IBA.

4. When the participant has a monthly share of cost for their Medicaid benefits, the share of cost amount is typically obligated to the participant's Medicaid HCBS DD Waiver services. This could include the Medicaid DD provider(s). When the participant chooses to obligate their share of cost to the DD services, the following process should be followed:

a. The PCP team discusses which provider is responsible for collecting the share of cost from the participant when there is more than one DD provider.

b. When the amount paid for one provider's services is less than the participant's share of cost, the share of cost 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, the participants' share of cost, and the total amount withheld from the providers' payments.
e. DDA pays the provider for services billed minus the participant's share of cost.
f. The provider must bill the participant for the share of cost portion of payment, and the participant is responsible for paying the share of cost 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) Developmental Disabilities (DD) Waiver services. Person-Centered Plan (PCP) is an individualized plan based on the participant's unique preferences, assessments, and habilitation 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 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, 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 needs of the participant and the services and supports required to meet those needs. 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; and
11. Empowers the participant to design their PCP with the support of the PCP team.

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 the age of the participant:

    a. Use language matching the participant's age and understanding;
    b. Encourage age-appropriate activities, hobbies, and interests while respecting their preferences. For example:

        i. A participant who enjoys coloring may be offered an adult coloring book.
        ii. A participant who likes toys may display them as a collection instead of having a toy box.

    c. Accept the participant's right to make age-appropriate choices (such as smoking, drinking alcohol, and relationships); and
    d. Make sure the environment where the participant lives and works are age-appropriate while reflecting the participant's personality (such as décor and furnishings).

5. 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 home, or apartment).

6. 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.

7. 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.

8. Understand and advocate for the participant's rights.

a. The participant may need assistance to understand and exercise their rights.
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 wellbeing.

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 to address the participant's medical, behavioral, and adaptive needs.
b. Team members sharing 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 Medicaid Home and Community-Based Services (HCBS) DD Waiver services and who they wish to provide these services.

1. There are two types of providers of Medicaid HCBS DD Waiver services:

a. A DD agency provider:

i. A company enrolled as a Medicaid provider;
ii. Certified by DHHS to provide developmental disability services; and
iii. Responsible for hiring and supervising employees or contractors who work with the participant.

b. A DD independent provider:

i. A person or a vendor enrolled as a Medicaid provider; and

ii. Hired and supervised by the participant. When a participant chooses an independent provider, they are self-directing services.

c. Each Medicaid HCBS DD 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.
d. Self-directed services give a participant more control but also include more responsibility. Some services cannot be self-directed because only agency providers can offer them.
e. A participant may have both independent and agency providers and can choose to self-direct some services and have agency providers manage others.
f. The PCP includes exploring what could help the participant be more independent and if they would like to self-direct any services.

5.2 Funding Tiers

Some services incorporate a tiered rate structure to compensate providers based on the acuity of the participant. The following services have tiered rates: Day Supports, Community Integration, Child Day Habilitation, Continuous Home, Host Home, Shared Living, and Youth Continuous Home. Reimbursement for these services is tiered based on the participant's Case Mix Index (CMI) score, as developed through the interRAI assessment framework.

CMI scores are derived from case-mix groupings generated through interRAI assessments. Case-mix systems classify individuals into groups with similar support needs and expected resource utilization, promoting consistent and equitable allocation of funding. A CMI of 1.0 represents the average cost to serve a participant; values below 1.0 indicate lower-than-average cost, while values above 1.0 indicate higher-than-average cost.

For funding alignment, Nebraska applies CMI ranges to the Basic, Intermediate, High, and Advanced tiers across waivers. The children and youth budget system utilizes Child and Youth Resource Index (ChYRI) groupings, while the adult budget system utilizes Case-Mix Groups for Developmental Disabilities (CMGDD) groupings. Participants of all ages use the same CMI ranges for alignment to funding tiers.

The four funding tiers representing CMI scoring bands from the lowest CMI to highest CMI scores are: Basic Tier, Intermediate Tier, High Tier, and Advanced Tier. The level of supports differ between tiers and service options at each tier are available to support participants. The Clinical Support Team may provide a funding tier exception of Risk for individuals with high supervision and support needs based on behavioral or medical complexities.

Nebraska Funding Tier	Child/Youth ChYMH Groups	Adult Group Number	CMI Range
Basic	E	1-4	0.45-0.75
Intermediate	G, F	5-20	0.76-1.23
High	D, H, A	21-29	1.24-1.50
Advanced	B, C	30-33	1.51-2.01
Risk	Clinical Exception	Clinical Exception	Clinical Exception

Advanced Tier individuals typically require 1:1 supervision for safety as required by the PCP. Individuals at the Risk always require 1:1 but may require additional intermittent supervision for safety as required by the PCP.

5.3 Exception Process for Funding

This section is not applicable to the Family Support Waiver because the annual budget is capped at $10,000.

When the PCP team determines the participant's needs cannot be safely met with the amount of services, that can be purchased within their annual individual budget (IBA) amount, the team can request additional funds with an exception. The amount of exception funding is for the cost of additional services to meet the participant's needs.

A. When the increased needs are likely to be long-term, DDA may complete a new interRAI assessment, instead of considering exception funding.

B. When the participant's team determines that exception funding is needed, the team must:

1. Consider other resources, such as consultation with the primary care provider or clinical providers, other Medicaid services, other DHHS program resources, or natural supports, which could meet the participant's increased needs. All other resources must be exhausted before the use of Medicaid HCBS DD Waiver exception funding;
2. Review the most recent interRAI assessment. When the most recent interRAI assessment does not reflect the participant's current needs, the team will discuss if a new interRAI assessment is needed;
3. Identify what services and supports are needed that may require exception funding, such as additional staffing or additional or awake overnight staffing; and
4. Ensure the supporting documentation is inputted into Therap with the Request for Exception to the Individual Budget Amount (Request for Exception to the IBA) form. Supporting documentation may include:

    a. Records from the last 90 days, such as a nursing plan, health plan, safety plan, behavioral assessment, incident reports, medication records, or habilitative program data.
    b. Clinical documentation, such as assessments from medical or behavioral health providers.

5. The Service Coordinator completes the Request for Exception to the IBA form, which includes the reason for the request.

    a. The Service Coordinator completes Part 1 with information from the PCP team and sends the form to the provider.
    b. The provider verifies that Part 1 is accurate based on the PCP team discussion, completes Part 2, and attaches the identified documentation according to the instructions on the form.

6. When an exception request is approved:

    a. DDA distributes the Request for Exception to the IBA form to the Service Coordinator and Provider, which includes an explanation of the decision and any recommendations made by DDA, to the PCP team. This consists of the duration of the approval, the approved rate, and expectations for the provider.
    b. DDA sends a notice of decision to the participant.
    c. After DDA makes the exception decision, the PCP team should meet to discuss the decision and any recommendations.

        i. The team must decide how to follow the recommendations.

ii. The provider must follow the decision made by DDA.

7. When an exception request is denied:

   a. DDA gives the Service Coordinator and PCP team "A Request for Exception to the IBA" form, which includes an explanation of the decision and any recommendations made by DDA.
   b. DDA sends a notice of decision, with appeal information, to the participant.
   c. The team meets to discuss the explanation of the decision and any recommendations made by the DDA clinical team.

5.4 Documentation in the Person-Centered Plan

Description of what the participant's PCP must contain.

A. What is important to the participant, including:

   1. Good things or achievements from the past year;
   2. Their personal goals;
   3. Their interests, likes, and dislikes;
   4. The participant's desired level of community integration and activities that are important to the participant; and
   5. How they learn and communicate;

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

   1. All Medicaid HCBS DD Waiver services, including services provided virtually, and all non-waiver services;
   2. The specific providers who work with the participant; and
   3. The general weekly schedule for each service and provider;

C. Plans to address the participant's identified risks, which may include:

   1. A safety plan;
   2. A behavior support plan;
   3. A seizure protocol;
   4. Another type of plan or protocol addressing a specific risk;
   5. The participant's supervision needs; and
   6. Any rights restrictions implemented at the direction of the team;

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. Psychotropic medication prescribed;
   5. Physicians and therapists treating the participant;
   6. When the participant was last seen by their physicians and therapists, and
   7. Who is responsible for the participant's medical care.

E. The participant's habilitation programs for the upcoming year and the assessments that the programs are based on, including:

   1. Habilitation goals;
   2. Baseline information used to develop the current habilitation program;

3. The needs being addressed by the habilitation programs; and
4. A summary of progress on the previous year's programs;

F. The participant's finances, including:

1. How the participant accesses their money;
2. The participant's needs in managing their money;
3. Any support the participant receives from a provider in managing their money;
4. The payee, when the participant has one, and
5. When there is a Medicaid share of cost.

G. The participant's day services and employment, including:

1. The participant's current employment or day services activities;
2. How things are going with current services;
3. Plans and objectives for any supported employment services;
4. The participant's involvement in vocational rehabilitation services; and
5. A back-up plan for times when the participant's provider is not available.

H. The participant's residential services, including:

1. Where the participant lives and what services they receive;
2. How things are going with the current services; and
3. A back-up plan for times when the participant's provider is not available.

5.5 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. DD 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. DD agency and independent providers who work with the participant; and
4. The participant's guardian, when there is one.

C. The PCP team holds 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 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.

5.6 Individual Family Meeting

The individual family meeting (IFM) is held prior to the start of a new PCP year. The SC contacts the participant to discuss the new PCP year. This allows the participant to direct the PCP process.

A. The IFM is a conversation with the participant about how things are going, things they enjoy, things they may want to change, and what their hope is for the future.
B. The IFM can be a phone call or in-person.
C. The guardian, family, or other people chosen by the participant may provide information.
D. The SC discusses available types of Medicaid HCBS DD Waiver services and providers and may provide informational handouts.
E. The SC, participant, guardian, and family discuss the amount of money the participant can spend for Medicaid HCBS DD Waiver services IBA.
F. The SC contacts the provider and other team members when someone expresses a concern or other feedback is given before the PCP meeting.
G. The SC obtains signatures for the release of information and the Notice of Rights and Obligations. When a participant has more than one guardian, best practice is to have each guardian sign the documents.

5.7 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 to achieve their plan and personal goals.

A. The annual PCP meeting will be held 30-60 calendar days before the start of a new PCP year. The Service Coordinator schedules and organizes the meeting on behalf of the participant.
B. DDA expects the participant to attend their meeting. Team members should make every effort to make this happen.

    1. When the participant chooses not to attend, the team assigns a member to review the PCP with them after the meeting.
    2. Team members encourage the participant to come to future meetings.
    3. The PCP documents the reason the participant chose not to attend, and the team member assigned to review the information.

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;
        e. Likes and dislikes; and
        f. Desired level of community integration.

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

    a. Any assessments assigned to the DD provider by the PCP team;

        i. Summary of assessments and baselines completed, including identified needs.

            (1) The PCP team may assign assessments prior to a PCP meeting to identify the strengths, needs, and preferences of the participant and help the team develop the next annual PCP.

            (2) DDA does not require a DD provider to complete certain standard assessments when an interRAI has been completed.

                (a) The provider is responsible for finding and completing assessments to identify the strengths, needs, and preferences of the participant.

                (b) There are assessment templates in the state-mandated web-based case management system.

        ii. A behavioral assessment completed by a clinician, when applicable.

    b. Habilitation programs, behavior support plans, and other waiver supports are provided.

    c. When assigned to the provider, a general discussion of finances and upcoming needs or large expenditures, Medicaid renewal or recertification due dates, information about other benefits, and any benefits planning needed;

    d. Employment goals and strategies:

        i. Current employment, including place of employment, hours worked, and supports needed.

        ii. Involvement in Vocational Rehabilitation services, including progress.

    e. Plans to minimize health and safety risks, including safety plans, seizure protocols, and use of emergency safety interventions;

    f. Back-up plan for Medicaid HCBS DD Waiver services for when they are unable to be provided;

    g. Supervision needs, including “alone time” both within and outside the residence;

    h. Restrictions, including appropriateness and progress on reducing restrictions; and

    i. Psychotropic medications, including how the medicines are working, any recommended reduction, and any noted side effects.

    j. Plans to address community integration needs.

3. The SC shares information and leads 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;

    d. Referrals for other services to meet identified unmet needs;

    e. Any legal needs the participant has, including court dates and probation requests;

f. Employment, including:

i. Involvement in Vocational Rehabilitation services, current milestones and progress, and any anticipated long-term supports; and
ii. Current employment, including place of employment, hours worked, and supports needed; and

g. Health status and medical service needs, including:

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

D. After an annual 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 DD 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 participants needs. Service Coordination does this through monthly contact with or on behalf of the participants and quarterly in-person service reviews in the environments in which waiver services are delivered.

5.8 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.

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

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. DDA expects the participant to be involved in the additional PCP meeting. Team members should make every effort to make this happen.

1. When the participant chooses not to participate, the PCP is reviewed with them following the meeting.
2. Team members encourage attendance for future meetings.
3. The PCP documents the reason the participant chose not to attend, and the team member assigned to review the information.

C. An additional PCP meeting may be held when:

1. The PCP is not meeting the participant's needs, due to:

a. Behavioral changes;
b. Medical changes;

c. Increases in reportable incidents;
d. Change in habilitation needs; or
e. Changes in health and safety risks;

2. The participant moves from one residence or day site to another within the same provider;
3. The participant's employment circumstances change;
4. The participant changes providers;
5. Requesting exception funding; or
6. DDA approves or denies an exception request, so the team can review recommendations and changes to the participants' annual individual budget amount.

D. After an additional 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. When there are changes to the PCP, the provider will train staff accordingly.
2. Team members are responsible for cooperating with other DD providers, therapists, and other clinical providers.

5.9 Service Authorizations

The Service Coordinator authorizes services and funding amounts. A service authorization is an agreement between the provider and DDA to allow the provider to bill Medicaid HCBS DD Waiver services.

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

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

a. Participant changes the type of Medicaid HCBS DD Waiver service they choose to purchase; or
b. Participant changes providers.

5. Service Coordination may shut off a service authorization when:

a. Adequate supervision is not provided;
b. Habilitative data is not collected;
c. A provider self-assessment for the site was not completed and/or was completed but found to be out of compliance;
d. A provider is not following statutes or regulations correctly; and
e. Required supporting documentation, such as a safety plan or programs, is not provided for the Annual PCP.

B. The SC completes service authorizations and notifies providers of new or updated service authorizations through the state-mandated web-based case management system.

5.10 Habilitation Programs

When a participant receives a habilitative service, a habilitation program must be provided to teach the participant new skills or maintain or improve current skills to be as independent as possible in their home, work, and community. DDA expects providers to take advantage of "teachable moments" that occur during daily life. Teachable moments are opportunities to include the participant in meaningful activities throughout the day.

A. A habilitation program is a structured method of teaching skills, with goals and data collection, which is required for any habilitative service provided under the HCBS DD Waivers.

1. The provider must implement at least one habilitation program whenever a habilitative service is provided.

   a. The majority of billable hours, with the exception of continuous residential services, must be spent on habilitation during each period of delivery.

   b. For a service to be considered habilitative, staff must provide active teaching, coaching, cueing, prompting, modeling, skill practice, skill maintenance, skill generalization, or other interventions designed to increase, maintain, or improve the participant's independence.

   c. Time spent solely supervising, monitoring, transporting, observing, or performing tasks on behalf of the participant does not constitute habilitation unless those activities are directly connected to implementation of a documented habilitation program.

2. The following services are habilitative and require habilitation programs:

   a. Behavioral In-Home Habilitation;
   b. Community Integration;
   c. Continuous Home;
   d. Day Supports;
   e. Employment Exploration;
   f. Host Home;
   g. Independent Living;
   h. Medical In-Home Habilitation;
   i. Prevocational;
   j. Shared Living;
   k. Small Group Vocational Support;
   l. Supported Employment – Follow-Along;
   m. Supported Employment – Individual;
   n. Supported Family Living; and
   o. Youth Continuous Home.

B. **Developing Habilitation Programs.** A participant's habilitation program addresses needs identified by the participant's Person-Centered Plan (PCP) team and teaches skills not yet learned. The team identifies what needs will have habilitation programs based on assessments and team discussion. When a participant has many needs, the provider may teach the task that will lead to the most independence or is the basis for other skills. Programs may be in the areas

of cognitive skills, social skills, motor skills, or communication. All habilitative programs must be written and executed in accordance with the DD Habilitation Plan Writing Guide.

1. Habilitation programs are developed through the following process:

    a. The SC completes a Charting the LifeCourse tool with the participant;
    b. The PCP team prioritizes participant's needs based on assessments for increasing their independence, while decreasing dependence on others;
    c. The provider conducts baselines;
    d. The PCP team reviews baseline information and develops individualized habilitation program goals;
    e. The provider writes the habilitation program;
    f. The provider implements the program and collects data for the habilitation provided;
    g. The provider measures progress of the program; and
    h. The SC monitors services to determine if habilitation programs continue to meet the needs of the participant.

2. An assessment is not a baseline, and a baseline is not a habilitation program. Each has its purpose when outlining a plan to develop a habilitation program to help a participant achieve independence.
3. The provider must implement each habilitation program with data collected as stated in the program. The program should state the frequency of data collection, based on team discussion.
4. The provider must implement at least one habilitation program, with data collected, whenever a habilitative service is provided.
5. The habilitation programs must be relevant to the participant's needs, based on assessment, and support the need for the Medicaid HCBS DD Waiver service. For example:

    a. When a participant uses Community Integration services, habilitation is focused on teaching the participant skills to be an active member in their community; or
    b. When a participant uses Continuous Home, Host Home, Shared Living, or Youth Continuous Home services, habilitation focuses on teaching the participant skills to live in their home as independently as possible.

6. The provider must consistently implement a habilitation program in all settings when opportunities occur; however, data collection is not required at every opportunity.
7. The provider must record data each time they provide the habilitative service.
    a. Documentation must demonstrate the connection between the billed service and the participant's habilitation program and include, at a minimum:
        i. The habilitation goal, objective, or skill addressed;
        ii. The intervention, teaching strategy, or support method utilized, such as modeling, prompting, task analysis, visual supports, role-playing, coaching, reinforcement, or skill practice;
        iii. The level of support provided to the participant, including independence, verbal prompting, gestural prompting, physical assistance, or other supports; and
        iv. Any barriers, significant events, or factors affecting implementation of the program.

b. Documentation must provide sufficient detail for an independent reviewer to determine what habilitation occurred, how the habilitation supported the participant's goals, what progress or outcome resulted from the intervention, and be reasonable to the duration of service.

i. When habilitative services are delivered for extended periods of time, documentation must reflect habilitation activities occurring throughout the service period.

(1) For services exceeding four hours in duration, documentation should include multiple interventions, activities, or skill-building opportunities demonstrating active implementation of habilitative programming during the course of service delivery.

(2) Providers are expected to document significant habilitative activities, participant responses, and progress across the service period rather than only a single activity for an entire period of service.

8. When a participant has a diagnosed regressive medical condition, such as dementia or Parkinson's disease, which makes learning new skills difficult or unlikely, and the participant has not made progress in habilitation programs, the team may determine habilitation programs should focus on maintaining current skills.

C. **Assessments.** Assessments identify the participant's strengths, needs, safety risks, preferences, and abilities. The PCP team uses information from assessments to plan services and habilitation programs. An assessment is not a substitute for a habilitation program.

1. DDA requires the completion of an assessment of institutional level of care annually, with information from PCP team members.
2. The provider completes additional assessments as determined by the PCP team, based on the personal goals of the participant. Additional areas to assess may include money management, daily living skills, and employment skills.

a. The provider can complete an assessment at any time when the PCP team or provider thinks there may be a change in abilities.

3. DDA does not endorse or require use of any specific assessments aside from the level of care assessments completed by DDA.

D. **Baselines to Plan Habilitation.** When an assessment identifies a need for habilitation, a baseline is developed. A baseline is a measurement of a participant's ability to perform a task on their own. The provider collects baseline data over a short period, and the provider cannot use a baseline instead of a habilitation program on a long-term basis. A provider develops a habilitation program from baseline data.

1. The provider is responsible for completing baselines.

a. A provider can conduct a baseline at any time when the PCP team or provider identifies a new need or change in need.

2. The provider writes habilitation program goals based on the current skill level determined by the baseline.

E. **Goals and Short-Term Objectives.** After the assessment determines the participant's needs and the baseline measures the participant's current skill level, the PCP team develops a habilitation program goal.

1. A goal is a long-term outcome that the participant works to achieve. The long-term goal (LTG) is written using SMART guidelines – Specific, Measurable, Achievable, Realistic, and Timely.

    a. Specific – The goal clearly defines what the participant will learn and the criteria for meeting the goal.
    b. Measurable – The provider can track data to determine progress. The provider must be able to observe the taught behavior in order for it to be measurable.
    c. Achievable – The goal challenges the participant, but the participant is capable of reaching the goal.
    d. Realistic – The goal must be something the participant needs or wants to learn.
    e. Timely – The goal includes a timeframe for the participant to meet their goal, usually within the PCP year. When the provider notes little progress, the PCP team can decide to continue the goal for the next PCP year, with revisions.
    f. Example of a long-term goal with SMART guidelines: When given a verbal prompt, I will wash my upper body for 95% of trials for three consecutive months.

2. A short-term objective (STO) is a step toward achieving the long-term goal.

    a. An STO is specific and teaches one step or part of the goal.
    b. STOs must build on each other to reach the long-term goal of the habilitation program.
    c. Example of an STO: When given two verbal prompts, I will wash my upper body for 75% of steps for three consecutive months.

3. When the team has approved the habilitation program goals, the provider is responsible for writing and implementing a habilitation program matching the goals developed by the team.
4. When a participant meets their habilitation program goal, the provider must contact the PCP team to develop and approve a new goal. The PCP must document the new goal.
5. The PCP meets and reviews progress toward goals at least once a year.

    a. The provider presents information from their monthly reviews to the PCP team; and
    b. The team discusses progress and decides if the provider needs to make changes to the program.

F. **Behavioral Assessment.** An assessment used to identify and analyze behavior in order to increase desirable behavior and decrease undesirable/problematic behavior. The behavioral assessment is the foundation of the Behavior Support Plan and frequently the Safety Plan. See the FBA BSP Safety Plan Flowchart to see how these work together.

1. The provider must complete or arrange for the completion of a behavioral assessment to determine the purpose or function of a problem behavior and make recommendations to address the problem behavior via teaching replacement behaviors and developing preventive and response strategies to mitigate problem behavior, to be used in the Behavior Support Plan (BSP).

2. The behavioral assessment is both the assessment and the baseline used to develop the behavior support plan. The assessment includes:

    a. Various components as identified in the FBA Checklist found here.
    b. Tools to hypothesize the function of the problem behavior(s), such as the FAST, QABF, Functional Assessment Interview, etc.
    c. All of these assessments/tools can be completed by the provider.

3. Ways to get the Behavioral assessments completed
    a. The provider is able to complete a behavioral assessment using the resources noted in this section.
    b. A Functional Behavior Assessment completed by the provider clinician
    c. An Applied Behavior Analysis Identification Assessment (ABA Assessment) is covered by Medicaid and can completed by a Medicaid/MCO approved practitioner for participants 21 and older (for those under 21, this is covered through EPSDT), such as the following:
        i. Licensed Independent Mental Health Practitioner (LIMHP)
        ii. Licensed Psychologist; or
        iii. Board-Certified Behavior Analyst/Licensed Behavior Analyst (BCBA/LBA)
    d. Use the Considering a Functional Behavioral Assessment document to help determine who is to complete and when to complete such an assessment.
    e. Behavioral assessments are to be completed when a problem behavior has been identified, a new behavior has been identified, and/or an old behavior has reemerged.
    f. The behavioral assessment must be reviewed annually for accuracy, updates and addendums completed as necessary to maintain accuracy (e.g., a new behavior has emerged).
    g. When an individual is at the Risk Tier, the FBA is to be completed by the provider employed clinician (e.g., BCBA/LBA, LIMHP, Licensed Psychologist).
        i. This assessment includes criteria from the FBA Checklist found here.
        ii. The FBA is used to develop the BSP, which the employed clinician must either author or, at a minimum, review and sign off on, to be implemented.
    h. Additional Resources are available to help provide guidance and direction for behavioral assessments; such as checklists, templates, etc.

4. The behavioral assessment must be reviewed annually for accuracy, with updated and addendums as necessary to maintain accuracy (e.g., a new behavior has emerged).
5. When an individual is at the Risk Tier, the BSP must meet the following additional criteria:
    a. The BSP must be developed based on an FBA.
    b. The FBA used to develop the BSP must be completed by a licensed psychologist, advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), or a board-certified behavioral analyst (BCBA).
        i. A behavioral assessment is covered by Medicaid as an Applied Behavioral Analysis Identification Assessment (ABA Assessment) for participants aged 21 and older. It is covered for participants under 21 through EPSDT.
    c. A provider-employed clinician must either author the Risk Tier individual's BSP or, at a minimum, review and sign off on it to be implemented.

6. Resources are available to determine additional situations when a behavioral assessment may be necessary:
    a. Functional Behavioral Assessment Template
    b. FBA Checklist and
    c. Additional resources are located under the and/or a non-clinical FBA.
        i. These can be completed by the provider. Functional Behavioral Assessments, Behavior Support Plans, and Safety Plans section at the DHHS DD Waiver Providers webpage.

G. **Behavior Support Plan (BSP) and Behavior Tracker.** BSP is a specific type of habilitation program that teaches appropriate replacement behavior and decreases the problem behavior.

1. The responsibility of developing the BSP falls upon the provider.

    a. Guides supporting the writing of these plans can be found here and include the BSP Checklist, Behavior Support Plan Resource, Behavior Tracking in Therap Resource, and the Habilitation Program Overview.

2. Using the information and recommendations from the behavioral assessment, a BSP is developed to address the problem behavior.

    a. The BSP is a habilitation program used to teach skills to increase independence and the accompanying prevention and behavioral response strategies to support those skills.

    b. The BSP cannot include rights restrictions.

        i. Rights restrictions are outlined in the Safety Plan (see section H, below).

3. The BSP includes the following:

    a. Teaching and Prevention: Replacement behavior that is actively being taught.

    b. Behavior Tracking and Response Strategies: Used for documenting the frequency of problem behaviors and how to respond to problem behaviors, up to the implementation of the Safety Plan.

        i. Behavior Tracking in Therap Resource.

H. **Safety Plans Address Risks.** When an assessment identifies a safety risk, the provider must develop a safety plan.

1. A safety plan addresses any identified risks and makes sure those who provide direct support know the participant's risks and supports that are in place or need to be utilized in times when additional support is necessary.
2. A safety plan is not a habilitation program, and it cannot be used it in place of a habilitation program; data collection is not required, but a Safety Plan could be combined with a Behavior Tracker.
3. A safety plan must include:

    a. A summary of all identified risks for the participant, including any known triggers or warning signs;
    b. A detailed description of all supports, strategies, and equipment used to address the identified risks, including any rights restrictions and non-restrictive supports;
    c. A description of supervision needs, including alone time both within and outside the residence; and

d. Specific instructions for when and how the provider uses all supports, strategies, and equipment, including descriptions of when the use of a rights restriction starts and ends.

4. The safety plan must match the PCP team's decisions about what supports the participant's needs, and when and how a rights restriction is used.
5. When the PCP team determines the participant needs a safety plan, the provider is responsible for developing the safety plan. The provider cannot include a support or rights restriction not agreed upon and approved by the PCP team.
6. Additional resources include:

   a. A Safety Plan Checklist, to ensure the basic components are included;

   b. Safety Plan Example; and

   c. Safety Plan Template

6. Self-Direction

Self-direction is not a service but refers to participants' opportunity to direct HCBS DD Waiver services when working with independent providers. When a participant chooses to work with an independent provider, they are responsible for managing all aspects of service delivery in a person-centered planning process.

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

A. Benefits of self-direction 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 self-direction 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 self-direct an independent provider, the team should discuss the following questions to help the participant decide if self-direction is a good fit:

1. Can an independent provider meet the participant's medical, behavioral, and safety needs?
2. Is the participant aware if 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 and hire providers to help in their home or the community?
7. How does the participant plan to train and supervise 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. Does the participant have a general concept of money, including understanding their benefits and individual budget to purchase Medicaid HCBS DD Waiver services?
11. Will the participant be able to tell a provider what they like or do not like about the provider's work?
12. Does the participant understand what may happen when they choose not to share some information with the provider about their medical needs?
13. Will the participant be afraid to dismiss a provider because they do not want to lose an independent provider or damage a relationship?
14. What would the participant do when they are home alone and there is an emergency?
15. Is the participant willing to accept help from their Service Coordinator?
16. Does the participant want to appoint someone as their advocate to help with self-direction?

When the participant's PCP team supports self-direction through the person-centered planning process. Team members may assist the participant in self-direction as requested.

A. Team members talk with the participant about their services and whether their needs are being met. The SC monitors services being provided to the participant.

B. The following may be signs of self-directed services not meeting the participant's needs:

1. There is a decline in health or skills;
2. Services are not occurring as outlined in the PCP;
3. The participant does not understand when actions by their independent provider may be abuse or neglect;
4. The participant is not accepting services, for example, canceling services or not allowing the provider into their home;
5. The participant is not directing or supervising their provider, for example, not telling the provider when they are not happy with services, not providing training, not making expectations clear; or
6. The participant is not following their backup plan when needed.

C. When the participant is not self-directing in a way that meets their needs, the team discusses whether the participant should:

1. Choose an advocate to assist with self-direction;
2. Select a different independent provider; or
3. Select an agency provider.

D. When anyone on the PCP team thinks self-direction 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 self-direction; or
2. Select an agency provider.

E. In self-direction, independent providers are hired by, and work at the direction of the participant.

1. A participant may hire any person as an independent provider when the person:

a. Meets general Medicaid HCBS DD Waiver provider requirements;

b. Is not legally responsible for the participant; and
c. Meets the expectations of the participant.

2. Medicaid HCBS DD Waiver service definitions explain which services independent providers can provide.
3. Each self-directed service has specific provider requirements.

6.1 General Self-Direction Responsibilities

When the participant self-directs services, they must be willing and able to accept increased responsibility for managing their Medicaid HCBS DD Waiver services. The participant must advocate for their wants and needs.

A. The participant must actively direct the PCP planning process and communicate with their team when they need help with self-direction.
B. The participant accepts all employer responsibilities. This includes finding, interviewing, hiring, training, scheduling, supervising, monitoring, and dismissing independent providers.

1. The participant tells their independent provider the job requirements and their expectations and preferences. They provide feedback to their provider when they do not meet the participant's requirements or expectations.
2. The participant's Service Coordinator may advise or support the participant as requested but cannot be responsible for carrying out the participant's self-direction duties.

C. The participant is responsible for managing their use of the annual individual budget amount (IBA), as outlined in the PCP.

1. The participant negotiates the hourly rate paid to each independent provider, up to the maximum rate set by DDA.

a. DDA pays independent providers at the rate chosen by the participant; and
b. DDA withholds and pays required federal employment taxes.

2. The participant must monitor services billed by their provider to ensure the provider bills the authorized services correctly.

a. A participant can monitor the provider's billing by accessing the state-mandated web-based case management system or by requesting copies of the billing documents from their provider.
b. The participant is responsible for knowing what the provider can bill for as part of a service.
c. When the participant has questions about the provider's schedule or when the provider's billing does not match the participant's records, the participant should direct the provider not to submit bills to DDA. It may be helpful for the participant to keep a calendar documenting services provided. Differences must be resolved before the provider can bill.
d. The participant must report any billing concerns to their Service Coordinator.

i. The Service Coordinator can help ensure the provider meets the participant's needs.
ii. The participant should notify their Service Coordinator anytime they change the schedule for the provider, as this might affect the budget.

iii. When the provider does not correct billing after the participant notifies them, this may be suspected fraud and must be reported to Medicaid. *For links to DHHS contact information, see Appendix E: Contacts and Resources.*

3. The participant directs the use of the annual IBA based on needs identified from their assessment:

   a. The participant should not hesitate to ask others when they need help, as budgeting could be complicated and overwhelming.
   b. The participant's Service Coordinator can help the participant in managing their budget.

4. A participant can monitor their IBA use throughout the PCP year to ensure there is enough funding to receive services for the entire PCP year.

   a. The participant can do their monitoring on the state-mandated web-based case management system, or by requesting reports from their Service Coordinator.
   b. When the participant does not spend all the money in their IBA, it does not carry over into the next PCP year.
   c. When a participant uses all the money in their IBA before the PCP year is over, additional Medicaid HCBS DD Waiver funds are not available until the new PCP year starts.

5. When Medicaid is paying for a community-based waiver service, the participant cannot agree to pay additional money for Medicaid HCBS DD Waiver services.

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.

6.3 Finding, Interviewing, and Hiring an Independent Provider

A. When self-directing services, the participant must find their 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 to hire someone they know, including a neighbor, friend, or family member.

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

         i. It may be easier to find a provider; and

ii. The provider is already familiar with the participant and familiar with their preferences.

b. There are also risks to hiring 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 interview 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, pay, and schedule they want;
b. Provider requirements for the services to be provided;
c. Description of what the participant wants to learn and 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 no smoking, no cell phone use, or not bringing children or 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 the 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 interview the potential provider.

a. The interview may 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 that even if they do not hire the person, the person now knows their address.

b. The interview may 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 during the interview.

a. Before the participant starts to ask questions of the potential provider, they should explain 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 interview 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 with disabilities?
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.

d. At the end of the interview, the participant may ask for references.

C. The participant reviews all information from the interview and references and decides if they will hire the potential provider. A participant may hire more than one provider, or a primary and a backup provider.

1. The participant should not promise a potential provider that they will be hired. A participant cannot make a final decision until the Medicaid enrollment process is complete.
2. A participant should tell the provider they cannot provide services until the provider enrollment is complete, and a service authorization is completed.
3. The participant notifies their SC when they want to hire an independent provider.
4. 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 Employing 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. A provider is required to know how to write habilitative plans in order to provide habilitative services. Habilitation training is not required for provider enrollment. Knowing how to write habilitation plans may come from previous experience. When a provider needs training, they should check the DDA training page to find free pieces of training that are available.

4. 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 available to independent providers online on the DDA training page.

5. The participant should keep a written record of all trainings 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;
    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 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 the job 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. The participant is responsible for dismissing their provider when the provider is not working out or fails to meet expectations.

1. When the participant does not want to continue working with the provider, they should plan how and when to dismiss the provider.

    a. When dismissing a provider, the participant should make plans to fill the provider's role.
    b. When dismissing a provider, the participant should explain why they are dismissing the provider. It is important for the participant to remain calm and provide facts about what was not working.
    c. It can be difficult to dismiss a provider, and it may be helpful for a participant to have someone with them when dismissing the provider.
    d. When the provider has keys to the participant's home or other property, the participant should ask the provider to return them.

2. When the participant thinks the provider puts their health or safety at risk, the participant should talk to their service coordinator.

    a. When the SC agrees that the provider put the participant's health or safety at risk, the participant may consider dismissing the provider.
    b. 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 they 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.

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 employed.

6.5 Service Coordinator Responsibilities in Self-Direction

When a participant chooses to work with an independent provider, they are responsible for self-directing Medicaid HCBS DD Waiver services. Self-direction gives a participant responsibility for managing most 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.
2. The SC works with the participant to create the participant's plan to self-direct by guiding with recruiting, hiring, and managing 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 backup plan when a provider does not arrive when scheduled or quits.

B. The SC monitors how self-direction is going, including:

1. How often does an independent provider miss 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 or dismiss 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 Developmental Disabilities Waiver providers.

A. There are two types of DD providers:

1. An agency provider is a company that is an enrolled Medicaid provider and certified by DHHS to provide DD services. The agency provider is responsible for hiring or contracting and supervising employees and contractors who work with the participant, and other administrative functions.
2. An independent provider is a person or vendor enrolled as a Medicaid provider and employed by a participant. The participant is responsible for hiring and supervising their provider.

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

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

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

        i. DDA Central Office completes a referral to the electronic provider enrollment system for the potential provider.
        ii. The potential provider submits required documentation in the electronic provider enrollment system.
        iii. The electronic provider enrollment system 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 Maximus approves them to become a Medicaid provider, they sign a Medicaid provider agreement.

        i. The Medicaid provider agreement is a contract between DD 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.

4. 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.

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

a. Providers of Medicaid services; and
b. Providers of DD services.

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

11. 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.
12. A non-relative legal guardian or spouse of the non-relative legal guardian shall not be the owner, part owner, manager, administrator, or employee of an agency provider who is providing residential care in a community-based setting.
13. 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 hires 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. 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 conflict 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, Shared Living contractor, or Host Home provider.

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.
   a. 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.

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

1. The use of natural or community supports is identified during the person-centered planning process. These supports do 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. When there is an authorization for Shared Living or Host Home , the agency is responsible for conducting background checks and providing training for anyone assisting with the participant during the provision of waiver services.
   a. Background screening is required for all provider staff and members of the provider's household who have contact with the participant, except for children in the household under the age of 13. Refer to section G(1)(b) for additional information about background check requirements.
   b. 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. Natural and community support are required to notify the provider agency of any critical incidents or other reportable incidents. The provider is responsible for completing GERs and any other critical incident reporting as needed. Information regarding GERs and critical Incident reporting can be found in Chapter 12, Appendix A of this manual.
4. 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).
   a. Back-up staff must be enrolled in Maximus as a provider.

E. **Habilitative Services:** Habilitative services include teaching throughout a participant's daily activities, implementation of habilitation programs, the provision of personal care, supervision, medication administration, and other supports as outlined in the PCP.

1. In order to bill for a habilitative service, a provider must implement a habilitation program with data collection whenever they provide the habilitative service.
2. Personal care, supervision, medication administration, and other supports are components of a habilitative service, but a service is not billable when no habilitation program is run.

F. **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.

G. **Assistance with Health Services:** All providers must observe and respond to the participant's health needs and physical condition.

1. Unless otherwise assigned in the PCP, the provider:

    a. Arranges for or assists the participant to get medical evaluations and services based on their need. This includes medical services, dental services, mental health services, physical and occupational therapy, speech therapy, audiological services, vision services, nutrition services, and other related evaluations and services.
    b. Provides or arranges for provision of the participant's healthcare, treatment, and medications as ordered by healthcare professionals.

2. When a participant uses assistive and adaptive devices, all providers must support the participant in use of the devices.
3. A provider assigned responsibility for medical care in the PCP must arrange for repair or replacement of a device when needed.
4. 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.

H. **Transportation:** When a provider drives a participant, the provider may bill for transportation as a separate service under the Medicaid HCBS DD Waivers. When transportation is included in the rate for some Medicaid HCBS DD Waiver services, the provider must drive the participant during the service when needed. 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. This may include:

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

    e. The provider has:

        i. Enough available vehicles to drive participants.
        ii. Enough staff in a vehicle to ensure safety and meet participants' needs.

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

    a. Transportation can be billed as a Medicaid HCBS DD Waiver service;
    b. Transportation is included in the rate of a Medicaid HCBS DD Waiver service; or
    c. Transportation for non-emergency medical needs is available through Medicaid.

3. A provider may pay for public transportation, such as a bus or taxi, rather than directly providing transportation. The provider is responsible for ensuring transportation meets the participant's needs and the participant can use public transportation safely.

I. **State-Mandated Web-Based Case Management System:** DDA uses the state-mandated web-based case management system is used for service planning, documentation, reporting, secure communication (SComm), and billing. Providers must 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 PRN (as needed) 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 and the right amount;
        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. Billing and attendance;
3. Employment History;
4. Incident reports, also known as general event reports (GER);
5. Habilitation programs and data collection; and
6. Health records.

    a. The appointments form in the Therap Health Tracking module is required for recording annual physicals and any other medical appointments occurring on or after the effective date.
    b. Therap Health Tracking module may be found on the Therap training page.

J. **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 DD waiver services include personal care and some are provided to participants in their homes, EVV must be implemented for DD services that meet the description in the 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. Homemaker;
    b. Independent Living;
    c. LRI Personal Care;
    d. Respite In-Home; and
    e. Supported Family Living.

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

    a. When a provider chooses the state-mandated web-based case management system 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 DD 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 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 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 an Independent Provider has no availability to a smartphone or tablet to capture GPS, then Interactive Voice Response (IVR) can be used as a last resort. IVR is a conditional method of collecting EVV data and requires State approval prior to using it. Note: Only phone numbers associated with a verified landline will be approved for IVR use.

        i. Provider makes IVR approval request to the DHHS by email at DHHS.IVR@nebraska.gov

K. **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 Health Insurance Portability and Accountability Act (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.

L. **Billing for Services:** A provider bills by submitting a claim for Medicaid HCBS DD 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 180 days of the date of service;
   b. Be within the service amount assigned to the provider according to the service authorization; and
   c. Meet the requirements outlined in the definition of the service provided.

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.

iii. Therap began an automatic validation of all attendance hours entered for services with a daily rate to ensure attendance hours match billing type (hourly, partial day, daily).

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;
   b. Habilitation programs and data as outlined in the PCP for any habilitative service provided; and
   c. Location of service provided when service requires community integration.

M. **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 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. Reportable incidents include:

   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

2. A provider 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 it is 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 must 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 participant is not aware that a reportable incident has occurred.

c. The provider must approve the written report in the web-based case management system within 72 hours of submission.

3. 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 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).

4. Agency providers have additional responsibilities to investigate incidents and submit reports to DDA.
5. Providers may use low-level GERs for internal reporting. DDA does not mandate or monitor these.
6. There is a guide available on how to complete incident reports.

a. It is found on the state-mandated web-based case management system.
b. The guide is also on the DDA public website under DD Waiver providers.

N. **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.

O. **Death of a Participant:** Providers are responsible for reporting the death of a participant to the Division of Developmental Disabilities.

1. When a participant dies, the provider must:

    a. The provider must verbally report to the Service Coordinator as soon as possible, but no more than 4 hours after becoming aware of the death;
    b. Complete an incident report in accordance with the requirements as outlined in the Division of Developmental Disabilities' Incident Reporting & GER Guide.
    c. Submit a Notification of Death form to the Division of Disability and Agingwithin 10 calendar days of the death;

        i. The form is in the Forms section on the Provider page of the Division of Disability and Aging website, or a provider can request it from any Service Coordinator.
        ii. The form can be submitted by either of the following:

            (1) Clicking the submit button at the end of the form;
            OR
            (2) Emailing to: nebraska.quality.help@libertyhealth.com.

    d. Promptly submit any additional relevant information as it becomes available to the above email inbox.
    e. Respond promptly to any requests from the Division of Disability and Aging or their designee for additional information.

2. When the death of a participant occurs during a time when they are not receiving services:

    a. The death must be reported.
    b. The first provider who becomes aware of the death is responsible for the completion and submission of both the incident report and Notification of Death form according to the timeframes as outlined above.
    c. There are two separate forms, and providers are required to complete both.

P. **Remediation:** DHHS may take remediation action on providers for circumstances which include, but are not limited to, identifying concerns such as serious risks to the health, safety, welfare, or rights of a participant; failure to implement a participant's person-centered plan; failure to comply with HCBS waivers; or failure to comply with department policies or regulations.

1. DHHS or designee notifies the provider in writing of the decision to take remediation actions. The following types of remediation may be taken:

    a. Require the provider to submit a plan of improvement;
    b. Require the provider to implement a plan of improvement developed by the department within a specified timeframe;
    c. Require the provider to train employees or contractors at their own cost;
    d. Monitor the provider as a safeguard against further harm or injury to participants or serious risk to the safety of the participants;
    e. Set a probation period and conditions under which the provider must operate; or
    f. Limit the provider's ability to accept participant referrals, provide certain Medicaid HCBS DD Waiver services, or operate at specific service locations.

2. DHHS or designee may conduct an on-site review or request information from the provider for monitoring purposes.
3. Remediation ends when DHHS verifies the concerns have been resolved and sends written notification of compliance to the provider.
4. When a concern involves immediate and serious risk to a participant's health or safety:

    a. DHHS immediately notifies the provider verbally of the concern;

        i. The provider must take immediate action to remove the risk and implement corrective action to prevent further risk to health and safety; and
        ii. For each participant directly affected, the provider must notify:

            (1) The guardian when the participant has a guardian;
            (2) A family member when the participant has requested a family member be notified; and
            (3) The participant when participant is not aware of the situation.

    b. The provider submits written evidence to DHHS of correction or when the circumstances causing the immediate and serious threat no longer exist and safeguards are in place to ensure the health and safety of participants;
    c. Upon receipt of the provider's evidence of correction, DHHS determines the provider's certification. DHHS can conduct a revisit to verify compliance; and
    d. When the provider fails to remove risk to any identified participant and implement measures to prevent further harm, further Remediation or Corrective Action Plans may be implemented.

Q. **Requesting Alternative Compliance:** The alternative compliance process allows a provider to request to provide services to a participant using a method differing from regulations. A provider should only make a request for alternative compliance when the participant's health, safety, or welfare cannot be maintained by delivering services as outlined in regulations. *Alternative Compliance is not used with the Family Support Waiver.*

1. A request for alternative compliance must include the following information:

    a. The state regulation for which alternative compliance is requested;
    b. The reason alternative compliance is requested, along with any needed documentation, such as doctor's notes or incident documentation;

c. When appropriate, which agency policies or procedures are to be used in place of the requirement in the regulation;
d. Documentation about other agency policies and procedures that have been attempted and were unsuccessful, and showing alternative compliance is requested as a last resort;
e. How the provider will protect the rights, health, safety, and well-being of the participant;
f. The date the provider wants to start the alternative compliance policy or procedure;
g. The plan to end the alternative compliance and a goal end date;
h. The date the team reviewed the alternative compliance request; and
i. Required authorizations:

    i. For agency providers, the signature of the provider agency director and authorization from the provider's governing board or designee to request an alternative compliance.
    ii. For independent providers, the signature of the independent provider who will use the alternative policy or procedure, and the signature of the participant directing services.

2. Once the provider gathers the information, they send an alternative compliance request to the DDA central office, using the internal communication method within the state-mandated web-based case management system. A request may be:

    a. Submitted directly by the provider after the PCP team review; or
    b. Sent to the Service Coordinator for PCP team review and then submitted by the Service Coordinator.

3. DDA may approve the request for alternative compliance when the proposed steps are taken:

    a. Are consistent with the intent of the regulations for which alternative compliance is requested;
    b. Are requested as a last resort, and there is documentation about other actions that have been attempted and were unsuccessful; and
    c. Protect the rights, health, safety, and well-being of the participant.

4. DDA issues a written decision via the state-mandated web-based case management system within 30 calendar days of receiving a request. DDA may delay a decision when DDA requests additional information.
5. When an alternative compliance request is granted:

    a. The approval is for a set period of time;
    b. The provider must receive written approval before using the alternative policies or procedures; and
    c. During the approved period, the provider must meet all conditions set by DDA.

6. Alternative compliance may be denied for the following reasons:

    a. Other options have not been attempted and determined to be unsuccessful;
    b. There is no identified need to justify alternative compliance;
    c. The request for alternative compliance does not include all required information;
    d. Additional assessment is needed;

e. The PCP team for the participant affected has not reviewed the provider's proposed actions;
f. State or federal law has changed in a way that does not allow previously approved alternative compliance;
g. Alternative policies or procedures do not protect the rights, health, safety, and well-being of the participant; or
h. Proposed alternative policies or procedures are not consistent with the intent of the regulations.

7. When DDA denies or revokes alternative compliance, the provider cannot appeal the decision.

7.2 Agency Provider Requirements

A. A DD agency provider is an entity certified by the Department of Health and Human Services Division of Public Health (DPH) to provide Medicaid HCBS DD Waiver services.

1. An agency provider is responsible for all administrative aspects related to providing DD services, such as hiring, dismissing, scheduling, training, and paying employees and contractors who work with participants.
2. An agency provider must follow all core requirements for agency providers of Medicaid HCBS DD Waiver services. A DD agency provider must be a Medicaid-enrolled agency provider.
3. An agency provider must also:

a. Have written policies to describe how their business runs and procedures giving direction to employees and contractors;
b. Complete background checks on all employees and contractors working directly with participants; DD 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.
c. Ensure all employees and contractors meet requirements for education and experience, and other requirements;
d. Ensure contractors comply with all applicable laws, rules, regulations, policies, and procedures;
e. Maintain any licensure (for example, Centers for Developmentally Disabled (CDD) when a home has four or more participants) with DPH;
f. Maintain certification with DPH for all DD services provided; and
g. Maintain certification of insurance on or before the first date of service, including:

i. Worker's Compensation as required by state law;
ii. Commercial motor vehicle liability coverage;
iii. Professional liability coverage; and
iv. General liability.

4. The following Medicaid HCBS DD Waiver services may be offered by an agency provider:

a. Adult Day;
b. Assistive Technology;
c. Behavioral In-Home Habilitation;

d. Benefits Counseling;
e. Child Day Habilitation;
f. Community Integration;
g. Continuous Home;
h. Day Supports;
i. Employment Exploration;
j. Environmental Modification Assessment;
k. Family Caregiver Training
l. Family Peer Mentoring
m. Home Modifications;
n. Homemaker;
o. Host Home;
p. Independent Living;
q. LRI Personal Care;
r. Medical In-Home Habilitation;
s. Prevocational;
t. Remote Supports;
u. Respite;
v. Shared Living;
w. Small Group Vocational Support;
x. Supported Employment – Follow-Along;
y. Supported Employment – Individual;
z. Supported Family Living;
aa. Transitional;
bb. Transportation;
cc. Vehicle Modifications; and
dd. Youth Continuous Home.

B. Before starting a business to provide Medicaid HCBS DD 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 DD; and
3. Adequate funding to operate the business. DHHS does not provide start-up funding.

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

1. The safety of all participants served in a specific residential or day service site; 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.

D. **How to Become an Agency Provider:** A potential agency provider must complete the following steps to be certified as an agency provider:

1. DHHS requires a potential agency provider to attend orientation and satisfactorily complete a competency activity.

a. Orientation gives information on DHHS divisions, DD services, agency provider requirements, how to complete the enrollment and certification processes,

citations, and corrective action, and is an opportunity for a potential agency provider to ask questions.

b. Competency-based training is intended to better support potential providers to be fully aware of the expectations of being certified.

c. A potential agency provider must contact DDA central office to sign up for orientation. *For DDA central office contact information, see Policy Manual Appendix E: Contacts and Resources*.

d. DHHS offers orientation at least quarterly.

e. A potential agency provider must attend orientation in its entirety, via the platform offered (in-person or live webinar).

f. A potential agency provider must attend orientation before receiving the competency activity and submitting an application.

g. After attending orientation, the DDA central office provides a link to the competency activity.

h. The applicant must complete the competency activity and return to DDA.

i. When the applicant returns the competency activity with a score of 85% or above, DDA Central Office provides an application packet to the potential agency provider.

ii. When the applicant returns the competency activity with a score less than 85%, DDA gives the applicant an opportunity to re-take the competency.

(1) The applicant may take the competency activity up to three times.

(2) When the provider does not achieve 85% after three attempts, DDA requests the applicant repeat orientation at the next scheduled session.

i. The application packet includes:

i. An application/letter of intent form; and

ii. A policy and procedure worksheet.

2. An entity who wants to become a certified agency provider of Medicaid HCBS DD Waiver services must complete an application.

a. Becoming a certified agency provider may take several months. The length of time depends on completion of an application and development of policies and procedures by the potential agency provider.

b. The application includes the following:

i. A completed application form and letter of intent, which includes:

(1) Which Medicaid HCBS DD Waiver services the agency provider intends to offer; and

(2) Where the agency provider will be located and offer services;

ii. The agency provider's written policies and procedures.

(1) The policies and procedures must reference how the provider addresses specific state regulations.

(2) An agency provider is required to use a worksheet to demonstrate how their policies and procedures meet the regulations.
(3) DHHS will not consult with an agency provider to develop policies and procedures. DHHS only reviews policies and procedures to determine when they are acceptable.
(4) DHHS does not approve or reject policies and procedures. When policies and procedures are not acceptable, DHHS will return them for revision.

(a) The agency provider may make revisions and resubmit to DHHS.
(b) There is no limit on how many times a provider may resubmit policies and procedures however, DHHS may put the certification process on hold when the provider has made several revisions that are not acceptable.
(c) When the policies and procedures are clearly not in line with state regulations, DHHS may deny certification.

c. The applicant must electronically submit their application to DHHS.DDDCommunityBasedServices@nebraska.gov.
d. Providing incomplete or incorrect information can result in the denial of an application. When the application is complete, DDA forwards to Department of Public Health (DPH).
e. DPH reviews the application, letter of intent, and policies and procedures. Based on their review, DPH may:

i. Deny certification;
ii. Ask for revisions; or
iii. Schedule an administrative review.

f. When DPH has determines policies and procedures are acceptable, DPH meets with agency provider administration for a DPH administrative review.

i. The administrative review is an interview where the agency provider gives specific information about how they will implement the policies and procedures they have submitted.
ii. After the administrative review, DPH may:

(1) Deny certification;
(2) Ask for any issues identified in the administrative review to be corrected; or
(3) Give initial certification, allowing the provider to begin providing Medicaid HCBS DD Waiver services.

g. The agency provider receives written notification of the outcome of the administrative review from DPH.
h. When initial certification is given, the notification contains instructions for completing Medicaid agency provider enrollment.

i. An agency provider must complete the Medicaid agency provider enrollment requirements in the DHHS mandated electronic Medicaid agency provider enrollment system.
ii. Once Medicaid agency provider enrollment is completed, DDA sets up an agency provider account in the state-mandated web-based case management system so the agency provider may start taking referrals.

3. When DPH gives an initial certification and the Medicaid agency provider enrollment is completed, an agency provider can accept referrals to provide the Medicaid HCBS DD Waiver services DPH approved them to offer.

   a. When an agency provider accepts their first referral, the agency provider must notify DPH. DPH will complete a review before the agency provider can begin serving a participant.
   b. DPH gives an initial certification for a six-month period. When an agency provider has not provided services to a participant for at least 90 days before the initial certification ends, DPH can extend initial certification for six months.

4. After an agency provider has started providing services to a participant, DPH conducts an initial certification review.

   a. The initial certification review includes:

      i. Unannounced on-site visits;
      ii. Observation of service delivery;
      iii. Interviews with administration, employees, contractors, and participants; and
      iv. Review of documentation.

   b. DPH sends the results of the certification review to the agency provider in writing. The agency provider must submit a plan of improvement to DPH for any identified concerns as a result of the certification review.
   c. Based on the initial certification review, DPH action may include:

      i. Issuance of a one- or two-year certification; or
      ii. Deny certification. Certification may be denied:

         (1) When there are serious risks to the health, safety, welfare, or rights of participants;
         (2) When an agency provider is not implementing participants' PCP or habilitation programs; or
         (3) When an agency provider has failed to comply with applicable regulations.

5. After an agency provider is initially certified, they must renew the certification before it expires.

   a. An agency provider must submit an application to renew certification 90 days before the certification expiration date.
   b. DPH conducts an on-site certification review following the same process as the initial certification review.

c. Based on review of the renewal application and the results of the on-site certification review, DPH determines whether to deny a renewal certification or to renew the certification.

i. DPH may renew certification for one or two years. DPH determines the length of certification.
ii. DPH may give a one-year certification when it is determined an agency provider requires more frequent review, based on:

(1) The number of citations the agency provider receives during certification review;
(2) The severity of the citations the agency provider receives during certification review; or
(3) Repeated citations for similar concerns identified in the most recent certification review or complaint investigations.

6. DPH issues an agency provider certification only to the person(s) named in the application as the certified agency provider. When a change of ownership occurs, the new owner assumes responsibility for correcting any previously cited deficiencies.

E. **Required Notifications to DDA:** An agency provider must notify DDA Central Office in writing:

1. Within ten business days of:

a. Change in agency provider ownership;
b. Change in agency provider director;
c. Change in contact information, including physical business address, phone number, mailing address, or email address; or
d. The Agency being in Financial trouble to the point that payroll can not be made.

2. At least 30 calendar days before adding a new service option to the Medicaid agency provider agreement; and
3. At least 60 calendar days before:

a. Ending a service option currently provided; or
b. Expanding services into a city or county not included in the agency provider certification.

F. **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 DD 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. Habilitation;
   c. Positive behavioral support procedures;
   d. DDA approved emergency safety intervention procedures;
   e. The incident reporting system;
   f. Process for responding to alleged or suspected abuse, neglect, or exploitation;
   g. Process for quality improvement;
   h. Participant rights and restrictive measures;
   i. A rights review committee;
   j. Entry to services;
   k. Employee and contractor training; and
   l. Disaster preparedness.

G. **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 will provide approved services in their home, 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.
      iv. When the employee or contractor will provide 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.

v. Employees and contractors who provide direct support services cannot work alone with a participant until the registry and criminal history checks are completed and meet regulatory requirements.

vi. 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 any crime outlined in the list of specific crimes published on the Medicaid Program Integrity website under the Prodifer Screen Guidelines.

vii. The employee or contractor cannot provide services 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 when convicted or charged and awaiting resolution with any crime in the list of specific crimes published on the Medicaid Program Integrity website under the Provider Screening Guidelines. An employee or contractor must notify the agency provider immediately when they are charged or convicted of any crime in the list of specific crimes 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. In accordance with 404 NAC 4. 003.03(B) All employees and contractors responsible for providing services to a participant must have adequate and suitable training to respond to injury, illness, and emergencies.

i. All employees must also provide effective habilitation and support to participants.

ii. Required training includes:

(1) Participant choice;
(2) Participant's rights in accordance with state and federal law;
(3) Confidentiality;
(4) Dignity and respectful interactions with participants;
(5) State reporting requirements and prevention of abuse, neglect, and exploitation;
(6) Emergency procedures;
(7) Infection control;
(8) CPR (cardiopulmonary resuscitation) and basic first aid; which includes in-person training and skills verification.
(9) DDA approved emergency safety intervention procedures;
(10) Implementation and development of the PCP and PCP team process;
(11) Positive support techniques;
(12) Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the participant;

(13) Use of adaptive and augmentative devices used to support participants, as necessary;
(14) The HCBS Final Settings Rule.

d. The agency provider must ensure 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 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.

e. An agency provider must maintain enough employees and contractors to provide services, supports, and supervision to meet the needs of each participant at all times.

H. **Shared Living Provider Requirements**

1. The agency provider must complete a Home Study Survey with any potential SLP contractors in the home and with all adult members of the household.
2. When there are changes to the home, a new Home Study Survey must be done.
3. For all new SLP settings, the agency provider must complete the Home Study Survey on-site at least seven (7) calendar days before the participant's team meeting.

a. Providers must upload a copy to Therap in a case note and submit to the participant and their guardian.

4. The Home Study Survey can be found here. When Service Coordination has a concern about the placement or survey response, the SC will work with the agency provider to make any updates or corrections.

a. The agency provider is responsible for ensuring all concerns are addressed and resolved with the SLP.
b. Service Coordination reviews all submitted surveys and materials and discusses with the participant's team. They may move forward with a service authorization or a placement denial at any point in this process.

i. Service authorizations will not be approved until the SLP has completed the Home Study Survey, has a compliant Final Settings Rule Site Assessment, is affiliated with Maximus, has completed a Service Coordination on-site walkthrough, and a team meeting has been held to discuss the potential placement.

ii. When the placement is denied, the agency provider, not the SLP, may request a fair hearing.

5. No person residing in the natural family home of the participant will be approved to be a Shared Living Provider when caregiver capacity needs are identified on the interRAI assessment. Caregiver capacity will be reassessed annually.
6. The agency provider must document on-site visits:

a. Monthly for Basic-High Tier participants, and
b. Two times per month for Advanced-Risk Tier participants.

7. In each 90-day period, the agency provider must make unscheduled visits:

   a. At least two visits for Basic-High Tier participants, and
   b. Four visits for Advanced-Risk Tier participants.

8. When an SLP is supporting a participant on the Basic, Intermediate, or High Tier, there can only be two state funded people in the home, including CFS, Probation, and DD, AD, or TBI Waivers.

   a. No other state-funded people are allowed to live in the home when the participant is on the Advanced or Risk Tier.
   b. The agency provider must notify the SC when a person funded by any HCBS Waiver, CFS, Probation, or any other state agency lives in the home.
   c. Service Coordination will verify approval of CFS, Probation, or any other state agency before approving the SLP.

9. When an SLP is supporting a participant on the Advanced-Risk Tier, there must be two providers living full-time in the home and available during residential service hours, on the contract.

   a. When a participant is approved for a temporary exception funding request, a participant may continue to live in their current SLP with one provider on the contract for the duration of the temporary exception funding.

10. When an SLP has children under the age of 13, another adult, not on the SLP contract, must live full-time in the home and be noted in the Home Study Survey to provide care and supervision to the child in the event of an emergency.
11. Any residence that the SLP and participant live in must have its own United States Postal Service-recognized address. No separate basement apartments, apartments over garages, or apartments not fully integrated into the home are permitted.
12. The agency provider is responsible for uploading documentation in Therap case notes:

    a. The completed Home Study Survey;
    b. The lease, signed by the participant or guardian; and
    c. The SLP Contract, signed by the SLP and agency provider.

13. Failure to comply with staffing ratios for specific risk tiers either initially or anytime thereafter may result in denial of SLP approval.

    a. Requests for exceptions to this shall be submitted to DHHS central office to be evaluated and determined whether, at DHHS's discretion, an exception should be allowed.

14. When SLP approval is denied, the Agency Provider may appeal the decision by requesting a fair hearing.

    a. An SLP does not have the right as a sub-contractor to initiate an appeal.

15. In addition to all other requirements, two years of human services experience is preferred, but not required.
16. DDA Central Office Approval is required for any participant 18 years or younger to receive waiver services in a Shared Living setting.

a. No parent or person residing in the natural family home, of the participant will be approved to be a Shared Living Provider.

I. **Contracting:** An agency provider may contract with employees and people who are not employed by the agency. An agency provider is responsible for all actions and services provided by a contractor.

1. Contracting: An agency provider may contract with people not employed by the agency provider to deliver Shared Living. Employees of the agency provider must deliver all other Medicaid HCBS DD Waiver services.
   a. An agency provider may contract with people, such as maintenance workers, who do not deliver Medicaid HCBS DD Waiver services.
   b. An agency provider is responsible for all actions and services provided by a contractor.
2. Employees can contract as an SLP if their regular employment position meets both of the following criteria:
   a. They hold no position of authority or management over the agency.
   b. They have no direct or indirect responsibility for the oversight, monitoring, or quality assurance for the provision of services at the agency.
      i. Examples include Maintenance personnel, IT staff, Direct Support Professionals, etc.
3. Employees cannot contract as an SLP if an employee holds a position that meets the following criteria, which create a conflict of interest:

   a. Administrative authority to hire, fire, discipline, or alter the compensation of agency staff.

   b. Responsibility for the management, coordination, or oversight of the SLP or monitoring service delivery and staff.

      i. Examples include Residential Coordinators, Human Resources, Agency Owners, Executives, etc.

J. **Record Keeping:** An agency provider must maintain accurate, current, and complete participant and business 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 them. It is acceptable to abbreviate participant names to maintain confidentiality.

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. Incident reports, also known as general event reports (GER);
   d. Safety Plans and need protocols;
   e. Habilitation programs and data collection;
   f. Documentation of a participant's employment; and
   g. 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 recorded in an electronic file with appropriate provisions for back up.

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 authenticated 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, but is not limited to:

a. Attendance records;
b. Habilitation programs and data;
c. Incident reports;
d. Authorization for medical treatment and consents;
e. Financial records; and
f. Health records.

7. Measurable data must be documented daily.
8. An agency provider must maintain participant health-related records in the state-mandated web-based case management system, unless a participant's PCP assigns responsibility for the participant's healthcare to another person or entity. This includes, but is not limited to:

a. Physician contact forms;
b. Medication administration records;
c. Medical orders or recommendations;
d. Physician documentation for psychotropic medication;
e. Hospital records and discharge instructions;
f. Therapy notes or progress reports;
g. Results of medical assessments or exams; and
h. Documentation of health care monitored by the agency provider, such as blood sugar or weight.

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

K. **Participant Rights and Rights Review Committee:** An agency provider must ensure participant rights are protected. *This section is not applicable to the Family Support Waiver because rights restrictions are not permitted.*

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 room and board costs or an agency provider-wide smoking policy.
    c. The provider must give information the participant can easily understand verbally and in writing.

2. An agency provider must have a rights review committee, which meets at least twice a year. This committee reviews:

    a. All use of restraints or emergency safety interventions;
    b. All supports and practices which restrict the rights of a participant;
    c. All incidents in which a violation of a participant's rights may have occurred; and
    d. All reported allegations of abuse, neglect, or exploitation.

3. When there are items to review between rights review committee meetings, an agency provider must have a process for giving interim approval.
4. The rights review committee members must be free of conflict of interest and ensure they keep participant information confidential.

    a. Agency provider employees who write programs for or directly provide services to a participant cannot make committee decisions for the participant.
    b. At least half the committee members must be participants, family of participants, or other interested people who are not agency provider employees.
    c. An agency provider may include mental health, behavioral, and medical professionals to provide expertise when reviewing rights restrictions related to mental health, problem behavior, psychotropic medication, or medical needs.

L. **Participant Finances and Property:** An agency provider must safeguard the funds and property of a participant, whether or not the agency provider acts as payee for a participant.

1. An agency provider must ensure participant personal funds and property are:

    a. Accessible to the participant;
    b. Not used or withheld as reward or punishment for a participant's behavior or completion of a task;
    c. Not used as payment for damages caused by a participant, unless doing so is team approved and documented in the participant's PCP;
    d. Not used as payment for damages caused by a participant when the agency provider failed to provide supports as documented in the participant's PCP; and
    e. Not borrowed or used by agency provider employees or contractors.

2. When a participant does not have the skills to manage their finances, the participant may temporarily transfer management of their finances to an agency provider.

    a. A participant must give informed consent to the agency provider before the agency provider begins managing the participant's finances.
    b. Management of a participant's financial resources by the agency provider:

        i. Must not be done for the convenience of the agency provider;
        ii. Must be temporary and reviewed at least annually;
        iii. Must not be transferred to another entity; and

iv. Should be free of charge to the participant.

c. A participant's PCP team must discuss and document in the PCP:

i. The amount of involvement the participant will have in management of their finances;
ii. The participant's informed consent for an agency provider to manage finances; and
iii. The reason for an agency provider to manage finances.

d. When an agency provider is responsible for management of participant funds, the agency provider must:

i. Keep a separate financial record for each participant, which includes petty cash;
ii. Provide a statement with account balances and records of transactions to each participant at least quarterly and as requested by the participant;
iii. Ensure expenses over $150 are approved by the participant and their PCP team is notified of the expenses;
iv. Address financial errors, overdrafts, late fees, and missing funds due to agency provider error, including taking responsibility for any service charges or fees, replacing missing funds promptly, and taking steps to correct a participant's credit history; and
v. Maintain a separate accounting for each participant when the agency provider maintains participant funds in a common trust.

e. An agency provider must notify a participant of all costs associated with receiving services from the agency provider and terms of payment.

i. The notice of cost specifies a participant is not responsible for costs covered through available funding sources, such as Medicaid.
ii. The provider gives written notice before services begin and before any change to a participant's costs.

(1) The provider must give the participant notice of the change at least ten calendar days before the change takes place to allow a participant time to respond.
(2) The notice must be given in a language the participant understands.

M. **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.

N. **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. Participant room and board;
   b. Agency provider startup costs; or
   c. 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 DD 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.

3. When a participant receives Continuous Home, Host Home, Shared Living, or Youth Continuous Home, the rate for this service includes 15 eight-hour days in which the participant does not attend their regularly scheduled day services and remains in their home.

   a. The agency provider cannot bill for additional services for the first 15 days.
   b. When a participant has more than 15 days, the agency provider may bill for delivery of other Medicaid HCBS DD Waiver services.
   c. The agency provider is responsible for documenting the 15 days and providing documentation when requesting to bill other waiver services.
   d. DDA counts the 15 days per calendar year, which is January to December.

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

P. **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 followed:

   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.
4. Within 14 calendar days of submitting the initial incident report, the agency provider must:

   a. Submit a written report of the investigation, via GER Resolution form, in the state-mandated web-based case management system; and
   b. Notify the participant and, when applicable, the participant's guardian, of the outcome of the investigation and any actions taken by the agency provider which affect the participant.

5. An agency provider must complete a quarterly report analyzing all reported incidents.

   a. The provider submits the report to DDA central office.
   b. The report is due no later than 30 calendar days after the last day in the quarter.
   c. The report must include a compilation, analysis, and interpretation of data.
   d. The report must evaluate performance with the intended result of reducing the number of incidents over time.

Q. **State Transition Plan Requirements:** CMS established new rules for all home and community-based settings receiving Medicaid HCBS DD Waiver funds, to make sure people have opportunities to access their communities and receive services in the most integrated settings. Requirements include, but are not limited to:

1. The participant chooses the setting where they receive services.
2. A participant must have the same responsibilities and protections from eviction, which tenants have under state and local laws. When these laws do not apply, there must be a lease or other legally binding agreement in place to provide those protections.
3. A participant must have privacy in their residence or bedroom, with a lock controlled by the participant and appropriate employees or contractors.

4. A provider must allow a participant to furnish and decorate their own room and living areas, to have access to food at any time, and to have visitors of their choosing at any time.
5. A participant sharing a residence must have choice of their housemates.
6. A participant must have the opportunity to choose individualized and meaningful activities throughout the day;
7. The interests of a participant are the primary focus when scheduling their activities;
8. The service setting is located in the community, and facilitates community integration;
9. Tasks and activities are comparable with those available to people who do not receive Medicaid HCBS DD Waiver services;
10. The service setting offers a location for everyone to securely store their belongings; and
11. A provider must keep all schedules for a participant's therapies, medications, diet, and other personal information in a private area, away from general operating areas of the setting.

R. **HCBS Settings Assessments:** As a part of the Medicaid Final Setting Rule, which amends federal regulations implementing Medicaid HCBS Waivers within Section 1915(c) of the Social Security Act, all provider-owned, operated, or controlled settings must be assessed for Final Rule compliance.

Service Authorizations will not be approved until a setting is fully compliant. Providers will not be able to bill for services before the authorization is approved.

1. Agency providers are required to:
    a. Complete an electronic self-assessment for all new settings prior to providing services in the setting; and
    b. Both Residential and Non-Residential Self-Assessments can be accessed here.
    c. Submit self-assessments to DDA 15 business days prior to beginning services in the setting.
2. DDA reviews the assessment within 15 business days to determine if:
    a. The agency provider is partially compliant. The agency provider is required to correct the identified issues and submit evidence of remediation to DDA.
    b. The agency provider is fully compliant. The agency provider is permitted to begin providing services in that setting or
    c. DDA needs to complete an on-site visit. When an on-site visit is determined necessary, DDA will notify the provider by phone to schedule the visit.
3. DDA emails notification letters to agency providers with results of the self-assessments.
4. The agency will not be permitted to begin services in the setting until the setting is found to be fully compliant by DDA.
5. This same process is used when DDA completes ongoing, on-site monitoring of settings to ensure continued compliance.
    a. Sampling is randomized and stratified.
    b. Targeted selection of on-site monitoring may also occur at the discretion of DHHS.

S. **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.

T. **Terminating Agency Provider Certification:** DDA or DPH may terminate an agency provider's certification when:

1. An immediate and serious threat exists to a participant's health and safety;
2. The agency provider failed to report suspected abuse or neglect;
3. The agency provider committed a crime in the list of specific crimes published on the Medicaid Program Integrity website under the Provider Screening Guidelines, or allowed one to be committed;
4. The agency provider has not corrected problems identified by DHHS;
5. The agency provider has not used quality improvement activities to ensure compliance on an agency provider-wide basis;
6. The agency provider failed to disclose information or provided incomplete or incorrect information on the application; or
7. The agency provider has failed to submit an acceptable plan of improvement or follow disciplinary action as directed by DHHS.

U. Failure to comply with provider requirements may result in reduction in or reimbursement of funds, disciplinary action, or termination of certification.

7.3 Independent Provider Requirements

A. An independent provider must follow all core requirements for providers of Medicaid HCBS DD 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 DD Waiver services.

1. An independent provider is employed by a participant, rather than being an employee of an agency. When a participant uses an independent provider, they are self-directing services.
2. An independent provider:

    a. Is found, hired, dismissed, scheduled, trained, and supervised by a participant;
    b. Must become enrolled as a Medicaid independent provider;
    c. Must meet requirements and have an authorization to provide each Medicaid HCBS DD Waiver service;
    d. Cannot be legally responsible for a participant who employs them; and
    e. Cannot live with a participant when providing respite, homemaker, or home modifications.

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

    a. Assistive Technology;
    b. Child Day Habilitation;
    c. Community Integration;
    d. Environmental Modification Assessment;
    e. Home Modifications;
    f. Homemaker;
    g. Independent Living;

h. LRI Personal Care;
i. Remote Supports;
j. Respite;
k. Supported Employment – Follow-Along (not available on the FSW);
l. Supported Employment – Individual (not available on the FSW);
m. Supported Family Living;
n. Transitional (not available on the FSW); and
o. Transportation.

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

B. **Considerations for a Potential Independent Provider:** Before becoming an independent provider of Medicaid HCBS DD Waiver services, a potential independent provider should have:

1. Knowledge, education, or experience in working with people who have DD; and
2. The ability to keep electronic records in the state-mandated web-based case management system.

C. **How to Become an Independent Provider:** A potential independent provider must complete the following steps to enroll as an independent provider:

1. DDA recommends a potential independent provider attend orientation.

   a. At orientation, DDA gives information on DHHS divisions, DD services, independent provider requirements, and how to complete the Medicaid enrollment process.
   b. Orientation is an opportunity for a potential independent provider to ask questions.
   c. A potential independent provider must contact DDA central office to sign up for orientation.
   d. DDA offers orientation monthly.

2. A participant refers a potential independent provider to DD service coordination to start the Medicaid enrollment process.
3. The Service Coordinator works with the potential independent provider and participant to complete a referral form and sends the form to DDA Central Office.
4. DDA Central Office enters the referral into the DHHS mandated electronic Medicaid independent provider enrollment system. The potential independent provider will receive an email or a mailed application packet from the Medicaid independent provider enrollment system.
5. A potential independent provider completes and submits the Medicaid independent provider application using the Medicaid independent provider enrollment system. Instruction for independent provider screening and enrollment is available online. *For enrollment instructions, see Policy Manual Appendix E: Contacts and Resources.*
6. The Medicaid independent provider enrollment system completes screening and background checks on a potential independent provider.

   a. The potential independent provider must complete and provide documentation of training in the following areas to be enrolled as a Medicaid independent provider:

      i. State reporting requirements and prevention of abuse, neglect, and exploitation; and

ii. CPR (cardiopulmonary resuscitation) and basic first aid from a program, which includes in-person training and is OSHA-approved for the workplace.

b. Verification of the potential independent provider's age and qualifications to provide Medicaid HCBS DD Waiver services offered by the independent provider.
c. All background, criminal history, and registry checks required by state and federal regulation are completed, including checks of the Central Registry of Child Protection Cases and Adult Protective Services and the Nebraska State Patrol Sex Offender registry.

7. When a potential independent provider will provide approved services in their home, all members of the potential independent provider's household age 13 or older must pass the same background and registry checks as the potential independent provider.
8. A potential independent provider cannot be enrolled to provide services 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 when convicted or charged awaiting resolution with any crime in the list of specific crimes published on the Medicaid Program Integrity website under the Provider Screening Guidelines..
9. When Medicaid denies enrollment, DDA central office and the independent provider receive a notification from the Medicaid independent provider enrollment system.

a. DDA central office notifies the participant's Service Coordinator; and
b. The PCP team discusses a plan to explore alternative options.

10. When Medicaid approves enrollment, Medicaid notifies the independent provider and DDA central office.

a. DDA central office notifies the participant's Service Coordinator;
b. The Service Coordinator makes sure the PCP includes services, schedule, and expectations for the new independent provider; and
c. The Service Coordinator authorizes the approved services.

D. **Training:** Once an independent provider is enrolled, the participant who employs the independent provider is responsible for training.

1. The participant must provide any training and information needed for the independent provider to meet the participant's needs and expectations.
2. The participant must direct the independent provider to resources to receive additional training to meet DDA expectations. This may include:

a. The state-mandated web-based case management system; and
b. Habilitation.

3. It may be helpful to the participant and independent provider to have a written record of the participant's expectations and training.
4. DDA has developed some training for independent providers of Medicaid HCBS DD services. These trainings are available on the DDA website.
5. An independent provider is responsible for the cost of all training.

E. **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. Habilitation programs and data;
    c. Employment History;
    d. Incident reports;
    e. Financial records; and
    f. Health 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.
5. An independent provider must maintain participant health-related records in the state-mandated web-based case management system when a participant's PCP assigns responsibility for the participant's healthcare to an independent provider. This includes, but is not limited to:

    a. Physician contact forms;
    b. Medical orders or recommendations;
    c. Hospital records and discharge instructions;
    d. Therapy notes or progress reports; and
    e. Results of medical assessments or exams.

F. **Billing:** DDA pays an independent provider at the rate chosen by the participant for services billed.

1. A participant negotiates the hourly rate DDA pays their independent provider, up to the maximum rate set by DDA. *For a link to the fee schedule with maximum rates, see Policy Manual Appendix E: Contacts and Resources.*
2. A participant is responsible for managing their annual individual budget amount, setting rates, and scheduling services based on their needs and budget.
3. DDA withholds FICA (Federal Insurance Contributions Act) taxes from payments for the following services:

    a. Homemaker; and
    b. Respite when provided in a participant's home.

4. Taxes withheld and paid by DDA do not include state or federal income tax or other taxes. It is the responsibility of an independent provider to pay all applicable taxes.
5. An independent provider cannot bill for some activities related to providing services to a participant.
6. 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 to be attending school or can be receiving services provided through the educational system.

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

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

8. A participant who employs an independent provider monitors the independent provider's billing to ensure the independent provider bills accurately for services provided.

   a. When a participant has questions about an independent provider's schedule or an independent provider's billing does not match the participant's records, the participant should direct the independent provider not to bill until any differences are resolved.
   b. The participant is required to report any billing concerns to their Service Coordinator.

G. **Participant Finances and Property:** An independent provider must safeguard the funds and property of a participant.

1. An independent provider must ensure the participant's personal funds and property are:

   a. Accessible to the participant;
   b. Not used or withheld as reward or punishment for the participant's behavior or completion of a task;
   c. Not used as payment for damages caused by the participant, unless doing so is team-approved and documented in the participant's PCP;
   d. Not used as payment for damages caused by the participant when the independent provider failed to provide supports as documented in the participant's PCP; and
   e. Not borrowed or used by the independent provider.

2. An independent provider may act as a payee for a participant's benefits, and may assist a participant in managing their finances, such as wages, personal assets, or inheritances.

   a. The independent provider cannot be the parents of a minor participant, or a participant's guardian, conservator, spouse, or power of attorney.
   b. When an independent provider is a Social Security Administration (SSA) representative payee, they must follow all SSA payee requirements.

7.4 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.

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. A person may make 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 E: Contacts and Resources.*

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

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
Email: DHHS.HIPPAOffice@nebraska.gov

7.5 Virtual and Remote Supports as Modalities within Existing Services Provider Requirements

This section is specific to the use of virtual or remote supports as a modality of delivering an existing service. Guidance on virtual or remote supports in this section is not the same as guidance for the standalone Remote Supports service.

A. Virtual and remote supports are the provision of direct supports by a provider who is at a different location from the participant, by engaging with the participant through electronic devices capable of live, real-time audio and video connection, which allows the provider and participant to see and hear each other.

1. Virtual and remote supports are intended to:

   a. Maximize the use of technology to increase flexibility and choice for the participant in choosing when and where they receive support virtually;
   b. Maintain or improve a participant's functional abilities, while promoting increased independence, meaningful community integration, and flexibility in service; and
   c. Be structured and scheduled, or offered on-demand, depending on the participant's preferences and need.

2. Virtual supports are available to participants in the basic and intermediate funding tiers.

   a. The participant's needs must be able to be met by verbal cuing and other supports that can be provided virtually.
   b. The participant must be able to operate the devices and communication platforms used for virtual support without in-person assistance.
   c. Participants in the high, advanced, or behavioral risk funding tiers cannot use virtual supports, as they typically have needs and risks which require in-person service provision.

3. Remote supports are available to participants receiving Continuous Home, Host Home, or Shared Living services.

   a. Remote supports are not intended to monitor ADLs.
   b. Video cameras or monitors are not permitted in bedrooms or bathrooms.
   c. The participant must have the option of in-person services at any time they choose.

B. **The following services can be delivered via virtual support:**

1. Independent Living and Supported Family Living

   a. The majority of each service provided weekly must be provided in-person.
   b. Virtual support can be used for up to 10 hours per week, within the weekly service amount.

2. Benefits Counseling, Community Integration, Day Supports, Employment Exploration, Prevocational, and Supported Employment – Individual

   a. The majority of each service provided weekly must be provided in-person..

b. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours.
c. The 10 hours are included in the 1,820 annual cap on day services.

3. Family and Peer Mentoring

C. **The following services can be delivered via remote supports:**

1. Continuous Home

a. The majority of each service provided weekly must be provided in-person.
b. Remote supports can be used for up to 10 hours per week during awake hours.

2. Host Home and Shared Living

a. The majority of each service provided weekly must be provided in-person.
b. Remote supports can be used for up to 10 hours per week.

D. **Considerations for using virtual and remote supports:** Virtual supports must be person-centered and promote the independence of the participant.

1. The participant must have informed choice between in-person and virtual or remote supports and must affirmatively choose virtual or remote supports over in-person supports.
2. Informed choice includes ensuring the participant received information on how services will be delivered, any risks associated with not having the provider on-site, possible impact to the privacy of the participant, and discussion of back-up plans.
3. Use of virtual or remote supports must not lead to the isolation of the participant from the community or from interacting with other people.
4. The participant must have opportunities for community integration and interaction through other waiver services they receive or supports should not be delivered virtually or remotely.
5. A participant may choose to discontinue virtual or remote supports at any time, effective immediately.

E. **Virtual and remote supports are not intended to be used:**

1. For the convenience of the provider;
2. Due to shortage of staff;
3. With a sleeping participant (with the exception of participants receiving Continuous Home); or
4. To assess a participant's medical needs or condition.

F. **Agency and independent providers must:**

1. Be attentive to the needs of the participant when providing virtual or remote supports and not be responsible for other participants or have other responsibilities.
2. Ensure Privacy:

a. Technologies used to deliver virtual supports must comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534; and

b. Educate the participant and direct support professionals on appropriate topics to discuss when virtual or remote supports are being provided when the participant is in a public place or where others can hear the conversation.

3. Procure devices used in virtual or remote supports for service:

a. Provide ongoing training on use of devices; and
b. Maintenance and replacement of devices.

i. The provider is responsible for procurement, maintenance and replacement of devices used by the provider.
ii. The provider is exempt from these requirements when a participant already possesses a device which can be used to deliver virtual or remote supports or when the device used for virtual or remote supports are procured using the Assistive Technology waiver service.

4. Have back-up plans for when devices malfunction or when in-person support is needed. The provider must have:

a. A back-up power system;
b. A system for notifying emergency personnel, such as police, fire, or emergency medical services (the provider should always know the physical location of the participant when providing virtual or remote services in the event EMS needs to be contacted); and
c. Detailed written protocols for responding to the participant's needs as specified in the participant's plan, including contact information for the back-up support person to provide in-person support as needed.

i. A back-up support person is required for a participant receiving virtual services. This person is responsible for responding to where the participant is in the event of an emergency or when the participant receiving support needs in-person assistance.
ii. The back-up support person may be a natural support or a paid provider.
iii. The back-up support person must be available to respond when an emergency or need for in-person support occurs.
iv. When the back-up person cannot be reached, the provider responsible for remote supports will maintain contact with the participant to monitor for safety while continuing attempts to reach the back-up person until in-person supports can be arranged.

G. **Agency providers:** When providing a portion of allowable services virtually or remotely, policies and procedures must address:

1. Identifying whether the participant's needs, including health and safety needs, can be addressed safely via virtual or remote supports;
2. Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
3. Obtaining written informed consent from the participant, guardian (when applicable), and any others potentially impacted by provision of virtual or remote supports, and maintaining records of these consents;

4. The process for requesting support from the back-up person or contacting EMS when the participant experiences an emergency during virtual or remote support or requires on-site support; and

H. **Independent providers:** When a participant chooses to receive a portion of allowable services virtually, the independent provider and the participant will develop a written plan outlining:

1. When in-person support may be needed;
2. How in-person support will be provided in the event of:
    a. The device malfunctioning;
    b. In the event of an emergency; and
    c. When the participant requires on-site support rather than virtual support.
3. Independent providers must submit their written plan for providing virtual supports to the participant's Service Coordinator for approval.

I. **Billing Virtual Support:** Services delivered virtually are billed using the Attendance module in the state-mandated case-management system.

1. Services delivered virtually will not be billed through EVV.
2. There are specific service codes for virtual supports, so services delivered via virtual supports must be billed separately from services delivered in-person.

J. **Billing Remote Supports:** Services delivered remotely as part of Continuous Home, Host Home, and Shared Living will not be billed separately. They are a part of the service and will be included in the daily rate.

7.6 Provider Financial Requirements

As a part of the ongoing effort to improve the quality of services funded by DHHS, DDA has created a new Cost Report. This Cost Report will be used to document their Nebraska-based revenues and expenses. All providers are required to submit a cost report. DDA intends to use data aggregated from these cost reports for rate setting purposes.

A. All providers are required to submit Cost Reports for a 12-month period annually according to their fiscal year.
    1. These submissions are due no later than six months after the closure of the provider's fiscal year.
    2. Providers will be contacted if there are any incomplete sections or incorrect responses included in the report and will be required to return corrections according to DDA's request. Division will mail a letter 30 days prior to due date as a courtesy.
        a. Failure to complete any section of the Cost Report or any of the accompanying materials within six months of the closure of the provider's fiscal year will result in an incomplete submission.
    3. Failure to complete the cost report or request up to a 90-day extension through alternative compliance may result in sanctions.
        a. A one-time approval of extensions may be granted for good cause at the sole discretion of DHHS. The provider will be notified in writing of the approval or denial. A "good cause" is one that supplies a substantial reason, affords a legal excuse for the delay, or explains an intervening action beyond the provider's control.
        b. Requests for alternative compliance extensions must be submitted to dhhs.ddcostreports@nebraska.gov prior to the reporting deadline.

B. A completed Cost Report and accompanying materials must be submitted electronically by e-mail to DDA to: dhhs.ddcostreports@nebraska.gov.

C. The provider Cost Report includes:

1. A cover page, which includes:
   a. **Agency Provider –** Name of the Agency Provider completing the Cost Report.
   b. **Completed by –** Name of the individual responsible for completing the Cost Report.
      i. Third-party CPAs should include the name of their firm.
   c. **Submission Date –** Date of submission to DDA. This cell does not need to be completed before completing the remainder of the Cost Report.
   d. **Contact Information –** Phone and e-mail address for the individual completing the Cost Report.
   e. **Reporting Period**
      i. **Fiscal Year –** Fiscal year reported in the Cost Report (YYYY).
      ii. **Period Start Date –** First day of the fiscal year reported in the Cost Report (MM/DD/YYYY). Failure to input this information before completing the Cost Report will limit the functionality of the Cost Report.
      iii. **Period End Date –** Last day of the fiscal year (MM/DD/YYYY). This information will be automatically populated based on the information provided for the Period Start Date.
2. **Schedule A (*Expenses*) –** This section organizes all provider expenses by waiver service type and cost account code. Additionally, non-DDA related expenses and funding will be broken out in separate columns. Providers are only expected to list expenses accrued as a result of their Nebraska-based operations. This section will be populated by the provider.
   a. **Horizontal Axis:** Waiver Services, Other Non-DDA Program, Fund Raising, and Total columns.
      i. **Waiver Services** – The first 26 columns of the horizontal breakout distinguish provider costs by each waiver service (Adult Day Habilitation, Respite, etc.).
         (1) Whoever fills out the Cost Report will indicate which services are offered by the agency provider with a yes or no in the yellow cell at the top of each column.
         (a) Selections made on Schedule A will carry over to Schedule B.
         (2) Any methodology for breaking out expenses that apply across different services must be documented in the provider's accompanying Cost Allocation Plan.
      ii. **Other Non-DDA Programs –** This column is for reporting expenditures for services other than those listed in the appendices in this Cost Report. Report Expenditures associated with services not purchased by DDA would fall into this category.
      iii. **Fund Raising –** Expenses normally charged to this function include costs of transmitting appeals to the public and the salaries of the staff members who fund raise for the agency.
         (1) These staff should include the staff members who devote time to record keeping for fund raising.
      iv. **Total –** This column adds each of these respective columns together. The sum of all totals in this column should represent the total expenses from the operating statements of the agency for the reporting period. The total of the expenses must reconcile to the independent audited financial statement.

b. **Vertical Axis:** Cost Center Totals
   i. Costs should be allocated by direct assignment to the benefitting cost centers based on time study or activity logging unless otherwise indicated. Personnel costs listed on Schedule A should match those logged in the 1010, 1020, and 1030 sections of the Cost Report unless a discrepancy is explained in the "Notes" section of the Cost Report. Any discrepancies will be reviewed by DDA.
   ii. Please refer to Appendix A: DDA Proposed Chart of Accounts for a detailed description of each account.

c. **Attachment to Schedule A (Parent-Subsidiary/Related Organization Disclosure)** – Providers must disclose any costs applicable to services, facilities, and supplies furnished to a provider by a parent-subsidiary/related organization. If such costs exist, the provider must also produce an appropriate statement of costs to demonstrate that the costs do not exceed the lower of the cost to the parent- subsidiary/related organization or the price of comparable services, facilities, or supplies purchased elsewhere, primarily in the local market.

3. **Schedule B (*Revenues*)** – This section organizes all provider revenues by waiver service type and revenue account code. Additionally, non-DDAD-related revenues and funding will be broken out in separate columns. Providers are only expected to list revenues earned as a result of their Nebraska-based operations. This section will be populated by the provider.

   a. **Horizontal Axis:** Waiver Services, Other Non-DDA Programs, Fund Raising, and Total Columns
      i. **Waiver Services** – The first 26 columns of the horizontal breakout distinguish provider costs by each waiver service (Adult Day Habilitation, Respite, etc.).
         (1) Selections from Schedule A indicating whether the agency provider offers a specific waiver service will automatically carry over to Schedule B. Failure to make a selection on Schedule A first will prevent the completion of Schedule B. Do not input any data into columns for waiver services not offered by the agency provider. If data is inadvertently placed in the column an "ERROR" message will appear.
         (2) Any methodology for breaking out revenues that apply across different waiver services must be documented in the provider's accompanying Cost Allocation Plan.
      ii. **Other Non-DDA Programs** – Use this column for reporting revenues associated with services other than those listed in the appendices in this Cost Report. Report revenues associated with services not purchased by the DDA would fall into this category.
      iii. **Fund Raising** – Include all revenues connected with fund raising for the agency, capital campaigns, foundations, etc. in this section.
      iv. **Total** – This column adds each of these respective columns together. The sum of all totals in this column should represent the total revenues from the operating statements of the agency for the reporting period. The total of the revenue must reconcile to the independent audited financial statement.
      v. If the variance between DD reported allocations and provider reported DD allocations are greater than 10% a letter of clarification will be sent to the provider requesting an explanation.

   b. **Vertical Axis:** Revenue Center Totals
      i. Please refer to Appendix A: DDA Proposed Chart of Accounts for a detailed description of each account.

4. **Schedule C (*Census*)** – Providers of DDA services are not required to fill out Schedule C (Census). This section will automatically populate based on the 1010, 1020, and 1030 Attachments. Staff information and descriptions will pre-populate based on the selections in the attachments. Schedule C gives information on the following:
    a. Total Salaries by Staff Position:
        i. Administrative;
        ii. Professional Program Staff; and
        iii. Support Staff.
    b. Total FTEs by Staff Position
    c. Total Turnover by Staff Position
5. **Schedule D (*Turnover*)** – *Providers of DDA services are not required to fill out Schedule D (Turnover)*. This section will automatically populate based on the 1020 Attachment. This section gives DDA an understanding of turnover for Direct Support Professionals (DSP) at a provider's agency. It allows DDA to gain insight into the following:
    a. Track turnover by agency and have individual conversations about how their metrics have trended over time.
    b. Assess correlation by agency between turnover and other key metrics (i.e., salary, employment duration) using payroll data.
    c. Reliably benchmark and monitor turnover to measure the impact of change initiatives.
    d. Used in conjunction with the SSSR, a second source of turnover data allows comparison and verification of existing turnover metrics.
6. **Staffing and Payroll Attachments –** The 1010, 1020, and 1030 Attachments should be filled out by the provider. Each attachment gives payroll information on the following employees:
    a. **1010 Attachment** – Administrative Staff – Office staff who do not spend more than 10% of their time providing direct care supports for participants.
    b. **1020 Attachment** – Professional Program Staff - DSPs and front-line supervisors who spend at least 75% of their time providing direct care supports for participants.
    c. **1030 Attachment** – Support Staff – Support staff who spend 75% or less of their time in the provision of direct care supports. Examples of these include Counselors (CCDC, MH, DD, REHAB, etc.), Speech, Physical and Occupational Therapists, Direct Support Professionals, Supervisors and Residential Managers. The provider only needs to complete the unlocked columns that are highlighted in black on the top of the worksheet (Employee ID Number, Agency Provider Position Title, Staff Name, Start Date, End Date, Reason, Salaried/Hourly, Regular Hours, Training Hours, Overtime Hours, Reduced Pay (Call/Overnight) Hours, Paid Leave (Vacation & Personal), Sick Leave, Pooled Paid Time Off, Base Wage/Salary and Bonus). The remaining columns that are highlighted in grey (# Leavers, Total Hours Paid, Total Wages, and Wage per Hour) will automatically populate. Please note that answers for Position ID, Reason, and Salaried/Hourly should be selected from the drop-down menus in each column.
7. **Notes** – Each section in the Cost Report is followed by a section for notes. This is where any revenue or expenses that could not be easily categorized into an existing account can be explained. This can also be used to clarify any assumptions made when completing the Cost Report or any other relevant notes that would assist DDA in reviewing the Cost Report.
8. **Accompanying materials –** In addition to the Cost Report form, providers must also include the following accompanying documents to supplement their submissions.
    a. **Chart of Accounts** – Each provider must submit a copy of its Chart of Accounts. While providers are not required to use the Division's proposed chart of

accounts, each provider must demonstrate how its chart of accounts compares to the Division's proposed chart of accounts. See Appendix A for additional information.

b. **Cost Allocation Plan** – Each provider must submit a Cost Allocation Plan that:
   i. Identifies each expense account in the provider's Chart of Accounts that contains expenses shared across multiple waiver services and/or shared between DDA and non-DDA services.
   ii. Documents the method used for allocating the expenses.

c. **Data Validation tool** – Each provider must submit the DDA Cost Report Data Validation Tool to validate the value for Total Revenues, Total Expenses, and Total Payroll Expenses reported in the Cost Report against the same values reported in the provider's audited financial statements.

d. **Financial Loss Reporting Requirement** – Providers reporting a financial loss on their cost report will be required to complete an additional tab within the cost report explaining the loss and providing supporting information regarding the agency's financial condition and sustainability plan.

e. **Audit Report** – Providers with more than $1,500,000 in gross receipts from Medicaid Home and Community Based Services developmental disabilities waiver program payments for its fiscal year must submit an audit report with their cost report, completed by a certified public accountant including the following information:
   i. A review of receipts and disbursements;
   ii. A review of cash control procedures;
   iii. An audit of the provider's income statement, balance sheet, source, and use of funds statement;
   iv. An accounting of all lease agreements and mortgages;
   v. A review of the cash balance on hand at the beginning and end of the fiscal year;
   vi. A disclosure of all related party transactions, or a statement attesting that no such transactions were found;
   vii. A disclosure of all deficiencies in internal control over financial reporting identified during the audit; and
   viii. An accounting of all business lines of credit for which the provider is approved at the end of its fiscal year.

D. All cost and revenue figures in the document should be rounded to the nearest dollar unless specifically requested otherwise.

E. Amendments to reported costs will not be allowed after the Cost Reports have been used to determine rates.

F. A provider should maintain the required records and financial information sufficient for a proper audit or review.
   1. This should include documentation to support the rationale for assigning costs and revenues to specific waiver services and cost centers.
   2. Sufficient data must be available on the audit date to fully support any item being claimed on the Cost Report.
   3. Accounting or financial information regarding related organizations must be readily available to substantiate costs.

G. Providers must maintain financial records used for the preparation of the Cost Report for a minimum of five years.

8. Partnership with Assistive Technology Partnership (ATP)

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's 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 vehicle modification will need to speak with their Service Coordinator to fill out an ATP Referral.

8.2 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 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. 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.

C. 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.

8.3 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.
   2. When the referral meets the 3 criteria, and the explanation of limitations is clear, ATP will complete the EMA to determine possible solutions.

B. Refrain from making recommendations for specific solutions 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 authorizing representatives for the AD and TBI waivers.
    2. This referral form will be used for participants determined to be eligible for services under those waivers.

8.4 Conditions of Provision

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

B. Services include:
    1. 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.

8.5 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:
    4. Modifications that are considered general utility and home repairs;
    5. Standard housing obligations;
    6. Carpeting;
    7. Roof repair;
    8. Sidewalks;
    9. Storage and organizers;

10. Hot tubs;
11. Whirlpool tubs;
12. Landscaping;
13. General construction costs in a new home or additions to a home purchased after enrollment in the waiver;
14. 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;
15. Improvements exclusively required to meet local building codes;
16. Adaptations to assisted living apartments; and
17. Modifications to facility provider settings.

D. Items excluded from eligibility for Vehicle Modifications:
18. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
19. Purchase or lease of a vehicle;
20. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications; and
21. 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.

8.6 Funding Exceptions

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 and the participant, family, or guardian is unable to cover the remaining cost, the SC will consult with their SCS on a modification funding exception and route a request to DDA Central Office for final approval.

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

9. Partnership with Vocational Rehabilitation

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 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 DD Waiver services can only be used after all other available resources.

9.1 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 worker's 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 Person-Centered Plan (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.

9.2 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. Lost their job.

C. To complete a referral to VR:

1. A participant, their DD Service Coordinator, 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 Service Coordinator 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 Medicaid HCBS DD 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. When a participant would like some assistance in determining the impact of working more hours, they may benefit from utilizing the Benefits Counseling service.

9.3 Services Provided by Nebraska VR and NCBVI

DDA expects participants ages 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 HCBS DD 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. A DD provider can become a vocational rehabilitation provider.
2. The DD 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.

9.4 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. A DD 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 DD 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. A DD 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.

9.5 DDA Role

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

1. When a student transitions from school to a Medicaid HCBS DD 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.
3. When long-term DD support is needed to continue employment:

a. The participant cannot be offered the Medicaid HCBS DD Adult Day Waiver until they turn 21 years old; or
b. When the person is a participant of the Medicaid HCBS Comprehensive DD Waiver, they cannot use employment-related DD services until the end of the school year in which the participant turns 21.

B. When a participant is using vocational rehabilitation services, their VR counselor should participate in service planning with the PCP team.

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.

9.6 Availability of Developmental Disabilities Services

The availability of employment-related Medicaid HCBS DD 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. When the participant is eligible for and receiving vocational rehabilitation services, Small Group Vocational Support is not available.
B. A participant using vocational rehabilitation can use other DD day services:

1. Adult Day Services;
2. Behavioral In-Home Habilitation;

3. Community Integration;
4. Day Supports;
5. Independent Living;
6. Medical In-Home Habilitation;
7. Prevocational (initial referral to VR and only during Milestone #1);
8. Respite;
9. Supported Family Living.

C. When a participant is receiving vocational rehabilitation services and day services, the total combined day hours cannot exceed 1,820 hours per year.

1. Service coordination should receive a copy of the vocational rehabilitation authorization.
2. The PCP team must discuss a schedule for services when the day hours are split between DD services and VR services.

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

1. Medicaid HCBS DD 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.

E. When a participant is ineligible for VR services, they may decide to use Small Group Vocational Support:

1. Small Group Vocational Support, where a participant works in a business setting.

    a. Small Group Vocational Support is not a competitive integrated job because the business does not employ the participant.
    b. The DD provider has an agreement with an employer for the job. The employer pays the DD provider, and the provider pays the participant.
    c. When the participant needs to learn skills related to being in a business, Small Group Vocational Support may be beneficial as a stepping-stone to competitive integrated employment.
    d. Once the participant has gained employable skills, they must be referred to VR.

F. When a participant refuses VR services or does not make it past VR referral, day services are limited. The following Medicaid HCBS DD Waiver day services are not available:

1. Prevocational;
2. Small Group Vocational Support;
3. Supported Employment – Follow-Along; and
4. Supported Employment – Individual.

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

1. When a participant needs continued support to maintain employment, they can use their budget to purchase a Medicaid HCBS DD Waiver-supported employment service.
2. When the participant's vocational rehabilitation provider is also a DD provider, there is no gap in services when a participant shifts from the VR to Medicaid HCBS DD Waiver funding.

3. A vocational rehabilitation service is not a Medicaid HCBS DD Waiver service, so it does not meet the requirement for a participant to use a Medicaid HCBS DD 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. Benefits Counseling authorizations beyond 30 hours per year;
B. Behavioral In-Home additional occurrences after 90 calendar days;
C. Community Integration and Respite serving individuals 18 years and older and children 13 years and younger;
D. Continuous Home for individuals 18 years and younger;
E. LRI Personal Care provided by an independent provider;
F. Home and Vehicle modifications above $10,000;
G. Host Home for individuals 18 years and younger;
H. Medical In-Home additional occurrences after 90 calendar days;
I. Shared Living for individuals 18 years and younger; and
J. Youth Continuous Home for more than 12 months in 3 years.

10.1 Benefits Counseling Authorizations Beyond 30 Hours Per Year

A. DDA Central Office approval is required for authorization of Benefits Counseling beyond 30 hours in a 1-year period.
B. Benefits Counseling is a service designed to inform the participant of their pathways to obtaining individualized, integrated employment or self-employment, including how employment may impact their current benefits.

10.2 Community Integration and Respite Serving Individuals 18 Years and Older with Children 13 Years and Younger

DDA Central Office approval is required for settings where Community Integration and Respite services are being provided for individuals aged 18 and older and children aged 13 and younger. Community Integration and 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 Community Integration and/or 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 (PCP).

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.
   1. Following review and approval by the DDA Central Office, the youth participant's assigned SC will document the approved setting in the youth's PCP.

2. The provider is responsible for documenting communication with the teams of all other participants supported in the setting, confirming that the youth will be served in the setting and that those teams agree the arrangement is appropriate.

C. DDA requires that all minor children and adult participants receiving waiver services within the same setting have a documented team discussion and approval prior to receiving services in the setting.

10.3 Youth Continuous Home Extension

DDA Central Office approval is required for participants to receive Youth Continuous Home services for more than 12 months in a 3-year period.

A. The SC will facilitate a meeting with the participant and their PCP Team (including the Youth Continuous Home provider) to discuss the request and complete the appropriate forms.

B. DDA Central Office will review the information for final approval.

10.4 Residential Settings for Youth Ages 18 and Younger (Continuous Home, Host Home, Shared Living)

DDA Central Office approval is required for participants aged 18 and younger to receive Continuous Home, Host Home, or Shared Living services.

A. The SC will facilitate a meeting with the participant and their PCP Team to discuss the request and complete the appropriate forms.

B. DDA Central Office will review the information for final approval.

10.5 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, including requests submitted within the five-year limitation period.

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 SC will review the participant's IBA to ensure they have sufficient funds to cover the remaining cost of the modification.

1. When the modification request has been completed by our ATP partner and is over $10,000 within the 5-year timeframe, the ATP designee will submit the exception request for DDA Central Office approval.
2. When the modification request has been submitted by a provider other than ATP and is over the $10,000 within the 5-year timeframe, the SC will consult with the SCS.

10.6 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 every six months.
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.

10.7 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 area agency providers every six months.
D. When an agency provider is able to 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.

10.8 Shared Living Compliance

A. When there is a significant change to the participant's needs or the home configuration, the agency has 10 days to notify DHHS.
    1. Any changes made should be discussed with the PCP team.
    2. Once notified, the SC will complete the Shared Living Compliance Form.
B. A new home study might need to be completed due to the change being requested.
C. Changes requiring Central Office reviewing include, but are not limited to, the following:

    1. Modifications to the home that may negatively impact the participant(s).
    2. Changes to individuals listed on the Shared Living Provider contract with the agency provider.
    3. An increase in the participant's funding tier to Advance or Risk.
    4. Additional individuals moving into the home.

D. This information will be submitted for Central Office Approval. Once a determination has been made, a letter will be sent to the team.

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. The 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:

1. Nebraska's routine data reviews;
2. Stakeholder complaints; or
3. 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

1. Community Integration
2. Individual Rights
3. Choice and Autonomy
4. Provider-Owned or Controlled Settings Requirements
5. 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**: The 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 State Transition Plan (STP) requirements and applicable federal regulations,
2. Procedure Updates: This STP 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 Setting Rule

A. DD Providers will have an assessment completed by their Service Coordinator (SC) 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 they complete the heightened scrutiny worksheet. The HCBS Final Settings 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 of 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 support, 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.

D. The grievance process is available to participants as an option, with additional details on how to submit grievances provided in the Grievance System Resource document.

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

Chapter 12: Appendices

Appendix A: Incident Reporting and GER Guide

Introduction

The instructions in this guide are for **all providers of Medicaid Home and Community-Based (HCBS) developmental disabilities (DD) waiver services** (both agency and independent) unless otherwise stated. This guide outlines who is responsible for reporting incidents and timelines for required reporting, defines reportable incidents, and describes how incident information should be entered in Therap.

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

- A provider may choose to document/track other incidents that are not reportable to DDA in Therap using GERs with low notification level for internal use, but this is not required.

This guide outlines 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" refers to an independent provider or an employee or contractor of an agency provider unless otherwise specified.

Responsibility for Reporting Incidents

The independent or agency provider delivering a service to the participant at the time the reportable incident occurs is responsible for completing all reporting requirements.

- When a provider discovers that a reportable incident occurred while a different provider was supporting a participant, the provider who learns of the incident must contact the provider who was delivering services at the time of the incident to ask that the responsible provider complete the reporting requirements.
- For example, Tom returns to his group home, which is operated by Provider A, and reports to group home staff that he has a bruise because a peer hit him while at day services operated by Provider B. Provider A is not responsible for completing a report, because the incident did not occur while they were delivering services, but must notify Provider B of the information given by Tom, so that Provider B can complete required reporting.

When an incident occurs at a time when no services are being delivered to the participant, it is **not reportable,** and a GER 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 (SC), so any needed follow-up by the PCP team can be arranged, the SC will complete a case note, but a GER should not be completed.
- 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, a GER is not required, but the provider must still

report the suspected abuse/neglect/exploitation to the DHHS Abuse and Neglect Hotline or law enforcement (see contact information on page 4).

Reporting and Notification Requirements

It is required that all reportable incidents listed in this guide be reported to DDA and that other people be notified that an incident occurred as indicated in the table below. The chart below lists the required reports and notifications, required timelines, and how the reports and notifications must be made.

When reports to DDA are not made as outlined in the table below, the provider is not in compliance with the reporting requirements outlined in state regulation.

Required Notification/ Report	How Notification/Report is Completed	Required Timeframe for Notification/Report
Verbal report to DDA made to the participant's Service Coordinator (SC)	Phone call/voicemail ***If unable to reach SC by phone **and** unable to leave voicemail, notification can be made by secure email or SComm in Therap.* ***Do **not** use text messages, as it is not secure communication.*	As soon as possible but no more than 4 hours after observing or discovering the reportable incident
Verbal notification to the participant's guardian(s) ***Not applicable when the participant has no guardian.* ***When there are multiple guardians, at least 1 guardian must be notified, and the provider must attempt to notify all guardians.*	Phone call/voicemail ***When the provider cannot reach the guardian, a voicemail is sufficient to meet notification requirements.* ***When the provider cannot reach/leave a voicemail for the guardian, all attempts are recorded in the GER.*	*Preferred:* As soon as possible upon observing/discovering the incident *Required:* Within 24 hours of the verbal report to the SC
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 GER.	*Preferred:* As soon as possible upon observing/discovering the incident *Required:* Within 24 hours of the verbal report to the SC
Written report to DDA – All incidents identified in this guide	GER **submitted** in Therap	Within 24 hours of the verbal report to the SC
	Submitted GER **approved** in Therap	Within 72 hours of GER submission

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

- The name of the person making the verbal report and the provider agency they work for (when applicable)
- The participant's name
- The type of incident being reported
- A summary of the incident
- 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 incident, 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
- Death of a Participant
- Emergency Situations
- Fall Requiring More than First Aid
- Fall without significant injury
- Fatal 5 (as defined on page 6)
- Incidents Involving Emergency Personnel Requiring Emergent 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 Emergency Safety Interventions
- 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 GER for agency provider management to review and make a determination.**

When an incident involves suspected or alleged **abuse, neglect, or exploitation**, the 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 providers of HCBS services are *mandatory* reporters of abuse, neglect, and exploitation.

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

For some incident categories related to illness and injury, there are specific illnesses, injuries, or changes in condition that DDA requires to be reported, regardless of whether medical treatment is received or other circumstances. **These criteria are only given as direction for incident reporting.** *DDA 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, back blows, or requiring medical attention.

Allegation or Suspicion of Verbal, Physical, Sexual, Psychological, or 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 the **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.
    - For example, Tom and Sue are participants receiving services at a provider day site. Tom threatens and intimidates Sue so she will give him $10. This is exploitation. Staff discover the situation and contact the abuse and neglect hotline. Sue would have a GER for allegation or suspicion of abuse, neglect, or exploitation, and Tom would have a GER for 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 can be found 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 **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* the 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 HCBS 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 unsafe/damaged in any way.

Definitions of injury and displacement can be found 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 can be found in 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 of sufficient severity to most 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 5 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 can be found in 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. If police respond to an ambulance call but are not directly needed, a law enforcement event would not be required.

Ambulance: The purpose of an ambulance is to capture those events when assistance is needed from emergency medical personnel, regardless of if 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, smoke, etc. 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, and where said insects or animals present a risk of property damage, injury to person, or are known disease vectors.

The presence of an infestation may be detected by observing bites or rashes on the participant's person. Other signs of infestation include, but are not limited to, 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 mosquitos), 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 that are 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 appear 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 back, chest, abdomen, 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.

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

  A definition of injury can be found in Incident Guide Definitions.

Injury Requiring Medical or Nursing Intervention Beyond First Aid

A reportable incident in this category is any injury of **sufficient severity** to 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 a person not receiving HCBS 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 considered to be of sufficient severity to likely require assessment or treatment from a physician:

- Concussion;
- Dislocation;
- Fracture;
- Poisoning;
- Pressure sores/ulcers – newly discovered or untreated; and
- Burns – 3rd degree.

  A definition of injury can be found in 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 can be found in the Incident Event Type Chart.

Misconduct Not Involving Law Enforcement

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

Providers must assess whether the severity of the event meets this criterion, based on whether a person not receiving HCBS services would potentially receive criminal charges for similar conduct. 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 or without prior authorization, and is gone for more than 30 minutes or what is outlined in their person-centered plan.

Misuse or Unauthorized Use of Restrictive Interventions or Seclusion

A reportable incident in this category is when a provider misuses or uses a restrictive intervention or seclusion without authorization.

PRN Psychotropic Medication

A reportable incident in this category is any administration of ***prescribed*** psychotropic medication on a PRN (as needed) basis used as a last resort method when all other behavioral interventions have been ineffective.

A definition of psychotropic medication can be found in 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.

This is only a reportable incident if property damage is not tracked or addressed through other means such as a behavior support plan.

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 will not be 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, or 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 Emergency Safety Intervention

A reportable incident in this category is **any** use of a physical hold that restricts, or is meant to restrict, the movement or normal functioning of a participant as an immediate response to an emergency safety situation.

- The use of emergency safety intervention (ESI) is always reportable, regardless of whether it is an approved intervention in the participant's plan.

  Definitions of physical restraint, and emergency safety situations can be found in Incident Guide Definitions.

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, except when used as ESI;
- 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 can be found in Incident Guide Definitions.

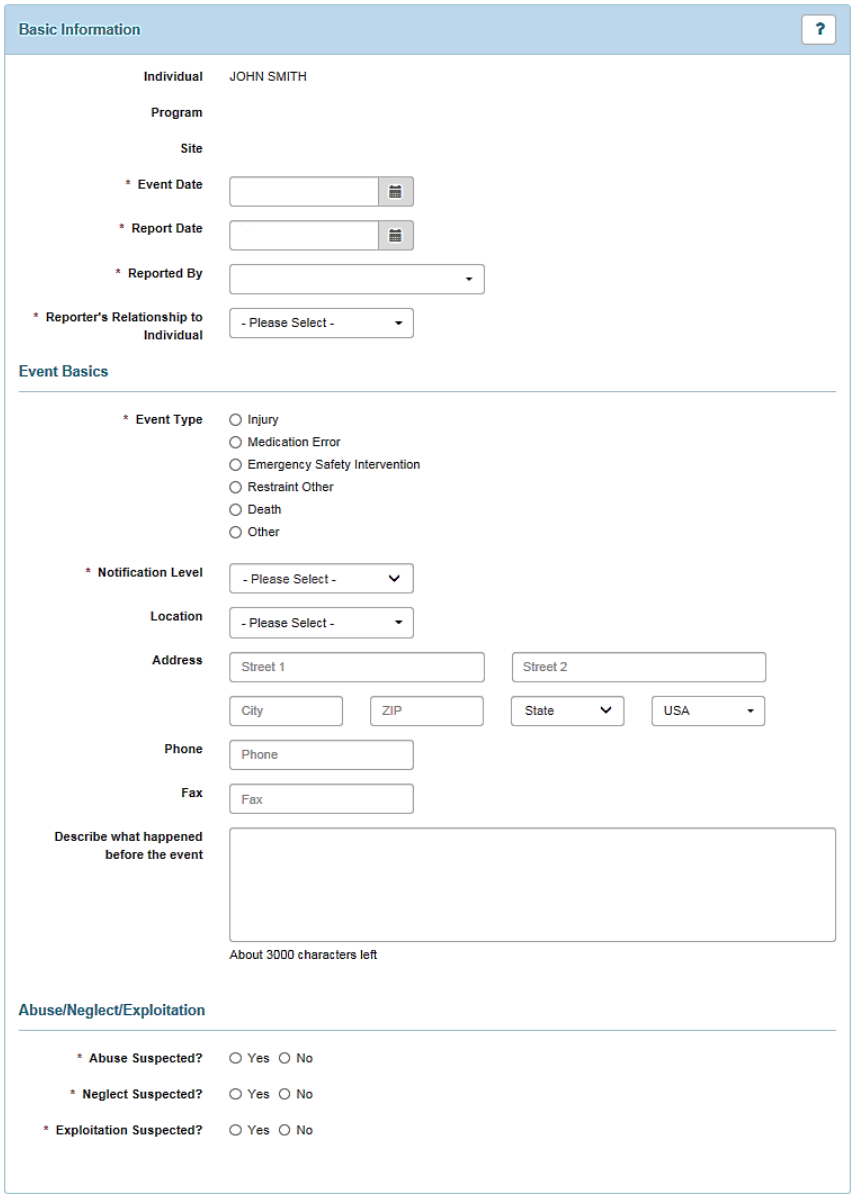
Vehicle Accident

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 can be found in Incident Guide Definitions.

Guidelines for Completing General Event Reports (GERs)

Basic Information



- *Event Date* is the date the incident **occurred**.
    - 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 GER is entered. This must not be changed. The *Report Date* and submission date for the GER must match.
- *Reported By* must be changed to the primary person witnessing the event if not being completed by the same person. If the person who witnesses the event does not complete the GER, a written signed statement from the witness must be uploaded to the GER.
- *Event Type* is determined based on the category of the incident being reported, according to the chart in the Incident Event Type Chart.
    - Incidents **must be** categorized exactly as outlined in the chart in the Incident Event Type Chart.
- **The *Notification Level* must match the chart in the Incident Event Type Chart for all incidents designated as reportable to DDA.**
- *The location* must be filled out. If the physical address where the incident occurred is known, it should be filled out.
- Phone information for the location should be filled out if 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 involved in the incident were doing before the start of the incident.

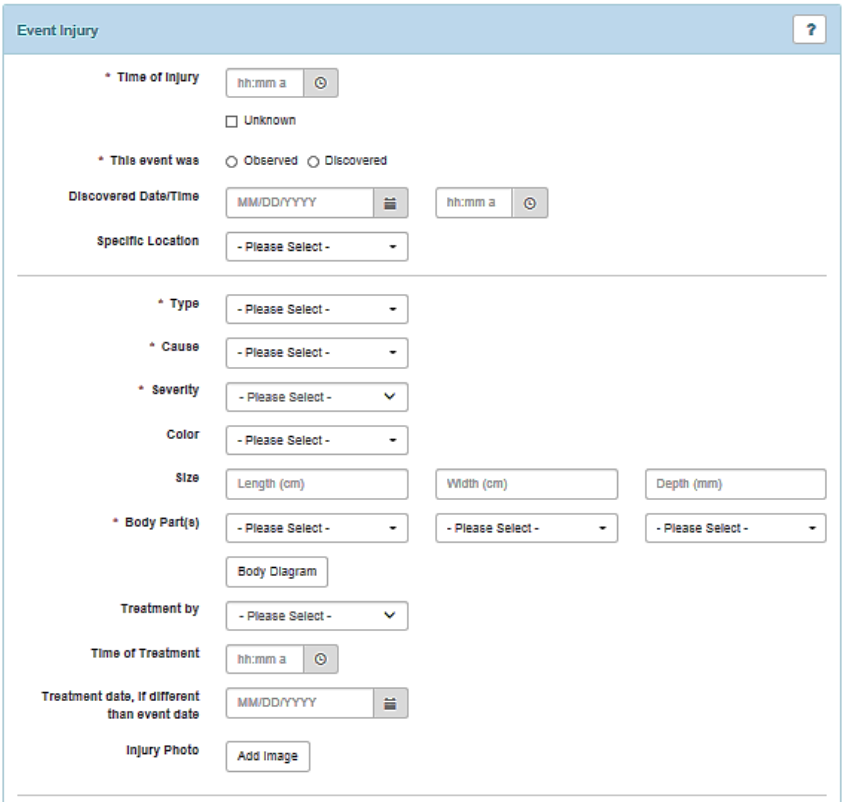
- **This section cannot contain the same information as the event summary.**

- *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 (defined in the Incident Guide Definitions) but does not meet state statute, the provider would mark *No* 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, ESI, Restraint Other, Death, and Other). There are different instructions for completing each type of form.

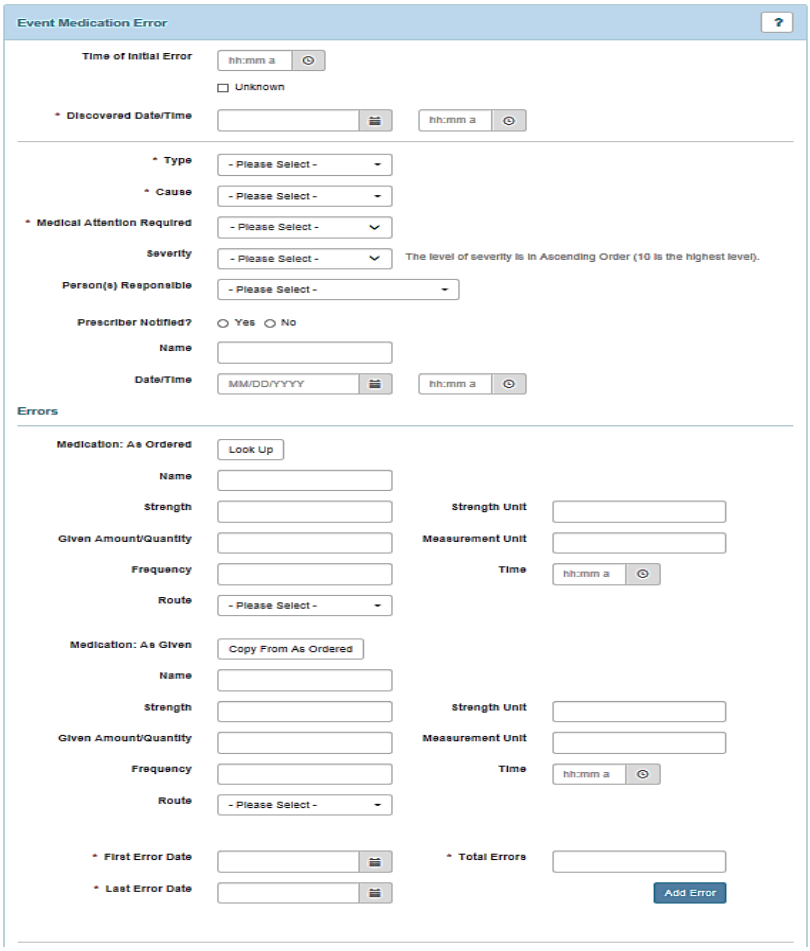
Event Injury Information



- *Time of Injury* is the time the injury occurred. When the injury was not observed, *Unknown* should be marked.
- The GER 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 (parent/guardian, community member, peer, etc.).
- *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.
  - Some incidents **must** be entered with a specific *Type*. When a specific *Type* is required, it is specified in the chart in the Incident Event Type Chart.
  - When no *Type* is specified for a category, select the *Type* that most closely matches the injury.
- *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.

Therap Basic Information screen image *Event Medication Error* Information

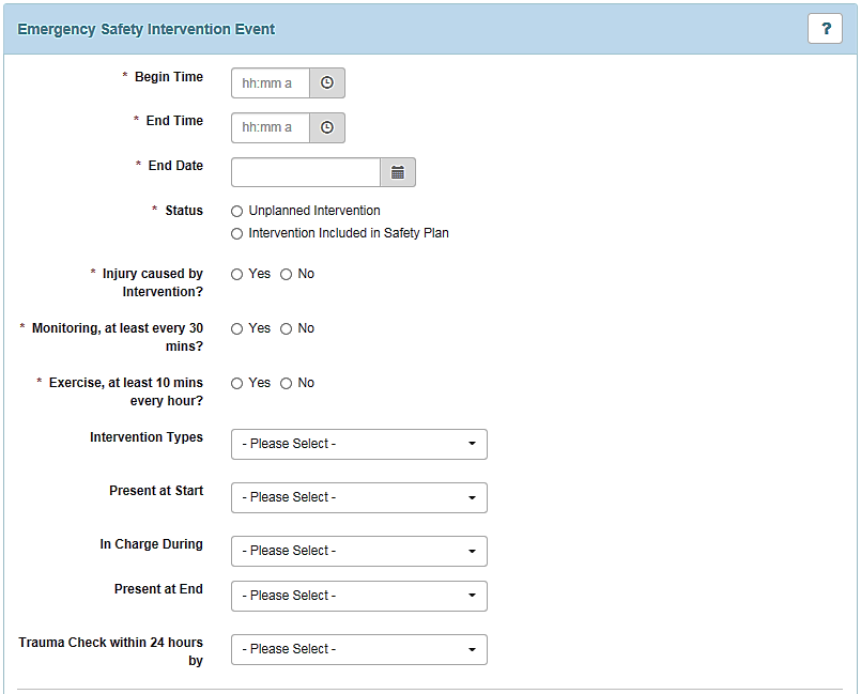


- *Discovered Date/Time* is when **the medication error** was discovered.
- *Type* is the type of error. Only the following types should be used:
    - Omission (medication was forgotten or refused)
    - Wrong Dose
    - Wrong Individual
    - Wrong Medication
    - Wrong Route
    - Wrong Time
- *Cause* 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 when the medication error is reportable in a ***high*** GER:
    - 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.
- *Errors* section must be completed in its entirety.
    - This section should only list the medication error(s) that directly contributed to the serious illness or injury.
- *Medication: As Ordered* and *Medication: As Given* show differences corresponding with the type of error marked.
    - 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*.

- *First Error Date*, *Last Error Date*, and *Total Errors* are the actual dates of the medication error(s) and the number of errors that led to the reportable incident.
    - When the serious illness/injury was caused by a single error, *First Error Date* and *Last Error Date* are the same and the *Total Errors* is one.
    - When several errors led to the reportable incident, the *First Error Date* is the date of the first error and *Last Error Date* is the date the errors were discovered. *Total Errors* is the number of all errors between the dates.
    - Do not include errors that led to illness in the past. Each episode of illness due to medication error is documented independently.

Event Emergency Safety Intervention Information

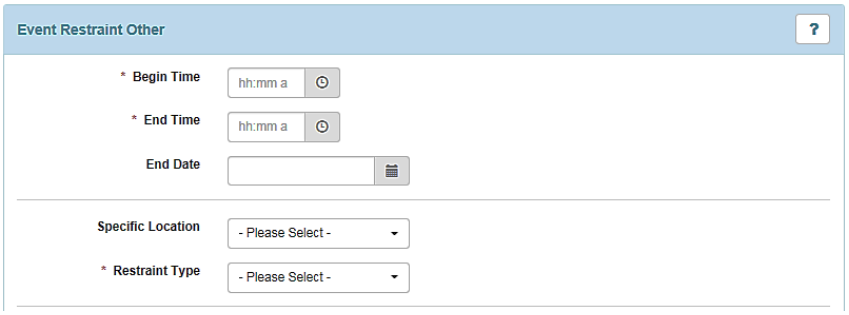
- *Begin Time* is the beginning time of the ESI on the date used.
- *End Time* and *End Date* are the date and time the ESI ended.
- *Status* is whether the ESI is approved in the participant's PCP.
- *Intervention Included in the Safety Plan* is marked when the use of ESI is approved in the participant's safety plan **and** is documented as an approved rights restriction in the PCP.
    - *Unplanned Intervention* is marked when the use of ESI is not approved in the participant's safety plan **and** documented as a non-approved rights restriction in the participant's PCP.



- *Intervention Types* lists types of physical intervention used as ESI.
    - When the intervention used does not match exactly with any listed option, mark the closest corresponding option, and provide further explanation in the *Summary*.
- *Present at Start, In Charge During,* and *Present at End* must list all agency provider employees or contractors, or independent providers who were present and in charge at any point during the ESI.

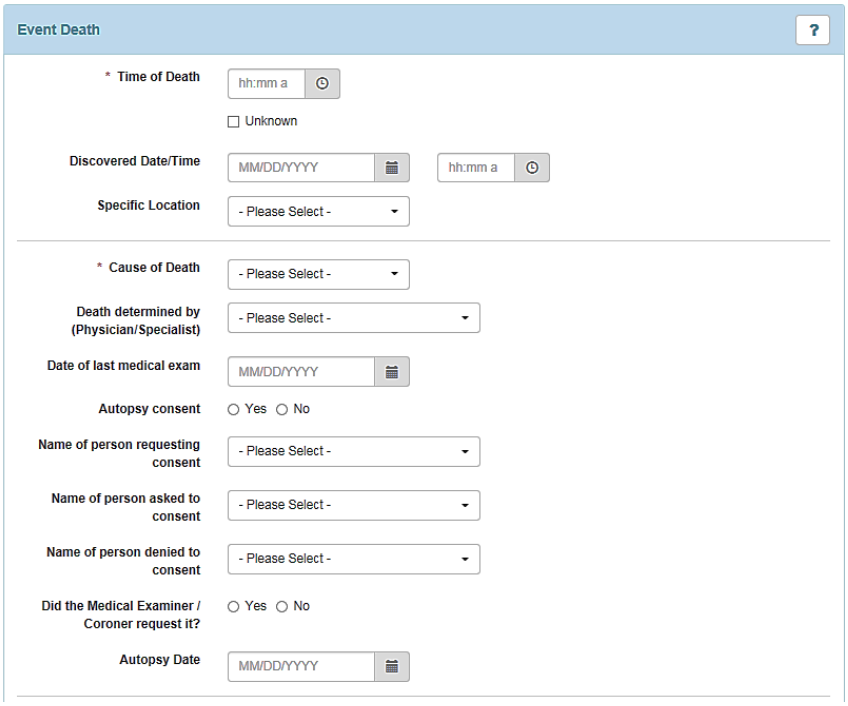
Event Restraint Other Information

- This event type is **not to be used**. Information gathered here should be captured under ESI. If the intervention was not an emergency safety situation, this should be reported under Event Type “Other: Prohibited Practices.”



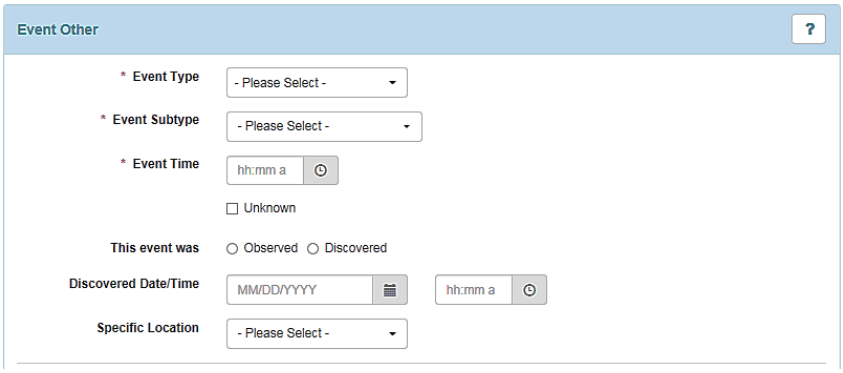
Event Death Information

- *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 GER 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 GER submission. GER 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.
- *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 GER is also responsible for the participant’s medical care.
- Autopsy information can be completed when known.
    - The autopsy fields may be left blank when the provider does not have information at the time the GER is submitted/approved.

Event Other Information



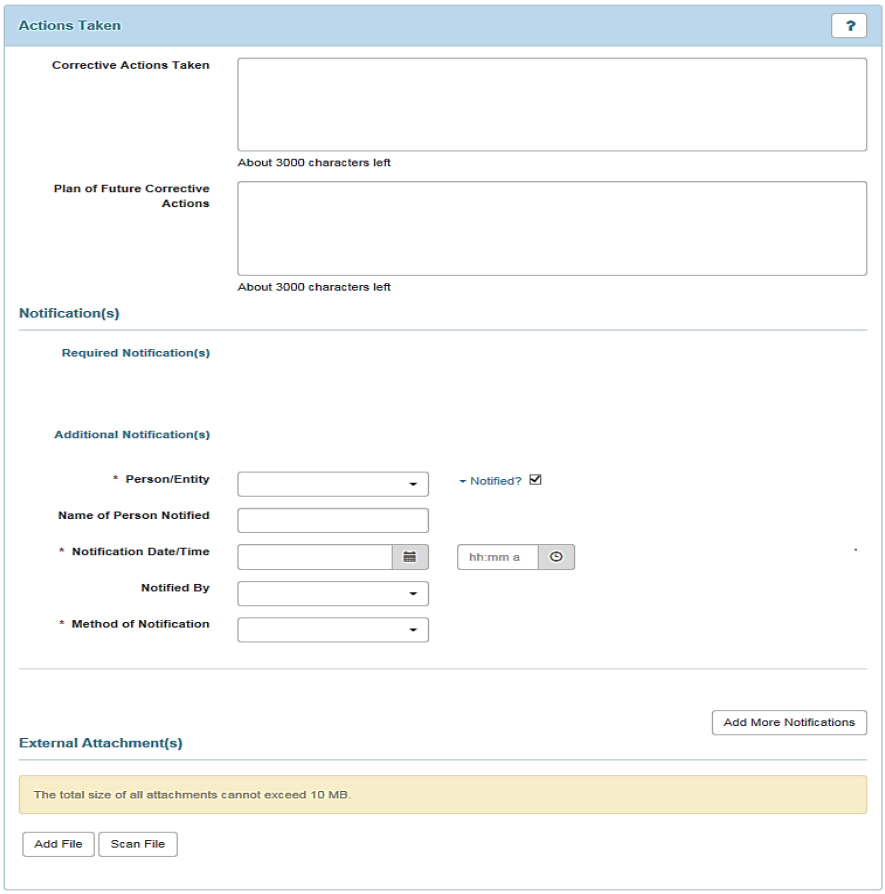
- *Event Type* is the type of event that occurred. This must be marked exactly as specified in the chart in the Incident Event Type Chart. Event types not specified in the chart cannot be used in a high/medium GER.
    - When some *Event Types* are marked, an *Event Subtype* field appears. *Event Subtype* 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 GER must document whether the incident was observed or discovered.
    - Observed means that the provider directly witnessed the incident.
    - Discovered means that 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 GER, 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 GER Instructions and Frequently Asked Questions* section.

- *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 circumstances and actions 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 GER is submitted/approved, document that no action is planned.
    - Most incidents require some type of action to prevent incidents in the future. The rationale for 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 GER:
  - Participant;
  - Guardian, when applicable;
  - Service Coordinator;

- Law enforcement or DHHS Children and Family Services (CFS) Abuse/Neglect Hotline for any allegation/suspicion of abuse/neglect/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. However, external attachments *cannot* be uploaded instead of providing any required information in the GER form.
  - For example, when documents from a hospitalization are uploaded, the incident summary *cannot* say "see attached" instead of including a summary of the incident on the GER.

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 DDA or having specific instructions for how they should be completed are covered in this guide. When a field is not required and is not discussed in the guide, it is optional and can be used for whatever information the provider decides is appropriate or helpful.

How should the participant, peers, and providers/staff be named in a GER event summary?

The participant for whom the GER is being written must be referred to by their legal first name.

Any peers (participants other than the one for whom the GER is written) involved in the reportable 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.

Staff must be referred to by either their full name or first initial and last name, and they must clearly be designated as a provider or staff 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 incident.

Examples of identifying/naming other people in a participant's GER:

- "Provider A. Smith saw Susan begin to have a seizure." (A. Smith is 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 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 a 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 all participants, a GER 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 potential 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. An incident 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 GER 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, which meets the criteria for a reportable incident category. Therefore, only one GER is required for the participant who had the behavioral episode.
- 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.

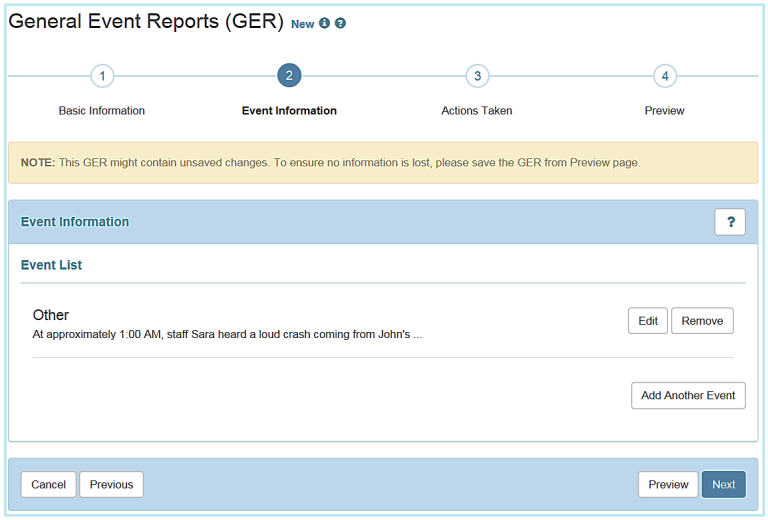
When there is a part of an incident that is related to the reportable incident but is not reportable **by itself** and does not meet the criteria for a GER or is at a different notification level, it will be documented in a separate *Event Information* form in the GER and the GER Notification level will be at the level of the highest event reported.

- For example, a participant has a behavioral episode where they damage personal property, then gets a minor cut on their hand while breaking glass, and staff use an ESI to maintain the safety of the participant and others:

Each event will have its own *Event Type* entered into the GER. Although two of the event types are medium, and the injury is low, the GER will receive a MEDIUM notification level due to the property damage and use of ESI.

To add multiple *Event Information* forms to a GER:

- Complete *Basic Information*, select the *Event Type* for the first event to be entered, and click *Next*.
- Complete *Event Information* for the first event in the GER and click *Next*.
- The *Event List* page will appear.
  - Click *Add Another Event* to add more *Event Information* forms to the GER.
  - 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 GER, click *Next*.



What if a provider needs to correct an error, add additional information, or add another event to a GER that has already been approved?

- The provider should send a SComm to the participant's Service Coordination Supervisor or the DHHS Quality Team, requesting removal of the approval and a brief description of the corrections/additions the provider is making. The provider may also send an email to NeGERHelp@libertyhealth.com to request the removal of an approval.
- If the provider is adding an additional event to an approved GER, the new event must have occurred on the **same day** as the original incident.

- Once the approval of the GER has been removed, the provider will have two business days from the disapproval date to make the adjustments and reapprove the GER.

What if an additional event related to a previous incident occurs on a different day?

The provider must complete a new GER 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 GER is completed with *Event Information* forms reflecting the injury requiring care from a physician, the use of an emergency room, and the hospital admission. After the GER has been approved, the participant dies from the injury for which they were hospitalized. The death arises from the same incident on which a GER has already been completed but cannot be added to an approved GER; so, a new GER reporting the participant's death must be completed.

Are there any other reporting requirements not outlined in this guide?

Providers are required to complete an investigation (GER Resolution) and submit a written report to DDA of the follow-up and action taken within 14 calendar days of the submission of the GER and are required to submit an aggregate report of incidents to DDA quarterly.

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 action 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 GER 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 GER to DDA, 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 a TLog or a seizure tracker, the seizure GER is still required.
- Exception: Behavioral events that are captured in BSP/Behavior trackers or other methods are not required to have a GER entered.

Is an incident reportable if the actions taken are an approved part of the participant's plan?

Yes. It is required that any incident that meets any of the criteria described in this guide be reported through a GER to DDA, regardless of whether the action that makes the incident reportable is an approved part of the participant's plan.

- For example, a participant's team has approved ESI as a rights restriction, and it is included in the participant's safety plan. **All** use of ESI must be reported whether or not it has been approved by the participant's team.

If DDA staff are already aware of a reportable incident, is the provider required to submit a GER?

Yes. Even when one, or more, DDA employees are aware that a reportable incident occurred, all reporting requirements, including submission of a GER, must be completed. This includes situations in which DDA staff have discovered that a reportable incident has occurred and alerted the provider.

It is the responsibility of the provider delivering services at the time of the reportable incident to complete the incident report, even when the incident was witnessed by a DDA staff.

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. If 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 if an event meets state statute, it should err on the side of caution and enter the GER as meeting statute.

The definition of Injury can be found in Incident Guide Definitions.

If 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 hotline *or* local law enforcement, so contacting either will meet the statutory reporting requirement.

However, when a participant's health or safety is at immediate risk due to the abuse, neglect, or exploitation being 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 DDA in a GER.

How can an emergency safety intervention (ESI) or prohibited practice be discovered, rather than observed?

An ESI or restraint would be considered to be discovered when an ESI or prohibited practice is used by a provider/staff but is not identified as an ESI or prohibited practice by the provider/staff using the intervention or observing the incident but is later identified as the use of ESI or a prohibited practice by agency management or other agency employees, a participant's guardian, or DHHS staff. In those situations, DDA considers the incident to be discovered at the time it is identified that the use of an ESI or prohibited practice occurred.

Who should complete the GER?

The primary provider staff or independent provider that witnessed the incident should complete the GER. If the primary witness is unable to complete the GER, the person completing it should ensure they change the "Reported by" section to the primary witness and include in the summary of the event the reason that the primary witness is not completing the report. A signed written statement clearly describing the incident from the primary witness will be uploaded to the attachments of the GER.

Is the Provider required to notify a Power of Attorney (POA) if the participant does not have a guardian?

If the participant does not have a guardian, but does have a Power of Attorney in place, the PCP team will meet to discuss and determine the scope of the POA and document the POA scope in the PCP. For example, a participant may have a Financial POA in place, this party would not have the ability to be notified of incident information outside of possible exploitation or other monetary incidents. The determination of the PCP team 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/ER/Urgent Care Visit	Medium	Other	*Event Type: Unplanned Hospitalization*	*Sub Event: Admission/ER 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 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*

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 a participant's statement is not a reportable allegation. If there is a belief that the allegation is spurious, the Provider will have 4 hours from observation/discovery of the event to have the event reviewed by a trained investigator. If 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 GER.

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, or 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.

Emergency Safety Situation: Unanticipated behavior by a participant that places the participant or others at serious threat of violence or injury when no intervention occurs and that requires ESI.

Examples of emergency safety situations include:

- A participant suddenly begins running toward or into moving traffic on a street;
- A participant is attacking staff and bystanders by hitting them in the face with a closed fist and all supports in the safety plan and BSP have not been successful in stopping the aggressive behavior; or
- A participant has a weapon, such as a knife, and is talking about harming them self or actively attempting to harm themselves.

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 a 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 a 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 (open wound) or where blunt force causes an injury such as a bruise or fracture (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 and approved by the PCP team.

Physical Abuse: Any allegation or suspicion of any knowing or intentional act of physical violence committed by a provider, peer of the participant, family member or anyone else towards a participant of HCBS waiver services. An injury or otherwise adverse outcome does not need to be present for an incident report to be required.

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 (PA) and advanced practice registered nurses (APRN). This does not include registered or licensed practical nurses (RN or LPN), therapists, or other types of doctors and medical professionals (dentists, clinical psychologists, etc.).

PRN Medication: Medication 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, 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 if 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.

Quality Reporting definition: The expanded abuse, neglect and exploitation definition within the GER guide, which includes verbal, physical, sexual, psychological, or emotional abuse, or neglect or exploitation of a child or vulnerable adult, which meets the CMS definition that in excess of the Nebraska Revised Statutes §28-311.08, §28-319, §28-320, §28-351 and §28-703.

Reportable Critical Incident: Any actual or alleged event or situation that creates or could lead to a rights violation, injury, or harm to the physical or mental health, safety or well-being of a participant including:

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 a part of ESI* 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.
- Prevented from leaving or having contact with others means that the participant is physically prevented by a provider or a door, partition, or other physical barriers.

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 person impacting a person receiving Medicaid HCBS 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 19 years of age or older who has substantial mental or functional impairment or for whom a guardian or conservator has been appointed under the 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.

Appendix B: Incident Follow-up Guide

Introduction

The instructions in this guide are intended for providers of Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services. This guide outlines current requirements for follow-up on reportable incidents: when follow-up must be completed, timelines for completing follow-up, what follow-up must include, and how follow-up is documented and submitted to the Department of Health and Human Services (DHHS) Division of Disabilities and Aging (DDA).

Follow-up includes an initial review and, depending on the nature of the incident and the initial review may include a more thorough full investigation. The purpose of incident follow-up is to assess whether supports and services were being provided as required immediately before, during, and after the incident, and to determine whether any further action should be taken to ensure the safety of the participant and others or reduce the frequency and severity of reportable incidents over time.

By completing the follow-up outlined in this guide, a provider has met the regulatory requirements for an investigation of each reportable incident (404 NAC 4).

When is Incident Follow-up Required?

Follow-up **must** be completed for **every** reportable incident (*each* medium and high general event report (GER) submitted in Therap).

Definitions for reportable incidents and instructions for completing the initial GER can be found in the Incident Reporting and GER Guide. **All** incidents defined as reportable in the Incident Reporting and GER guide must be reported to DHHS as outlined in the guide.

No follow-up is required for non-reportable incidents a provider chooses to document in a low GER or elsewhere.

Timelines for Completing Required Incident Follow-up

Follow-up Steps	How/Where Documented	Required Timeframe
Initiation of Incident Follow-up	GER Resolution – the creation date of the resolution form should be within the required timeframe.	Within 1 business day of approval of the GER.
Completion of Incident Follow-up	GER Resolution – the form should be fully completed as outlined in this guide and closed within the required timeframe.	Within 14 calendar days of the *submission* of the GER. *There are no exceptions to this timeline, including when the 14th calendar day is a weekend or holiday.*

Completion of Corrective Action	GER Resolution – by marking recommendations complete and attaching evidence of completion	Completion of corrective action should be completed in a timely manner based on the nature of the issue it is addressing (see guidelines in the Recommendations section of this guide). All corrective action plans must be complete and documented in Therap within 60 calendar days of the completion of the incident follow-up/GER Resolution.

When the follow-up is delayed for any reason, the reason for the delay must be documented in the summary of the follow-up. For example, when law enforcement or Adult Protective Services (APS) are investigating an allegation of abuse, neglect, or exploitation, they may ask the provider to put their investigation on hold until the law enforcement or APS investigation can be completed. When this occurs, it should be documented in the follow-up summary.

Who Completes Incident Follow-up?

The provider who submits the GER is responsible for the completion of the follow-up outlined in this guide. The provider may assign any employee or contractor to be responsible for incident follow-up; this person is called "the investigator" in this guide.

The investigator must:

- Have any knowledge, experience, or training needed to complete a thorough review and make recommendations to ensure the safety of the participant and others, and reduce the likelihood of future incidents;
- Have no involvement in the reported incident under review; and
- Be free from conflict of interest in order to objectively and impartially review the incident and incident report.

Incident Follow-up Requirements

Incident follow-up must meet the minimum requirements outlined in this section to meet the regulatory requirements for investigation (404 NAC 4-008.01.5.c). Depending on the nature and severity of the incident, some incidents may require only an initial review, while others may require a full investigation.

The incident follow-up must answer the following questions:

- Is the information in the GER complete and accurate?
- Were all applicable laws, regulations, waiver requirements, and DHHS policies followed?
- Were all agency policies and procedures followed?
- Was the participant's Person-Centered Plan (PCP) followed?
- Are all the participant's needs and risks adequately addressed by the supports in the current PCP? When not adequately addressed, did this contribute to the incident?
- Are there any patterns or trends of similar incidents over the past six months?
- Was any action taken at the time the incident occurred to maintain the safety and well-being of the participant?

The incident follow-up must also include recommendations to address any concerns or contributing factors identified.

See *Guidelines for Answering Follow-up Questions* for a description of what should be considered in answering these questions.

Ensure Safety

The first step in incident follow-up is to ensure the safety of the participant and others while follow-up is ongoing. The investigator should review the incident and action taken to confirm the provider's actions immediately after the incident were adequate to protect the participant and others. Action taken to protect the participant may include separating involved staff or other participants, temporary safety plans, or other actions, based on the nature of the incident.

When appropriate actions were not taken to protect the participant and others at the time of the incident, this must be addressed by the provider immediately upon being identified by the investigator.

Initial Review

The initial review is completed for **all** reportable incidents, regardless of type or severity.

- The initial review *must* include a review of the approved GER and the relevant portions of the participant's PCP, at a minimum.
- It may also include a review of other supporting documentation and interviews with staff and participants involved, as needed, to answer the follow-up questions listed above.
    - When the investigator requires additional information to answer the follow-up questions, it is not required that they complete a full investigation. However, the investigator should review any additional documentation or interview any participants or staff involved to get the information needed to answer the follow-up questions.

Full Investigation

A full investigation is required:

- For all reported incidents in the following categories:
    - Participant deaths;
    - Situations that adversely affect the physical or emotional well-being of an individual served;
    - Incidents of suspected or alleged abuse, neglect, or exploitation; and
    - Emergency safety situations that require the use of emergency safety interventions
    - Use of prohibited practices; or
- When the initial review indicates:
    - A full investigation is needed to ensure the safety of the participant or others due to the circumstances or severity of the incident;
    - Staff involved did not follow applicable laws, regulations, requirements, agency policies, or the participant's PCP, and the incident may have been prevented had the staff followed all policies and requirements as written; or
    - Staff did not follow applicable laws, regulations, requirements, agency policies, or the participant's PCP, and the initial review indicates it is not an isolated occurrence; or
- When directed to complete a full investigation by the participant's team or DDA immediately following the incident or upon reviewing the summary of the initial review.

When a full investigation is required, the investigator must:

- Complete all initial review requirements;
- Interview all staff involved in the incident;

- Interview all staff who witnessed the incident or others who may have relevant information;
- Interview the participant(s) involved in the incident, unless the PCP team has determined that it may be potentially traumatic or result in a behavioral episode to interview them;
- Review all potentially relevant documentation, including but not limited to:
    - Daily logs/TLogs from the days surrounding the incident;
    - Behavior support plans (BSP)/habilitation plans and data from the days surrounding the incident;
    - Recent medical documentation from physicians/hospitals treating the participant;
    - Medical protocols/plans and data from the days surrounding the incident;
    - Staff logs, mileage logs, medication administration records (MARs), or any other documentation kept by the provider which could have relevant information; and
    - Photographs, audio, or video evidence.

Recommendations

The investigator must make recommendations to address **all identified concerns or contributing factors discovered during the course of the incident follow-up.** For example, policies are not followed or the participant's plan is not implemented as written.

- Recommendations for the agency provider may include, but are not limited to:
    - Providing training/education to staff involved in the incident;
    - Providing training/education to all staff working at a specific site or agency-wide;
    - Review of staffing for a specific participant or at a specific site;
    - Review of provider policies and procedures for potential revision; and
    - Suggested modifications of environments.
- Recommendations for Service Coordination or the PCP team may include, but are not limited to:
    - Consider review and revision of the participant's plan and/or supports;
    - Consider referral for medical care, medication review, or therapy; and
    - Consider referral for new assessments.

Recommendations must include timeframes for completion to ensure all identified concerns are addressed in a timely manner appropriate to the risk to ensure the safety of the participant and others. Recommendations must be completed and documented within the GER Resolution no later than 60 days after the completion of the incident follow-up/GER Resolution.

The follow-up on all recommendations must be documented in the follow-up summary to demonstrate that the responsible personnel reviewed the recommendations and either took action to address the identified concern or provided justification for why the recommended action was not taken.

When recommendations are completed, the provider must upload evidence of completion to the supporting documentation section of the *GER Resolution*. Supporting documentation may include but is not limited to training records, revised policy and procedures, plan changes, evidence of environmental modifications or repairs, etc.

Upon a quality assurance review, the provider or PCP team may be required to take additional actions to remediate any issues that were not adequately addressed.

Examples of possible remediation activities and timelines for completion:

Corrective Action Category	Time Frame for Remediation
Alleged Perpetrator corrective action to include training	Must be done prior to working with participants.
General Re-training	Staff/Providers directly involved in the incident – no more than 10 business days. Other staff/providers as deemed necessary – no more than 30 business days.
Revision/Development of Policies and Procedures	No more than 30 business days.
Critical Event Response (i.e., medication error resulting in hospitalization)	No more than 5 business days.
Environmental Modifications (i.e., repairs)	Potential for significant injury/illness – prior to participant(s) return All Others – request/referral for repairs must be made within 30 business days with ongoing evidence of requests until repairs are made.
Other	Negotiable – within a reasonable time but no more than 60 calendar days.

Documenting Incident Follow-up

There must be written documentation of all aspects of incident follow-up, including:

- All information gathered, through review of documentation and interviews, which is not already documented in the GER;
- A summary of the review of the follow-up questions and any concerns identified;
- Any other issues identified during the course of incident follow-up; and
- Recommendations for addressing all concerns identified.

It is required for written documentation of the incident follow-up to be submitted to DDA using the *GER Resolution* form in Therap.

- Some providers have their own forms for documenting incident follow-up.
- When a provider wants to continue using their own existing form to document incident follow-up but does not want to duplicate documentation in the *GER Resolution*, the provider may attach the completed form documenting the incident follow-up to the *GER Resolution*, as long as:
    - The attached form covers **all** required documentation outlined in this guide.
    - The follow-up questions and answers are all entered into the *GER Resolution* in the *Notes* section of the *Resolution Summary*.
    - All recommendations made by the investigator and progress towards addressing those recommendations are entered in the *GER Resolution* in the *Recommendations* section.

Required Notifications

When the incident follow-up is complete, the investigator must notify the participant's Service Coordinator (SC) *via SComm*. This notification is the agency provider's evidence the incident follow-up summary was submitted to DDA (as required in 404 NAC). This notification is used by DDA to assess whether the provider met the required timelines in submitting documentation.

- When the provider makes revisions to the *GER Resolution* form after the form is "closed" and the SC has been notified, the SC must be notified of the changes made.
    - This requirement does not apply to updates made to the *GER Resolution* form to document the completion of recommendations made by the investigator.

The provider must also notify the participant and their guardian(s), when applicable, of the outcome of the follow-up.

Guidelines for Answering the Follow-up Questions

In order to answer the follow-up questions, the investigator will review the initial GER, the participant's PCP, and other relevant documentation, interview staff, and participants involved in the incident, and review relevant statutes, regulations, agency policies, and guidelines. The investigation should include the collection and review of **all** available information needed to answer the questions and make recommendations to address any identified concerns.

Is the information in the GER complete and accurate?

The investigator should consider:

- Does the GER contain all necessary information or is additional information needed?
- Are there any inconsistencies or inaccuracies in the GER?

When any issues with the GER are identified, the investigator must review additional documentation, complete interviews with staff and participants, and review evidence to resolve any inconsistencies or conflicting information and correct any inaccuracies.

Additional documentation may include:

- PCP;
- Safety Plan;
- Behavior Support Plan;
- Other safety or medical plans/protocols;
- Relevant medical documentation such as physician contact forms or discharge instructions;
- TLogs; and
- Past GERs and *GER Resolutions* for similar incidents.

Were all applicable laws, regulations, waiver requirements, and DDA policies followed?

This question relates to things that occurred which **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider:

- Were any supports or interventions used during the incident prohibited by state law, state regulations governing developmental disabilities services, or Medicaid HCBS DD Waiver requirements?
- Did any employee or contractor of the agency provider allegedly commit abuse, neglect, or exploitation of a child or vulnerable adult in violation of state law?
- When the incident involved potential abuse, neglect, or exploitation, was a report made to the Abuse/Neglect Hotline or law enforcement, as required by state law?
- When any potentially restrictive measure was used, was it compliant with state regulations governing developmental disabilities services? This includes whether it was used with approval from the PCP team, consent from the participant/guardian, and approval from a rights review committee.

- When any staff have a professional license or certification, were they compliant with relevant laws/regulations which govern their licensed or certified role? This includes medication aides or nurses.
- When the incident took place in a licensed facility, were all licensure regulations for the facility followed?

*When it is identified any applicable law, regulation, waiver requirement, or DDA policy was **not** followed, the provider is responsible for taking action to address the identified issue, based on the recommendation of the investigator.*

Were all agency policies and procedures followed?

This question relates to things that occurred which **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider whether any applicable agency policies and procedures were not followed, such as those related to:

- Use of restraint or emergency safety intervention;
- Emergency preparedness;
- Medication administration;
- Provider-wide seizure protocol;
- When to consult with provider medical staff; and
- When to consult with a supervisor, on-call supervisor, or administrative staff.

*When it is identified any applicable agency policy or procedure was **not** followed, the provider is responsible for taking action to address the identified issue, based on the recommendation of the investigator.*

Was the participant's PCP followed?

This question relates to things that occurred, that **directly** relate to the incident being reviewed, including immediately before, during, and immediately after the incident.

The investigator should consider:

- Did staff provide supervision of the participant as outlined in the PCP?
- Did staff follow the participant's behavior support plan?
- Did staff follow the safety plan?
- Did staff follow any other procedures/plans/protocols outlined in the PCP?
- Were all supports and interventions used correctly (for example, used at the right time, in the right situation, in the right way, etc.)?

*When it is identified any supports or services were **not** provided as specified in the PCP, the provider or PCP team is responsible for taking action to address the issue, based on the nature of the issue and the recommendation of the investigator.*

- When the issue is related to staff training or with parts of the PCP written by the provider (such as a safety plan or habilitation program), the provider is responsible for addressing the issue.
- When the issue is related to how the needed supports and services are documented in the PCP (for example, when the PCP does not contain sufficient information to correctly implement needed supports/interventions or is written in a way that is difficult for staff to understand), the PCP team is responsible for addressing the issue.

Are there participant needs or risks that contributed to the incident and may not be adequately addressed by current supports?

The investigator should consider whether the incident could have been prevented or minimized if different supports or interventions were identified in the PCP to address the participant's needs/risks. This could include:

- New interventions not currently in the PCP
- Changes to current interventions to better meet the participant's needs

When it is identified changes to the participant's current supports may be beneficial in preventing or reducing future incidents, the PCP team is responsible for reviewing the participant's plan to determine if revision is appropriate, based on the recommendation of the investigator.

Are there any relevant patterns or trends of similar incidents, circumstances, or other factors over the past six months?

The investigator should review all reportable incidents for the participant over the past six months to determine if there have been other incidents similar to the incident being investigated.

When there have been similar incidents, the investigator should consider:

- Are there any common factors/patterns to the similar incidents?
    - This could include similar times of day, days of the week, staff present, peers present, location, activity, etc.
- Does the frequency of similar incidents appear to be increasing, decreasing, or remaining the same?
    - When the frequency is increasing or remaining the same, the investigator should review actions taken in response to the previous incidents to determine if different actions or changes to the participant's plan may be more effective going forward.

When any trends, patterns, increasing frequency, etc. are identified in the review of similar incidents, the provider or the PCP team is responsible for taking action to address the issue, based on the recommendation of the investigator.

- When the issue is related to staff training, parts of the plan written by the provider (such as a safety plan), or other factors under the provider's control, the provider is responsible for addressing the issue.
- When the issue can be addressed through a review of or changes to the participant's plan, the PCP team is responsible for addressing the issue.

Were all needed actions taken at the time of the incident to ensure the safety of the participant and others?

Based on the nature of the incident, it may be necessary to take immediate action to ensure the safety of the participant, including changes to staffing/personnel, modification of the environment, seeking medical attention, or contacting law enforcement.

The investigator reviews action taken immediately after the incident. When it is identified that needed action was not taken to maintain the participant's safety, the investigator is responsible for immediately notifying the appropriate staff to ensure action is taken to maintain the participant's safety as soon as possible.

The provider is responsible for taking action when no action was taken at the time of the incident, based on the recommendation of the investigator.

Quality Review of GER Resolution

The Department of Health and Human Services (DHHS) Division of Disability and Aging (DDA), with its contracted agent, Liberty Healthcare Corporation (Liberty) conducts oversight and monitoring of incident follow-up activities. All High GERS and a sample size of medium GERS will receive a quality review. Through this process, the *GER resolution* and recommendations made by the provider and PCP team will be reviewed for:

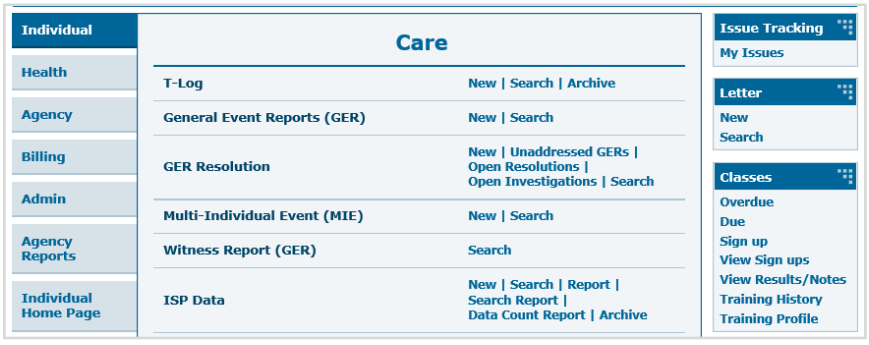
- Quality and thoroughness: Were all questions answered appropriately and accurately?
- Remediation Appropriateness: Do the recommendations made by the provider/PCP team address all concerns noted and are they appropriate for the event type?
- Remediation Completion: Were the recommendations made by the provider PCP team completed on time and was evidence provided?

If any issues are identified, or further information is needed, the reviewer will SComm the provider requesting additional items. The provider will review the recommendations made and has the option to agree with the recommendations or disagree.

- If the provider agrees, they will have two business days to update the *GER Resolution*. DDA will continue to monitor the resolution for completion and evidence.
- If the Provider does not agree, they will SComm the requesting party with justification for the disagreement. The reviewer will escalate the incident to DDA leadership for further review.
    - If the leadership reviewer agrees with the provider's justification, initial reviewer will update the Quality Review to reflect the agreement.
    - If the leadership reviewer does not agree with the provider's justification, the provider will receive a SComm on the same day as the decision with the recommendations that must be entered into the resolution and completed by the provider.

Further provider disagreement may be made by submitting a complaint form: Division of Disability and Aging.

Submitting Required Documentation in Therap

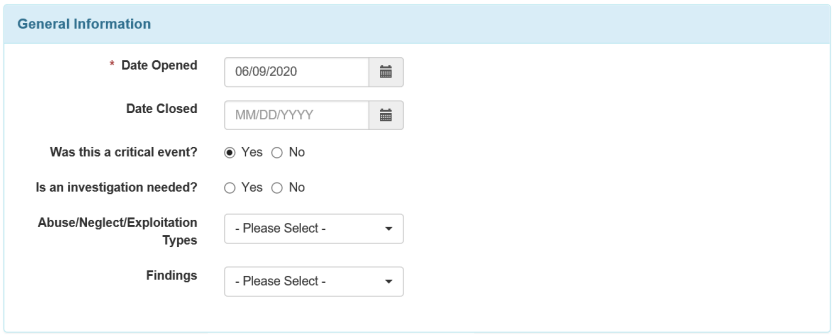
Documentation of the required follow-up for each reportable incident must be submitted using the *GER Resolution* form in Therap. When a provider completes a follow-up on a reportable incident but does not submit documentation of the follow-up as outlined in this guide, the provider has not met the regulatory requirements to submit documentation of an investigation to DDA.	
To document the investigation, go to the *Individual* tab in Therap and select *Unaddressed GERs* under *GER Resolution.* In the list of unaddressed GERs, select the GER for which the investigation is being documented and click *Next*.	

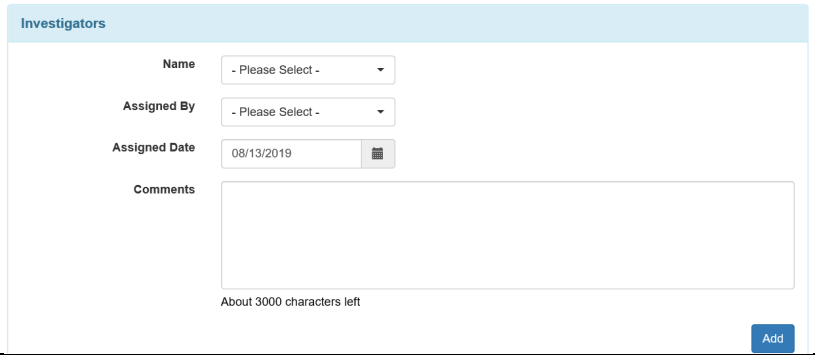
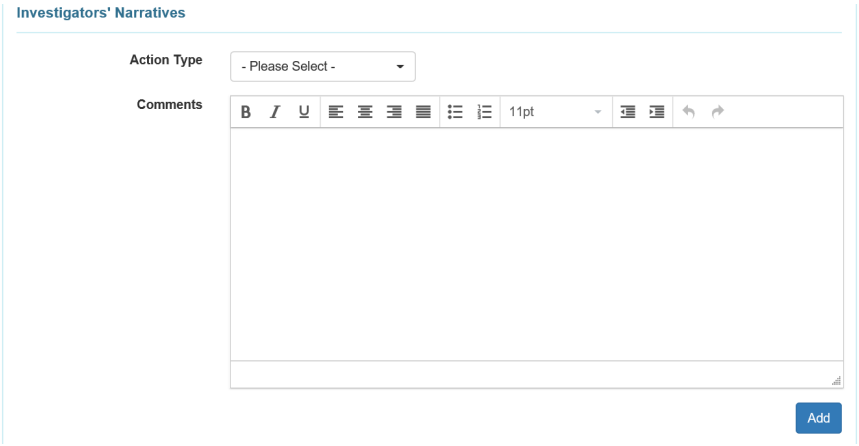
In the *GER Resolution* form, the *GER Information* section contains the participant's information, the date of the event in the linked GER, and a link to the GER.

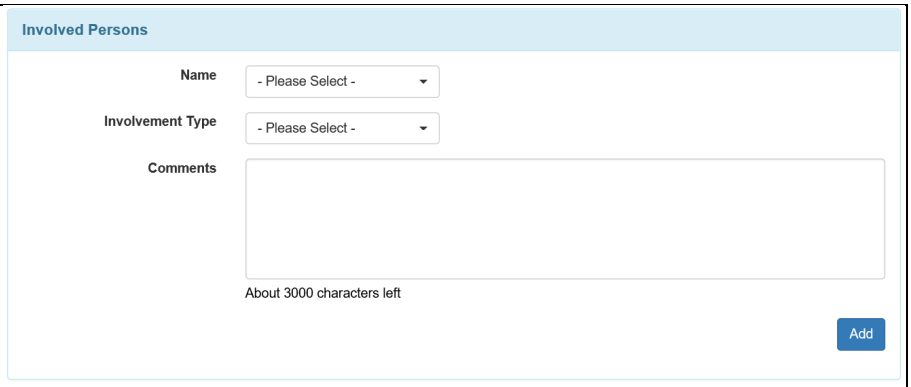
Before beginning to complete subsequent sections of the *GER Resolution* form, be sure the linked GER is the same GER for which the investigation is being documented.

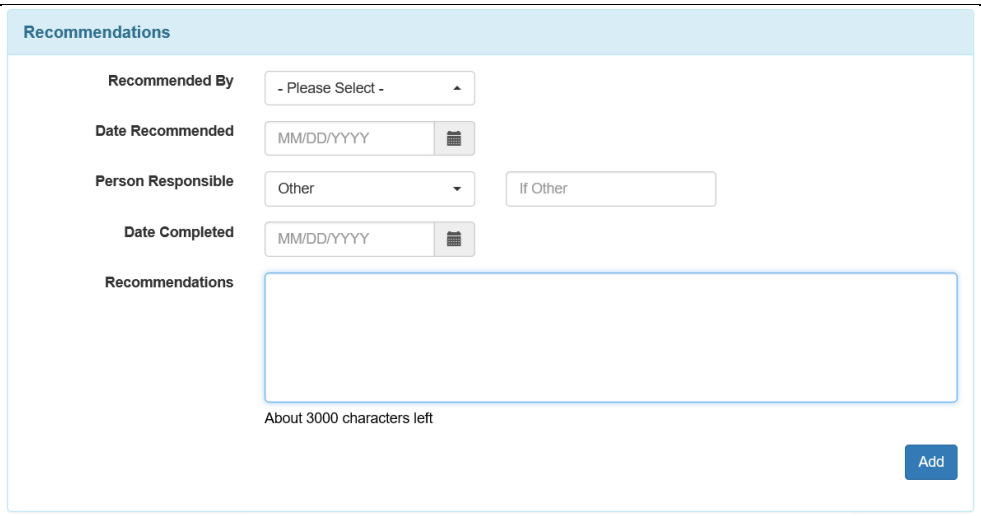
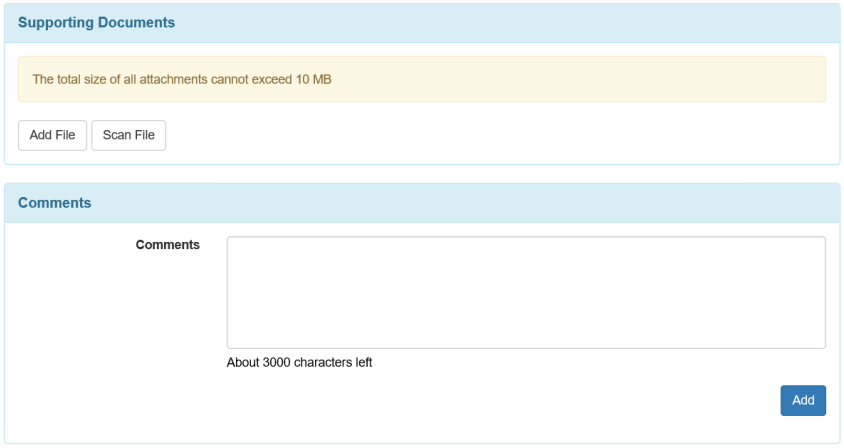
In the *General Information* section:

- *Date Opened* is the date incident follow-up was started.
- *Date Closed* is the date incident follow-up was finished and SC notified via SComm.
- *Was this a critical event?* should be marked *Yes* for all follow-ups of reportable incidents. When a provider chooses to complete a *GER Resolution* form for low GERs, this would be marked *No.*
- *Is an investigation needed?* should be marked *Yes*.
- When the reported incident involves suspected/alleged abuse, neglect, or exploitation, and it was accepted for investigation by DHHS Division of Children and Family Services (CFS), the next two items **must** be completed.
    - Under *Abuse/Neglect/ Exploitation Types*, select the option from the dropdown which most closely corresponds to the reported incident.
    - Under *Findings,* select *Abuse, Neglect,* or *Exploitation* when the incident was



substantiated. When CFS determined no abuse/neglect/exploitation took place, select *Unsubstantiated.* ○ When the investigation by DHHS CFS is not complete when the *GER resolution* is due, this should be documented in the body of the report.	
In the *Investigators* section: • *Name* is the name of the assigned investigator. • The provider may choose to document who assigned the investigator and when, but it is not required.	
In the *Investigators' Narratives* section, the investigator provides a summary of the information reviewed during the incident follow-up, including documentation reviewed and witnesses interviewed. • Any documentation or photographs reviewed should be summarized under the *Evidence* category. • Any witnesses providing information should be summarized under the *Interviews* category. • Other information should be entered under the *Other* category. The summary doesn't need to be lengthy or comprehensive but should include all information relevant to any concerns identified or conclusions reached by the investigator. A separate record should be added for each document reviewed, person interviewed, etc.	

In the *Involved Persons* section, the provider may choose to list people involved in the incident, but it is not required, as this information is in the GER.	
In *Resolution Summary*, the investigator provides a summary of the incident follow-up and any identified concerns. • *Narrative*: A summary of the relevant points of the incident follow-up and any conclusions reached by the investigator. • *Notes*: The seven Follow-up Questions and the answers identified in the course of incident follow-up. When any questions identify an issue or concern, those issues and concerns must be summarized. ○ When a provider chooses to use an existing form to document the summary of the investigation, ***this section must still be completed.*** • *Staff Actions*: Summary of any provider action taken related to the incident, including any actions already taken to address recommendations of the investigator.	

In *Recommendations*, all the investigator's recommendations should be listed. At a minimum, the recommendation, due date, and the person responsible for addressing it must be documented. When a recommendation has been addressed, the *Date Completed* should be filled in. A separate record should be added for each recommendation. When a provider chooses to use an existing form to document the summary of the investigation, this section must still be completed.	
In *Supporting Documents*, the provider may attach any additional information, documents, or photographs they deem relevant as well as evidence of completed recommendations, such as training records • When the provider chooses to use an existing form to document the summary of the investigation, it must be attached here. *Comments* can be used for any information that does not fit in elsewhere in the *GER Resolution* form.	

Root Cause Analysis

A Root Cause Analysis is a systematic and comprehensive assessment that supports responsible parties in identifying important root causes of incidents and system gaps, in a way to mitigate future incidents.

Upon completion of the Quality Review of both the General Event Report (GER) and the *GER Resolution,* the incident will be reviewed to determine if a Root Cause Analysis is required.

Root Cause Analysis activities will be initiated when at least one of the following criteria is met:

- APS or provider substantiated abuse, neglect, or exploitation events;
- Incident is flagged for an "Others-At-Risk" event, and there has been one or more HIGH notification level event(s) in the previous 30 days for the participant;

- Incident involves any use of prohibited practices or unauthorized use of restraints resulting in a negative outcome such as injury, death, police intervention, or hospitalization;
- Incident demonstrates a trend of three or more incidents related occurring within 30 days for significant injuries, financial issues, unexplained hospitalizations, increased number of falls, frequent police calls to the site, or ongoing staffing issues;
- Incident demonstrating a trend of two or more medication errors resulting in adverse outcomes such as hospitalization;
- Incident involving a missing participant for 24 hours or longer;
- Incident demonstrating a significant trending of similar incidents across a provider;
- Referral as a result of a mortality review that discovered significant quality of care or abuse/neglect/exploitation issues and potentially others at risk; or
- Others as determined based on the seriousness of the event.

The Root Cause Analysis may involve multiple steps, including both a desk review and onsite activities.

Desk Review

To begin the Root Cause Analysis process, reviewer will send an email or letter notifying the following parties that a Root Cause Analysis will be initiated:

- The service provider;
- The participant; and
- The participant's legal representative, as applicable.

The reviewer will review all pertinent documents available inside of Therap. When further information is needed to complete the desktop review, an additional request for further documentation from the service provider may be sent. The service provider will have five business days to return the requested documents and information to the reviewer.

Documentation requests may include, but are not limited to:

- Daily logs relevant to the participant's care, staffing, and day-to-day events (which may be in the form of paper shift notes or other paper documentation held by the provider);
- Medical documentation not found in Therap;
- Human and Legal Rights committee reviews, decisions, and meeting notes as applicable;
- Relevant provider policies, procedures, or expectations;
- Medical and Safety Protocols/Plans/Risk Plans;
- Staff training records;
- Staff schedules, mileage logs, or other staff documentation; and
- Any other documentation not found in Therap relevant to the incident as deemed appropriate by the Incident Review Specialist.

When the reviewer cannot adequately create a Root Cause Analysis brief with action plans from the desk review, the incident will move to an On-site Root Cause Analysis.

On-Site Root Cause Analysis

On-Site reviews are a collaborative effort to identify the root cause of an incident and require key personnel to be present for participation.

Required personnel will include:

- Provider personnel involved directly in the incident;
- Agency provider decision-makers;

- One to two Incident Review Team members;
- Participant's team members, as applicable; and
- The participant (if their presence would not cause any undue mental anguish).

The On-Site Root Cause Analysis will typically take four hours or less to complete, depending on the nature of the incident being reviewed. The provider will be responsible for creating a secure environment to complete all activities and ensuring that all needed parties are present.

On-site activities will include, but are not limited to:

- Interviews with involved parties;
- Visits to involved locations;
- Further documentation requests/review; and
- Round-robin collaborative meeting.

Root Cause Analysis Brief – Action Plans

When all Root Cause Analysis activities are finished, the reviewer will complete a Root Cause Analysis Brief including a description of completed activities, reviewed documents, and identified action plans. Upon approval of the brief, a copy will be made available to the provider responsible for completing the action steps. The action steps will have clearly identified goals, due dates, and required verification documents to close the action plan. The provider is required to complete all action steps by their due date and provide evidence of completion via Therap SComm to the assigned reviewer.

Action Steps may include, but are not limited to:

- Personnel training;
- Policy/Procedure creation or revision;
- Environmental repairs or updates;
- Person-Centered Plan revisions or updates;
- Referral for specialty consult (such as a physician, occupational therapist, physical therapist, or psychiatric services); and
- Other as deemed necessary by the Root Cause Analysis activities.

The Action Plan will be monitored by DDA until all action steps are completed and verified by the provider.

Appendix C: Acronyms and Abbreviations

Acronym	Definition
AD or A&D 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 Developmental Disabilities
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 D: 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 submitting an application 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.
Developmental Disabilities 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.
Developmental Disability	A severe, chronic disability, including an intellectual disability, other than mental illness, which: 1. Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness; 2. Is manifested before the age of twenty-two years; 3. Is likely to continue indefinitely;

	4. Results in substantial functional limitations in one of each of the following areas of adaptive functioning. a. Conceptual skills, including language, literacy, money, time, number concepts, and self-direction; b. 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 c. Practical skills, including activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living; and 5. 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 PCP. This is also called 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	Term 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 PCP, 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 developmental disabilities 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. 3. 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.

	4. 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 E: Contacts and Resources

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

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

Statutes, Regulations, and Medicaid HCBS DD Waivers

Nebraska Revised Statutes – A listing of all chapters of Nebraska statutes
https://nebraskalegislature.gov/laws/browse-statutes.php

The Developmental Disabilities Services Act (Neb. Rev. Stat. §§83-1201-83-1227) – Statutes governing the administration of developmental disabilities services by DDA.
https://nebraskalegislature.gov/laws/display_html.php?begin_section=83-1201&end_section=83-1225

Nebraska Administrative Code (NAC) – A listing of state regulations maintained by DHHS, specific to the Division of Disability and Aging
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 Comprehensive Developmental Disabilities (CDD) waiver and Developmental Disabilities Adult Day (DDAD)
https://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx

Application and Eligibility Resources

iServe Nebraska – Website with online application for developmental disabilities services
https://iserve.nebraska.gov/

Paper Application for Developmental Disabilities Services
http://public-dhhs.ne.gov/Forms/DisplayPDF.aspx?item=3443

Paper Application for Developmental Disabilities Services in Spanish
http://public-dhhs.ne.gov/Forms/DisplayPDF.aspx?item=3519

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

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

Funding/Financial Responsibility Resources

DHHS Financial Assistance Appointment of DHHS as Agent – Consent to allow DDA to withhold and pay employment taxes for independent providers on behalf of a self-directing participant.
http://public-dhhs.ne.gov/Forms/Home.aspx

Medicaid HCBS DD Waiver Services

Fee Schedule and Service Codes – Webpage with fee schedules outlining the service codes and rates of all Medicaid HCBS DD Waiver services, including rates by provider type, group size, funding tier and unit.
https://dhhs.ne.gov/Pages/DD-Providers.aspx

Participant Resources

Participant Guides and Resources – Guides with helpful hints for participants and their families navigating DD services.
https://dhhs.ne.gov/Pages/DD-Resources.aspx

Free Training for People with Disabilities – Webpage with self-advocacy and transition training for people with disabilities
http://dhhs.ne.gov/Pages/DD-Training.aspx

Provider Resources

Provider Guides and Templates – Guides and optional templates for direction on providing DD waiver services.
https://dhhs.ne.gov/Pages/DD-Resources.aspx

Provider Information – Information for providing HCBS waiver services.
https://dhhs.ne.gov/Pages/Medicaid-Home-and-Community-Services-Provider-Information.aspx