

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

# GUIDANCE DOCUMENT

“This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.”

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

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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 Developmental Disabilities (DDD) aims to improve 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 people who meet the same level of care, which would otherwise be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

### 1.2 Purpose of the 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 help to ensure the health and safety of those you serve. All providers of DD services must comply with this 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 Policy Manual

- A. **Organization of Content:** A table of contents is followed by an introduction and 12 chapters, each of which describes expectations and requirements related to a particular component of service delivery. Following the body of the manual, appendices present information referenced in the manual. Appendix A lists commonly used abbreviations. Appendix B is the glossary, which lists terms and phrases used throughout the manual. Appendix C is a 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 through the entire manual.

## 1.4 Development, Distribution, and Update of the Policy Manual

- A. **Development.** Stakeholders, including participants, family members, advocates, and DD providers were involved in the development of this manual. We extend our sincere thanks for their patience and willingness to devote time and energy to the completion of the Policy Manual.
- B. **Distribution.** This manual is available on the DDD website. When you need accommodations to view the manual, call DDD at 1 (877) 667-6266.
- C. **Update.** DDD updates the manual when there are changes in policy and requirements. A separate document will give a summary of the latest updates. This Policy Manual supersedes all previous policy manuals. When changes to the manual are needed:
1. DDD will make reasonable effort to provide notification to stakeholders prior to updating the DDD manual.
  2. DDD will post the Policy Manual with any proposed changes on the DDD webpage for public comment. When updates are for consistency with changes to regulations or waivers, DDD notes the changes for information only; public comment for those changes occurs when the regulation or waiver is up for public comment.
    - a. Subscribers to the DDD webpage will get an automated email.
    - b. DDD will email a link to DD provider lists and those signed up to receive stakeholder emails.
  3. DDD will address public comments and post the revised Policy Manual on the DDD website. The final revised version will replace the older version, thereby being located at the same link.
    - a. The Policy Manual will be a guidance document.
    - b. DDD will send notice of the update to DD provider lists and those signed up to receive stakeholder emails.

## 1.5 Relationships with Participants

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 providers and DD service coordination develop and maintain effective working relationships with participants and any advocates who may assist the participant to exercise their rights.
- B. Information in the manual outlines requirements and resources intended to promote respectful, effective relationships between participants, service coordination, and providers.

## 1.6 Description of 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 DD in 1987.

- A. DDD 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.

## 1.7 State and Federal Laws, Rules, Regulations, and Policies Governing Programs

Federal and state statutes and regulations govern DD services.

- A. **Federal Law:** Title XIX (19) of the Social Security Act establishes laws for Medicaid services, including those provided in institutional settings, like an ICF/IID and nursing facilities. This law allows federal Medicaid funds to match state funds to provide services to people residing in institutional settings who meet eligibility criteria.
  - 1. The Social Security Act gives states the authority to request a waiver of Medicaid rules to allow people to choose to receive long-term care services in their homes and communities rather than in an institution.
  - 2. This authority allows states to establish Medicaid HCBS waiver programs, including the Medicaid HCBS DD Waivers available in Nebraska.
- B. **Code of Federal Regulations:** The Code of Federal Regulations (CFR) is the rules and regulations established by departments and agencies of the federal government.
  - 1. Title 42 of the CFR contains regulations for Medicaid HCBS Waivers.
  - 2. In 2014, the federal government added requirements for settings where a provider delivers HCBS services.
  - 3. Nebraska has a transition plan to work towards meeting these new requirements.
- C. **Nebraska Revised Statutes:** A state law is created when a bill is passed by the Nebraska Legislature and signed into law by the governor. Laws are called Nebraska Revised Statutes (Neb. Rev. Stat.).
  - 1. Neb. Rev. Stat. §§83-1201 - 83-1228, also called the Developmental Disabilities Services Act, was passed in 1991 to govern DD services.
    - a. The legislature revises this act as necessary to meet the changing needs of people with DD.
    - b. The Developmental Disabilities Services Act includes, but is not limited to:
      - i. Direction for DDD to administer Medicaid HCBS DD Waivers as approved by the federal Centers for Medicare and Medicaid Services (CMS);

- ii. The definition of developmental disability used by DDD to determine eligibility for DD services; and
  - iii. The funding priorities, which determine the order in which eligible individuals receive funding for Medicaid HCBS DD Waiver services.
2. Other state statutes related to DD services include:
- a. The Developmental Disabilities Court-Ordered Custody Act, Neb. Rev. Stat. §§ 71-1101 to 71-1134, outlines when a person with DD may be placed under court-ordered custody and requirements for DDD to provide services to participants under court-ordered custody.
  - b. Neb. Rev. Stat. §§ 68-1530 to 68-1533 outlines
  - c. The Adult Protective Services Act, Neb. Rev. Stat. §§ 28-348 to 28-387, and the Child Protection and Family Safety Act, Neb. Rev. Stat. §§ 28-710 to 28-727, define abuse, neglect, and exploitation of children and vulnerable adults, and specify mandatory reporters of abuse, neglect, and exploitation.
  - d. Neb. Rev. Stat. §§ 30-2601 to 30-2628 outlines legal guardianship for minors and incapacitated adults, including the responsibilities and authority of the guardian, required training, documents filed yearly with the court, and court proceedings.

**D. Nebraska Administrative Code:** State agencies develop and implement state regulations, or the Nebraska Administrative Code (NAC), as directed in state statute.

- 1. State agencies develop proposed regulations or revisions with assistance from agency attorneys. The state agency for DD services is DHHS.
  - a. DHHS drafts regulations and submits to the Governor’s Policy Research Office for review. When this review is complete, DHHS posts draft regulations on the DHHS website for public comment.
  - b. After a 30-calendar day public comment period, DHHS holds a public hearing. Stakeholders and community members may attend the hearing and comment on draft regulations.
  - c. DHHS addresses feedback from public comments in writing and makes it available to the public. DHHS attorneys determine necessary changes.
  - d. The Attorney General’s office reviews draft regulations.
  - e. The Governor’s Policy Research Office reviews and the governor signs the regulations.
  - f. Approved regulations are filed with the Secretary of State, who signs the regulations, and the regulations go into effect five calendar days after they are filed and are posted on the DHHS public website.
- 2. DDD is responsible for Titles 403 and 404 of the Nebraska Administrative Code (NAC).
  - a. Title 403 NAC governs application and eligibility for services, funding, the registry, participant self-direction, and the services provided under the Medicaid HCBS DD Waivers.
  - b. Title 404 NAC governs requirements for providers of Medicaid HCBS DD services.
- 3. Regulations maintained by other DHHS divisions and relevant to DD services include:
  - a. Title 172 NAC governs professional and occupational licensure, including medication aides in HCBS provider settings.



- b. Title 175 NAC governs health care facilities and services licensure, including regulations for licensure of Centers for Developmental Disabilities (CDD).
  - c. Title 202 NAC governs the determination of ability to pay for DD service coordination when a person does not receive Medicaid and is on the registry.
  - d. Title 471 NAC governs the services provided under Nebraska’s Medicaid program. Each chapter deals with a specific service and includes definitions and descriptions, limitations, prior authorization requirements, billing requirements, and payment provisions.
  - e. Title 477 NAC establishes Medicaid eligibility rules.
- E. **Conflicts between Laws, Rules, Regulations, and Policies:** DHHS attempts to ensure consistency in all governing requirements for programs.
- 1. Laws and regulations may change, resulting in temporary conflicts with policies. When this occurs, the language in the statute, rule, or regulation governs until DDD can update policies, including this policy manual.
  - 2. When a federal law, rule, or policy conflicts with a state law, rule, or policy, the general rule is that the federal standard governs. The federal government does not typically consider states to be in conflict with federal requirements when they establish standards more stringent than the federal minimum requirement.

## 1.8 State and Federal Agencies Involved in Administration, Operation, and Oversight

- A. **Centers for Medicare and Medicaid Services:** CMS is the federal agency within Health and Human Services (HHS) responsible for implementing federal regulations governing Medicaid. CMS provides funding to designated Single State Medicaid agencies for the administration of Medicaid programs in each state, including Medicaid HCBS waiver programs.
- 1. CMS reviews and approves waiver applications, develops federal Medicaid regulations and policy, provides technical assistance to states, and conducts periodic audits to ensure compliance with federal requirements.
  - 2. An approved waiver application serves as a contract between CMS and the state for operation of an HCBS waiver program.
- B. **Nebraska DHHS Divisions of Medicaid and Long-Term Care and Developmental Disabilities:** The Division of Medicaid and Long-Term Care (MLTC) is the state Medicaid agency and partners with DDD to administer the Medicaid HCBS DD waiver programs. DDD is composed of a central office and four service districts with offices across the state. Functions performed by DHHS include:
- 1. Oversight of agency and independent providers;
  - 2. Developing and implementing policies and procedures;
  - 3. Oversight of eligibility and the intake process for people seeking DD services;
  - 4. Enrollment of program participants;
  - 5. Maintaining a registry of people meeting DD eligibility requirements;
  - 6. Developing individual support plans (ISPs) and authorizing Medicaid HCBS DD Waiver services;
  - 7. Processing provider billing for Medicaid HCBS DD waiver services;
  - 8. Providing technical assistance to providers;

9. Implementing a quality improvement (QI) system to ensure Medicaid HCBS DD Waiver services are provided in accordance with state and federal laws, regulations, rules, and policies;
10. Monitoring provider compliance with the participant's ISP;
11. Implementing complaint and appeal procedures; and
12. Providing informational materials to providers, participants, and their families, potential applicants for Medicaid HCBS DD Waiver services and other interested stakeholders.

## 1.9 Honoring the Governor's Mission and Priorities

Nebraska's mission is to create opportunity through effective, efficient, and customer-focused state government.

A. The governor has set the following priorities for state government:

1. Efficiency and Effectiveness
2. Customer Service
3. Growth
4. Public Safety
5. Reduced Regulatory Burden

B. The governor has set the following values for state government:

1. The Taxpayer
2. Our Team
3. Simplicity
4. Transparency
5. Accountability
6. Integrity
7. Respect

## 1.10 Following the DHHS Mission

A. The mission of Nebraska DHHS is "Helping people live better lives." DDD embraces this mission and is dedicated to serving people with DD in Nebraska.

B. DDD values are to be recognized and followed by all partners in service delivery:

1. A person-centered focus must be maintained. Participants are the most important members of their team.
2. Participant rights must be honored. DDD is committed to ensuring participants are afforded the same rights, dignity, and respect as members of society who are not disabled. Participants have the right to live, work, and recreate with people who are not disabled.
3. Participant-friendly information promotes understanding, choice, and direction of Medicaid HCBS DD waiver services.
4. Participant choice is the foundation of service planning and delivery. Participants have access to a full array of age-appropriate services consistent with their needs, goals, and abilities.
5. Person-centered planning identifies opportunities with the participant to accomplish personal outcomes, live a meaningful life, and be an active member of their community in the development and implementation of Individual Support Plans (ISP). Services and

supports must provide opportunities to increase the participant's independence and integration into the community.

6. Safety and risk identification are essential for participants to achieve personal outcomes by balancing personal choice and protection from harm.
7. Collaboration between DDD and providers in the provision of Medicaid HCBS DD Waiver services results in achievement of participants' personal outcomes. Effective service and support planning and coordination are crucial to the quality of life, health, and safety of participants.
8. Service monitoring focuses on achieving participant outcomes and ongoing compliance with the ISP.
9. Stakeholder input is essential to developing and maintaining an effective and person-centered waiver program.
10. Quality improvement (QI) processes are implemented on an ongoing basis. Reliable and valid data and information is accessible to all stakeholders and is used to identify systemic issues, provider compliance issues, and individual problems to plan for improvement of Medicaid HCBS DD waiver services.
11. Compliance with applicable state and federal statutes, rules, regulations, and policies are necessary to ensure adequate funding is available to provide access to services.
12. DDD provides training and technical assistance opportunities to ensure providers achieve and maintain compliance with applicable statutes, regulations, and Medicaid HCBS DD waivers.

## 2. Eligibility, Registry, and Entry into Services

This chapter describes the process the Division of Developmental Disabilities (DDD) 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 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 in order to receive Medicaid HCBS DD Waiver services:

- A. Meet Medicaid eligibility requirements;
- B. Meet DD eligibility requirements outlined in state statute and regulations; 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, visit Medicaid’s website:
  1. Online at <https://iserve.nebraska.gov/>;
  2. Call Medicaid’s toll-free number (855) 632-7633; or
  3. Contact a local DHHS office. *For DHHS office locations, see Policy Manual Appendix C: Contacts and Resources.*
- C. A person who is eligible for Medicaid may have a share of cost to pay for their Medicaid services.
  1. When a participant’s income is greater than federal Medicaid income limits, the participant will have a share of cost. A share of cost is a monthly amount, which must be obligated for Medicaid services, including HCBS waiver services. The participant may pay the share of cost directly to the provider(s) to whom it is obligated.
  2. Questions or concerns about Medicaid and share of cost should be directed to Medicaid.

### 2.3 Statutory Requirements for Developmental Disability

In addition to being Medicaid eligible, an applicant must have a developmental disability as defined in state law (Nebraska Revised State Statute §83-1205):

- A. Developmental disability shall mean a severe, chronic disability, including an intellectual disability, other than mental illness.
- B. The applicant must demonstrate substantial limitations in each of the following three areas of adaptive skills:
  - 1. Conceptual skills, which include language, literacy, money, time, number concepts, and self-direction;
  - 2. 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
  - 3. Practical skills, which include activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living.
- C. A developmental disability must begin in the developmental period, which ends at age 22.
- D. A developmental disability is expected to be lifelong.
- E. At set times, DDD reevaluates whether the person meets DD requirements. An applicant's eligibility is verified:
  - 1. At the age 9 years; and
  - 2. At the age 18 years.

## 2.4 Institutional Level of Care Requirements

DDD 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:
  - 1. When a person is determined eligible for DD services and meets a funding priority in state statute;
  - 2. When a person is determined eligible for DD services and goes on the registry;
  - 3. Annually, when a participant is only receiving service coordination services;
  - 4. When funding is offered, and
  - 5. Annually, when a participant is receiving Medicaid HCBS DD Waiver services.
- B. The level of care assessment is completed by DDD staff, providers, and others who are familiar with the person.
- C. DDD determines Medicaid HCBS DD Waiver services eligibility. A DDD staff reviews the most recently completed ICF/IID institutional level of care assessment, which shows the person's needs, and will receive services and supports similar to what is provided in an ICF/IID.
- D. When a person meets ICF/IID institutional level of care, the person is eligible for Medicaid HCBS waiver services.
- E. When a person does not meet ICF/IID institutional level of care requirements:
  - 1. The Service Coordinator may compare the level of care assessment with other assessments or documentation to determine whether the results of the level of care assessment is accurate or needs revision.
    - a. The Service Coordinator 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 an ISP meeting.

2. Based on a review of the level of care through information and team discussion, a Service Coordinator may revise the level of care assessment.
  - a. When the revised assessment shows the person does meet ICF/IID institutional level of care, services continue.
  - b. When the revised assessment shows the person does not meet ICF/IID institutional level of care, they cannot receive Medicaid HCBS DD Waiver services.
3. When the person does not meet ICF/IID level of care, DDD staff sends out a notice of decision to the person ending any DD services the person currently receives.
  - a. The person receives the notice of decision at least ten calendar days before services end. The person may appeal when they think DDD made the decision in error.
  - b. The Service Coordinator will assist the person to find other services and supports to replace DD 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 DDD, a person must submit an application and be determined eligible. *For links to DHHS contact information, see Appendix C: Contacts and Resources.*

- A. A person may apply for DD services at any age. A person with the disability or their guardian can submit an application. *For a link to the application, see Policy Manual Appendix C: Contacts and Resources.*
- B. A valid application includes:
  1. Name and mailing address of 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 DDD 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.
- C. When DDD receives the application, they request documentation as indicated by the applicant. This may include, but is not limited to:
  1. Medical records showing 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 the MDT is still accurate or complete a new one;
        - (2) An MDT cannot serve as a diagnosis;
        - (3) An MDT may show needs exist in the three adaptive skill areas, conceptual, social, and practical, required by state law (Nebraska Revised State Statute §83-1205).
        - (4) MDTs give a history of needs and help show needs will likely continue; and
        - (5) An MDT may include an IQ score, which DDD considers in determining eligibility.
- D. A person may submit their application for DD services online; in person; or 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. DDD cannot access an application until the applicant submits it.
  2. Apply at any local DHHS office. *For locations of DHHS local offices, see Appendix C: Contacts and Resources.*
    - 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.
  3. Apply with a paper application.
    - a. A paper application can be printed from <https://iserve.nebraska.gov/> or requested:
      - i. By phone at 1 (877) 667-6266;
      - ii. By mail to:
 

DDD Eligibility  
301 Centennial Mall South  
PO Box 98947

Lincoln, NE 68509-8947;

- iii. By email to [DHHS.DDEligibility@nebraska.gov](mailto:DHHS.DDEligibility@nebraska.gov); or
- iv. In person at a local DHHS office.

b. A paper application can be submitted by mail, email, in person as stated above.

E. 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 DDD website.
- 2. Receive application assistance and use a computer to complete an online application at a local DHHS office. *For links to DHHS contact information, see Appendix C: Contacts and Resources.*
  - a. Translation is available for an applicant with limited English proficiency. Paper applications are available in Spanish.
  - 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.

F. When an applicant is determined not eligible for services, they may reapply with new 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. DDD does not consider an application for DD services submitted during the fair hearing process valid. 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

DDD makes eligibility determination upon received information. An applicant may correct information or submit additional information any time before the date of decision.

- A. When DDD receives an application, DDD assigns a member of the Eligibility and Enrollment team (E&E) to determine whether the applicant meets statutory 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. When the applicant did not intend to apply for DD services, they can withdraw their application by email, letter, or verbally.
      - ii. DDD does not send a notice of decision when an application is withdrawn.
      - iii. The applicant does not have to wait to reapply after an application is withdrawn.
    - b. E&E will explain:
      - i. The DD eligibility process; and
      - ii. The DD services registry.



- c. DDD may use Social Security Income (SSI) records as part of the eligibility determination. E&E determines if the applicant has applied for SSI, is currently receiving SSI, or has been denied SSI;
  - d. Review the information on the application to ensure it is correct and complete, including who to contact for supporting documents; and
  - e. Verify the person with the disability or their guardian signed the application.
2. The E&E team member considers immediacy of an applicant's need for Medicaid HCBS DD Waiver funding.
  3. 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. DDD 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 eligibility criteria as defined in state law, 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 DDD Clinical Team, which is a part of the DDD Central Office Administrative Team, may assist in determining eligibility by consulting about diagnoses, adaptive skills, or testing results.
- E. Once DD eligibility is determined, DDD sends a written notice of decision to the applicant. The notice of decision includes the decision, effective date, explanation of decision, and information about the appeal process.

## 2.7 Registry for Medicaid HCBS DD Waiver Services

The Federal Centers for Medicare and Medicaid Services (CMS) allows registry for Medicaid HCBS Waivers. DDD funding comes from appropriations by the Nebraska Legislature and CMS. Because there is not enough funding to provide Medicaid HCBS DD Waiver services to all eligible people in Nebraska, there is a registry of eligible people who want services.

- A. DDD uses the registry to make funding offers. DDD organizes the registry by date of application to create a first come, first served basis for all eligible people who are waiting for funding based on priority level.
- B. To be on the registry, an eligible person must:
  1. Be enrolled in Medicaid or is under age 19 and would otherwise be eligible for Medicaid if not for their parental income;
  2. Meet statutory eligibility requirements when reviewed at ages 9 and 18 years; and
  3. Continuously meets ICF/IID institutional level of care requirements.
- C. When DDD offers the person on the registry a Medicaid HCBS DD Waiver, the person must decide whether to accept.

- D. A person may be on the Medicaid HCBS DD Family Support Waiver (FSW) while on the registry for the Medicaid HCBS DD Adult Day (DDAD) Waiver or the Medicaid HCBS Comprehensive DD (CDD) Waiver.
- E. A person may be on the Medicaid HCBS DD Adult Day (DDAD) Waiver while on the registry for the Medicaid HCBS Comprehensive DD (CDD) Waiver.
- F. Service Coordination is an available service for persons on the registry with active Medicaid or through Ability to Pay (ATP). DDD assigns a Service Coordinator when requested.

## 2.8 Funding Offers for Medicaid HCBS DD Services

DDD authorizes funding for Medicaid HCBS DD Waiver services for eligible people according to funding availability and funding priority status. Nebraska state statute lists the priority categories for funding for Nebraska Medicaid HCBS DD Waiver services. A person must be on the registry to request priority status.

- A. Priorities for the DDAD and CDD waivers are:
  1. People in immediate crisis with no other possible options to meet the person’s needs. Reasons for immediate crisis include, but are not limited to:
    - a. Caregiver death;
    - b. Homelessness; or
    - c. A threat to the life and safety of the person.
  2. People who have lived in an institutional setting in Nebraska for at least the past 12 months and want to live in the community. Institutional settings are:
    - a. ICF/IID;
    - b. Nursing facility; or
    - c. Inpatient hospital.
  3. People under the supervision of the Office of Probation Administration leaving the juvenile justice system, people leaving foster care at age 19, or people who are state wards of DHHS.
  4. People transitioning upon age 21 from eligibility for Nebraska educational services to eligibility for Medicaid HCBS DD Adult Day Waiver.
    - a. The local school district is responsible for providing services through the end of the school year in which the person turns 21 years; and
    - b. People may transition from school services to Medicaid HCBS DD Adult Day Waiver services up to their 22nd birthday.
  5. People who are dependents of a member of the United States military.
    - a. The person must be a legal resident of Nebraska due to the military member’s assignment in Nebraska; and
    - b. The dependent must be under age 19.
  6. All other people on the registry, as funding is available, based on their date of application.
- B. The person or their guardian may request priority status. The following steps are taken to determine priority status:

1. A person contacts DDD central office or their Service Coordinator to request priority status.
  2. DDD Central Office or the Service Coordinator:
    - a. Checks if the person has applied for and accepted all available resources. Available resources may include but not limited to other Medicaid services; other DHHS program resources, community resources, and Vocational Rehabilitation.
    - b. May ask for records, such as physician or clinician reports, to indicate the person's needs.
    - c. May complete assessments to identify the person's priority need and how to support it.
  3. DDD Central Office makes the decision to approve or deny a person's priority request based on meeting the criteria established by state statute for prioritization and the information presented. DDD sends a notice of decision, with appeal information, to the person.
    - a. When DDD approves priority status, a funding offer is made.
    - b. When DDD denies priority status, the person remains on the registry.
- C. Priority Status for the Family Support Waiver are:
1. Disabled children and family units in crisis situations in which the disabled child tends to self-injure or injure siblings and other family members;
  2. Disabled children who are at risk for placement in juvenile detention centers, other institutional settings, or out-of-home placements;
  3. Disabled children whose primary caretakers are grandparents because no other family caregivers are available to provide care;
  4. Families who have more than one disabled child residing in the family home; and
  5. Based on the date of application.

## 2.9 Funding Offer Process

Funding offers will be made for either the Comprehensive Developmental Disabilities (CDD) Waiver, the Developmental Disabilities Adult Day (DDAD) Waiver, or the Family Support Waiver (FSW).

- A. DDD central office contacts the person by mail to make a funding offer.
- B. When the funding offer is accepted:
  1. DDD will check for Medicaid status and request State Review Team (SRT) complete a disability assessment as necessary.
  2. Once Medicaid eligibility has been determined, DDD assigns a Service Coordinator when the person does not already have one.
  3. DDD completes the objective assessment process to determine the person's annual individual budget amount (IBA), which is the amount of funding available to purchase Medicaid HCBS DD Waiver services for the DDAD and CDD waivers. *This step is not completed for the Family Support Waiver.*
  4. The Service Coordinator discusses service and provider options with the person.
- C. When the funding offer is declined:
  1. A person who declines the offer for the FSW or DDAD Waiver and is on the registry for the CDD Waiver may remain on the registry for the CDD Waiver.

2. A person who declines the offer for the CDD Waiver is removed from the registry and will need to reapply if they want DD services in the future.
3. A participant on the DDAD Waiver who declines the offer for the CDD Waiver, will be taken off the registry for the CDD Waiver and continue receiving DDAD Waiver Services.

## 2.10 Waiver Participation Requirements

- A. To receive waiver services, a person must be eligible for a Medicaid HCBS DD Waiver and maintain eligibility. This means a person must:
  1. Be enrolled in Medicaid;
  2. Meet the definition of developmental disability, as determined by DDD according to Neb. Rev. Stat. §83-1205;
  3. Be eligible for DD services by meeting ICF/IID level of care;
  4. Be age birth to 21 years for the Family Support Waiver
  5. Be 21 years or older for Medicaid HCBS DD Adult Day Waiver; and
  6. Choose, by signing a form, to receive Medicaid HCBS DD Waiver services instead of services in an institutional placement.
- B. In addition to meeting DD eligibility requirements, a participant must:
  1. Receive services from only one Medicaid HCBS waiver at a time. A participant may receive services from one waiver while on the registry for a different waiver.
  2. Not live in an institution. DHHS defines an institution as a hospital, ICF/IID, or nursing facility. The participant must choose to receive community-based services as the alternative to institutional care.
  3. Be age birth to 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. *This is not applicable for the Family Support Waiver.*

## 2.11 Determining Individual Budget Amount

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

When a person accepts a funding offer for 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:** DDD uses the objective assessment process to determine the annual IBA. DDD 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 DDD bases the person's funding on their needs.
- B. The objective assessment process includes completing the Inventory for Client and Agency Planning (ICAP) assessment.
  1. DDD uses the ICAP to assess the adaptive skill level and need for support.
  2. The ICAP is completed:
    - a. When a funding offer is accepted;

- b. When there is a significant change in needs;
  - c. Reviewed biennially; and
  - d. When requested by DDD Central Office.
3. The ICAP measures four categories of adaptive skills. Adaptive skill areas include the skills people use daily, and include:
- a. Motor Skills, such as standing, walking, or grasping an object;
  - b. Social and Communication Skills, such as interacting with others, taking turns, or asking questions;
  - c. Personal Living Skills, such as bathing, dressing, or cooking; and
  - d. Community Living Skills, such as using public transportation, crossing the street, or purchasing items.
4. The ICAP measures eight categories of problem behavior. All categories include how often the participant engages in the behavior and the severity of the behavior:
- a. Self-injurious behavior, such as hitting self, banging head, or pulling out own hair;
  - b. Hurtful behavior to others, such as hitting, kicking, or biting;
  - c. Property destruction, such as deliberately breaking, throwing, or tearing items;
  - d. Disruptive behavior, such as picking fights, interrupting, yelling, or teasing others;
  - e. Unusual or repetitive behavior, such as pacing, talking to self, or eating inedible items/materials;
  - f. Socially offensive behavior, such as using vulgar language, lying, or spitting at others;
  - g. Withdrawal or inattentive behavior, such as avoiding other people, showing little interest in activities, or being unable to concentrate on a task; and
  - h. Uncooperative behavior, such as refusing to follow rules or refusing to attend school or work.
5. DDD completes the ICAP with input from people who know the participant best.
- a. DHHS does interviews in person, when possible.
  - b. Interviews may include teachers, para-educators, family members, or DD providers.
    - i. DD agency providers will designate an ICAP Agency Liaison.
    - ii. The ICAP Agency Liaison collaborates with DDD staff to select interviewees who meet interviewee criteria.
  - c. The people interviewed must:
    - i. Know the person being evaluated for at least three months; and
    - ii. Sees the person being evaluated regularly throughout the week.
6. DDD staff reviews documentation, such as school records, program and behavioral data within the last 90 days, medical records, incident reports, and provider-completed assessments.
7. The ICAP score determines the annual IBA, which the participant uses to purchase Medicaid HCBS DD Waiver services.

## 2.12 Ending Services

- A. The participant, a provider, or DDD can end DD services. There are different types of services which can be ended:
1. Service coordination service when the person is on the registry for a Medicaid HCBS DD waiver;
  2. Medicaid HCBS DD waiver services with a specific provider; or
  3. All Medicaid HCBS DD waiver services.
- B. **Ending Service Coordination:** DDD may end service coordination or the person receiving service coordination may choose to end the service.
1. The person may choose to end service coordination service.
    - a. The person contacts their Service Coordinator and says that they no longer want the service.
    - b. When service coordination is the only service the person receives, the Service Coordinator will complete a notice of decision and end the service.
  2. DDD ends 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.
      - i. Medicaid eligibility may be lost because:
        - (1) Social Security benefits end;
        - (2) Resources exceed Medicaid's limit; or
        - (3) Requested information is not provided during the annual Medicaid renewal process.
      - ii. When Medicaid eligibility is lost, the person is assessed an ability to pay for service coordination.
    - b. The Service Coordinator is unable to contact the person.
    - c. The person moves out of state. In this case, the Service Coordinator ensures Medicaid Long Term Care and Economic Assistance have been notified of the move.
    - d. A review of eligibility determines the person is no longer eligible for DD services.
    - e. The person passes away.
  3. DDD sends a notice of decision to the person at least ten 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 a 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 Service Coordinator 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, DDD 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. DDD 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, DDD 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 Individual Support Plan (ISP) 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 DDD may end Medicaid HCBS DD Waiver services.
    - a. The participant may choose to end services at any time, for any reason.
      - i. The Service Coordinator discusses with the participant if they want to restart services in the future.
        - (1) When the participant is ending the FSW or DDAD Waiver, they may remain on the waitlist for the CDD Waiver.
        - (2) When the participant is ending the CDD Waiver, they must reapply.
        - (3) When found eligible, they will be on the registry by the date of the new application.

- b. DDD ends services when:
  - i. The participant loses Medicaid eligibility, which may happen because:
    - (1) Social Security benefits end;
    - (2) Resources exceed Medicaid's limit; or
    - (3) Requested information is not provided during the annual Medicaid renewal process.
  - ii. The participant has not used a Medicaid HCBS DD Waiver service during a consecutive 90-day period. The Service Coordinator makes reasonable efforts to encourage the participant to use a service at least every 90 days.
  - iii. The person moves out of state. In this case, the person should notify MLTC and Economic Assistance of the move. The Service Coordinator will notify when the person does not.
  - iv. A review of eligibility determines the participant is no longer eligible for Medicaid HCBS DD Waiver services.
  - v. The individual support planning (ISP) team was unable to develop a plan for services and supports, which met the person's health and safety needs in a community-based setting.
  - vi. The participant passes away. In this case, the Service Coordinator notifies MLTC and Economic Assistance of the death.
- 2. The Service Coordinator calls the provider(s) to verify the participant/guardian has notified them of the notice and to communicate the last day the authorization is effective.
- 3. DDD 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's Medicaid HCBS DD Waiver spot may remain available to them when a participant temporarily stops 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. DDD central office determines whether to approve or deny the request to stay on the waiver.
  - a. When DDD approves the request, DDD holds the participant's waiver spot for them.
  - b. When DDD denies the request, the participant's waiver spot is no longer available and DDD ends waiver services.



## 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 Division of Developmental Disabilities 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 themselves, not a person legally authorized to act on behalf of the participant.

- A. State and federal laws and constitutions guarantee basic legal, human, and civil rights.
- B. 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.
- C. 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 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 which has not been opened and use the phone and 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.

- D. DDD 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.
- E. 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.
- F. 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.
- G. A participant may have difficulty maintaining their own 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 individual support plan (ISP) team, due process requires ISP 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 the participant has not approved.
  - 3. A rights restriction, other than one used by a DD provider at the direction of the ISP team, requires a different due process. Examples of a rights restriction not directed by the ISP 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 ISP 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 an important role in supporting participants to be safe and should be used, when necessary, as long as all policy guidelines and regulations are followed.
- C. The ISP 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 ISP 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 order 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, pose 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 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 the restriction may injure the participant.
    - b. Some medical conditions may increase the risk of a rights restriction resulting in injury.

## 3.2 Individual Support Plan Team Review of Restrictions

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

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

- A. It is important to identify when an intervention is a rights restriction, so it can be regularly reviewed by the ISP 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. ISP 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 ISP team must review a rights restriction at least twice a year.
- C. The ISP 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 used the rights restriction when needed and there are clear instructions for how the provider should use the restriction. The ISP team should consider:
    - a. In what specific situations, times of day, and locations should the provider use 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 starts using a restriction when the participant engages in physical aggression and stops 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 ISP team to specify back-up equipment is readily available so there is no gap in needed support.
  2. The reason the rights restriction is used. The ISP 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 ISP 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 ISP 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. An ISP 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 ISP team should document it to assist in future service planning.
  4. What are the specific criteria to reduce a rights restriction?

- a. The ISP 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 ISP team should consider reduction. When the ISP team agrees 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 ISP team's criteria are met or the ISP team is concerned the medication has a negative impact on the participant's quality of life, the ISP 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. It is important to describe the benefits and potential negative effects of the restriction so the participant can decide if the benefits of the restriction outweigh the risks before giving consent. The following information is provided to the participant:
- 1. A complete description of the proposed rights restriction, including what it is, and how and when it will be used;
  - 2. 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
  - 3. 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 (HLR) review committee is responsible for protecting participant rights by monitoring agency provider practices. A HLR 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 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 ISP 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 to approve the rights restriction when the ISP team has not tried less restrictive supports.
  - c. The committee may recommend the ISP team consider a 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 to 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 negative effects. 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 there is a rights restriction, there must be a habilitation program, behavior support plan, or other supports in place to reduce the risk, which requires the rights restriction.
    - b. When there is no habilitation program or other support, the review committee cannot give approval.
  6. Criteria set by the ISP 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 ISP team, the rights review committee cannot approve the rights restriction.
    - c. When the participant has met criteria, but the ISP team decided not to 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. ISP team approval for the rights restriction before use and semi-annually thereafter, as documented in the ISP;
  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, habilitation program data comes from the behavior support plan.
    - ii. When the rights restriction addresses risk related to adaptive skills, 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; and
- 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, the rights review committee 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.

### 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, 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.

- 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 ISP team’s decisions about needed supports, including when and how the provider uses a rights restriction.
- C. When the ISP 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 ISP team and human rights committee.

## 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 ISP 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 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) supervised by a licensed psychologist, LIMHP, or APRN, acting within their scope of practice.
  - 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 or drug, which alters brain function, resulting in changes to a person's perception, mood, consciousness, or behavior. Use of psychotropic medication may be a rights restriction. DDD does not consider vitamins and supplements, such as melatonin or St. John's Wort, to be psychotropic medications. Over the counter medication may be 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 ISP 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 has had problem behavior in the past, the ISP team must decide how long the participant must go without problem behavior to consider it no longer a current behavior, based on the participant's history and the risk presented by the behavior.
- C. A provider must not use psychotropic medication to deal with under-staffing, or ineffective or inappropriate supports or environments.
- D. The participant's ISP team must review all use of psychotropic medication at least twice a year. The ISP 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 ISP team must review documentation from the prescribing physician to determine if the psychotropic medication is restrictive.
      - i. 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.
      - c. When documentation from the prescribing physician is not available for ISP team review, or available documentation does not meet the required criteria, the psychotropic medication is a rights restriction.
        - i. 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 ISP team.
        - ii. The ISP team must use documentation from the prescribing physician to determine if a medication is a rights restriction. Documentation from other medical providers, medication administration records, or other sources do not meet the required criteria.
- E. The ISP 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 DDD.
  3. Each time a PRN psychotropic medication is given, it must be reviewed by the ISP team;
    - a. When the provider gives the PRN medication more than once per week, the ISP team must review the first administration of the PRN medication and the ongoing use of the medication.
    - b. The ISP team must discuss:

- i. If the PRN psychotropic medication was administered as prescribed;
      - ii. If administration of the PRN psychotropic medication was necessary and used as a last resort;
      - iii. If the supports in the participant’s ISP 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 ISP must document each review.
  - 4. The Service Coordinator may refer use of PRN psychotropic medication to the DDD clinical team for review and recommendations, 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 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 available within moments to assist the participant.
  - 1. Physical restraint is any physical hold, which restricts, or is meant to restrict 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. DDD 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 emergency safety intervention after all other interventions they tried were unsuccessfully.
  - 1. When possible, staff must use all other supports specified in the participant’s ISP, 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 an emergency safety intervention 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 DDD approved intervention procedures and how the provider monitors use of emergency safety interventions.

1. Any new provider must use The Mandt System – Relational + Conceptual + Technical level for use with all ESI.
  2. Current providers must train staff in The Mandt System – Relational + Conceptual + Technical level by February 1, 2025.
  3. Agency provider staff receives training in approved safety interventions and positive behavior support techniques.
  4. All ESI systems, at a minimum, must include in-person teaching methods addressing the following:
    - a. Recognizing stimulus, triggers, de-escalation techniques:
      - i. An explanation of the cycle of behavior (from antecedent to conclusion of behavior);
      - ii. Communication skills for de-escalation; and
      - iii. Identification of when ESI is appropriate;
    - b. Body mechanics:
      - i. Stance and balance; and
      - ii. Awareness of position, posture, and proximity;
    - c. Emergency Safety Interventions (physical interaction skills):
      - i. Accompanying;
      - ii. Assisting;
      - iii. Escorting;
      - iv. Supporting;
      - v. Avoiding;
      - vi. Redirecting;
      - vii. Releasing; and
      - viii. Restraining;
    - d. Identification of symptoms of medical distress; and
    - e. Identification of prohibited interventions, that may include, but are not limited to hyperextension, pressure on the chest/neck, and infliction of pain.
- D. The provider must report all use of emergency safety interventions to DDD in an incident report.
- E. The participant’s ISP team and agency provider HLR committee must review all use of emergency safety interventions as a rights restriction.
1. For a participant who requires the use of an emergency safety intervention on a frequent basis, the ISP team may decide to make an emergency safety intervention an approved part of the participant’s safety plan.
    - a. When an emergency safety intervention is an approved part of the participant’s safety plan, this does not give team approval for use of emergency safety intervention in situations where they did not try other interventions, or the emergency safety intervention is not an emergency safety situation.
    - b. The ISP team determines whether the frequency of emergency safety intervention use justifies including it in the safety plan. Emergency safety interventions should only be included in the safety plan when an emergency safety intervention happens on a frequent basis.

- c. The ISP team must document use an emergency safety intervention in the participant’s ISP 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 emergency safety intervention is included in the participant’s ISP as a rights restriction, it is not required for the ISP team or rights review committee to review each use of an emergency safety intervention. The team reviews the rights restriction and all use of emergency safety interventions at least semi-annually.
  - f. The provider must report each use of an emergency safety intervention to DDD in an incident report and must be reviewed through the incident reporting process. When a concern is identified during the incident reporting process, it may be necessary for the ISP team to review the incident.
2. When emergency safety intervention is not an approved part of the participant’s safety plan:
- a. The ISP team must review any use of an emergency safety intervention.
    - i. The ISP team must discuss if the emergency safety intervention was necessary and used as a last resort.
    - ii. The ISP team reviews the participant’s ISP to determine if changes or additional supports are needed to reduce the risk, which led to use of an emergency safety intervention.
    - iii. The Service Coordinator documents this review in the ISP.
  - 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 Developmental Disabilities (DDD) prohibits the use of some interventions because these interventions excessively restrict the rights of the participant and increase risk of negative outcomes. DDD may only approve use of a prohibited practice through the alternative compliance process. A provider must report unauthorized use of a prohibited practice to DDD 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, which 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 is able to stand up independently, but the lap belt prevents him from standing to get out of his 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, which 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. DDD prohibits physical restraint, which does not meet the definition of an emergency safety intervention.
  2. DDD prohibits use of physical restraint as a preventative intervention. A preventative intervention, such as always linking arms, is one used during times when the ISP team feels it is possible the participant will 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 prevent 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, which is painful, frightening, or potentially harmful to the participant's health or safety.
- G. Corporal punishment is causing pain as consequence for undesired behavior.
- H. Verbal abuse is use of oral, written, or gestured language, which 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, comfortable and clean shelter, and treatment for physical needs.
- K. Discipline is 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 participant's rights as privileges and used as reinforcement for positive behavior or withheld due to undesired behavior. An ISP 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 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. DDD 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. DDD does not consider it 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 which other children of the same age are typically allowed to do or is likely to result in injury.

### 3.10 Complaints

Any person has the right to make a complaint to DDD when they have a concern, and to have the complaint addressed by DDD.

- A. Possible examples of types of complaints:
  - 1. Concerns for the safety and wellbeing 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; or
  - 7. Any other concern to which the department should be made aware.
- B. A person may make a complaint by:
  - 1. Visiting <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 Developmental Disabilities
    - PO Box 98947
    - Lincoln, NE 68509-8947;



3. Emailing a complaint or complaint form to:  
[DHHS.DDDCommunityBasedServices@nebraska.gov](mailto:DHHS.DDDCommunityBasedServices@nebraska.gov);
  4. Contacting DDD by phone toll-free at 1 (877) 667-6266; or
  5. Visiting any DHHS office. *For DHHS office locations, see Policy Manual Appendix C: Contacts and Resources.*
- C. Once the complaint has been resolved, DDD send 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-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. DDD maintains a record of all complaints received and their resolution.

### 3.11 Appeal/Fair Hearing

When a person disagrees with an action or decision made by DDD, they have the right to appeal the action or decision by requesting a fair hearing. When DDD makes a decision, DDD 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 participant when:
1. An application for DD services is not accepted because it is invalid;
  2. DDD did not process an application in a timely manner;
  3. Funding for a Medicaid HCBS DD Waiver was not approved;
  4. A change is made in their Medicaid HCBS DD Waiver funding;
  5. A Medicaid share of cost for Medicaid HCBS DD Waiver services is assigned;
  6. The level of care for an intermediate care facility for individuals with intellectual disabilities (ICF/IID) is not met;
  7. They are determined not eligible for DD services; or
  8. The amount or type of their DD services has changed.
- 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. DDD imposes disciplinary action.
- C. DDD 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 starts the day after DDD mails the notice of decision.
    - b. When the last day of the 90-day period 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-day period, the decision is final.
2. When the participant submits a request for a fair hearing within ten calendar days of DDD 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 DDD 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. DDD central office notifies providers and DHHS staff affected by the decision.
3. The written request for fair hearing may be made with the DDD form found on the DDD 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. DDD 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 DDD.
  - 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](mailto: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 C: Contacts and Resources.*

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

1. DDD assigns the request to a staff person. The assigned person:
  - a. Notifies the person their request for a fair hearing was received;
  - b. Verifies 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 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 DDD 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 which is convenient for all parties.
5. DHHS Legal and assigned DDD 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 it is more likely than not the decision made by DDD is incorrect.
  - b. DDD presents evidence explaining how DDD 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 the Hearing Officer not allow the use of evidence, which 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 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 DDD Director;
  - 3. The DDD Director makes a decision based on the recommendations from the Hearing Officer; and
  - 4. DDD sends the final decision to each party by certified mail.

## 4. Service Coordination for Registry and Waiver Services

For people on the registry and for participants on a Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver, a Division of Developmental Disability (DDD) 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 ISP. 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 replacing of natural supports or Medicaid State Plan services.

### 4.1 Service Coordination for People on the Registry

When an eligible person is on the registry for Medicaid HCBS DD Waiver services, they can choose to receive service coordination. When a person on the registry wants service coordination, DHHS provides one. The Service Coordinator assists with accessing resources and encourages independence, productivity, and community integration.

- A. For people who are not participating in a Medicaid HCBS Waiver, service coordination services can be provided in two ways:
  - 1. Case Management is a Medicaid State Plan coverable service for people who are on Medicaid and want DD service coordination while on the registry.
  - 2. Service Coordination is a service available to people who are not eligible for Medicaid but who are able to pay for the service.
    - a. When a person requests or is receiving service coordination services and is not eligible for Medicaid, the person is assessed an ability to pay.
      - i. An ability to pay is the amount determined by DHHS for a person to pay for DD service coordination when they meet qualifications for DD eligibility but is not eligible for Medicaid.
      - ii. DHHS bases an ability to pay on the person's financial assets, income, and expenses.
      - iii. When the person is 19 years or older, ability to pay is calculated on the person's taxable income, unearned income, and other financial resources; and
      - iv. When the person is 18 years or younger, ability to pay is calculated on the person's financial resources and their parental taxable income.

- b. DDD central office staff sends financial paperwork from DHHS Financial Services to the person in order to determine their ability to pay. The person is responsible for completing and submitting the paperwork.
  - i. When a person on the registry requests service coordination services and they are not eligible for Medicaid, a Service Coordinator is not assigned until the ability to pay has been determined, the person is made aware of the amount, and has agreed to pay it.
  - ii. When a person only receives service coordination services and they lose Medicaid, the Service Coordinator will assist them to complete the necessary financial paperwork to determine ability to pay.
  - iii. DHHS sends out financial paperwork annually for redetermination.
- c. When a person says they are unable to afford the ability to pay amount, the DDD central office staff directs them to DHHS Financial Services.

**B. Requirements to Receive Service Coordination:** The following requirements must be met to receive DD service coordination while on the registry:

- 1. The person must receive Medicaid or agree to an ability to pay;
- 2. The person must not be living in an institution, such as an intermediate care facility for individuals with intellectual I disabilities (ICF/IID) or a nursing facility;
- 3. The person must not be participating in the Medicaid HCBS Aged and Disabled (AD) Waiver or Traumatic Brain Injury (TBI) Waiver.
  - a. Medicaid provides payment for service coordination services under only one Medicaid HCBS Waiver program at a time.
  - b. DHHS can assign an additional Service Coordinator up to six months before switching to a different Medicaid HCBS Waiver. Medicaid provides payment for both Service Coordinators during this limited transition period.

**C. Service Coordinator Assignment:** A person on the registry chooses whether they receive service coordination services.

- 1. This decision can be made at any time while on the registry:
  - a. When DDD tells the person they are eligible for DD services, DDD offers service coordination.
  - b. A person on the Medicaid HCBS DD Waiver registry can either accept service coordination or choose to request service coordination later by contacting DDD central office.
- 2. When DHHS receives the service coordination request, DDD central office assigns a Service Coordinator.
- 3. When DHHS assigns a Service Coordinator, DDD will bill either Medicaid or the person monthly. DDD bills Medicaid unless the person does not have Medicaid; then DDD bills the person based on their ability to pay.
- 4. The Service Coordinator contacts the person to begin the service planning process.

**D. Responsibilities of the Service Coordinator:** The Service Coordinator provides the following:

- 1. Completion of an annual assessment for ICF/IID institutional level of care and arranges for additional assessments as needed.
- 2. Completion of service planning and development of service goals by:

- a. Holding an individual family meeting (IFM) in-person or by phone with the person to discuss needs and goals;
  - b. Determining appropriate resources to meet the person’s needs. This includes natural supports, such as family, friends, or neighbors; agency; or non-agency resources; and
  - c. Developing an Individual Support Plan (ISP), which includes types of non-waiver services provided to meet the person’s goals, and resources to provide the supports and services while the person is the registry.
3. Assists with:
- a. Applying for programs within the Department of Health and Human Services (DHHS), such as Medicaid or Economic Assistance; and
  - b. Applying for other programs, such as community organization services, housing assistance, legal aid, medical services, Social Security, or Vocational Rehabilitation.
  - c. The Individual Educational Plan (IEP) for students, by attending the school-led meeting and receiving a copy of the document.
4. Monitors the plan by:
- a. Assessing if the plan is meeting the person’s needs on a regular basis;
  - b. Making monthly contact with the person; and
  - c. Reviewing the plan at least once a year with the person.

## 4.2 Service Coordination for Waiver Services

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

- A. A DD Service Coordinator works with each participant to:
1. Provide information on services available through the Medicaid HCBS DD Waivers;
  2. Develop the participant’s service plan, known as the Individual Support Plan (ISP), which is based on the participant’s personal life goals and their needs;
  3. Monitor the implementation of the participant’s ISP;
  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 DDD, 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;
  9. Help advocate for what the participant wants and needs from their provider, family, and community; and
  10. Complete annual ICF/IID institutional level of care assessment for continued participation in a Medicaid HCBS DD Waiver.
- B. **Service Coordinator Assignment:** When a person accepts a funding offer for a Medicaid HCBS DD Waiver, they may or may not have a Service Coordinator already assigned. DHHS

assigns a Service Coordinator based on where the participant lives. Service Coordination offices are located throughout the state.

1. When a person has a DD Service Coordinator assigned while on the registry, the Service Coordinator does not change when the person begins HCBS DD Waiver services, unless a participant moves to a different service area or requests a different Service Coordinator.
2. When a person does not have a DD Service Coordinator while on the registry, DDD central office assigns a Service Coordinator.
3. The Service Coordinator makes regular ongoing contact with or on behalf of the participant, at least monthly.
4. Service planning begins when DHHS makes a funding offer.
5. When a Service Coordinator is not available due to illness, vacation or job vacancy, the Service Coordination Supervisor will direct other Service Coordinators at the local office to ensure the participants' needs are being met.

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

1. A participant's Service Coordinator provides information about the Medicaid HCBS DD Waiver program, available services, and providers.
  - a. Per federal regulation, DDD must inform a participant they have the right to choose between services provided in an ICF/IID or Medicaid HCBS Waiver services.
    - i. When a participant enters services, they sign the Waiver Consent/Election of Waiver Services form, verifying they understand they may choose to receive ICF/IID or Medicaid HCBS Waiver services, and have chosen to receive Medicaid HCBS DD Waiver services.
    - ii. DDD keeps this form in records, and the participant does not need to sign a new one annually.
  - 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 Service Coordinator provides information to support the participant in making an informed choice, including:
    - i. Written and electronic resources that list and describe available Medicaid HCBS DD Waiver services;
    - ii. A list of DD agency providers available in the participant's area; and
    - iii. Information about self-direction and working with independent providers.
    - iv. *For a link to the public website, see Appendix C: Contacts and Resources*
  - c. The Service Coordinator is required to provide the following general information and education to the participant upon entry into services and annually thereafter:
    - i. The participant's rights and responsibilities; and
    - ii. How to report abuse, neglect, and exploitation, make a complaint to DDD, or appeal a decision made by DDD.



- d. The Service Coordinator discusses resources not funded by DDD, such as community organizations, housing assistance, legal aid, medical services, or Vocational Rehabilitation. The Service Coordinator provides:
  - i. Resource and contact information; and
  - ii. When requested by the participant, assistance with scheduling an appointment or completing paperwork, or accompanying them to appointments.
- 2. When a participant has chosen the Medicaid HCBS DD Waiver services they want to receive, the Service Coordinator 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 Service Coordinator:
    - 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 Service Coordinator:
    - 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. **Completing Assessments:** The Service Coordinator completes the ICF/IID institutional level of care and risk screen assessments yearly. A participant's provider may complete additional assessments related to the services they will be providing. Assessments identify the strengths, needs, and preferences of the participant. Assigned team members complete the assessments before the annual ISP meeting. The ISP team reviews assessments at the annual ISP meeting, as assessments are an important part of person-centered planning for the next year.
  - 1. The Service Coordinator completes the ICF/IID institutional level of care assessment with input from the ISP team.
  - 2. The Service Coordinator completes risk screens with information provided by the participant and members of the ISP team through interview and discussion. The following risk screens are completed for each participant:
    - a. Behavioral Risk – measures behaviors, which put the participant and others at risk of harm.
    - b. Health Risk – measures overall health and risks associated with medical conditions.
    - c. Spine and Gait – measures risks associated with walking and fall risk.
    - d. Physical Nutrition Management or Enteral Feeding – measures risks with nutritional intake and aspiration or choking risk. The Service Coordinator only

completes one of these assessments for a participant, based on whether they receive the majority of nutritional intake orally or through enteral feeding.

E. **Service Planning:** The Service Coordinator's main responsibility is to advocate with the participant. The Service Coordinator uses a person-centered approach to ensure the focus of the team planning process is participant-driven. The Service Coordinator:

1. Completes service planning and development of service goals by:
  - a. Establishing an ISP team to support the participant. The team must include:
    - i. The participant;
    - ii. Service Coordinator;
    - iii. DD agency and independent providers who work with the participant;
    - iv. The participant's guardian, family members, advocate, and friends; and
    - v. Other organizations who support the participant;
  - b. Scheduling meetings at a time and place which works best for the participant, including the Annual ISP meeting, the Semi-Annual Review of the ISP and other team meetings when needed;
    - i. Holding an individual family meeting (IFM) with the participant to discuss their needs and goals, annual individual budget amount, and available services and providers; and
    - ii. Holding team meetings to develop the ISP including types of services, provider choice, participant goals, and supports and services.
  - c. During ISP meetings:
    - i. Facilitates discussion and documents ISP information;
    - ii. Obtains and documents information from other team members;
    - iii. Advocates with the participant receiving services;
    - iv. Encourages team members to explore differences and reach mutual consensus; and
    - v. Documents the specific responsibilities of each team member regarding ISP implementation.
    - vi. Ensures a participant's needs are being met through natural and paid supports.
  - d. After an ISP meeting:
    - i. Completes service authorizations;
    - ii. Finalizes the ISP document based on discussions at the meeting;
    - iii. Attaches any additional information to the ISP, including the signature sheet indicating who was at the meeting;
    - iv. Makes sure the participant and guardian agree with the ISP when either of them was not present for all of the ISP meeting; and
    - v. Makes the finalized ISP available to the team on the state-mandated web-based case management system or by mailing.

F. **Service Monitoring:** The Service Coordinator 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 ISP;
  - 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 ISP 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 Service Coordinator formally reviews services across all environments by completing service reviews.
- a. The review looks at services in the ISP to ensure the provider implements habilitation programs, delivers other supports as outlined, and identifies when revisions may be needed.
  - b. The Service Coordinator 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 Service Coordinator:
    - 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 ISP 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 occur in the setting where services are provided and when the participant is present.
  - e. The Service Coordinator 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 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 Service Coordinator will notify the participant and guardian, and appropriate people, such as agency provider administration;
  - ii. The Service Coordinator will not leave the participant in an unsafe situation; and
  - iii. When necessary, the Service Coordinator will call the Adult Protective Services Abuse and Neglect hotline at 1-800-652-1999 or local law enforcement.
- h. The Service Coordinator 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 list timelines for follow-up.
    - (2) When concerns are not resolved, DDD central office may notify DHHS-Public Health or DDD Quality Team.
4. The Service Coordinator 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 Service Coordinator 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 Service Coordinator 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.
- G. Budgeting and Service Authorizations:** The Service Coordinator is responsible for ensuring a participant's annual individual budget amount (IBA) is managed correctly.
1. The Service Coordinator 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 Service Coordinator completes service authorizations to assign funding to DD providers chosen by the participant.
  3. The Service Coordinator tracks the use of the participant's IBA during the ISP 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 Service Coordinator updates the participant's ISP 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 Individual Support Plan (ISP) 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 Service Coordinator documents the share of cost amount and the provider responsible for collecting the share of cost in the participant's ISP and 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. DDD 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 to pay the share of cost to the provider.

## 5. Individual Support Planning and Implementation

In accordance with 42 C.F.R. § 441.540, a person-centered service plan is developed for each participant of Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services. The Individual Support Plan (ISP) is an individualized person-centered plan based on the participant's unique preferences, assessments, and habilitation to meet identified goals and needs. 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

Person-centered planning is the process used to develop a meaningful ISP. The ISP must provide guidance to help the participant achieve important person-centered outcomes, to attain and maintain the needed skills to achieve their life goals, and to live as independently as possible in their community. The ISP clearly describes the needs of the participant and the services and supports required to meet those needs. The participant owns the ISP. The participant is encouraged and supported to lead the person-centered planning process.

A person-centered approach is designed to assist the participant in reaching their personal goals and to live as independently as possible. The process involves family members, friends, and professionals the participant wants, as well as required team members. This team assists the participant to live the life they choose. The process encourages communication from the participant about their supports and services, the progress they have made, and any changes wanted or needed.

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 inclusion as valued members of both community and society; and
11. Empowers the participant to design their ISP with the support of the ISP 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 own 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 participant 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 environments 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 connect to their community to the fullest extent 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 ISP team to guide the development of their ISP.
  - 1. The participant reports to the ISP team what is working and not working.
  - 2. The participant follows through with their ISP.
  - 3. The participant directs changes to their ISP.
  
- D. It is important to develop a plan balancing what is important to the participant and what is important for them.
  - 1. The ISP 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, which 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 ISP team considers what is most important *for* the participant to be safe, healthy, and as independent as possible.
    - a. Things that are important for the participant include supports to address the participant's needs, such as medical needs, behavioral needs, and adaptive needs.
    - b. The team members share information gathered through observations and assessments to identify what is important for the participant.
    - c. In some cases, supports, which are important for the participant, may 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 providers to help them live their life as they wish.
  - 1. The participant chooses from the services available to them under the Medicaid HCBS DD Waiver they receive.
  - 2. The participant chooses a provider based on the service they want.
    - a. There are two types of providers of Medicaid HCBS DD Waiver services:
      - i. A DD agency provider:
        - (1) A company enrolled as a Medicaid provider;
        - (2) Certified by DHHS to provide developmental disability services; and
        - (3) Responsible for hiring and supervising employees or contractors who work with the participant.
      - ii. A DD independent provider:
        - (1) A person or a vendor enrolled as a Medicaid provider; and



- (2) Hired and supervised by the participant. When a participant chooses an independent provider, they are self-directing services.
    - b. Each Medicaid HCBS DD Waiver service has specific provider types and requirements, as listed in the service definition in Chapter 8 of this manual. A participant must choose a provider who meets the requirements of the service they want to receive. Some services cannot be self-directed because only agency providers can offer them.
  3. The participant controls the services they receive and the providers who deliver the services.
    - a. Self-directed services give a participant more control, but also include more responsibility.
    - b. A participant may have both independent and agency providers and can choose to self-direct some services and have agency providers manage others.
    - c. The ISP includes exploring what could help the participant be more independent and if they would like to self-direct any services.

## 5.2 Funding Tiers

*This section is not applicable to the Family Support Waiver (FSW) because the waiver does not use funding tiers. Refer to rate sheet for FSW rates.*

The participant's ICAP score corresponds with one of five funding tiers. The participant and their Individual Support Plan (ISP) team determines the services and supports a participant receives. Services must be provided as specified in the participant's ISP and as described for the funding tier. Provider staffing must be adequate to meet the participant's needs at any given time. The following are definitions of each funding tier with examples of services and supports which may be included in each tier:

- A. Basic Tier is for a participant who needs limited supports and personal attention.
  1. Staff should be on-site or available when the provider is billing for services.
  2. Supports may be provided by staff working with more than one participant.
  3. Examples of support needed in this tier could include:
    - a. Participant needs occasional support and services because they are fairly independent;
    - b. Participant may follow daily routine with limited staff assistance;
    - c. Participant may be alone for periods of time throughout the day;
    - d. Participant usually does not need support during overnight hours; and
    - e. Some days, the participant may not need support.
  4. Participant needs are met with reminders, habilitation programs, or a behavior support plan as required by the service being provided.
  5. Providers must provide services and supports as specified in the participant's ISP and staffing must be adequate to meet the participant's needs at any given time.
- B. Intermediate Tier is for a participant who usually needs full-time supports.
  1. Staff is available on-site for immediate response to meet the participant's needs when the provider is billing services. Immediate response means available within moments to assist the participant.

2. Supports may be provided by staff working with more than one participant.
  3. Examples of support needed in this tier could include:
    - a. Participant needs staff presence and some assistance with activities of daily living;
    - b. Participant needs structure and routine throughout the day; and
    - c. Participant usually does not need staff assistance during overnight hours.
  4. Participant needs are met with reminders, habilitation programs, or a behavior support plan as required by the service being provided.
  5. Providers must provide services and supports as specified in the participant's ISP and staffing must be adequate to meet the participant's needs at any given time.
- C. High Tier is for a participant who needs full-time services and supports with staff available on-site.
1. Staff is available on-site for immediate response to meet the participant's needs when the provider is billing for services. Immediate response means available within moments to assist the participant.
  2. Supports may be provided by staff in a shared setting.
  3. Examples of support needed in this tier could include:
    - a. Participant needs staff presence throughout the day and evening for reinforcement, positive behavior support, personal care, and community or social activities;
    - b. Participant needs frequent staff interaction and personal attention due to physical, medical, or behavioral needs; and
    - c. Participant may need staff assistance during overnight hours.
  4. Participant physical, medical, and behavioral needs are met with habilitation programs, behavioral support plans, or medical protocols as required by the service being provided.
  5. Providers must provide services and supports as specified in the participant's ISP and staffing must be adequate to meet the participant's needs at any given time.
- D. Advanced Tier is for a participant who needs full-time services and supports with staff available on-site.
1. A sole, non-shared staff is required to provide direct support during all waking hours when the provider is billing for services, except when the ISP team agrees on deviation from a sole, non-shared staff and the Service Coordinator documents this in the ISP.
  2. A participant may need this level of service when they have intense physical, medical, or behavioral needs.
  3. Examples of support needed in this tier could include:
    - a. Participant needs staff presence during all waking hours, with staff being close by much of the time;
    - b. Participant needs full-time staff assistance due to physical, medical, or behavioral needs;
    - c. Participant may need two or more non-shared staff for some activities and in response to physical, medical, or behavioral needs; and
    - d. Participant often needs staff assistance during overnight hours.

4. Participant physical, medical, and behavioral needs are met with intensive habilitation programs, behavioral support plans, or medical protocols as required by the service being provided.
  5. Providers must provide services and supports as specified in the participant's ISP and staffing must be adequate to meet the participant's needs at any given time.
- E. Behavioral Risk Tier is for a participant who has intense behavioral needs, which require full-time services, supports, and supervision with a non-shared staff on-site.
1. A sole, non-shared staff must provide direct support during all waking hours when the provider is billing for services.
  2. Examples of support needed in this tier could include:
    - a. Participant needs supervision during all waking hours, with staff being close by much of the time;
    - b. Participant needs a non-shared staff presence during overnight hours. When the participant is sleeping, their staff may be awake or asleep; and
    - c. Participant needs a sole non-shared or higher staffing ratio.
  3. Regular clinical oversight by a Clinical Psychologist, a Licensed Independent Mental Health Practitioner, or an Advanced Practice Registered Nurse employed by the provider is required for a participant in this tier. Clinical oversight must include:
    - a. Participation in team meetings at least once a year;
    - b. Development and monitoring of behavioral support plan;
    - c. Specialized training for direct support staff in risk and behavioral support and participant needs; and
    - d. Analyzing data and tracking outcomes of the participant.
  4. Participant needs are met with intense supervision, intensive habilitation programs, or behavioral support plans.
  5. Providers must provide services as specified in the participant's ISP and staffing must be adequate to meet the participant's needs at any given time.

### 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 ISP team determines the participant's needs cannot be safely met with the amount of services, which 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, DDD may complete a new ICAP, instead of considering exception funding.
- B. When the participant's team determines 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 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 annual risk screens. When the most recent risk screens do not reflect the participant's current needs, the screens must be updated before requesting an exception funding;
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. Identify what supporting documentation the ISP team should be submit with the Request for Exception to the Individual Budget Amount (Request for Exception to the IBA) form and assist the Service Coordinator to obtain the documentation. 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 ISP team and sends the form to the provider.
  - b. The provider verifies Part 1 is accurate according to ISP team discussion, completes Part 2, and attaches identified documentation according to instructions on the form.
6. When an exception request is approved:
  - a. The participant's Service Coordinator distributes the Request for Exception to the IBA form, which includes an explanation of the decision and any recommendations made by DDD, to the ISP team. This includes the duration of the approval, the approved rate, and expectations for the provider.
  - b. DDD sends a notice of decision to the participant.
  - c. After DDD makes the exception decision, the ISP 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 DDD.
7. When an exception request is denied:
  - a. The Service Coordinator gives the ISP team "A Request for Exception to the IBA" form, which includes an explanation of the decision and any recommendations made by DDD.
  - b. DDD 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 DDD clinical team.

## 5.4 Documentation in the Individual Support Plan

Each participant's ISP 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 which 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. The participant's risk screen scores and identified risks, which may include:
1. Medical risks, such as seizures or diabetes;
  2. Behavioral risks; and
  3. Other safety risks, such as falls or choking.
- D. 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;
- E. The participant's medical care, including:
1. Medical diagnoses and general health status;
  2. Allergies to medications, food, or 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;
- F. The participant's habilitation programs for the upcoming year and the assessments that programs are based on, including:
1. Habilitation goals;
  2. Baseline information used to develop current habilitation program;
  3. The needs being addressed by the habilitation programs; and
  4. A summary of progress on the previous year's programs;
- G. 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, the amount and who is assigned;
- H. 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; and
- I. 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 Individual Support Plan Team

The ISP is developed each year through a team process. The participant chooses their ISP team. When the participant does not want a specific person at their ISP meeting, the team will make every effort to honor the request. The Service Coordinator must be invited all team members to all meetings. The team holds at least two ISP meetings each year, an annual and semi-annual.

- A. The team includes the:
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 who support the participant.
- B. The following team members must participate in the ISP 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 ISP 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.
1. The Service Coordinator may contact other team members to decide if the ISP team needs to meet or the team can address the member's concern without a meeting.
  2. When the ISP team needs to meet, the Service Coordinator is responsible for scheduling and inviting all team members.

## 5.6 Individual Family Meeting

The individual family meeting (IFM) is held no more than 90 calendar days, but no less than 30 calendar days, before the start of a new ISP year. The Service Coordinator contacts the participant to discuss the new ISP year. This gives the participant the opportunity to direct the ISP 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 Service Coordinator discusses available types of Medicaid HCBS DD Waiver services and providers and may provide informational handouts.
- E. The Service Coordinator, participant, guardian, and family discuss the amount of money the participant can spend for Medicaid HCBS DD Waiver services. DDD calls this annual individual budget amount (IBA).
- F. The Service Coordinator contacts the provider and other team members when someone expresses a concern or other feedback is given before the ISP meeting.
- G. The Service Coordinator 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 Individual Support Plan Meeting

The annual ISP 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 ISP meeting is to identify waiver and non-waiver services, interventions, strategies, and supports to assist the participant to achieve their plan for the future, and personal goals.

- A. The ISP team holds the annual ISP no more than 90 calendar days, but no less than 30 calendar days before the start of a new ISP year. The Service Coordinator schedules and organizes the meeting on behalf of the participant.
- B. DDD 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 ISP with them after the meeting.
  - 2. Team members encourages the participant to come to future meetings.
  - 3. The ISP documents the reason the participant chose not to attend, and the team member assigned to review the information.
- C. DDD expects each team member to contribute to the ISP meeting. When the participant is unable to communicate information, the ISP 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 ISP 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 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 ISP team;
      - i. Summary of assessments and baselines completed, including identified needs.
        - (1) The ISP team assigns assessments at the semi-annual ISP meeting to identify the strengths, needs, and preferences of the participant and help the team develop the next annual ISP.

- (2) DDD does not require a DD provider to complete certain standard assessments.
      - (a) The provider is responsible to find and complete 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 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 Service Coordinator shares information and leads discussion of:
  - a. The level of care assessment and plans to address identified needs.
  - b. The risk screen results and plans to minimize risks identified in the screens;
  - 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 ISP meeting, each team member is responsible for completing assigned tasks to implement the ISP.
  - 1. Providers are required to implement the ISP. Agency providers who employ direct support staff, or contract with an independent contractor, are required to ensure staff training of the ISP, including habilitative programs.
  - 2. Team members are responsible for cooperating with other DD providers, therapists, and other clinical providers.

## 5.8 Semi-Annual Individual Support Plan Meeting

The semi-annual ISP is a meeting to review the plan created at the annual ISP.

- A. The Service Coordinator schedules and organizes the semi-annual ISP meeting four to six months after the start of the ISP year.
- B. DDD expects the participant 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 ISP with them after the meeting.
  - 2. Team members encourages the participant to come to future meetings.
  - 3. The ISP documents the reason the participant chose not to attend, and the team member assigned to review the information.
- C. The semi-annual ISP meeting covers a review and update on everything documented in the annual ISP and progress, including:
  - 1. Good things or achievements from the last six months;
  - 2. Personal goals the participant would like to continue work on;
  - 3. Review of current habilitation plans, behavior support plans, discussion of progress, and any needed revisions;
  - 4. Changes in employment and vocational rehabilitation involvement;
  - 5. Review of other Medicaid HCBS DD Waiver services provided, such as respite, home modifications, or vehicle modifications;
  - 6. Assignment of any assessments and baselines needed before the next annual ISP meeting;
  - 7. Review of participant risks, if their services and supports addresses those risks, and if anything needs to change;
  - 8. Review of any reported incidents since the annual ISP meeting to determine if any change to the ISP is needed to reduce the likelihood of future incidents;
  - 9. Restrictions, including psychotropic medication, interventions, and progress on reducing restrictions;
  - 10. Review of safety plans, seizure protocols, and use of emergency safety interventions, including how they are working, if changes are needed, and if reduction or elimination is appropriate; and
  - 11. Any financial and legal needs of the participant.
- D. After a semi-annual ISP meeting, each team member is responsible for completing assigned tasks to implement the ISP.
  - 1. Providers are required to implement the ISP. Agency providers who employ direct support staff, or contract with an independent contractor, are required to ensure staff

- training of the ISP, including habilitative programs. When there are changes to the ISP, the provider will train staff accordingly.
2. Team members are responsible for cooperating with other DD providers, therapists, and other clinical providers.

## 5.9 Additional Individual Support Plan Meetings

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

- A. When a team member wants an additional ISP meeting, they contact the Service Coordinator.
  1. The Service Coordinator may contact other team members to decide if the team needs to meet or the team can address the member's concern without a meeting.
  2. When the team needs to meet, the Service Coordinator is responsible for scheduling and inviting all team members.
- B. DDD expects the participant to be involved in the additional ISP meeting. Team members should make every effort to make this happen.
  1. When the participant chooses not to participate, the ISP is reviewed with them following the meeting.
  2. Team members encourages attendance for future meetings.
  3. The ISP documents the reason the participant chose not to attend, and the team member assigned to review the information.
- C. An additional ISP meeting may be held when:
  1. The ISP 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. DDD 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 ISP meeting, each team member is responsible for completing assigned tasks to implement the ISP.
  1. Providers are required to implement the ISP. Agency providers who employ direct support staff, or contract with an independent contractor, are required to ensure staff training of the ISP, including habilitative programs. When there are changes to the ISP, the provider will train staff accordingly.
  2. Team members are responsible for cooperating with other DD providers, therapists, and other clinical providers.

## 5.10 Service Authorizations

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

- A. The Service Coordinator 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 ISP meeting so services can start at the beginning of the new ISP 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.
- B. The Service Coordinator completes service authorizations and notifies providers of new or updated service authorizations through the state-mandated web-based case management system.

## 5.11 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. DDD expects providers to take advantage of “teachable moments” which 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. The following services are habilitative and require habilitation programs:
  - 1. Behavioral In-Home Habilitation;
  - 2. Consultative Assessment;
  - 3. Community Integration;
  - 4. Day Supports;
  - 5. Independent Living;
  - 6. Medical In-Home Habilitation;
  - 7. Prevocational;
  - 8. Residential Habilitation;
  - 9. Small Group Vocational Support;
  - 10. Supported Employment – Follow-Along;
  - 11. Supported Employment – Individual; and
  - 12. Supported Family Living.
- B. **Developing Habilitation Programs.** A participant’s habilitation program addresses needs identified by the participant’s Individual Support Plan (ISP) 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 which 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.

1. Habilitation programs are developed through the following process:
    - a. The Service Coordinator and provider complete assessments;
    - b. The ISP team prioritizes participant needs based on assessments for increasing their independence, while decreasing dependence on others;
    - c. The provider conducts baselines;
    - d. The ISP 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 habilitation provided;
    - g. The provider measures progress of the program; and
    - h. The Service Coordinator 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 own 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 frequency of data collection, as 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 Residential Habilitation services, habilitation focuses on teaching the participant skills to live in their home independently.
  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.
  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 ISP team uses information from assessments to plan services and habilitation programs. An assessment is not a substitution for a habilitation program.
1. DDD requires the Service Coordinator complete an assessment of institutional level of care and risk screens annually, with information from ISP team members.

2. The provider completes additional assessments as determined by the ISP team, based on the personal goals of the participant. Additional areas to assess may include money management, daily living skills, and employment skills.
    - a. At the semi-annual ISP meeting, the ISP team may assign assessments to determine specific needs.
    - b. The provider can complete an assessment at any time when the ISP team or provider thinks there may be a change in abilities.
  3. DDD does not endorse or require use of any specific assessments aside from the risk screens and level of care assessments completed by the Service Coordinator.
- 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 habilitation program from baseline data.
1. The provider is responsible for completing baselines.
    - a. At the semi-annual ISP meeting, the ISP team reviews the participant's goals and needs identified in the assessments to determine areas to complete a baseline.
    - b. A provider can conduct a baseline at any time when the ISP 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 ISP team develops a habilitation program goal.
1. A goal is a long-term outcome the participant works to achieve. The long-term goal is written using SMART guidelines – Specific, Measurable, Achievable, Realistic, and Timely.
    - a. Specific – The goal clearly defines what the participant will learn and 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 ISP year. When the provider notes little progress, the ISP team can decide to continue the goal for the next ISP 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 ISP team to develop and approve a new goal. The ISP must document the new goal.
  5. The ISP meets and reviews progress toward goals at least twice a year.
    - a. The provider presents information from their monthly reviews to the ISP team; and
    - b. The team discusses progress and decides if the provider needs to make changes to the program.
- F. **Behavior Support Plans.** When a participant has an identified problem behavior, they must have a behavior support plan. A behavior support plan is a specific type of habilitation program, which teaches an appropriate replacement behavior and decreases the problem behavior.
1. The provider must complete or arrange for completion of a behavioral assessment to determine the purpose, or function, of a problem behavior and make recommendations to address the problem behavior.
    - a. The behavioral assessment is both the assessment and the baseline used to develop the behavior support plan.
    - b. A behavioral assessment must be completed when:
      - i. No behavioral assessment has been completed in the past;
      - ii. The most recent behavioral assessment does not address all current problem behaviors; and
      - iii. The ISP team decides the participant's current behavior support plan or other behavioral supports do not meet their needs.
    - c. Behavioral assessments must be completed by one of the following professionals acting within their scope of practice:
      - i. Licensed Independent Mental Health Practitioner (LIMHP);
      - ii. Licensed Psychologist;
      - iii. Advanced Practice Registered Nurse (APRN); or
      - iv. Board-Certified Behavioral Analyst (BCBA) supervised by an LIMHP, APRN, or licensed psychologist.
    - d. A behavioral assessment can be completed under the Consultative Assessment waiver service for participants over age 21.
  2. Using the information and recommendations from the behavioral assessment, a behavior support plan is developed to address the participant's problem behavior.
    - a. The behavior support plan cannot include rights restrictions. A behavior support plan is a habilitation plan used to teach skills towards independence. Rights restrictions are used to address safety risk, but do not teach skills, so must not be included in the behavior support plan.
    - b. Rights restrictions to address risks related to problem behavior are outlined in a safety plan. The safety plan contains instructions to maintain the safety of the

participant and others when other supports, such as the behavior support plan, have been attempted and are unsuccessful.

- G. For Habilitation Plan Overview, see *Policy Manual Appendix C: Contacts and Resources*.
- H. **Safety Plans Address Risks.** When an assessment identifies a safety risk, the provider must develop a safety plan. A safety plan addresses any identified risks and makes sure those who provide direct support know the participant's risks and supports. A safety plan is not a habilitation program; data is not collected and a provider cannot use it in place of a habilitation program.
  - 1. 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.
  - 2. The safety plan must match the ISP team's decisions about what supports the participant need, and when and how a rights restriction is used.
  - 3. When the ISP team determines the participant needs a safety plan, the provider is responsible to develop the safety plan. The provider cannot include a support or rights restriction not agreed upon and approved by the ISP team.

## 6. Self-Direction

When a participant chooses to work with an independent provider, they are responsible for self-directing Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services. Self-direction is not a service; it is a way a participant manages their services when working with their independent providers. Self-direction gives the participant responsibility 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 personal 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 not met by a provider who has a lack of medical knowledge or training;
2. Isolation or decrease in community integration;
3. Vulnerability to abuse or neglect; and
4. Possibility that 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 find 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?
- D. When anyone on the ISP 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, they must be willing and able to accept increased responsibility for managing their Medicaid HCBS DD Waiver services. It is important the participant advocates for their own wants and needs.

- A. The participant must actively direct the ISP 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 ISP.
1. The participant negotiates the hourly rate paid to each independent provider, up to the maximum rate set by DDD.
    - a. DDD pays independent providers at the rate chosen by the participant; and
    - b. DDD 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 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.
    - a. The participant is responsible for knowing what the provider can bill for as a part of a service.
    - b. 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 DDD. It may be helpful for the participant to keep a calendar documenting services provided. Differences must be resolved before the provider can bill.
    - c. 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 any time 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 C: Contacts and Resources.*
  3. The participant directs the use of the annual IBA:
    - 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 ISP year to ensure there is enough funding to receive services for the entire ISP year. The participant can do their monitoring on the state mandated web-based case management system, or by requesting reports from their Service Coordinator.
    - a. When the participant does not spend all the money in their IBA, it does not carry over into the next ISP year.
    - b. When a participant uses all the money in their IBA before the ISP year is over, additional Medicaid HCBS DD Waiver funds are not available until the new ISP 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 ISP 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 ISP team must monitor possible conflict of interest to 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 ISP 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 to 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 Service Coordinator 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 Service Coordinator 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 Service Coordinator to attend; and
      - iii. Must be aware of 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 which 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, which 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 back-up provider.
  1. The participant should not promise a potential provider 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 provider enrollment is complete and a service authorization is completed.
  3. The participant notifies their Service Coordinator when they want to hire an independent provider.
  4. When the potential provider is not already a Medicaid-enrolled provider, DDD 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, DDD 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 training of their provider in any medical conditions the participant have which 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.
    - a. Habilitation training is not required for provider enrollment;
    - b. Knowing how to write habilitation plans may come from previous experience; or

- c. When a provider needs training, they should check the DDD training page to see what free training is 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 also.
    - 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 DDD 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 ISP, 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 back-up 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 a good idea 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 put their health or safety at risk, the participant should talk their service coordinator.
    - a. When the Service Coordinator agrees 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, DDD policy requires the provider's agreement 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, it is the participant's obligation to report this information to their Service Coordinator 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 they will no longer be employed.

## 6.5 Individual Support Plan Team Responsibilities

The participant's ISP 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 if their needs are being met. The Service Coordinator 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 ISP;
  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 back-up plan when needed.
- C. When a team member is concerned self-directed services are not meeting the participant's needs the concerned team member should:
  1. Discuss concerns with the participant;
  2. Discuss concerns with the Service Coordinator;
  3. Request, when necessary, the ISP team meet:



- a. The team should discuss what needs to change, how it should change, and by when.
  - b. When the participant is willing to accept feedback and make the changes identified by the team, the team will revisit after the agreed-upon timeframe.
- D. When the participant is not self-directing in a way which 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.

## 6.6 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 Service Coordinator.

- A. The Service Coordinator provides information and assists the participant with connecting to natural and informal supports.
- 1. The participant is in charge of their meeting and leads the discussion. The Service Coordinator assists the participant by making sure the team discusses all needed information at the ISP meeting. The Service Coordinator writes the ISP.
  - 2. The Service Coordinator works with the participant to create the participant's plan to self-direct by providing guidance with recruiting, hiring, and managing independent providers. The Service Coordinator does not perform these tasks directly, but assistance may include:
    - a. Directing the participant to resources for finding providers;
    - b. Attending interviews 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 Service Coordinator.
      - ii. When the potential provider is not already enrolled as a Medicaid provider, the Service Coordinator makes a referral to DDD central office.
      - iii. When the potential provider is enrolled as a Medicaid provider, the Service Coordinator authorizes services.
    - d. Making sure there is a back-up plan when provider does not arrive when scheduled or quits.
- B. The Service Coordinator monitors how self-direction is going, including:
- 1. How often an independent provider misses work;
  - 2. If, and how often, the participant's back-up plan is being used;
  - 3. High turnover of independent providers;
  - 4. Participant satisfaction with services;
  - 5. If the participant's schedule is developed based on the participant's need 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 which 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 Service Coordinator has concerns 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

The Nebraska Department of Health and Human Services Division of Developmental Disabilities (DDD) provides funding and oversight of Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) 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 DDD, 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. DDD 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. Work drug-free and maintain a drug-free workplace;
5. Follow all statutes, regulations, and policies governing:
  - a. Providers of Medicaid services; and
  - b. Providers of DD services.
6. Follow HIPAA (Health Insurance Portability and Accountability Act) rules;
7. Have access to and the ability to use the state-mandated web-based case management system;
8. Comply with billing requirements, including submitting thorough and accurate claims through the state-mandated web-based case management system;
9. Be able to meet the participant's needs:
  - a. Follow and implement the participant's individual support plan (ISP);
  - b. Be physically able to provide services to participants;
  - c. Know what to do in emergency situations;
  - d. Be responsible for a participant's safety and property; and
  - e. Take steps to prevent incidents of abuse, neglect, and exploitation.
10. Not be legally responsible for the participant when providing direct services. Legally responsible people include:
  - a. Parent when the participant is under age 19;
  - b. Guardian;
  - c. Participant's spouse;
  - d. Conservator; or
  - e. Power of attorney.
11. Avoid all conflicts of interest and any appearance of conflicts of interest. A provider must immediately notify DDD of any conflicts of interest so the Individual Support Plan (ISP) 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 place 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 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 ISP 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 ISP 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. **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 ISP.
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.
- D. **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. DDD 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.
- E. **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 ISP, 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 ISP 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.
- F. **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 to ensure transportation meets the participant's needs and the participant is able to use public transportation safely.
- G. **State-Mandated Web-Based Case Management System:** DDD uses the state-mandated web-based case management system is used for service planning, documentation, reporting, communication, 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 agency provider staff administers routine or PRN (as needed) medications.
    - 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; and
      - iii. Receive no assistance with any activity related to medication administration.
  - 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.
- H. **Electronic Visit Verification:** In 2016, Congress passed the 21<sup>st</sup> 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 which require EVV:
    - a. Independent Living;
    - b. Supported Family Living;
    - c. Behavioral In-Home;
    - d. Medical In-Home;
    - e. Respite; and
    - f. Homemaker.
  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 and is the preferred option for DD providers. DHHS pays the cost 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 specific service provided;
    - d. The location the service is provided;
    - e. The date the service is provided; and
    - f. The start and end times of the service.
- I. **Record Keeping:** A provider must maintain accurate, current, and complete participant and business records. Agency and independent providers must keep different types of records. The following requirements apply to all providers:
1. DDD 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 ISP.
    - 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.
- J. **Billing for Services:** A provider bills by submitting a claim for Medicaid HCBS DD Waiver services the provider delivered.
  - 1. In order 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.
  - 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 ISP for any habilitative service provided; and



- c. Location of service provided when service requires community integration.

K. **Reporting Incidents:** When a situation occurs which may negatively affect a participant; alleged or suspected abuse, neglect, exploitation, or 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 Abuse, Neglect, or Exploitation of a Child or a Vulnerable Adult
  - c. Change of Condition/Medical Decline
  - d. Communicable Disease
  - e. Death of a Participant
  - f. Emergency Situations
  - g. Falls with Injury requiring more than first aid
  - h. Incidents Involving Emergency Personnel Requiring Emergent Response
  - i. Infestations
  - j. Injuries of Unknown Origin Raising Suspicion
  - k. Injury Requiring Medical or Nursing Interventions beyond First Aid
  - l. Medication Errors
  - m. Misconduct not Involving Law Enforcement
  - n. Missing Person(s)
  - o. PRN Psychotropic Medication Usage
  - p. Property Damage
  - q. Suicide Attempts
  - r. Swallowing Inedibles
  - s. Unplanned Hospitalization/Emergency Room/Urgent Care Visit
  - t. Use of Emergency Safety Interventions
  - u. Use of Restraint or Prohibited Practices
  - v. 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 Service Coordinator 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 the participant is not aware a reportable incident has occurred.
    - c. The provider must approve the written report in the web-based case management system within 72 hours of submitting.
  - 3. Agency providers have additional responsibilities to investigate incidents and submit reports to DDD.
  - 4. Providers may use low level GERs for internal reporting. DDD does not mandate or monitor these.
  - 5. There is a guide available on how to complete incident reports. It is found on the state-mandated web-based case management system. *For a link to the guide, see Policy Manual Appendix C: Contacts and Resources.*
- L. **Reporting Abuse, Neglect, and Exploitation:** Any suspected abuse, neglect, or exploitation must be reported to local law enforcement or to the 24-hour toll-free DHHS abuse and neglect hotline at 1-800-652-1999. This is in accordance with Nebraska Rev. State Stat. 28-372 of the Adult Protective Services Act or, in the case of a child, in accordance with Nebraska Rev. State Stat. 28-711 of the Child Protective Services Act.
- 1. Providers must report suspicion of abuse and neglect or exploitation following the DDD incident reporting requirements.
  - 2. Providers of waiver services are required to have training on identification of abuse, neglect, and exploitation, and reporting requirements.
- M. **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 Developmental Disabilities within 10 calendar days of the death;
      - i. The form is in the Forms section on the [Provider page](#) of the Division of Developmental Disabilities 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](mailto: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 Developmental Disabilities 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.

N. **Remediation:** The Department of Health and Human Services (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 the 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 makes a determination regarding 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.

- O. **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 regulation;
    - d. Documentation about other agency policies and procedures which 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 DDD 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 ISP team review; or
    - b. Sent to the Service Coordinator for ISP team review and then submitted by the Service Coordinator.
  3. DDD may approve the request for alternative compliance when the proposed steps being 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 have been attempted and were unsuccessful; and
    - c. Protect the rights, health, safety, and well-being of the participant.
  4. DDD issues a written decision via the state-mandated web-based case management system within 30 calendar days of receiving a request. DDD may delay a decision when DDD 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 DDD.
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 ISP team for the participant affected has not reviewed the provider's proposed actions;
  - f. State or federal law has changed in a way which 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 DDD 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;
    - 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. Child Day Habilitation;
  - e. Community Integration;
  - f. Consultative Assessment;
  - g. Day Supports;
  - h. Environmental Modification Assessment;
  - i. Family Caregiver Training
  - j. Family Peer Mentoring
  - k. Home Modifications;
  - l. Homemaker;
  - m. Independent Living;
  - n. Medical In-Home Habilitation;
  - o. Prevocational;
  - p. Residential Habilitation;
  - q. Respite;
  - r. Small Group Vocational Support;
  - s. Supported Employment – Follow-Along;
  - t. Supported Employment – Individual;
  - u. Supported Family Living;
  - v. Therapeutic Residential Habilitation;
  - w. Transitional;
  - x. Transportation; and
  - y. Vehicle Modifications.
- 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 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 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 DDD central office to sign up for orientation. *For DDD central office contact information, see Policy Manual Appendix C: 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, DDD central office provides a link to the competency activity.
  - h. The applicant must complete the competency activity and return to DDD.
    - i. When the applicant returns the competency activity with a score of 85% or above, DDD 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%, DDD 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, DDD 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](mailto:DHHS.DDDCommunityBasedServices@nebraska.gov).
  - d. Providing incomplete or incorrect information can result in the denial of an application. When the application is complete, DDD 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, DDD 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' ISPs 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 DDD:** An agency provider must notify DDD central office in writing:
- 1. Within ten business days of:
    - a. Change in agency provider ownership;
    - b. Change in agency provider director; or
    - c. Change in contact information, including physical business address, phone number, mailing address, or email address;
  - 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. DDD 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 18 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. 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 same background and registry checks as the employee or contractor.
      - iii. 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.
      - iv. An employee or contractor cannot provide direct support services to a participant if:
        - (1) They are listed on the Central Registry of Child Protection Cases and Adult Protective Services or the Nebraska State Patrol Sex Offender Registry; or
        - (2) They are charged and awaiting resolution or convicted of any crime outlined in applicable state regulations.
      - v. 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 outlined in state regulations.
- vi. An employee or contractor must notify the agency provider immediately when they are charged or convicted of any of any crime outlined in state regulation 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. All employees must also provide effective habilitation and support to participants. Required training includes:
- i. Participant choice;
  - ii. Participant's rights in accordance with state and federal law;
  - iii. Confidentiality;
  - iv. Dignity and respectful interactions with participants;
  - v. State reporting requirements and prevention of abuse, neglect, and exploitation;
  - vi. Emergency procedures;
  - vii. Infection control;
  - viii. CPR (cardiopulmonary resuscitation) and basic first aid; which includes in-person training and skills verification.
  - ix. DDD approved emergency safety intervention procedures (See section 3.8);
  - x. Implementation and development of the ISP and ISP team process;
  - xi. Positive support techniques;
  - xii. Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the participant; and
  - xiii. Use of adaptive and augmentative devices used to support participants, as necessary.
- 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. In addition to all other requirements, two years of human services experience is preferred, but not required.
- I. **Contracting:** An agency provider may contract with people not employed by the agency provider to deliver Residential Habilitation – Shared Living. Employees of the agency provider must deliver all other Medicaid HCBS DD Waiver services.
1. An agency provider may contract with people, such as maintenance workers, who do not deliver Medicaid HCBS DD Waiver services.
  2. An agency provider is responsible for all actions and services provided by a contractor.
- 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 reporting, also known as general event reports (GER);
    - d. Habilitation programs and data collection;
    - e. Documentation of a participant's employment; and
    - f. 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. An agency provider must maintain participant health-related records in the state-mandated web-based case management system, unless a participant's ISP 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.
8. When there are changes in ownership, the previous owner must transfer all participant records to the current owner.
9. Before an agency provider closes, the administrator must notify DDD 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 ISP;
    - 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 ISP; 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 ISP team must discuss and document in the ISP:
      - 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;
      - 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 ISP 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. 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.
- 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, ISP 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 Residential Habilitation, 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. DDD 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 DDD 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 ISP 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 to DDD 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 DDD 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:** Effective March 17, 2014, 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.

1. Agency providers are required to:
  - a. Complete an electronic self-assessment for all new settings prior to providing services in the setting; and
    - i. Non-Residential Self-Assessment Survey Monkey:  
<https://www.surveymonkey.com/r/Non-ResidentialSelf-Assessments>
    - ii. Residential Self-Assessment Survey Monkey:  
<https://www.surveymonkey.com/r/ResidentialSelfAssessments>
  - b. Submit self-assessments to DDD 15 business days prior to beginning services in the setting.
2. DDD 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 DDD.
  - b. The agency provider is fully compliant. The agency provider is permitted to begin providing services in that setting or
  - c. DDD needs to complete an on-site visit. When an on-site visit is determined necessary, DDD will notify the provider by phone to schedule the visit.
- 3. DDD 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 DDD.
- 5. This same process is used when DDD 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:** DDD 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 outlined in state regulation 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. Consultative Assessment (not available on the FSW);
  - d. Community Integration;
  - e. Environmental Modification Assessment;
  - f. Home Modifications;
  - g. Homemaker;
  - h. Independent Living;
  - i. Respite;
  - j. Supported Employment – Follow-Along (not available on the FSW);
  - k. Supported Employment – Individual (not available on the FSW);
  - l. Supported Family Living;
  - m. Transitional (not available on the FSW); and
  - n. Transportation.

- 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. DDD recommends a potential independent provider attend orientation.
    - a. At orientation, DDD 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 DDD central office to sign up for orientation.
    - d. DDD 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 DDD central office.

4. DDD 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 C: 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 outlined in state regulations.
9. When Medicaid denies enrollment, DDD central office and the independent provider receive a notification from the Medicaid independent provider enrollment system.
  - a. DDD central office notifies the participant's Service Coordinator; and
  - b. The individual support plan (ISP) team discusses a plan to explore alternative options.
10. When Medicaid approves enrollment, Medicaid notifies the independent provider and DDD central office.
  - a. DDD central office notifies the participant's Service Coordinator;
  - b. The Service Coordinator makes sure the ISP 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 DDD 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. DDD has developed some training for independent providers of Medicaid HCBS DD services. These trainings are available on the DDD 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. Participant records must be available when providing services.
  3. 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.
  4. An independent provider must maintain participant health-related records in the state-mandated web-based case management system when a participant's ISP 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:** DDD pays an independent provider at the rate chosen by the participant for services billed.
1. A participant negotiates the hourly rate DDD pays their independent provider, up to the maximum rate set by DDD. *For a link to the fee schedule with maximum rates, see Policy Manual Appendix C: 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. DDD 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 DDD 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.

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.
6. 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. ISP team meetings;
    - d. Habilitation program development; or
    - e. Shopping for supplies, maintenance, and cleaning when the participant is not present.
  7. 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 ISP;
  - 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 ISP; 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 Virtual Support Provider Requirements

- A. Virtual support is 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 support is 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;
    - c. Be structured and scheduled, or offered on-demand, depending on the participant's preferences and need; and
    - d. Be available to participants in the basic and intermediate funding tiers.
      - i. The participant's needs must be able to be met by verbal cuing and other supports that can be provided virtually.
      - ii. The participant must be able to operate the devices and communication platforms used for virtual support without in-person assistance.
      - iii. 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.
- B. **The following services can be delivered via virtual support:**
  1. Independent Living and Supported Family Living
    - a. The majority of the service provided each week must be provided in-person.
    - b. Virtual support can be used for up to 10 hours per week, within the weekly service amount.
  2. Community Integration, Day Supports, Prevocational, and Supported Employment – Individual
    - a. The majority of the service provided each week must be provided in-person.
    - b. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours. These 10 hours is included in the 35 hours per week cap on day services.
  3. Family and Peer Mentoring



- C. **Considerations for using virtual 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 supports, and must affirmatively choose virtual 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 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 inclusion and interaction through other waiver services they receive, or supports should not be delivered virtually.
  5. A participant may choose to discontinue virtual supports at any time, effective immediately.
- D. **Virtual support is not intended to be used:**
1. For the convenience of the provider;
  2. Due to shortage of staff;
  3. With a sleeping participant; or
  4. To assess a participant's medical needs or condition.
- E. **Agency and independent providers must:**
1. Be attentive to the needs of the participant when providing virtual 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 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 support 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 support or when the device used for virtual support is 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 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.
  5. **Agency providers:** When providing a portion of allowable services virtually, policies and procedures must address:
    - a. Identifying whether the participant's needs, including health and safety needs, can be addressed safely via virtual supports;
    - b. Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
    - c. Obtaining written informed consent from the participant, guardian (when applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
    - d. The process for requesting support from the back-up person or contacting EMS when the participant experiences an emergency during virtual support or requires on-site support; and
  - F. **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 an event of an emergency; and
      - c. When the participant requires on-site support rather than virtual support; and
    3. Independent providers must submit their written plan for providing virtual supports to the participant's Service Coordinator for approval.
  - G. **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.

## 8. DD Waiver Service Definitions

The Nebraska Department of Health and Human Services Division of Developmental Disabilities (DDD) administers the Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Adult Day and Comprehensive DD Waivers. The Comprehensive DD Waiver is available to participants of all ages who meet eligibility requirements. The DD Adult Day Waiver is available to participants ages 21 years and older who meet eligibility requirements.

- A. A participant may receive services from only one Medicaid HCBS waiver at a time. A participant may receive one waiver while on the registry for a different waiver. A participant can only use Medicaid HCBS DD Waiver when they have exhausted all other available resources.
- B. A participant chooses each service based on their needs.
  - 1. Services should increase independence and community integration; and
  - 2. The chosen waiver services and who provides them are documented in the participant's Individual Support Plan (ISP).
- C. There are two types of DD providers available to provide DD services:
  - 1. A DD agency provider is a company enrolled as a 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. A DD 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.
- D. Each service has a maximum rate and is paid hourly, daily, or partial-day rates, per mile, or per item.
- E. A relative of the participant, but not a guardian or other legally responsible person of the participant may provide a DD service when they meet other requirements.
- F. This chapter gives a description of each service in the approved Medicaid HCBS Waivers. Each service description will identify under which waiver DDD offers the service.
  - 1. A few services may have a portion of it provided virtually, as identified within the definition.
  - 2. For links to the Medicaid HCBS Comprehensive DD Waiver and the Medicaid HCBS DD Adult Day Waiver, both with full definitions, service standards, limitations, provider types and qualifications, and reimbursement, *see Policy Manual Appendix C: Contacts and Resources.*

## 8.1 Adult Day

Adult Day is a service providing day activities that are meaningful to a participant in a safe, supervised non-residential setting. Adult Day offers fewer opportunities for community involvement and cannot include employment or volunteer activities due to compromised health issues and significant limitations of a participant. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Adult Day is a service offered under the DDAD and CDD HCBS DD Waivers.
- B. Adult Day includes:
  - 1. Social and recreational activities that are meaningful to a participant;
  - 2. Staff are with participants to meet their needs and keep them engaged in the activities provided;
  - 3. Community involvement to the greatest extent possible based on the participant's limitations and preferences; and
  - 4. Assistance with activities of daily living, health maintenance, and supervision.
- C. Adult Day is not a habilitative service.
- D. Examples of Adult Day activities include but are not limited to:
  - 1. Group exercise, book club, or group discussions; or
  - 2. Going out to eat, shopping, or other community activities.
- E. Adult Day has the following limitations:
  - 1. Adult Day is only available to a participant aged 21 years or older.
  - 2. Adult Day cannot be provided in a residential setting or in the same room where other waiver services are provided.
  - 3. Adult Day cannot be provided by an employee who is providing other waiver services at the same time.
  - 4. A participant may not engage in work or volunteer type of activities.
  - 5. Adult Day is reimbursed at an hourly rate.
  - 6. A participant may receive Adult Day in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Behavioral In-Home Habilitation;
    - b. Community Integration;
    - c. Day Supports;
    - d. Medical In-Home Habilitation;
    - e. Prevocational;
    - f. Small Group Vocational Support;
    - g. Supported Employment – Individual;
    - h. Supported Employment – Follow-Along; and
    - i. Vocational Rehabilitation job seeking and job coaching.
  - 7. The cost of transportation is:
    - a. Included in the rate during Adult Day;
    - b. Not included in the rate to the site where Adult Day begins; and
    - c. Not included in the rate from the site where Adult Day ends.

8. Adult Day cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Adult Day can be provided in the hospital setting when a participant is admitted for critical care.
    1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
    2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
    3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
    4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
  - G. Adult Day can be offered by a DD agency provider.
  - H. Adult Day cannot be self-directed.
  - I. Adult Day must be purchased within a participant's annual individual budget amount.

## 8.2 Assistive Technology

Assistive Technology is a device, equipment, or appliance used to increase a participant's ability to complete activities of daily living or control their environment in their private or family home. Use of assistive technology may decrease a participant's need for staff assistance. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Assistive Technology is a service offered under all the HCBS DD Waivers.
- B. Assistive Technology includes:
  - 1. Purchase or lease of the device, equipment, or appliance;
  - 2. Designing, customizing, installing, maintaining, repairing, and replacing assistive technology items;
  - 3. Coordination and use of necessary therapies, interventions, or other services in the ISP with assistive technology devices;
  - 4. Training for a participant and other members of the household; and
  - 5. Training for a provider who supports the participant in their home.
- C. Examples of Assistive Technology include but are not limited to:
  - 1. Communication devices;
  - 2. Special beds; or
  - 3. Freestanding Hoyer lifts.
- D. Assistive Technology has the following limitations:
  - 1. All assistive technology must be provided in accordance with applicable state or local building codes or standards of manufacturing, design, and installation.
  - 2. An item over \$500 must include insurance or an extended warranty.
  - 3. An uninsured item that is damaged, stolen, or lost may be replaced once every two years.
  - 4. Assistive Technology is reimbursed per item.
  - 5. DDD may require an on-site assessment of the environmental concern by an appropriate Medicaid-enrolled professional provider. The assessment is provided under the Environmental Modification Assessment.
  - 6. A vendor cannot charge more than they would to the general public. A vendor who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 7. The cost of transportation is not included in the rate for Assistive Technology.
  - 8. Assistive Technology cannot overlap with, replace, or duplicate other similar services provided through Medicaid. A participant should find out if Medicaid would pay for assistive technology before requesting this service.
- E. Assistive Technology can be offered by a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- F. Assistive Technology can be self-directed.
- G. Assistive Technology must be purchased within a participant's annual individual budget amount. Assistive Technology has an annual budget cap of \$2,500. A participant may request funding over the annual budget cap due to a critical health or safety need. DDD approval is determined based on available funding.

## 8.3 Behavioral In-Home Habilitation

Behavioral In-Home Habilitation is a short-term habilitative service provided to a participant whose reoccurring severe mental health condition or behavior prevents them from participating in their regularly scheduled day service activities or employment and is unable to be home alone. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS Comprehensive DD Waiver.*

- A. Behavioral In-Home Habilitation is a service offered under the Medicaid HCBS Comprehensive DD Waiver.
- B. Behavioral In-Home Habilitation includes:
  - 1. Habilitative services for a participant who:
    - a. Experiences a reoccurring mental health condition; or
    - b. Is having a reoccurring severe behavioral crisis; and
  - 2. Assistance with activities of daily living, health maintenance, and supervision.
- C. Behavioral In-Home Habilitation is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Behavioral In-Home Habilitation has the following limitations:
  - 1. Behavioral In-Home Habilitation can only be provided in the participant's home.
  - 2. The provider must be providing service in the residence with the participant.
  - 3. The DDD clinical team must approve requests for this service prior to the service being authorized and provides ongoing monitoring of use of this service.
  - 4. A participant may receive Behavioral In-Home Habilitation in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Community Integration;
    - c. Day Supports;
    - d. Medical In-Home Habilitation;
    - e. Prevocational;
    - f. Small Group Vocational Support;
    - g. Supported Employment – Individual;
    - h. Supported Employment – Follow-Along; and
    - i. Vocational Rehabilitation job seeking and job coaching.
  - 5. Behavioral In-Home Habilitation is only available to participants receiving Residential Habilitation.
  - 6. Behavioral In-Home Habilitation cannot be used when participant receives Therapeutic Residential Habilitation, Independent Living, or Supported Family Living.
  - 7. Behavioral In-Home Habilitation is reimbursed at an hourly rate.
  - 8. Behavioral In-Home Habilitation requires the provider use electronic visit verification (EVV).
  - 9. The cost of transportation is not included in the rate for Behavioral In-Home Habilitation.

10. Behavioral In-Home Habilitation cannot include any service or part of a service available through public education:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  11. Behavioral In-Home Habilitation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- E. Behavioral In-Home Habilitation can be offered by a DD agency provider.
  - F. Behavioral In-Home Habilitation cannot be self-directed.
  - G. Behavioral In-Home Habilitation is based on the participant's need, which is routinely assessed by the DDD clinical team, and must be purchased within a participant's annual individual budget amount.
  - H. Behavioral In-Home Habilitation is limited to 90 calendar days per occurrence. Additional hours per occurrence must be approved by DDD Central Office administration.



## 8.4 Child Day Habilitation

Child Day Habilitation is a habilitative service, which provides teaching to develop, maintain or improve upon adaptive life skills to a participant who is 20 years or younger. Child Day Habilitation takes place in the community, separate from the participant's private family home where the focus is providing support to promote independence and personal growth, while encouraging community integration. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Child Day Habilitation is a service offered under the Medicaid HCBS Comprehensive DD Waiver and the Family Support Waiver.
- B. Child Day Habilitation includes:
  - 1. Habilitative activities to increase independence;
  - 2. Inclusive community activities to increase social and leisure skills;
  - 3. Physical, medical, personal care or behavior support a participant needs related to their disability or special health condition; and
  - 4. Supervision and oversight beyond what is normally provided to a participant without a disability or special health condition.
- C. Child Day Habilitation is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Child Day Habilitation include but are not limited to:
  - 1. Teaching a participant how to share with others;
  - 2. Teaching a participant how to participate in activities, such as games, coloring, and electronics, as related to their age; or
  - 3. Teaching a participant to tie shoes, zip/unzip coat, and wash hands and face.
- E. Child Day Habilitation has the following limitations:
  - 1. Available for participants who are under 21 years old and are living in their private family home.
  - 2. Child Day Habilitation does not include the basic cost of childcare unrelated to a participant's disability.
    - a. Basic cost of childcare is the rate charged by and paid to a childcare center or individual provider for children who do not have a disability or special health condition.
    - b. The basic cost of childcare or the cost of regular childcare is the parents or guardians' responsibility.
    - c. Child Day Habilitation pays for above and beyond regular childcare, due to the child's unique need as related to their disability or special health condition.
  - 3. Child Day Habilitation cannot be provided by a guardian or legally responsible member of the participant's family.
  - 4. The cost of transportation is:
    - a. Included in the rate during Child Day Habilitation;
    - b. Not included in the rate to the site where Child Day Habilitation begins as this is the responsibility of the parent or guardian; and
    - c. Not included in the rate from the site where Child Day Habilitation ends, as this is the responsibility of the parent or guardian.

5. Child Day Habilitation cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  6. Participants receiving Residential Habilitation or Therapeutic Residential Habilitation cannot receive Child Day Habilitation.
  7. Participants receiving Child Day Habilitation cannot receive Community Integration.
  8. This service cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Child Day Habilitation can be offered by a DD agency provider or independent provider.
- G. Child Day Habilitation can be self-directed.
- H. Child Day Habilitation must be purchased within a participant's annual individual budget amount.
- I. Child Day Habilitation has a weekly cap of 70 hours for participants on the Comprehensive DD Waiver. A week is defined as 12:00 am Monday through 11:59 pm Sunday.

## 8.5 Community Integration

Community Integration is a habilitative service, which provides teaching of self-help, behavioral, socialization, and adaptive skills. Community Integration takes place in the community in a non-residential setting. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Community Integration is a service offered under all the Medicaid HCBS DD Waivers.
- B. Community Integration includes:
  - 1. Habilitative activities designed to increase independence and personal choice;
  - 2. Opportunities to make connections and interact with community members; and
  - 3. Assistance with activities of daily living, health maintenance, and supervision.
- C. Community Integration is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Community Integration include but are not limited to:
  - 1. Teaching a participant how to join and participate in a community group, church group, book club, card club, or a fishing club;
  - 2. Teaching a participant how to go shopping, attend a concert, go out to eat, or attend a sporting event;
  - 3. Teaching a participant how to join and participate in volunteer activities, such as an animal shelter or Meals on Wheels; or
  - 4. Teaching a participant how to get around the community by using public transportation or riding a bike.
- E. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant's needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Community Integration provided each week must be provided in-person;
  - 4. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours; and
  - 5. These 10 hours are included in the 35 hours per week cap of day services.
- F. Community Integration has the following limitations:
  - 1. During Community Integration, a participant may not do paid or unpaid work for which others are typically paid, but can participate in volunteer activities and hobbies, which earn minimal money.
  - 2. During Community Integration, a provider cannot bill for non-integrated activities, such as van rides or going to empty parks, when there is little or no opportunity for interaction with community members.
  - 3. The majority, of the time billed in a week for Community Integration must occur in the community.
  - 4. Community Integration is reimbursed at an hourly rate.
  - 5. Community Integration may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.

6. A participant may receive Community Integration in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Day Supports;
    - d. Medical In-Home Habilitation;
    - e. Prevocational;
    - f. Small Group Vocational Support;
    - g. Supported Employment – Individual;
    - h. Supported Employment – Follow-Along; and
    - i. Vocational Rehabilitation job seeking and job coaching.
  7. The cost of transportation is:
    - a. Included in the rate during Community Integration;
    - b. Not included in the rate to the site where Community Integration begins; and
    - c. Not included in the rate from the site where Community Integration ends.
  8. Community Integration cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  9. Participants receiving Community Integration cannot receive Child Day Habilitation.
  10. This service cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- G. Community Integration can be provided in the hospital setting when a participant is admitted for critical care.
1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
  2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed, and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
  3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
  4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
- H. Community Integration can be offered by a DD agency provider or independent provider.
- I. Community Integration can be self-directed.
- J. Community Integration must be purchased within a participant's annual individual budget amount.

## 8.6 Consultative Assessment

Consultative Assessment is provided for the development and implementation of behavioral supports to assist a participant in maintaining their current services while ensuring their safety and the safety of others. Consultative Assessment increases the participant's independence and involvement in their community. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Consultative Assessment is a service offered under the DDAD and CDD Medicaid HCBS DD Waivers.
- B. Consultative Assessment includes:
  - 1. Observing a participant where they live and receive services in-person or by Telehealth;
  - 2. Completing a behavioral assessment;
    - a. A behavioral assessment identifies specific problem behavior, the purpose or function of the behavior, identifies a positive replacement behavior, and makes recommendations to address the problem behavior.
    - b. The behavioral assessment is used to develop a positive behavior support plan to teach positive replacement behaviors and reduce problem behaviors.
  - 3. Developing a positive behavior support plan, safety plan, and other supports;
  - 4. Providing training on the behavior support plan, safety plan, and other supports;
  - 5. Giving recommendations to the participant's ISP team; and
  - 6. Implementing, evaluating, and revising behavior support plan, safety plan, and other supports as necessary.
- C. Consultative Assessment is not a habilitative service, however it assists in the development of habilitative supports.
- D. Consultative Assessment has the following limitations:
  - 1. Consultative Assessment, including the behavioral assessment, must be provided by a Licensed Independent Mental Health Practitioner (LIMHP), Licensed Psychologist, Advanced Practice Registered Nurse (APRN), or a Board-Certified Behavior Analyst (BCBA) supervised by an LIMHP, licensed psychologist, or APRN.
  - 2. The provider or vendor must attend a minimum of two ISP team meetings per year, in-person, by phone, or by Telehealth.
  - 3. The provider's transportation and lodging costs are included in the rate for Consultative Assessment.
  - 4. Consultative Assessment is reimbursed at an hourly rate.
  - 5. Consultative Assessment cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- E. Consultative Assessment can be offered by a DD agency provider, independent provider, or a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- F. Consultative Assessment can be self-directed.
- G. The cost of Consultative Assessment does not come out of the participant's annual budget.

## 8.7 Day Supports

Day Supports is a habilitative service, which teaches self-help, behavioral, socialization, and adaptive skills. Day Supports takes place in a provider owned or leased, operated, or controlled non-residential setting. This service is provided when a participant does not have a personal employment goal and is not currently seeking competitive integrated employment. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Day Supports is a service offered under all the Medicaid HCBS DD Waivers.
- B. Day Supports includes:
  - 1. Habilitative activities to increase or maintain cognitive, social, motor, and communication skills; and
  - 2. Assistance with activities of daily living, health maintenance, and supervision.
- C. Day Supports is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Day Supports include but are not limited to habilitative activities to build skills such as:
  - 1. Gross motor skills, including grasping, stacking, or transferring items;
  - 2. Fine motor skills, including picking up small objects, holding small items, or using a keyboard;
  - 3. Attention to task;
  - 4. Improving physical abilities, such as sitting in a chair or standing for an extended period of time to complete a task;
  - 5. Following simple one- to two-step instructions;
  - 6. General social skills; or
  - 7. Self-help skills.
- E. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant's needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Day Supports provided each week must be provided in-person;
  - 4. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours; and
  - 5. These 10 hours are included in the 35 hours per week cap of day services.
- F. Day Supports has the following limitations:
  - 1. A participant may receive Day Supports in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Community Integration;
    - d. Medical In-Home Habilitation;
    - e. Prevocational;
    - f. Small Group Vocational Support;

- g. Supported Employment – Individual;
    - h. Supported Employment – Follow-Along; and
    - i. Vocational Rehabilitation job seeking and job coaching.
  - 2. The cost of transportation is:
    - a. Included in the rate during Day Supports;
    - b. Not included in the rate to the site where Day Supports begins; and
    - c. Not included in the rate from the site where Day Supports ends.
  - 3. Day Supports cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  - 4. Day Supports is reimbursed at an hourly rate.
  - 5. Day Supports cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- G. Day Supports can be provided in the hospital setting when a participant is admitted for critical care.
  - 1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
  - 2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed, and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
  - 3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
  - 4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
- H. Day Supports can be offered by a DD agency provider.
- I. Day Supports cannot be self-directed.
- J. Day Supports must be purchased within a participant's annual individual budget amount.

## 8.8 Environmental Modification Assessment

An Environmental Modification Assessment is an evaluation to identify modifications or devices needed for the health and safety of a participant, to help the participant access the community, and to increase the participant's independence. This service may be required before using Assistive Technology, Home Modification, and Vehicle Modification. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Environmental Modification Assessment is a service offered under all the Medicaid HCBS DD Waivers.
- B. Environmental Modification Assessment includes:
  - 1. Assessing if a modification or device is necessary to meet the participant's needs;
  - 2. Deciding what assistive technology, home modification, or vehicle modification is best for the participant; and
  - 3. Reporting when the modification or device is cost effective.
- C. Environmental Modification Assessment is not a habilitative service.
- D. Environmental Modification Assessment has the following limitations:
  - 1. Environmental Modification Assessment may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 2. A provider cannot charge more than they would to the general public. A provider who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 3. Environmental Modification Assessment cannot overlap with, replace, or duplicate other similar services provided through Medicaid. A participant should find out if Medicaid would pay for an environmental modification assessment before requesting this service.
  - 4. Environmental Modification Assessment is reimbursed per occurrence.
- E. Environmental Modification Assessment can be offered by a DD agency provider, independent provider, or a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- F. Environmental Modification Assessment can be self-directed.
- G. Environmental Modification Assessment must be purchased within a participant's annual individual budget amount. Environmental Modification Assessment has an annual cap of \$1,000.



## 8.9 Family Caregiver Training

Family Caregiver Training service is person-centered and provides individualized training and education to the unpaid caregiver currently living in the family home who provides support to the participant.

- A. Family Caregiver training is a service offered under the Medicaid HCBS DD Family Support Waiver.
- B. This service is intended to assist the unpaid caregiver in understanding and addressing the participant's needs by building upon their own skills and knowledge to become more proficient in assisting the participant in reaching their life goals.
- C. Family Caregiver Training service may address such areas as:
  - 1. Understand the disability of the participant supported;
  - 2. Achieve greater competence and confidence in providing supports;
  - 3. Develop or enhance key parenting strategies; and
  - 4. Other areas so that the unpaid caregiver can most effectively support the participant's desired goals and outcomes as described in the person-centered service plan.
- D. Family Caregiver Training service must be necessary in order to achieve the expected outcomes identified in the participant's person-centered service plan and must be directly related to the role of the unpaid caregiver in supporting the participant in areas specified in the person-centered service plan. All training for the caregiver who provides unpaid support to the participant must be included in the participant's service plan.
- E. Family Caregiver Training includes payment available for registration and training fees associated with formal instruction in areas relevant to the participant needs identified in the service plan. Payment is not available for the costs of travel/transportation, meals, and overnight lodging to attend a training event or conference.
- F. Family Caregiver Training may not be self-directed.
- G. Family Caregiver Training has the following limitations:
  - 1. The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.
  - 2. Educational and training programs, workshops and conferences registration costs for unpaid caregiver is limited up to \$500.00 per individual budget amount.
  - 3. This service may not be provided in order to train or educate paid caregivers.
  - 4. This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan, including EPSDT, or HCBS Waiver services.

## 8.10 Family and Peer Mentoring

Family and Peer Mentoring service provides a mentor(s) who have shared experiences with the participant, the family, or both, that will provide support and guidance by sharing experiences, strategies, and resources. The mentor explains community services and resources, programs, and strategies beyond those offered through the waiver.

- A. Family and Peer Mentoring is a service offered under the Medicaid HCBS DD Family Support Waiver.
- B. The outcome of this service is to support the participant, the family, or both in enhancing their knowledge and skills in understanding of available resources found in their local or surrounding community and how to access those resources. By knowing how to navigate available resources will assist the participant and their family in reaching the participant's goals and outcomes they have set for themselves.
- C. Family and Peer Mentoring may not be self-directed.
- D. Family and Peer Mentoring has the following limitations:
  - 1. The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.
  - 2. Family and Peer Mentoring is billed at an hourly rate.
  - 3. Providers of this service cannot mentor their own family members.
  - 4. Providers of this service cannot mentor other unpaid caregivers who reside in the family home.
  - 5. Transportation during the provision of Family and Peer Mentoring is included in the rate.
    - a. Non-medical transportation to the site at which Family and Peer Mentoring begins is not included in the rate.
    - b. Non-medical transportation from the site at which Family and Peer Mentoring ends is not included in the rate.
  - 6. This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan, including EPSDT, or HCBS Waiver services.

## 8.11 Home Modification

Home Modifications are changes to a participant's private home to make it easier and safer to get around. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Home Modifications is a service offered under all the Medicaid HCBS DD Waivers.
- B. Home Modifications include:
  - 1. Physical adaptation of a participant's private home necessary to increase the participant's ability to complete activities of daily living, function with greater independence, or access their home; and
  - 2. Modifications within the current square footage of the participant's private home.
- C. Home Modification is not a habilitative service.
- D. Examples of Home Modifications include but are not limited to:
  - 1. Ramps;
  - 2. Bathroom alterations, such as an accessible bathtub or shower;
  - 3. Widening doorways; or
  - 4. New or upgraded electrical or plumbing systems.
- E. Home Modifications have the following limitations:
  - 1. Modifications cannot include adaptations or improvements to the home of which are of general utility and are not of direct medical or remedial benefit to the participant. For example:
    - a. Replacing damaged carpet throughout the house;
    - b. Making multiple bathrooms accessible; or
    - c. Accessibility to an upper or lower level of the house when all needs can be met on the main floor.
  - 2. Home Modifications cannot adapt provider owned or leased, operated, or controlled settings including Shared Living or Host Homes.
  - 3. Modifications cannot add to the total square footage of a home, unless necessary to improve entrance to the home or adapt a bathroom to accommodate a wheelchair.
  - 4. Home Modification is reimbursed per occurrence.
  - 5. Proof of renter's insurance or homeowner's insurance may be requested.
  - 6. DDD may require an on-site assessment by an appropriate Medicaid enrolled professional provider. The assessment is provided under the Environmental Modification Assessment.
  - 7. A vendor cannot charge more than they would to the general public. A vendor who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 8. Home Modification may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 9. The cost of transportation is not included.
  - 10. Home Modifications cannot overlap with, replace, or duplicate other similar services provided through Medicaid. A participant should find out if Medicaid would pay for the home modification before requesting this service.

- F. Home Modifications can be offered by a DD agency provider, independent provider, or a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- G. Home Modifications can be self-directed.
- H. Home Modifications must be purchased within a participant's annual individual budget amount. Home Modifications have a budget cap of \$10,000 per five-year period. A participant may request funding over the budget cap due to a critical health or safety need. DDD approval is determined based on available funding.

## 8.12 Homemaker

Homemaker is a support to assist with general household activities when the family member usually responsible is temporarily absent or unable to manage the home. This service is only available to a participant age of 18 and younger who lives with an unpaid caregiver. This service is not available to a participant at or above the age of 19 because they can use other DHHS services to meet the same need. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS Comprehensive DD Waiver.*

- A. Homemaker is a service offered under all the Medicaid HCBS Comprehensive DD Waivers.
- B. Homemaker includes:
  - 1. Meal preparation;
  - 2. Laundry;
  - 3. Errands; and
  - 4. Routine household care.
- C. Homemaker is not a habilitative service.
- D. Examples of when Homemaker may be used include but are not limited to:
  - 1. Responsible family member is ill or in the hospital;
  - 2. Responsible family member is injured; or
  - 3. Responsible family member is out of town.
- E. Homemaker has the following limitations:
  - 1. Homemaker does not include direct care or supervision of the participant.
  - 2. Homemaker is provided in the participant's private home, and not a provider owned or leased, operated, or controlled residence.
  - 3. Homemaker cannot be provided by a provider who lives in the same home as the participant.
  - 4. Homemaker is reimbursed at an hourly rate.
  - 5. Homemaker requires the provider use electronic visit verification (EVV).
  - 6. Homemaker may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 7. Homemaker cannot be provided to a participant receiving:
    - a. Independent Living;
    - b. Residential Habilitation – Continuous Home;
    - c. Residential Habilitation – Shared Living;
    - d. Residential Habilitation – Host Home; or
    - e. Therapeutic Residential Habilitation.
  - 8. Homemaker cannot duplicate or replace natural supports, such as, other family members, neighbors, or friends.
  - 9. The cost of transportation is not included.
  - 10. Homemaker cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Homemaker can be offered by a DD agency provider, independent provider, or a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- G. Homemaker can be self-directed.
- H. Homemaker must be purchased within a participant's annual individual budget amount. Homemaker has an annual cap of 520 hours.

## 8.13 Independent Living

Independent Living is a habilitative, intermittent service, which teaches the participant skills related to living independently and community integration. Independent Living is provided in the participant's private home. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Independent Living is a service offered under all the Medicaid HCBS DD Waivers.
- B. Independent Living includes activities of daily living, such as but not limited to:
  - 1. Personal hygiene;
  - 2. Laundry and household chores;
  - 3. Meal preparation;
  - 4. Activities in the community; and
  - 5. Social and leisure skills.
- C. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant's needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Independent Living provided each week must be provided in-person; and
  - 4. Virtual supports may not exceed a weekly amount of 10 hours in the 70-hour weekly amount.
- D. Independent Living is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- E. Independent Living has the following limitations:
  - 1. Independent Living is an intermittent habilitative service provided to a participant who does not require continuous support 24 hours a day.
  - 2. Independent Living cannot be provided when the participant is sleeping.
  - 3. Independent Living is only available for a participant aged 19 years or older.
  - 4. Independent Living is reimbursed at an hourly rate.
  - 5. Independent Living requires the provider use electronic visit verification (EVV).
  - 6. Independent Living is generally provided in the participant's private home.
  - 7. Independent Living cannot be delivered in an agency provider owned or leased, operated, or controlled residence.
  - 8. Independent Living can be provided for up to three participants at the same time. Groups of more than three are not allowed within this service.
  - 9. Independent Living may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 10. Participants receiving Independent Living cannot receive:
    - a. Behavioral In-Home Habilitation;
    - b. Medical In-Home Habilitation;
    - c. Residential Habilitation – Continuous Home;
    - d. Residential Habilitation – Host Home;
    - e. Residential Habilitation – Shared Living;
    - f. Respite;
    - g. Supported Family Living; or

- h. Therapeutic Residential Habilitation.
- 11. Participants receiving Independent Living cannot earn money during the service.
- 12. The cost of transportation is:
  - a. Included in the rate during Independent Living;
  - b. Not included in the rate to the site where Independent Living begins; and
  - c. Not included in the rate from the site where Independent Living ends.
- 13. Independent Living cannot include any service or part of a service available through public education, including:
  - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
  - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
  - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
- 14. Independent Living cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Independent Living can be offered by a DD agency provider or independent provider.
- G. Independent Living can be self-directed.
- H. Independent Living must be purchased within a participant's annual individual budget amount. Independent Living has a weekly cap of 70 hours for participants on the Comprehensive DD Waiver and a weekly cap of 25 hours on the DD Adult Day Waiver. A week is defined as 12:00 am Monday through 11:59 pm Sunday.

## 8.14 Medical In-Home Habilitation

Medical In-Home Habilitation is a short-term habilitative service provided to a participant whose severe medical condition prevents them from participating in regularly scheduled day service activities or employment and is unable to be home alone. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS Comprehensive DD Waiver.*

- A. Medical In-Home Habilitation is a service offered under the DDAD and CDD Medicaid HCBS Comprehensive DD Waiver.
- B. Medical In-Home Habilitation includes:
  - 1. Habilitative services for a participant who:
    - a. Has recently been hospitalized and is recovering at home; or
    - b. Has a medical condition which makes leaving home unsafe under some circumstances, such as staying home when temperatures are below a certain degree or when air quality is poor. Circumstances must be:
      - i. Outlined in a doctor's, or other similar professional's, order;
      - ii. Specific to the participant;
      - iii. Evaluated and documented as a need on the day the service is used; and
      - iv. Evaluated at least annually by the doctor.
  - 2. Assistance with activities of daily living, health maintenance, and supervision.
- C. Medical In-Home Habilitation is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Medical In-Home Habilitation has the following limitations:
  - 1. Medical In-Home Habilitation must be provided in the participant's home.
  - 2. The provider must be providing service in the residence with the participant.
  - 3. The DDD clinical team must approve requests for this service prior to the service being authorized and provide ongoing monitoring of use of this service.
  - 4. A participant may receive Medical In-Home Habilitation in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Community Integration;
    - d. Day Supports;
    - e. Prevocational;
    - f. Small Group Vocational Support;
    - g. Supported Employment – Individual;
    - h. Supported Employment – Follow-Along; and
    - i. Vocational Rehabilitation job seeking and job coaching.
  - 5. Medical In-Home Habilitation is only available to participants receiving Residential Habilitation.
  - 6. Medical In-Home Habilitation cannot be used when participant receives Therapeutic Residential Habilitation, Independent Living, or Supported Family Living.



7. Medical In-Home is reimbursed at an hourly rate.
  8. Medical In-Home requires the provider use electronic visit verification (EVV).
  9. The cost of transportation is not included in the rate for Medical In-Home Habilitation.
  10. Medical In-Home Habilitation cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  11. Medical In-Home Habilitation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- E. Medical In-Home can be provided in the hospital setting when a participant is admitted for critical care.
1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
  2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed, and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
  3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
  4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
- F. Medical In-Home Habilitation can be offered by a DD agency provider.
- G. Medical In-Home Habilitation cannot be self-directed.
- H. Medical In-Home Habilitation must be purchased within a participant's annual individual budget amount.
- I. Medical In-Home Habilitation is limited to 90 calendar days per occurrence. Additional hours per occurrence must be approved by DDD Central Office administration.

## 8.15 Personal Emergency Response System (PERS)

PERS is an electronic device used by a participant to call for help in an emergency. When a PERS button is pushed, the device contacts a designated person or call center. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. PERS is a service offered under all the Medicaid HCBS DD Waivers.
- B. The Personal Emergency Response System includes:
  - 1. Providing instruction to the participant about how to use the device;
  - 2. Making sure the call center will respond 24 hours per day, 7 days per week;
  - 3. Replacing a PERS device when needed within 24 hours of notification;
  - 4. Updating a list of contacts at least twice a year;
  - 5. Monthly testing of the PERS device; and
  - 6. Providing ongoing assistance.
- C. PERS is not a habilitative service.
- D. PERS has the following limitations:
  - 1. PERS cannot be used by a participant who lives in a provider owned or leased, operated, or controlled setting unless a participant has a transition plan which outlines how PERS will assist them to move to an independent setting within 6 months. When there is no transition plan, PERS cannot be authorized for a participant receiving Residential Habilitation or Therapeutic Residential Habilitation.
  - 2. The cost of transportation is not included in the rate for PERS.
  - 3. PERS cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
  - 4. PERS is reimbursed at a one-time installation fee and a monthly rental fee.
- E. PERS can be offered by a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- F. PERS cannot be self-directed.
- G. PERS must be purchased within a participant's annual individual budget amount.

## 8.16 Prevocational

Prevocational is a habilitative service that helps the participant develop general skills, related to their interest, to help them get a future job in a community, integrated setting. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Prevocational is a service offered under the DDAD and CDD Medicaid HCBS DD Waivers.
- B. Prevocational includes:
  - 1. Having an overall goal to obtain employment in the community;
  - 2. Developing skills that are generalized and not job-task specific;
  - 3. Broad-based employment-related goals and habilitative programs for a participant on the Vocational Rehabilitation wait list, for as long as there is a VR wait list; and
  - 4. Assistance with activities of daily living, health maintenance, and supervision.
- C. Prevocational is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Prevocational habilitation programs to develop skills include but are not limited to:
  - 1. Communicating with others effectively;
  - 2. Commonly acceptable social skills and dress;
  - 3. Following multiple step directions and instructions;
  - 4. Staying on task for extended periods of time;
  - 5. Using technologies that are used in current industry;
  - 6. General problem-solving skills and strategies; and
  - 7. General safety and mobility skills across environments.
- E. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant's needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Prevocational provided each week must be provided in-person;
  - 4. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours; and
  - 5. These 10 hours are included in the 35 hours per week cap of day services.
- F. Prevocational has the following limitations:
  - 1. Prevocational is provided mainly in the community in a variety of locations.
  - 2. When Prevocational is provided in the same location of a provider owned or leased, operated, or controlled day service setting where other waiver services are provided, an employee who is providing other waiver services cannot provide Prevocational services at the same time.
  - 3. Prevocational is reimbursed at an hourly rate.
  - 4. Prevocational cannot be used for longer than 12 consecutive months.
  - 5. A participant may receive Prevocational in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;

- b. Behavioral In-Home Habilitation;
  - c. Community Integration;
  - d. Day Supports;
  - e. Medical In-Home Habilitation;
  - f. Small Group Vocational Support;
  - g. Supported Employment – Follow-Along; and
  - h. Supported Employment – Individual.
6. The cost of transportation for Prevocational is:
- a. Included in the rate during Prevocational;
  - b. Not included in the rate to the site where Prevocational begins; and
  - c. Not included in the rate from the site where Prevocational ends.
7. Prevocational cannot include any service or part of a service available through public education, including:
- a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
  - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
  - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
8. Prevocational cannot overlap with, replace, or duplicate other similar services provided through the Medicaid State Plan, HCBS Waiver service, or Vocational Rehabilitation.
9. Prevocational service must end when job seeking begins.
- G. Prevocational can be offered by a DD agency provider.
- H. Prevocational cannot be self-directed.
- I. Prevocational must be purchased within a participant's annual individual budget amount.

## 8.17 Residential Habilitation

Residential Habilitation is a habilitative, continuous service, which teaches the participant skills related to living independently, as well as community integration. A participant may choose one of three service delivery options: Continuous Home, Host Home, or Shared Living. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS comprehensive DD Waiver.*

- A. Residential Habilitation is a service offered under the Medicaid HCBS Comprehensive DD Waivers.
- B. Residential Habilitation includes:
  - 1. Services provided in one of the following settings:
    - a. Continuous Home is delivered in a provider-owned or leased, operated, or controlled residential setting and provided by agency provider shift staff not living in the setting.
    - b. Host Home is delivered in a private home owned or leased by an individual, couple, or a family known to the participant and who is an employee of the provider agency. The Host Home employee and the participant live together, and the participant shares daily life with the Host Home family in their home and community.
    - c. Shared Living is delivered in a private home owned or leased by an individual, couple, or a family known to the participant and who is an independent contractor of the agency provider. The Shared Living contractor and the participant live together in the same home and the participant shares daily life with the Shared Living family in their home and community. The home is both the Shared Living contractor and the participant's sole residence.
  - 2. Assistance with health maintenance and supervision.
- C. Residential Habilitation is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Residential Habilitation include teaching adaptive skills in activities of daily living, including but not limited to:
  - 1. Personal hygiene;
  - 2. Laundry and household chores;
  - 3. Meal preparation;
  - 4. Activities in the community; and
  - 5. Social and leisure skills.
- E. Residential Habilitation has the following limitations:
  - 1. The Host Home or Shared Living home must be the sole residence of the provider and cannot be owned or leased by a DD Agency Provider. The Host Home or Shared Living provider must reside in the home with the participant.
  - 2. Continuous Home may be provided to no more than three participants at the same time unless the residence is licensed as a Center for the Developmentally Disabled (CDD).

3. Participants receiving Residential Habilitation cannot receive Independent Living or Supported Family Living on the same day.
  4. Participants receiving Residential Habilitation cannot receive Child Day Habilitation, Respite, or Therapeutic Residential Habilitation.
  5. Residential Habilitation cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days; and
    - b. The school hours set by the local school district for the participant regardless of school chosen (public, private, or home).
  6. Residential Habilitation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Residential Habilitation is reimbursed at a daily rate.
1. The provider must be in the residence with the participant a minimum ten hours or more out of a 24-hour period 12:00 a.m. - 11:59 p.m.
  2. When providing fewer than ten hours out of a 24-hour period 12:00 a.m. - 11:59 p.m., the provider will be paid half of the daily rate.
  3. Part or all of the 10 hours in the day may be time the provider and participant are asleep, as long as this is appropriate per the participant's ISP and all needs are being met.
  4. The cost of transportation is:
    - a. Included in the rate during Residential Habilitation;
    - b. Included in the rate to the site where Residential Habilitation begins; and
    - c. Included in the rate from the site where Residential Habilitation ends.
- G. A lease, residency agreement, or other form of written agreement must be in place to protect the participant from eviction according to landlord and tenant laws.
- H. Residential Habilitation can be provided in the hospital setting when a participant is admitted for critical care.
1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
  2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed, and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
  3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
  4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
- I. Residential Habilitation can be offered by a DD agency provider.
- J. Residential Habilitation cannot be self-directed.
- K. Residential Habilitation must be purchased within a participant's annual individual budget amount.
- L. Host Home or Shared Living has the following additional requirements and limitations:

1. When a participant receiving services from a certified agency wants to receive services from a Shared Living Provider (SLP):
  - a. A Home Study Survey must be completed by the Provider with any potential SLP contractors in the home and all adult members of the household.
    - i. Once a participant is identified, the Home Study Survey must be completed by the Provider, on site, at least seven calendar days prior to a team meeting for all new SLP settings.
      - (1) Providers must upload a copy to Therap in a case note and submit to participant and/or guardian.
      - (2) Home Study Survey: <https://cip-dhhs.ne.gov/redcap/surveys/?s=HH4FHC8DPMJHXAXF>
2. When Service Coordination has a concern about the placement or survey response, the SC will work with the agency to make any updates or corrections. The Agency is responsible for ensuring all concerns are addressed and resolved with the SLP.
  - a. Service Coordination will review all submitted surveys, materials, and team discussion and 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 onsite walk through and a team meeting has been held to discuss the potential placement.
    - ii. If the placement is denied, the agency provider, not the SLP, may request a fair hearing per section 16 of this policy.
3. Provider agency must document monthly on-site visits for Basic-High Tier participants and two times monthly onsite visits for Advanced-Risk Tier participants. No less than two visits for Basic-High Tier participants or four visits for Advanced-Risk Tier participants must be unscheduled per 90-day period.
4. When an SLP Provider is supporting a participant on the Basic-High Tier then there can only be two state-funded (including CFS, DD, AD Waiver, and Probation) individuals in the home. No other state-funded individuals are allowed when the participant is on the Advanced-Risk Tier.
  - a. The Agency Provider must notify the SC when an individual funded by CFS, Probation, or any other state agency resides in the home. Service Coordination will verify approval of CFS, Probation, or any other state agency prior to SLP approval.
5. When a Shared Living Provider 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.

6. When a Shared Living Provider has children under the age of 13, another adult 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.
7. Any residence that the SLP and participant reside 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 will be permitted.
8. The lease, signed by the participant or guardian, must be uploaded by the Provider to Therap as a case note.
9. The SLP Contract, signed by the SLP and Provider, must be uploaded by the Provider to Therap as a case note.
10. Back-up staff chosen by the participant may be used in place of the Host Home employee or Shared Living contractor.
  - a. Back-up staff must deliver the same habilitative services to the participant in the participant's home, follow the participant's usual schedule, and meet all provider qualifications.
  - b. Use of backup staff must be documented in the participant's ISP.
  - c. A record of backup staff usage must be documented by the Agency and made available to the SC upon request.
  - d. The Host Home employee or Shared Living contractor cannot use backup staff for more than 360 hours per participant's ISP year.
    - i. One day (10-24 hours) of backup staff counts as just ten hours towards the cap of 360 hours per budget year.
    - ii. Unused backup staff hours cannot be carried over into the next ISP year.
11. Support staff chosen by the participant may be used to assist the Host Home employee or Shared Living contractor. This means the support staff works together with the Host Home employee or Shared Living contractor in the provision of services with the participant. Support staff cannot provide services independent of the Host Home employee or Shared living contractor.
  - a. Support staff must deliver the same Habilitative services to the participant, follow the participant's usual schedule, and meet all provider qualifications.
  - b. Use of support staff must be documented in the participant's ISP.
  - c. A record of support staff usage must be documented by the Agency and made available to the SC upon request.
  - d. The Host Home employee or Shared Living contractor cannot use support staff for a continuous, 24-hour period.
12. No SLP or adult living in the home can serve as day staff for any participant living in their home.
  - a. SLPs or adults living in the home may work for the agency which provides Day Supports to the participant but may not provide services to the participant living in their home.
  - b. No SLP or adult living in the home can become an Independent Provider in order to provide Day Supports to the participant living in their home.
  - c. SLPs or adults living in the home may provide services during the normal education hours when schools are not in session or over school breaks as long



as they are an employee of the residential provider agency or an independent provider with a specific authorization for day services.

13. Even when a participant is receiving SLP services, the Agency Provider is still responsible for the care of the participant and will need to provide 24/7 assistance to the SLP if needed. The team will need to document a backup plan for when a crisis or emergency should occur in the participant's ISP.
14. Back-up plans should be person-centered to meet the historical and potential future needs of the participant.
15. Any SLP not in compliance with sections L. 4, 5, and 6 at the time of policy publication will be considered compliant based on prior approval until there is a detrimental change in the Shared Living setting including a change in staff, change in service location, change of residents, or change in composition of the Shared Living home and may be rescinded at any time to preserve the health, safety, and well-being of the participants served.
16. Failure to comply with this policy either initially or anytime thereafter may result in agency sanctions or denial of SLP approval.
  - a. When SLP approval is denied, the Agency Provider may appeal the decision by requesting a fair hearing.
    - i. Fair Hearing policy is outlined in section 3.11 of the DD Policy Manual.
    - ii. An SLP does not have the right as a sub-contractor to initiate an appeal.

## 8.18 Respite

Respite is a non-habilitative service provided to a participant unable to care for them-self as relief for the participant's usual caregiver. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Respite is a service offered under all the Medicaid HCBS DD Waivers.
- B. Respite includes assistance with activities of daily living, health maintenance, and supervision.
- C. Respite is not a habilitative service.
- D. Examples of Respite activities include but are not limited to:
  - 1. Assistance with the provision of medication; or
  - 2. Supervision for activities at home or in the community.
- E. Respite has the following limitations:
  - 1. Respite can only be provided to relieve a usual caregiver living in the same private home as the participant.
  - 2. Respite cannot be used as adult or childcare when the usual caregiver is working or attending school.
  - 3. Respite may be provided in the participant's home, the respite provider's home, or during community activities.
  - 4. Respite is reimbursed at an hourly rate. Respite can be billed up to 8 hours a day. Any use of respite over 8 hours within a 24-hour period, 12:00 am -11:59 pm, is not reimbursable.
  - 5. Respite requires the provider use electronic visit verification (EVV).
  - 6. When no other option is available, respite may be provided in an institutional setting with prior approval by DDD.
  - 7. The cost of transportation is:
    - a. Included in the rate during Respite;
    - b. Not included in the rate to the site where Respite begins; and
    - c. Not included in the rate from the site where Respite ends.
  - 8. Respite cannot be provided by an independent provider who lives in the same private home as the participant.
  - 9. A Respite provider cannot provide respite to participants ages 18 years or older and children at the same time and location, unless approved by DDD.
  - 10. Respite cannot not be provided during the school hours set by the local school district for the participant. Regular school hours and days apply for a child who receives home schooling.
  - 11. Respite cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Respite can be offered by a DD agency provider or independent provider.
- G. Respite can be self-directed.
- H. Respite must be purchased within a participant's annual individual budget amount. Respite has an annual cap of 360 hours for participants on the Medicaid HCBS Comprehensive DD Waiver and an annual cap of 240 hours for participants on the Medicaid HCBS DD Adult Day Waiver. Unused Respite cannot be carried over into the next ISP year.

## 8.19 Small Group Vocational Support

Small Group Vocational Support is a habilitative service provided at a business or in the community. In Small Group Vocational Support, a participant or a group of participants, learn work skills and appropriate work behavior, which can be used to seek competitive employment in the future. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Small Group Vocational Support is a service offered under the DDAD and CDD Medicaid HCBS DD Waivers.
- B. Small Group Vocational Support includes:
  - 1. Opportunities for a participant to be paid while gaining work experience in a community business setting;
    - a. A participant receiving Small Group Vocational Support is not employed by the community business.
    - b. The agency provider holds a contract with the business for a job and the business pays the agency provider for the contract.
    - c. The agency provider pays the participant or group of participants who complete the job.
  - 2. Opportunities for interaction between participants and employees or customers; and
  - 3. Assistance with personal care, health maintenance activities, and supervision.
- C. Small Group Vocational Support is not competitive integrated employment.
- D. Small Group Vocational Support is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- E. Examples of Small Group Vocational Support include but are not limited to an individual or crew doing work such as:
  - 1. Landscaping;
  - 2. Mowing/snow removal;
  - 3. Cleaning;
  - 4. Sorting or folding documents;
  - 5. Newspaper routes;
  - 6. Laundry; or
  - 7. Clearing tables, dishwashing, or rolling silverware.
- F. Small Group Vocational Support has the following limitations:
  - 1. Small Group Vocational Support cannot be provided in a provider owned or leased, operated, or controlled setting.
  - 2. Small Group Vocational Support is only available when a participant is determined not eligible for vocational rehabilitation services.
  - 3. Waiver funds cannot be used to pay or add to a participant's wages.
  - 4. Small Group Vocational Support is reimbursed at an hourly rate.
  - 5. Medicaid HCBS DD Waiver funds cannot be used for incentive payments, subsidies to the business, unrelated vocational training expenses, or to supplement a participant's wages.

6. A participant may receive Small Group Vocational Support in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Community Integration;
    - d. Day Supports;
    - e. Medical In-Home Habilitation;
    - f. Prevocational; and
    - g. Vocational Rehabilitation job seeking and job coaching.
  7. The cost of transportation is:
    - a. Included in the rate during Small Group Vocational Support;
    - b. Not included in the rate to the site where Small Group Vocational Support begins; and
    - c. Not included in the rate from the site where Small Group Vocational Support ends.
  8. Small Group Vocational Support cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  9. Small Group Vocational Support cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
  10. Small Group Vocational Support must end when a participant starts a competitive, integrated job in the community.
- G. Small Group Vocational Support can be offered by a DD agency provider.
  - H. Small Group Vocational Support cannot be self-directed.
  - I. Small Group Vocational Support must be purchased within a participant's annual individual budget amount.

## 8.20 Supported Employment – Follow-Along

Supported Employment – Follow-Along is a habilitative service to help a participant maintain competitive integrated employment. This service is provided through job support and communication with the participant and the employer. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Supported Employment – Follow-Along is a service offered under the Medicaid HCBS CDD and DDAD Waivers.
- B. Supported Employment – Follow-Along includes:
  - 1. Regular contact and follow-up with the employer and participant;
  - 2. May be provided remotely and through phone calls between provider staff and the employer, but must be followed up in person with the participant to reinforce and ensure there are no problems at the job site; and
  - 3. Connecting participants with coworkers at the work site and advocating with the participant.
- C. Supported Employment – Follow-Along is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Examples of Supported Employment – Follow-Along may include but are not limited to:
  - 1. Observation of the participant at the work site a minimum of twice a month; and
  - 2. Teaching job tasks and skills;
  - 3. Clocking in or out;
  - 4. Requesting leave time or checking vacation balance;
  - 5. Calling in sick;
  - 6. Learning break or lunch routine;
  - 7. Getting along with co-workers; or
  - 8. Problem solving.
- E. Supported Employment – Follow-Along has the following limitations:
  - 1. A participant may receive Supported Employment – Follow-Along in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Community Integration;
    - d. Day Supports;
    - e. Medical In-Home Habilitation;
    - f. Supported Employment – Individual; and
    - g. Vocational Rehabilitation job seeking and job coaching.
  - 2. Supported Employment – Follow-Along does not include:
    - a. Activities taking place in a group, such as work crews or group employment;
    - b. Employee meetings;
    - c. Staff development; or
    - d. A job coach working the job instead of the participant doing the job.

3. A provider of this service cannot be the employer of the participant to whom Supported Employment – Follow-Along is provided.
  4. Supported Employment – Follow-along is reimbursed at an hourly rate.
  5. Waiver funds cannot be used to pay or add to a participant's wages.
  6. The cost of transportation is:
    - a. Included in the rate during Supported Employment – Follow-Along;
    - b. Not included in the rate to the site where Supported Employment – Follow-Along begins; and
    - c. Not included in the rate from the site where Supported Employment – Follow-Along ends.
  7. Supported Employment – Follow-Along cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days; and
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  8. Supported Employment – Follow-Along may be provided by a relative but not a legally responsible individual or guardian of the participant.
  9. Supported Employment – Follow-Along cannot overlap with, replace, or duplicate other similar services provided through Medicaid or Vocational Rehabilitation.
- F. Supported Employment – Follow-Along can be offered by a DD agency provider or independent provider.
- G. Supported Employment – Follow-Along can be self-directed.
- H. Supported Employment – Follow-Along must be purchased within a participant's annual individual budget amount. Supported Employment – Follow-Along has an annual cap of 25 hours per ISP year.

## 8.21 Supported Employment – Individual

Supported Employment – Individual is a habilitative service to provide a job coach for one-on-one teaching to help a participant maintain competitive integrated employment. Supported Employment-Individual must be provided in an integrated community employment setting. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Supported Employment – Individual is a service offered under the Medicaid HCBS CDD and DDAD Waivers.
- B. Supported Employment – Individual includes:
  - 1. Habilitation programs to maintain and increase employment-related skills;
  - 2. Connecting participants with coworkers at the work site and advocating for the participant;
  - 3. Developing a plan to decrease the need for a job coach; and
  - 4. Referring the participant to gain access to an employment network, Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified employment service programs, which provide benefits planning.
- C. Supported Employment – Individual is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. Supported Employment – Individual may include self-employment businesses.
- E. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant’s needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Supported Employment – Individual provided each week must be provided in-person;
  - 4. The total combined hours for virtual supports may not exceed a weekly amount of 10 hours; and
  - 5. These 10 hours are included in the 35 hours per week cap of day services.
- F. Examples of Supported Employment – Individual may include but are not limited to:
  - 1. Learning a work schedule;
  - 2. Working alongside with coworkers;
  - 3. Talking with the boss about work needs; or
  - 4. Learning job expectations.
- G. Supported Employment – Individual has the following limitations:
  - 1. Supported Employment – Individual cannot take place in a setting owned or operated by a DD provider.
  - 2. A participant may receive Supported Employment – Individual in combination with other day services, but the total combined hours cannot exceed 35 hours per week. A week is defined as 12:00 am Monday through 11:59 pm Sunday. Other day services are:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;

- c. Community Integration;
  - d. Day Supports;
  - e. Medical In-Home Habilitation;
  - f. Prevocational;
  - g. Supported Employment – Follow-Along; and
  - h. Vocational Rehabilitation job seeking and job coaching.
3. A provider of this service cannot be the employer of the participant to whom Supported Employment – Individual is provided.
  4. Income from a customized home business does not have to meet minimum wage requirements.
  5. Supported Employment – Individual is reimbursed at an hourly rate.
  6. Waiver funds cannot be used to pay or add to a participant’s wages.
  7. The cost of transportation is:
    - a. Included in the rate Supported Employment – Individual;
    - b. Not included in the rate to the site where Supported Employment – Individual begins; and
    - c. Not included in the rate from the site where Supported Employment – Individual ends.
  8. Supported Employment – Individual cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant’s local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days; and
    - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
    - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
  9. Medicaid HCBS DD Waiver funds cannot be used for incentive payments or subsidies to the business, or unrelated vocational training expenses.
  10. Supported Employment – Individual may be provided by a relative but not a legally responsible individual or guardian of the participant.
  11. Supported Employment – Individual cannot overlap with, replace, or duplicate other similar services provided through Medicaid or Vocational Rehabilitation.
- H. Supported Employment – Individual can be offered by a DD agency provider or independent provider.
  - I. Supported Employment – Individual can be self-directed.
  - J. Supported Employment – Individual must be purchased within a participant’s annual individual budget amount.



## 8.22 Supported Family Living

Supported Family Living is a habilitative, intermittent service teaching the participant skills related to living independently and community integration. Supported Family Living is provided in the participant's private family home. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Supported Family Living is a service offered under all the Medicaid HCBS DD Waivers.
- B. Supported Family Living includes teaching adaptive skills in activities of daily living such as but not limited to:
  - 1. Personal hygiene;
  - 2. Laundry and household chores;
  - 3. Meal preparation;
  - 4. Activities in the community; and
  - 5. Social and leisure skills.
- C. Supported Family Living is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- D. A portion of this service can be delivered virtually, which includes but is not limited to:
  - 1. The participant's needs must be able to be met with verbal cuing and other support that can be provided virtually;
  - 2. Available to participants in the basic and intermediate funding tier;
  - 3. The majority of Supported Family Living provided each week must be provided in-person; and
  - 4. Virtual supports may not exceed a weekly amount of 10 hours in the 70-hour weekly amount.
- E. Supported Family Living has the following limitations:
  - 1. Supported Family Living is an intermittent habilitative service provided to a participant who does not require continuous support 24 hours a day.
  - 2. Supported Family Living cannot be provided when the participant is sleeping.
  - 3. Supported Family Living is generally provided in the participant's family home.
  - 4. Supported Family Living is reimbursed at an hourly rate.
  - 5. Supported Family Living requires the provider use electronic visit verification (EVV).
  - 6. Supported Family Living cannot be delivered in an agency provider owned or leased, operated, or controlled residence.
  - 7. Supported Family Living can be provided for up to three participants at the same time. Groups of more than three are not allowed within this service.
  - 8. Supported Family Living may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 9. Participants receiving Supported Family Living cannot receive Behavioral In-Home, Habilitation, Independent Living, or Medical In-Home Habilitation.
  - 10. Participants receiving Supported Family Living cannot receive on the same day for:
    - a. Residential Habilitation – Continuous Home;
    - b. Residential Habilitation – Host Home;
    - c. Residential Habilitation – Shared Living; or

- d. Therapeutic Residential Habilitation.
- 11. Participants receiving Supported Family Living cannot earn money during the service.
- 12. The cost of transportation is:
  - a. Included in the rate during Supported Family Living;
  - b. Not included in the rate to the site where Supported Family Living begins; and
  - c. Not included in the rate from the site where Supported Family Living ends.
- 13. Supported Family Living cannot include any service or part of a service available through public education, including:
  - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days;
  - b. During the school hours set by the local school district for the participant regardless of school chosen (public, private, or home); and
  - c. Educational service hours provided or available are included in the total combined day service hours of 35 hours per week.
- 14. Supported Family Living cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Supported Family Living can be offered by a DD agency provider or independent provider.
- G. Supported Family Living can be self-directed.
- H. Supported Family Living must be purchased within a participant's annual individual budget amount. Supported Family Living has a weekly cap of 70 hours for participants on the Comprehensive DD Waiver and a weekly cap of 25 hours on the DD Adult Day Waiver. A week is defined as 12:00 am Monday through 11:59 pm Sunday.

## 8.23 Therapeutic Residential Habilitation

Therapeutic Residential Habilitation is a habilitative, continuous service, which assists participants in gaining the life skills needed to transition to the least restrictive setting and services in the community. Therapeutic Residential Habilitation is designed specifically for participants living with co-occurring disorders of developmental disabilities with severe mental illness. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS comprehensive DD Waiver.*

- A. Therapeutic Residential Habilitation is a service offered under the Medicaid HCBS Comprehensive DD Waivers.
- B. Therapeutic Residential Habilitation includes:
  - 1. Individualized therapeutic habilitation planning while addressing co-occurring conditions;
  - 2. Teaching adaptive skills in activities of daily living:
    - a. Personal hygiene;
    - b. Household chores;
    - c. Meal preparation;
    - d. Community transportation system;
  - 3. Social and leisure skills development; and
  - 4. Person-centered treatment and therapies, such as education and treatments on substance use.
- C. Therapeutic Residential Habilitation is delivered under the direction of a supervising mental health practitioner including:
  - 1. A board-certified Psychiatrist and
  - 2. One of the following:
    - a. Licensed Independent Mental Health Practitioner (LIMHP);
    - b. Clinical Psychologist; or
    - c. Advanced Practice Registered Nurse (APRN) who specializes in psychiatric mental health.
- D. Therapeutic Residential Habilitation is a habilitative service and must include habilitation programs. Individual habilitation programs must be conducted, and data recorded each time the service is provided.
- E. Therapeutic Residential Habilitation has the following limitations:
  - 1. Participants receiving Therapeutic Residential Habilitation cannot receive:
    - a. Adult Day;
    - b. Behavioral In-Home Habilitation;
    - c. Child Day Habilitation;
    - d. Consultative Assessment;
    - e. Community Integration;
    - f. Day Supports;
    - g. Medical In-Home Habilitation;
    - h. Prevocational,
    - i. Respite;
    - j. Small Group Vocational Support;

- k. Supported Employment – Follow-Along; or
    - l. Supported Employment – Individual.
  - 2. Participants receiving Therapeutic Residential Habilitation cannot receive Residential Habilitation services.
  - 3. Participants receiving Therapeutic Residential Habilitation cannot receive Independent Living or Supported Family Living on the same day.
  - 4. The cost of transportation is:
    - a. Included in the rate during Therapeutic Residential Habilitation;
    - b. Included in the rate to the site where Therapeutic Residential Habilitation begins; and
    - c. Included in the rate from the site where Therapeutic Residential Habilitation ends.
  - 5. Therapeutic Residential Habilitation cannot include any service or part of a service available through public education, including:
    - a. Programs in the participant's local school district, including after-school supervision and daytime services when school is not in session such as summer breaks, scheduled school holidays, and teacher in-service days; and
    - b. The school hours set by the local school district for the participant regardless of school chosen (public, private, or home).
  - 6. Therapeutic Residential Habilitation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
  - 7. Therapeutic Residential Habilitation is an all-inclusive continuous service reimbursed at a daily rate. The provider must be with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for a minimum of ten hours in a 24-hour period 12:00 am - 11:59 pm for the provider to bill a daily rate.
- F. Therapeutic Residential Habilitation can be provided in the hospital setting when a participant is admitted for critical care.
  - 1. Supports are designed to meet the needs of the participant while in a hospital setting and to assist for a smooth transition back to their home.
  - 2. Supports include teaching skills that will help the participant to maintain their current level of independence, providing behavioral support as needed, and assistance with daily living activities that assist the participant with their treatment and recovery while in the hospital.
  - 3. Supports do not include any health maintenance activities, treatments, procedures, medication administration, or practices, which must be done by hospital staff.
  - 4. The person-centered service plan will be updated when this service is provided in a hospital setting and when the participant leaves the hospital.
- G. Therapeutic Residential Habilitation can be offered by a DD agency provider.
- H. Therapeutic Residential Habilitation cannot be self-directed.
- I. Therapeutic Residential Habilitation must be purchased within a participant's annual individual budget amount.

## 8.24 Transitional

Transitional service assists with one-time household set-up expenses and supports to help a participant move into a private home so they may receive Medicaid HCBS DD Waiver services. Transitional service may be approved when the participant does not have funds for household expenses. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Transitional service is a service offered under the Medicaid HCBS DD Comprehensive Waivers.
- B. Transitional service includes expenses such as:
  - 1. Essential furniture;
  - 2. Household supplies;
  - 3. Security deposits, such as one month's rental amount to cover damages;
  - 4. Basic utility fees or deposits, such as water, gas, and electricity; or
  - 5. Moving expenses.
- C. Transitional service is not a habilitative service.
- D. Transitional service has the following limitations:
  - 1. Transitional service cannot be used to move into a provider owned or leased, operated, or controlled home.
  - 2. Transitional service is available to a participant moving from an institution in Nebraska to a private home. Transitional service can only be used when moving from the following institutional settings:
    - a. An intermediate care facility for individuals with DD;
    - b. A skilled nursing facility; or
    - c. A regional center.
  - 3. Transitional service cannot be used to pay rent or a rental deposit to hold the location.
  - 4. Transitional service is reimbursed per expense.
  - 5. Transitional service cannot be used for personal care items, food, or clothing, or items and services, which are not essential.
  - 6. A provider cannot charge more than they would to the general public. A provider who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 7. Transitional service may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 8. The cost of transportation is not included in the rate for Transitional services.
  - 9. Transitional service cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- E. Transitional service can be offered by a DD agency provider or independent provider.
- F. Transitional service can be self-directed.
- G. Transitional service must be purchased within a participant's annual individual budget amount. Transitional service has a one-time cap of \$1,500.

## 8.25 Transportation

Transportation is a service to provide non-medical transportation to and from Medicaid HCBS DD Waiver services, community activities, and resources. This is a standalone service, separate from transportation included in other waiver services. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Transportation is a service offered under all the Medicaid HCBS DD Waivers.
- B. Transportation must be provided in a vehicle in good working order, which meets the participant's needs, including any necessary adaptations, such as a wheelchair lift.
- C. Transportation is not a habilitative service.
- D. Examples of Transportation include but are not limited to:
  - 1. Transportation offered by a DD provider;
  - 2. Taxi or other car service; or
  - 3. Purchase of a handivan pass or city bus pass.
- E. Transportation has the following limitations:
  - 1. Transportation cannot replace other options, such as natural supports. These options should be fully utilized, and may include:
    - a. Specialized transportation from local community aging services;
    - b. Transportation service offered by a participant's managed care organization; and
    - c. Natural supports, including family, friends, and co-workers.
  - 2. Transportation does not include transportation to medical appointments.
  - 3. Transportation is provided for a participant to go to and from a location using the most direct route.
  - 4. Transportation does not include transportation to the site at which Child Day Habilitation begins and from the site at which Child Day Habilitation ends.
  - 5. Transportation is reimbursed per mile or a cost of a bus pass.
  - 6. Transportation may be provided by a relative of the participant, but not a legally responsible person or guardian of the participant.
  - 7. A provider cannot charge more than they would to the general public. A provider who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 8. Transportation cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Transportation can be offered by a DD agency provider, independent provider, or a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.
- G. Transportation can be self-directed.
- H. Transportation must be purchased within a participant's annual individual budget amount.

## 8.26 Vehicle Modification

Vehicle Modification provides adaptations to the participant's privately owned main vehicle to increase their ability to travel independently. *The service definition and limits outlined below do not include all details and requirements. For the service standards, limitations, provider types and qualifications, and reimbursement information, refer to the Medicaid HCBS DD Waivers.*

- A. Vehicle Modification is a service offered under all the Medicaid HCBS DD Waivers.
- B. Vehicle Modification includes:
  - 1. Physical adaptations necessary to meet the participant's needs or increase their independence; and
  - 2. Ongoing maintenance or repair of adaptations.
- C. Vehicle Modification is not a habilitative service.
- D. Examples of Vehicle Modification include but are not limited to:
  - 1. Wheelchair lift; or
  - 2. Adaptive control devices for the accelerator, brake, turn signals, steering wheel, or parking brake.
- E. Vehicle Modification has the following limitations:
  - 1. Vehicle Modification can only be used for a vehicle owned by:
    - a. A participant; or
    - b. A participant's family when the vehicle is the participant's main transportation.
  - 2. Vehicle Modification cannot be used for vehicles owned or leased by DD providers.
  - 3. Vehicle Modification cannot be used for:
    - a. Adaptations or improvements of general utility, such as:
      - i. Heated or cooled seats;
      - ii. DVD player; or
      - iii. Customized tires or rims.
    - b. Purchase or lease of a vehicle;
    - c. Paying for existing adaptations or adaptations already started; and
    - d. Regularly scheduled maintenance.
  - 4. Vehicle Modification is reimbursed per occurrence.
  - 5. Proof of vehicle insurance may be requested.
  - 6. DDD may require an on-site assessment by an appropriate Medicaid enrolled professional provider. The assessment is provided under the Environmental Modification Assessment.
  - 7. A vendor cannot charge more than they would to the general public. A vendor who offers a discount to a certain group of people, such as students or senior citizens, must offer the same discount to a participant in that group.
  - 8. A modification to a leased vehicle must be transferrable to the next vehicle.
  - 9. Vehicle Modification cannot overlap with, replace, or duplicate other similar services provided through Medicaid.
- F. Vehicle Modification can be offered by a vendor. A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a DD provider.

- G. Vehicle Modification cannot be self-directed.
- H. Vehicle Modification must be purchased within a participant's annual individual budget amount. Vehicle Modification has a cap of \$10,000 per five-year period. A participant may request funding over the budget cap due to a critical health or safety need. DDD approval is determined based on available funding.



## 9. Partnership with Vocational Rehabilitation

The Nebraska Department of Health and Human Services Division of Developmental Disabilities (DDD), Nebraska Vocational Rehabilitation (Nebraska VR), and the Nebraska Commission for the Blind and Visually Impaired (NCBVI) work together to provide employment opportunities. In this chapter, “VR” means the vocational rehabilitation agency, which is either Nebraska VR or NCBVI.

DDD, 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 DDD 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 Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Waiver services can only be used after all other available resources.

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.

*For contact information for Nebraska Vocational Rehabilitation or the Nebraska Commission for the Blind and Visually Impaired, see Policy Manual Appendix C: Contacts and 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 a 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 Individual Support Plan (ISP) 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. Have the ability to benefit from vocational rehabilitation services by successfully finding competitive integrated employment.
- B. DDD requires a referral be made to VR when the participant:
  1. Wants competitive integrated employment;
  2. Wants a different job;
  3. Wants to get another part-time, competitive integrated job; or
  4. Loses their job.
- C. To complete a referral to VR:
  1. A participant, their DD Service Coordinator, or another ISP 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 make a determination if the participant will benefit from vocational rehabilitation services. The participant will receive a determination letter from VR.
    - a. When a participant is determined to be not eligible, the letter includes the reason.
    - b. The ISP 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.

## 9.3 Services Provided by Nebraska VR and NCBVI

DDD 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 when the participant is employed.
- C. VR contracts with a provider to support a participant to find and maintain 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 ISP 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 Workforce Innovation and Opportunity Act makes sure 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, and 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. On a yearly basis thereafter.
  - c. The DD provider is responsible to track the completion of the CCIR and to provide information to Department of Labor's Wage and Hour Division when requested.
  - d. The participant's Service Coordinator receives documentation after completion of a CCIR.
2. Effective July 22, 2016, 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 DDD Role

- A. The Service Coordinator makes sure the school has connected the student with VR before they transition from high school, when the student is interested in competitive integrated employment.
  - 1. When a student transitions from school to 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 ISP team. The participant's ISP must document their involvement with VR.
  - 1. When the VR counselor is unable to attend ISP team meetings, the Service Coordinator may get an update from the VR counselor before the ISP meeting to share with team members.
  - 2. The ISP documents VR involvement, which may include referral date, determination of eligible or ineligible, the start of vocational rehabilitation services, what milestone they are on, and any other relevant information.
- C. The ISP documents any attempts of competitive integrated employment and the outcomes. When the participant has not been successful at competitive integrated employment, the ISP

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 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;
  - 8. Respite;
  - 9. Supported Employment – Follow-Along;
  - 10. Supported Employment – Individual; and
  - 11. Supported Family Living.
- C. When a participant is receiving vocational rehabilitation services and Medicaid HCBS DD Waiver day services, the total combined day hours cannot exceed 35 hours per week.
  - 1. Service coordination should receive a copy of the vocational rehabilitation authorization.
  - 2. The ISP team must discuss a schedule for services when the 35 hours are split between DD services and vocational rehabilitation 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 to get a second job.
- E. When a participant is ineligible for vocational rehabilitation services, the following Medicaid HCBS DD Waiver day service is available:
  - 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, and 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.
  - 2. Services not related to employment:

- a. Adult Day;
  - b. Community Integration;
  - c. Day Supports;
  - d. Behavioral In-Home Habilitation;
  - e. Medical In-Home Habilitation;
  - f. Independent Living;
  - g. Supported Family Living; and
  - h. Respite.
- F. When a participant refuses to work with VR, 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, completed 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.
- H. 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.

## Appendix A: Acronyms and Abbreviations

Acronym	Definition
<b>AD or A&amp;D Waiver</b>	Aged and Disabled Waiver
<b>ADA</b>	Americans with Disabilities Act
<b>APS</b>	Adult Protective Services
<b>ATP</b>	Ability to Pay
<b>ATP</b>	Assistive Technology Partnership
<b>BSP</b>	Behavior Support Program
<b>CCS</b>	Developmental Disabilities Community Coordinator Specialist
<b>CDD</b>	Licensed Center for people with Developmental Disabilities
<b>CDD</b>	Comprehensive DD Waiver
<b>CFS</b>	Children and Family Services
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CPS</b>	Child Protective Services
<b>CST</b>	Clinical Support Team
<b>DD</b>	Developmental Disabilities
<b>DDAD</b>	Developmental Disabilities Adult Day Waiver
<b>DDSC</b>	Developmental Disabilities Service Coordination
<b>DDSA</b>	Developmental Disabilities Services Act
<b>DHHS</b>	Nebraska Department of Health and Human Services
<b>DDD</b>	Nebraska Department of Health and Human Services Division of Developmental Disabilities
<b>DSP</b>	Direct Support Professional
<b>DSS</b>	Disability Services Specialist
<b>EFH</b>	Extended Family Home (is now Host Home or Shared Living)
<b>EN</b>	Employment Network
<b>EPSDT</b>	Early Periodic Screening, Diagnosis and Treatment
<b>ESI</b>	Emergency Safety Intervention
<b>ESU</b>	Education Service Unit
<b>EVV</b>	Electronic Visit Verification
<b>FBA</b>	Functional Behavioral Assessment

<b>FSW</b>	Family Support Waiver
<b>GER</b>	General Event Report (Therap) – Incident Reports
<b>HCBS</b>	Home and Community-Based Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HLRC</b>	Human and Legal Rights Committee
<b>IBA</b>	Individual Budget Amount
<b>ICAP</b>	Inventory for Client and Agency Planning
<b>ICF/IID</b>	Intermediate Care Facility for individuals with Intellectual Disabilities
<b>ID</b>	Intellectual Disability
<b>IDD</b>	Intellectual and Developmental Disabilities
<b>IDEA</b>	Individuals with Disabilities Education Act
<b>IDF</b>	Individual Data Form (Therap)
<b>IEP</b>	Individualized Education Plan
<b>IFM</b>	Individual/Family Meeting
<b>IPE</b>	Individual Plan for Employment
<b>ISP</b>	Individual Support Plan
<b>IQ</b>	Intelligence Quotient
<b>LOC</b>	Level of Care assessment, also called Developmental Index
<b>LTG</b>	Long Term Goal
<b>MAR</b>	Medical Administration Record (Therap)
<b>NAC</b>	Nebraska Administrative Code
<b>NCBVI</b>	Nebraska Commission for the Blind and Visually Impaired
<b>NCDHH</b>	Nebraska Commission for the Deaf and
<b>NDE</b>	Nebraska Department of Education
<b>NF</b>	Nursing Facility
<b>N-FOCUS</b>	Nebraska Family Online Client User System
<b>NMAP</b>	Nebraska Medical Assistance Program (Medicaid)
<b>NRRS</b>	Nebraska Resource Referral System
<b>OAP</b>	Objective Assessment Process
<b>OG</b>	Operational Guideline
<b>PAS</b>	Personal Assistance Services (Medicaid program)
<b>PASRR</b>	Preadmission Screening and Resident Review
<b>PASS</b>	Plan for Achieving Self-Support (Social Security Administration)
<b>PN</b>	Person Number
<b>PNM</b>	Physical/Nutritional Management
<b>POA</b>	Power of Attorney



<b>POC</b>	Plan of Correction
<b>POI</b>	Plan of Improvement
<b>P&amp;P</b>	Policy and Procedure
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>SDA</b>	Service District Administrator
<b>SC</b>	Service Coordinator
<b>SCS</b>	Service Coordination Supervisor
<b>SComm</b>	Secure Communication (Therap)
<b>SNA</b>	Supports Needs Assessment
<b>SNAP</b>	Supplemental Nutrition Assistance Program
<b>SOC</b>	Share of Cost
<b>SOC</b>	System of Care
<b>SpED</b>	Special Education Branch of the Nebraska Department of Education
<b>SPMI</b>	Severe and persistent mental illness
<b>SSA</b>	Social Security Administration
<b>SSDI</b>	Social Security Disability Insurance
<b>SSI</b>	Supplemental Security Income, a federal program providing direct financial assistance to the aged and disabled, available through Social Security offices
<b>SSN</b>	Social Security Number
<b>SSW</b>	Social Services Worker
<b>TDD</b>	Telephone Device for the Deaf
<b>TLog</b>	Therap Log (progress note; daily log)
<b>TTY</b>	Tele-typewriter for the Deaf
<b>TTW</b>	Ticket to Work
<b>VR</b>	Vocational Rehabilitation services, a Division in the Department of Education and services provided through separate Vocational Rehabilitation regions
<b>WIOA</b>	Workforce Innovation and Opportunity Act

## Appendix B: Glossary

The following definitions are used in the 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 if 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.

<b>Application Date</b>	The date DHHS Division of Developmental Disabilities (DDD) receives a completed application for Medicaid HCBS DD Waiver services with all information necessary to determine eligibility.
<b>Assessment</b>	An evaluation to identify a participant's preferences, skills, or needs.
<b>Assistive Technology</b>	A device, equipment, or appliance used to increase a participant's ability to complete activities of daily living or control their environment.
<b>Aversive Stimuli</b>	A procedure used to change unwanted behavior that is painful, frightening, or potentially harmful to the participant's health or safety.
<b>Back-up Staff</b>	Back-up staff is a person present in place of the Host Home or Shared Living provider.
<b>Behavior Support Plan (BSP)</b>	A type of habilitation program based on a behavioral assessment, which teaches an appropriate replacement behavior and decreases problem behavior.
<b>Behavioral Assessment</b>	Evaluation of participant behavior and baseline used to develop a BSP.
<b>Benefits</b>	Public assistance, such as Medicaid, Social Security Income (SSI), Supplemental Nutritional Assistance Program (SNAP), or Assistance to the Aged, Blind, or Disabled (AABD).
<b>Budget Year</b>	The 12 consecutive months following the start of a participant's individual support plan (ISP) during which their annual individual budget amount may be used to purchase Medicaid HCBS DD Waiver services. This is also called the ISP year.
<b>Business Days</b>	Monday through Friday, excluding state holidays.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	A federal agency under the US Department of Health and Human Services, which approves and oversees the Medicaid HCBS Waivers.
<b>Certification</b>	Approval by DHHS Division of Public Health (DPH) for an agency provider to deliver Medicaid HCBS DD Waiver services to participants.
<b>Chemical Restraint</b>	A drug used for discipline or convenience and not required to treat medical symptoms.
<b>Code of Federal Regulations (CFR)</b>	Rules set by federal government agencies.
<b>Competitive Integrated Employment</b>	Gainful employment in a job, which takes place in an integrated community setting where the participant receives a competitive wage for their, job.
<b>Competitive Wage</b>	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.

<b>Compliance</b>	To follow any applicable statutes, regulations, and policies.
<b>Comprehensive DD Waiver (CDD)</b>	A Medicaid Home and Community-Based Service (HCBS) Waiver administered by DDD 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.
<b>Conflict of Interest</b>	A situation when a provider or person's own interests may be inconsistent with their responsibilities to a participant.
<b>Contractor</b>	A person, organization, or business not employed by the agency, with whom an agency provider enters into an agreement to provide a service.
<b>Corporal Punishment</b>	Causing pain as consequence for undesired behavior.
<b>Customer Obligation</b>	Term used by Medicaid for share of cost.
<b>Customized Employment</b>	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.
<b>Denial Of Basic Needs</b>	Withholding access to food or water, clothing, shelter, and treatment for physical needs.
<b>Developmental Disabilities Adult Day Waiver (DDAD)</b>	A Medicaid Home and Community-Based Service (HCBS) Waiver administered by DDD 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.
<b>Developmental Disabilities Court-Ordered Custody Act (DDCA or DDCOCA)</b>	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.
<b>Developmental Disability</b>	<p>A severe, chronic disability, including an intellectual disability, other than mental illness, which:</p> <ol style="list-style-type: none"> <li>1. Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness;</li> <li>2. Is manifested before the age of twenty-two years;</li> <li>3. Is likely to continue indefinitely;</li> <li>4. Results in substantial functional limitations in one of each of the following areas of adaptive functioning. <ol style="list-style-type: none"> <li>a. Conceptual skills, including language, literacy, money, time, number concepts, and self-direction;</li> <li>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</li> </ol> </li> </ol>

- 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*

<b>DDD Central Office</b>	The administrative office of DDD which includes the Director, Deputy Directors, Administrators, Financial Officer, Medical Director, Clinical Team, Policy Team, Quality Improvement Team, and Provider Relations Team.
<b>DDD Clinical Team</b>	The team that includes the Medical Director, psychologists, nurses, behavioral professionals, and other medical professionals.
<b>DHHS-Mandated Electronic Medicaid Provider Enrollment System</b>	Maximus.
<b>Discipline</b>	Use of punishment to correct undesired behavior.
<b>Emergency Safety Intervention (ESI)</b>	Use of physical restraint or separation as an immediate response to an emergency safety situation.
<b>Emergency Safety Situation</b>	Unexpected participant behavior that places the participant or others at significant risk of serious or life-threatening harm.
<b>Emotional Abuse</b>	Humiliation, harassment, threats, or intimidation causing distress.
<b>Employee Benefits</b>	Worker's compensation, paid holidays, paid vacations, paid sick time, health insurance, and other compensation provided by an employer.
<b>Exploitation of a Vulnerable Adult</b>	<p>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:</p> <ol style="list-style-type: none"> <li>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</li> <li>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.</li> </ol> <p><i>Defined in Neb. Rev. Stat. §28-358</i></p>

<b>Family Support Waiver</b>	A Medicaid Home and Community-Based Services (HCBS) Waiver administered by DDD 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.
<b>Fair Hearing</b>	A meeting between DHHS and a person or provider appealing a decision in which a hearing officer reviews presented evidence.
<b>Final Settings Rule</b>	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.
<b>Funding Priority</b>	Criteria used to determine the order in which eligible people receive funding for developmental disabilities services.
<b>Gainful Employment</b>	A job in the community where a participant receives steady work and at least minimum wage.
<b>General Event Report (GER)</b>	State-mandated electronic form used to report incidents in the state-mandated web-based case management system (Therap).
<b>Habilitation Program</b>	A structured method of teaching skills, with goals and data collection.
<b>Habilitative Service</b>	A developmental disabilities service, which teaches a participant through habilitation programs and provides other supports such as personal care, supervision, and medication administration.
<b>Health Insurance Portability and Accountability Act (HIPAA)</b>	Federal law, which governs sharing of protected health information.
<b>Hearing Officer</b>	A DHHS attorney assigned to hold a fair hearing.
<b>Immediate Response</b>	Available within moments to assist the participant.
<b>Independent Provider</b>	A person who is an enrolled Medicaid provider and employed by a participant.
<b>Individual Budget Amount (IBA)</b>	Maximum amount of funding available to a participant during their ISP year to purchase Medicaid HCBS DD Waiver services.
<b>Individual Family Meeting (IFM)</b>	A conversation with the participant, held before the annual ISP meeting, about how things are going, things they enjoy, things they may want to change, and what their hope is for the future.
<b>Individual Support Plan (ISP)</b>	A plan of services, supports, activities, and resources based on the participant's personal goals and preferences, and assessments of strengths and needs.
<b>Individual Support Plan (ISP) Year</b>	The 12 consecutive months following the start of the ISP. This is also called the budget year.

<b>Individual Support Planning (ISP) Team</b>	The people who support a participant to develop and carry out the ISP. Members include the participant, their guardian, Service Coordinator, developmental disabilities providers, and others chosen by the participant.
<b>Informed Choice</b>	A well-considered decision made when given all options or information.
<b>Institution</b>	In-patient hospitals, skilled nursing facilities, intermediate care facilities for individuals with Intellectual disabilities (ICF/IID), and Regional Centers.
<b>Integrated Community Setting</b>	A place in the community where people with and without disabilities interact, and live and work together.
<b>Integration</b>	Full involvement in a person's community.
<b>Intelligence Quotient (IQ)</b>	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.
<b>Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/IID)</b>	An institution licensed by Public Health for people with developmental disabilities, which provides ongoing evaluation, planning, supervision, and habilitative services.
<b>Inventory For Client and Agency Planning (ICAP)</b>	An assessment tool measuring adaptive skills and behavioral needs, used as part of the objective assessment process.
<b>Legally Responsible Adult</b>	A person who is legally authorized to make decisions on behalf of a participant. Legally responsible adults include a parent (natural or adoptive) of a minor child, a spouse, a guardian, a conservator, or a power of attorney.
<b>Level of Care (LOC)</b>	An assessment completed to determine if a person requires the same level of services provided in an ICF/IID.
<b>Long-Term Goal (LTG)</b>	The planned outcome of a habilitation program reflecting what the participant will learn. The ISP team develops the long-term goal based on the participant's personal goals and assessed needs.
<b>Maximus</b>	DHHS-mandated electronic Medicaid provider enrollment system
<b>May</b>	An action or task, which is optional.
<b>Mechanical Restraint</b>	Any device, material, object, or equipment that restricts freedom of movement or normal access to the body, except: <ol style="list-style-type: none"> <li>1. The use of acceptable and age-appropriate child safety products, such as a car seat or booster seat;</li> <li>2. Use of car safety systems, such as seatbelts or wheelchair tie-down straps; or</li> <li>3. Equipment ordered by a physician or health care provider for the participant's safety, such as a lap belt on a wheelchair.</li> </ol>

<b>Medicaid</b>	Public health insurance program for people who have low-income or people with disabilities.
<b>Medication</b>	Any prescription or nonprescription drug intended for treatment or prevention of disease, or to affect body function.
<b>Medication Administration Record (MAR)</b>	Documentation of administered medications. A provider must maintain documentation in the state-mandated web-based case management system (Therap).
<b>Monthly Spend Down</b>	Term used by Medicaid for share of cost.
<b>Must</b>	An action or task which is required by DDD.
<b>Natural Supports</b>	A person who has a non-paid, personal relationship with a participant, including family members, friends, neighbors, and other community members.
<b>Nebraska Administrative Code (NAC)</b>	Nebraska state regulations.
<b>Neglect of Vulnerable Adult</b>	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. <i>Defined in Neb. Rev. Stat. §25-361.01</i>
<b>Notice of Decision (NOD)</b>	A written notice to an applicant or participant informing them of a decision made by the Department.
<b>Notice of Rights and Obligations</b>	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.
<b>Objective Assessment Process (OAP)</b>	Standardized process to determine a participant's annual individual budget amount (IBA).
<b>Obligated</b>	The assignment of the Medicaid share of cost to a specific Medicaid provider.
<b>Oversight</b>	Observation, direction, and monitoring by a person or people responsible for expertise in a specified area.
<b>Participant</b>	The person receiving Medicaid HCBS DD Waiver services and any person legally authorized to act on behalf of the participant.
<b>Party</b>	All people and organizations involved in a fair hearing, which include, the DHHS Hearing Officer, DDD and DHHS Legal, the person submitting the appeal, and any other person or entity identified by the person submitting the appeal.



<b>Person-Centered Approach</b>	A process to ensure a participant is at the center of decisions, which relate to their life. The process involves: <ol style="list-style-type: none"> <li>1. Listening to the participant; and</li> <li>2. Sharing ideas to support the participant in reaching their personal goals.</li> </ol>
<b>Person-First Language</b>	Speaking or writing which places the person before the disability. For example, “person with autism” instead of “autistic person.”
<b>Physical Restraint</b>	Any physical hold that restricts, or is meant to restrict, the voluntary movement of a participant.
<b>Plan of Improvement (POI)</b>	A written document outlining the provider’s plan to address any areas out of compliance during a certification or service review.
<b>Policy and Procedure (P&amp;P)</b>	Written policies describing how a business is ran, and procedures giving direction to employees and contractors.
<b>Power of Attorney (POA)</b>	Legal representative appointed by a person to make decisions on their behalf, such as medical or financial decisions.
<b>Private Home</b>	A participant’s own home, or their family’s home when living with their family; not provider owned or leased, operated, or controlled.
<b>PRN (Pro Re Nata) Medication</b>	A medication is taken as needed rather than on a set schedule.
<b>Provider Controlled or Operated Setting</b>	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.
<b>Provider Owned or Leased Setting</b>	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.
<b>Psychotropic Medication</b>	A medication, which generally alters brain function, resulting in changes to perception, mood, consciousness, or behavior.
<b>Punishment</b>	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.
<b>Quality Improvement (QI)</b>	A continuous process of performing reviews, analyzing data, evaluating current practices, and making changes to improve services.
<b>Risk Screen</b>	Assessments that measure the following risks: <ol style="list-style-type: none"> <li>1. Behavior;</li> <li>2. Health;</li> <li>3. Spine and Gait;</li> <li>4. Physical Nutrition Management; and</li> <li>5. Enteral Feeding.</li> </ol>

<b>Room and Board</b>	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).
<b>Safety Plan</b>	A guide for people providing direct support which includes: <ol style="list-style-type: none"> <li>1. A summary of all identified risks, triggers, and warning signs;</li> <li>2. A detailed description of all supports, strategies, and equipment used to address the identified risks; and</li> <li>3. Specific instructions for when and how all supports, strategies, and equipment are used.</li> </ol>
<b>Seclusion</b>	Being confined alone in an area and physically prevented from leaving or having contact with others.
<b>Self-Administration of Medication</b>	When a participant is able to: <ol style="list-style-type: none"> <li>1. Independently take or apply medication as prescribed, including at the right time and in the right amount;</li> <li>2. Independently monitor for the desired effects and side effects of the medication, and take appropriate actions; and</li> <li>3. Receive no assistance with any activity related to medication administration.</li> </ol>
<b>Self-Directed Services</b>	Services offered by independent providers employed by a participant.
<b>Self-Direction</b>	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.
<b>Separation</b>	Use of physical contact to remove a participant from a situation triggering unsafe behavior, another person, or a dangerous situation.
<b>Service Coordinator (SC)</b>	DDD staff assigned to help a participant find needed services and supports, facilitate the development of the ISP, and ensure the ISP is implemented as written.
<b>Setting</b>	A location where developmental disabilities services are provided.
<b>Shift Staff</b>	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.
<b>Short-Term Objective (STO)</b>	A step towards achieving a long-term goal.
<b>Should</b>	An action or task which is best practice and recommended by DDD.

<b>State General Funds</b>	Money that pays for developmental disabilities services when a Medicaid HCBS DD Waiver service cannot be billed.
<b>State-Contracted EVV provider</b>	Tellus.
<b>State-Mandated Web-Based Case Management System</b>	Therap.
<b>Supported Employment</b>	Ongoing assistance necessary for success in competitive, integrated employment.
<b>Telehealth</b>	Contact between a participant and a health care provider for diagnosis or treatment using audio and visual technology, rather than in-person interaction.
<b>Tellus</b>	The state-contracted EVV provider.
<b>Therap</b>	State-mandated web-based case management system.
<b>Vendor</b>	A vendor is a company or agency enrolled as a Medicaid provider, but not certified as a developmental disabilities provider.
<b>Verbal Abuse</b>	Use of oral, written, or gestured language that intentionally uses offensive terms towards a participant.
<b>Vocational Rehabilitation (VR)</b>	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.
<b>Vulnerable Adult</b>	<p>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.</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol> <p><i>Defined in Neb. Rev. Stat. §28-371</i></p>
<b>Week</b>	A calendar week beginning 12:00 AM Monday through 11:59 PM of the following Sunday.

## Appendix C: Contacts and Resources

### C.1 DDD Contacts and Office Locations

#### DDD Central Office Address

Nebraska Department of Health & Human Services - Division of Developmental Disabilities  
301 Centennial Mall, South  
P.O. Box 98947  
Lincoln, NE 68509-8947

#### DDD 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](mailto:DHHS.DDDCommunityBasedServices@nebraska.gov)

#### DDD Website

<http://dhhs.ne.gov/Pages/Developmental-Disabilities.aspx>

#### DDD Staff Directory and Local Office Locations

<http://dhhs.ne.gov/Documents/DDDMainDirectory.pdf>

### C.2 Department of Health and Human Services Contacts

#### DHHS Public Website

<http://dhhs.ne.gov/>

#### Medicaid Contact Information

Toll-Free: (855) 632-7633  
Lincoln: (402) 473-7000  
Omaha: (402) 595-1178  
TTY (for those who are deaf or hard of hearing): (402) 471-7256  
<http://dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx>

#### Reporting Abuse, Neglect, or Exploitation of Children or Vulnerable Adults

Toll-Free: (800) 652-1999

#### Economic Assistance

Toll-Free: (800) 383-4278  
<https://dhhs.ne.gov/Pages/Economic-Assistance.aspx>

#### DHHS Public Assistance Office Locations

<http://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx>

#### Financial Services for ability to pay

[DHHS.financialresponsibility@nebraska.gov](mailto:DHHS.financialresponsibility@nebraska.gov)

#### To Report Suspected Medicaid Fraud by a Provider or Recipient

<http://dhhs.ne.gov/Pages/Program-Integrity-Reporting-Fraud.aspx>

## C.3 Statutes, Regulations, and Medicaid HCBS DD Waivers

**Nebraska Revised Statutes** – A listing of all chapters of Nebraska statute  
<https://nebraskalegislature.gov/laws/browse-statutes.php>

**The Developmental Disabilities Services Act (Neb. Rev. Stat. §§83-1201-83-1227)** – Statutes governing the administration of developmental disabilities services by DDD.  
[https://nebraskalegislature.gov/laws/display\\_html.php?begin\\_section=83-1201&end\\_section=83-1225](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 Developmental Disabilities  
<https://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx>

**Medicaid HCBS Waivers** – Waiver agreement approved by the federal Department of Health and Human Services outlining services offered under the Comprehensive Developmental Disabilities (CDD) waiver and Developmental Disabilities Adult Day (DDAD)  
<https://dhhs.ne.gov/Pages/DD-Regulations-and-Waivers.aspx>

## C.4 Application and Eligibility Resources

**iServe Nebraska** – Website with online application for developmental disabilities services  
<https://iserve.nebraska.gov/>

**Applying for Developmental Disabilities Services** – A step by step guide for completing an application for developmental disabilities services  
<http://dhhs.ne.gov/DD%20Documents/Applying%20for%20DD%20Services%20Online.pdf>

**Developmental Disabilities Services Eligibility Brochure** – A quick guide outlining eligibility requirements for developmental disabilities services.  
<http://dhhs.ne.gov/DD%20Documents/Eligibility%20for%20DD%20Services.pdf>

**Directory of Community Partners** – A listing of community organizations across the state providing internet access to people applying for benefits and services  
<http://dhhs.ne.gov/Pages/Access-Nebraska-Community-Partners.aspx>

**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>

## C.5 Complaints and Appeals Resources

**Appeal/Fair Hearing Request** – Information and form for filing an appeal of a DHHS decision can be found here.  
<https://dhhs.ne.gov/Pages/DD-Notice-of-Decision.aspx>

**Complaint Form** – Form for submitting a complaint to DDD.  
<http://dhhs.ne.gov/DD%20Documents/Complaint%20Form.pdf>

**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>

## C.6 Employment Resources

### Nebraska Vocational Rehabilitation (VR) Contact Information

Toll-Free: 877-637-3422

Website: <http://www.vr.nebraska.gov/>

Local Offices: <http://www.vr.nebraska.gov/offices/>

### Nebraska Commission for the Blind and Visually Impaired (NCBVI) Contact Information

Toll-Free: (877) 809-2419

Website: <https://ncbvi.nebraska.gov/about/statewide-offices>

## C.7 Funding/Financial Responsibility Resources

**DHHS-Financial Assistance Appointment of DHHS as Agent** – Consent to allow DDD to withhold and pay employment taxes for independent providers on behalf of a self-directing participant.

<http://public-dhhs.ne.gov/Forms/Home.aspx>

**Title 471 NAC Chapter 3** – This chapter outlines State regulations for payment for Medicaid Services and share of cost.

[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-471/Chapter-03.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-03.pdf)

**Title 202 NAC Chapter 1** – This chapter outlines State regulations for ability to pay.

[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-202/Chapter-1.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-202/Chapter-1.pdf)

## C.8 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>

## C.9 Participant Resources

**Participant Guides and Resources** – Guides with helpful hints for participant's 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>

## C.10 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>