THE PROMISE OF THE GOOD LIFE

Community Inclusion for People with Developmental Disabilities

Disability Rights Nebraska

NEBRASKA COLLABORATIVE INCLUSION WORKGROUP 2015

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EXECUTIVE SUMMARY

In early 2013 Disability Rights Nebraska commissioned the Nebraska Collaborative Inclusion Workgroup. The workgroup's charge was to identify isolated, segregated and congregated facilities, programs, and services provided to people with intellectual and developmental disabilities in the state. In addition, the group was to identify policies and practices that perpetuate isolation and segregation and models of person-centered, inclusive services and supports to counter and replace them. The workgroup's findings and recommendations include:

1. **Eligibility Criteria and Determination Process**

   The report discusses criteria used for and the process of eligibility determination. Noted concerns are the application of the statutory definition of "developmental disability" and the lack of data on eligibility findings. Recommendations include revising the statutory definition of developmental disability, revising regulations related to dual diagnosis, studying the validity of the eligibility determination assessment, and tracking and analyzing eligibility findings.

2. **Funding**

   The method used to calculate an individual budget amount to pay for services is discussed. Concerns are raised about the reliability of the assessment, the validity of the methodology used to calculate funding, and funding constraints that hamper inclusion efforts. Recommendations to address reliability and validity concerns and remove constraints that affect inclusion are identified.

3. **Rules and Regulations**

   Specific regulations in Nebraska Administrative Code, Titles 404 and 175, are barriers to inclusion. The report makes recommendations for regulatory change.

4. **System Constructs**

   The report discusses Nebraska's developmental disability system constructs related to inclusion: Service Coordination, Quality Review Teams (QRT), and the Home and Community Based Services (HCBS) Transition Plan to implement the Centers for Medicare and Medicaid (CMS) Final Rule on HCBS. Recommendations include using these constructs to set expectations for inclusion and ensure that those expectations are being met.

5. **Development and Innovation**

   Recent federal legislation calls for action to promote employment for people with disabilities. The report discusses recommendations to develop employment initiatives, including establishing Nebraska as an Employment First state, using the Workforce Innovation and Opportunity Act (WIOA) as a guide. Pilot projects and data collection and analysis are tools to promote innovation and measure success.

BACKGROUND

In 2013, Disability Rights Nebraska, the Nebraska's designated Protection and Advocacy organization, commissioned the Nebraska Collaborative Inclusion Workgroup. The purpose of the workgroup was to identify isolated, segregated and congregated facilities, programs, and services for people with intellectual and developmental disabilities in the state, as well as any policies and practices that support isolation and segregation. In addition, the workgroup identified models for more person-centered, inclusive programs, services, and supports that could counter and eliminate policies, procedures and practices that isolate and segregate.

A group of 16 participants met several times beginning in July 2013 and throughout 2014 to discuss current policies and practices affecting community inclusion of Nebraskans with developmental disabilities. Areas of discussion included but were not limited to eligibility, funding, and the State's application of person-centered planning practices. Information presented in this report is based on the participants' experience with day-to-day practices of the Developmental Disabilities Division (DDD) of the Nebraska Department of Health and Human Services (DHHS) and an analysis of documents and information provided by DDD. Additional research was conducted to compare Nebraska's experience with inclusive services and supports with other states and entities.

The workgroup met as the Centers for Medicare and Medicaid (CMS) was issuing and providing interpretation of the Home and Community-Based Services (HCBS) Final Rule on what constitutes home and community-based settings and services funded by 1915(c) Home and Community-Based waivers[1]. This rule provides a vision for how supports and services could be changed to promote community inclusion.

Broadly, the Final Rule states that settings must:

1. Be integrated in and support full access to the greater community
2. Be selected by the individual from among setting options
3. Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint
4. Optimize autonomy and independence in making life choices
5. Facilitate choice regarding services and who provides them

[1] The rule's key provisions can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

In provider-owned or controlled home and community-based residential settings[2], the Final Rule also requires that an individual has:

1. A lease or other legally enforceable agreement providing similar protections
2. Privacy in their unit (including lockable doors)
3. Choice of roommates
4. Freedom to furnish or decorate the unit
5. Control of his/her own schedule including access to food at any time
6. Ability to have visitors at any time
7. Physical access to the setting

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

This report analyzes various legislation and initiatives currently in process, including the HCBS Final Rule implementation, and includes recommendations for procedural and system changes to chart a course to improve community inclusion of people with developmental disabilities.

[2] Additional exploratory questions for residential and non-residential settings provide additional insight into CMS' interpretive standards. These may be found at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf.

See also http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf

Current Laws, Regulations, Rules, Policies, Procedures and Practices Affecting Inclusion

Eligibility Criteria and Eligibility Determination Process

Both the application of eligibility criteria and the process for determining eligibility need review as they relate to community inclusion. Misapplication of eligibility criteria affects access to services that support inclusion of people to live and work in the community. Several members of the workgroup gave accounts of people whom they considered eligible but were denied eligibility for services and supports funding. Often, a secondary diagnosis of mental illness or borderline IQ range was noted. The application of the statutory definition of "developmental disability" and the process for determining eligibility and affording due process when appealing ineligibility were noted to be inconsistent. A lack of available data exists regarding the number of people found ineligible and the reasons for such a finding.

> *Appreciation of this comorbidity needs to be a fundamental component of both mental health and intellectual disability services.*
>
> *-- Einfeld, S. L., Ellis, L. A., & Emerson, E., 2011, p. 1*

The regulatory process for funding authorizations renders people with a dual diagnosis of a developmental disability and mental illness ineligible for funding based on the definition of "developmental disability". Title 404 of the Nebraska Administrative Code (NAC) outlines the DDD regulations for administering Community-Based Developmental Disability Services[3]. The regulations follow the statutory definition of developmental disability which excludes "a mental or physical impairment caused solely by mental illness" [4].

The incidence of co-occurring intellectual/developmental disability and mental illness is relatively high. According to The NADD, an association for persons with developmental disabilities and mental health needs, "The full range of psychopathology that exists in the general population also can co-exist in persons who have intellectual or developmental disabilities" [5], and "People with co-occurring IDD and MI are frequently referred to as a special population. It is important to recognize that this group makes up approximately one-third (32.9%) of the total number of individuals with IDD served by state developmental disability (DD) agencies nationwide"[6]. Other research indicates

[3] Title 404, Nebraska Administrative Code, available at http://dhhs.ne.gov/Pages/reg_t404.aspx
[4] Nebraska Revised Statute § 83-1205, available at http://nebraskalegislature.gov/laws/statutes.php?statute=83-1205
[5] NADD, "Information on Dual Diagnosis", available at http://thenadd.org/resources/information-on-dual-diagnosis-2/
[6] NADD, "Including Individuals with Intellectual/Developmental Disabilities and Co-Occurring Mental Illness: Challenges that Must Be Addressed in Health Care Reform", available at https://aaidd.org/docs/default-source/policy/including-individuals-with-intellectual-developmental-disabilities-and-co-occurring-mental-illness-challenges-that-must-be-addressed-in-health-care-reform.pdf?sfvrsn=0

that comorbidity of intellectual disability and mental disorders among children and adolescents ranges from 30-50%[7]. The NADD further recognizes:

> ". . .state [developmental disability] and [mental health] authorities and service systems continue to struggle in their attempts to provide effective and appropriate treatments and supports on a consistent and comprehensive basis…[such] efforts have been significantly hampered by administrative and funding barriers that diffuse responsibilities. . ."[8]

> *… these individuals frequently fall between the cracks, because the systems responsible for mental health and developmental disabilities are unable to provide treatment, services and supports."*
>
> *-- Florida Developmental Disabilities Council, 2009, p. 2*

However, Nebraska applies additional criteria when a person has a dual diagnosis. Consequently, an unknown number of people have been deemed ineligible. In July 2011, new regulatory limitations were added regarding eligibility for federal waiver funding, stating: "If an individual has a diagnosis of developmental disability and a diagnosis of mental illness, the diagnosis relating to developmental disability must be the primary disabling condition."[9] Workgroup members were aware of numerous people with a dual diagnosis terminated from services or determined ineligible when applying for services.

A search of the literature indicates no instance where a "primary disabling condition" between a developmental disability and a mental illness can be determined. The Florida Developmental Disabilities Council's report, *Guidelines for Understanding and Serving People with Intellectual Disabilities and Mental, Emotional, and Behavioral Disorders,* affirms:

> "Unfortunately, the age old argument of primary disability is still heard. . . [and that] the new understanding of brain development and the fact that cognitive abilities, emotional status and physical health are intertwined makes this discussion out of date."[10]

The regulatory change has done just that, people being denied eligibility for services and funding. The number of people who have been affected by this change is

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[7] Einfeld, S. L., Ellis, L. A., & Emerson, E., 2011, "Comorbidity of Intellectual Disability and Mental Children and Adolescents: A Systematic Review". *Journal of Intellectual and Developmental Disability*, 36(2), 137–143.

[8] NADD, "Including Individuals with Intellectual/Developmental Disabilities and Co-Occurring Mental Illness: Challenges that Must Be Addressed in Health Care Reform", available at https://aaidd.org/docs/default-source/policy/including-individuals-with-intellectual-developmental-disabilities-and-co-occurring-mental-illness-challenges-that-must-be-addressed-in-health-care-reform.pdf?sfvrsn=0, pg. 2

[9] See Title 404 Nebraska Administrative Code, especially 3-003.01D, part 4, available at http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-404/Chapter-03.pdf

[10] *Guidelines for Understanding and Serving People with Intellectual Disabilities and Mental, Emotional, and Behavioral Disorders*, 2009, at page 1, available at http://www.nasddds.org/uploads/documents/Florida_DD_Council_Guidelines_for_Dual_Diagnosis.pdf.

unknown. When asked, the DDD was unable to provide data on the number of people with a dual diagnosis found ineligible because mental illness was considered to be their primary diagnosis.

Eligibility Determination Tools

Before 1991, the DDD (then the Office of Mental Retardation) alone funded services for people with intellectual disabilities. With the passage of the Developmental Disability Services Act that same year, Nebraska broadened its eligibility criteria to include other developmental disabilities.

An assessment developed by the State of Ohio to measure functional limitations was selected for use in Nebraska by a legislatively mandated oversight committee. This assessment was chosen because it had been determined to have high reliability and validity, non-clinicians could be trained to administer it, and it had been tested for the same purposes in Ohio.

At some point, this assessment, known as the Eligibility Determination Instrument-A (for adults) or Eligibility Determination Instrument-C (for Children), was eliminated. The DDD adopted the Scales of Independent Behavior-Revised (SIB-R) for use in assessing substantial functional limitations (SFL) in areas of daily living.

There is no known study of the use of the SIB-R to identify substantial functional limitations for the purpose of determining eligibility. Perhaps more importantly, there is no known study of the correlation between the EDI and the SIB-R so that the use of the latter tool can be assessed for its effect on eligibility/ineligibility findings. Significant differences between the two may be why people found eligible using when the EDI was in use are now being found ineligible when a redetermination of eligibility using the SIB-R is completed. Below is a comparison of the two tools which illustrates their differences.

Table 1: Comparison between EDI and SIB-R

Eligibility Determination Instrument (EDI)	Scales of Independent Behavior (SIB-R)
Areas assessed for SFL	*Areas assessed for SFL*
Self-Care	Personal Living Skills: Eating and Meal Preparation; Toileting; Dressing; Personal Self-Care; Domestic Skills
Receptive and Expressive Language	Social Interaction and Communication Skills: Social Interaction; Language; Comprehension; Language Expression
Mobility	Motor Skills: Gross Motor and Fine Motor
Self-Direction	No correlated area of assessment
Capacity for Independent Living	Community-Living Skills: Time and Punctuality; Money and Value; Home and Community; Orientation
Learning	No correlated area of assessment
Economic Self-Sufficiency	No correlated area of assessment

The SIB-R does not include a method of scoring self-direction, learning, or economic self-sufficiency. An example of how this tool may affect eligibility relates to the measure of Economic Self-Sufficiency. Nearly all people receiving government benefits are considered substantially functionally limited in this area. If people are no longer being assessed in this area (because the SIB-R does not include a method of assessing it), the number of people eligible would be significantly fewer than if the EDI were used.

Eligibility Determination Process

Nebraska regulation, Title 404 NAC 3-001.03, states: "Service Coordination accepts referrals for eligibility determinations of all individuals and must make a determination of eligibility without regard to whether the Department has sufficient funds to provide or obtain needed services for the individual. Service Coordination must inform the individual or legal representative of findings of eligibility determination and the individual's right to contest the determination." The practice of having eligibility determination completed by service coordination was implemented as part of the Service Coordination Plan developed by DDD following the passage of the Developmental Disabilities Services Act. Eligibility determination has been removed from the responsibility of service coordination. The effect of that change has not been measured; eligibility findings and issues with the process were identified by the workgroup.

Statistical information on those found eligible/ineligible was provided by the DDD Director in September 2012 for the period from April 1, 2011 to September 7, 2012 and are as follows:

Table 2: Statistical Information Regarding Eligibility

Number of referrals	2,849
Number found ineligible	442
Number found eligible	379
Number in "other" status	1,988
Number of people who appealed	Not Available

Information about why people were found ineligible and how many of them appealed the decision was not provided. Responses to questions about how to obtain assistance in completing the eligibility determination process and how people could appeal an unfavorable determination revealed a lack of available support in these areas. The statistics indicate that only about 14% of those who applied during a 15-month period were found eligible, while about 86% were either found ineligible or were in an "other" status (in progress or had dropped out.)

During the same timeframe the state began using ACCESSNebraska to receive referrals and applications for eligibility. The DDD was unable to provide any information about how ACCESSNebraska may have affected applications for services. More

information is needed to evaluate the eligibility determination process. See Appendix A for the Eligibility Presentation outlining the process currently in use.

Funding and Inclusion

The workgroup discussed Nebraska's current process for funding home and community-based services for people with developmental disabilities. The funding methodology has undergone numerous changes in the past several years, notably the legislated requirement that an Objective Assessment Process (OAP) be in place to distribute equitably funding allocated for services. Objectivity and equitable allocation have not been achieved. Processes to obtain "exception" funding— that is exception to the OAP— circumvent due process rights to appeal such decisions. The funding methodology and its application supports a model where people are served in groups based on staff-to-individual ratios commensurate with funding levels. Rigid billing rules result in practices that are not person-centered and lack the flexibility needed to support people in/looking for employment or inclusive access to community activities.

Implementation of the Objective Assessment Process

The DDD uses the Inventory for Client and Agency Planning (ICAP) to determine a "score" that equates to a funding level for DD services. According to the examiner's manual, the ICAP is "a comprehensive, structured instrument designed to assess the status, adaptive functioning, and service needs of clients" (Bruininks et al, 1986). This instrument has been in use since 1986 and has been determined to have a high degree of reliability and validity. The policies directing how the ICAP is administered have not been published, and workgroup members report varied knowledge of and experience with how the process works. There is a lack of transparency about how the tool was used to develop the latest funding formula, including how various measures were weighted in the formula that results in an eventual funding level determination.

The workgroup raised the following concerns with OAP implementation:

1. *Training to Complete the Assessment*

   The ICAP examiner's manual (Bruininks et al, 1986) emphasizes that the primary criterion for rating a task is independence: "The top line of print does not (or could do) task completely without help or supervision, expresses the basic requirement that is applied to evaluating all four performance ratings for each task." Ratings are assigned on an absolute scale with a score of 3 assigned when a task is performed completely independently, a rating of 2 is assigned when a task is performed independently about three-quarters of the time, a rating of 1 is assigned when a task is performed independently about one-fourth of the time. The manual states that this rating is applied if an individual tries to do all parts of a task without help or supervision, but the result is not good. Respondents have reported that their understanding of the ratings is related to

how much assistance the individual requires to complete the task rather than how frequently they can complete a task independently.

2. *Identification of Who Completes the Assessment*

   The process relies on informants to complete the assessment; there is no provision for the person to take part in and provide information in its completion. It is vitally important that the person be involved in providing input to the assessment that will result in the level of funding they may use to purchase services. There is also no criteria set to determine who may be selected as an informant that completes the assessment. As applicable, day service and residential staff working with a person are interviewed by a DDD employee on all questions on the assessment. It has been stated that staff interviewed must "know the person well", but there is no method of determining that a staff member meets that criteria. Additionally, when a person is new to services and lacks a family member or other informant who knows them well, there is no standard or expectation to validate the assessment after more information is known about the person's abilities and needs.

3. *Inter-Rater Discrepancies in Assessment Ratings*

   When two or more informants vary in their assessment of the person's ability, the process to resolve discrepancies is not clear. The ICAP manual clearly states that when there is a discrepancy in ratings the lowest score given is applied. However, in a review of ICAPs that have been disputed, this requirement is not applied. In fact, Nebraska's training agenda and testimony in hearings indicate that examiners use additional information when determining their final rating. This information has not been formally weighted as to the impact on the final determination, nor has it been accounted for in the ICAP examiner's manual. This practice calls into question the objectivity of the assessment.

4. *Lack of Established Process to Review Results*

   Individuals and guardians are not able to review the completed ICAP without formally requesting a copy. No other respondent, such as provider staff, may review the results. This assessment can and should be used as any assessment to identify areas in which a person may need or desire supports. The results should not be unknown to those who contributed to its completion if the person agrees that it may be shared.

5. *Lack of Due Process in Disputing the Accuracy of Assessment Findings*

   There is no informal or formal method to resolve concerns when assessment information is believed by any party to be inaccurate. At present, the final funding amount can be appealed using the DDD's Informal Dispute Resolution (IDR) process or the appeals process for Administrative Hearings under NAC Title 207. However, when questions arise about the accuracy of the ICAP

responses there is no method to resolve those concerns and no information is provided about how the specific assessment results relate to the funding can be disputed.

6. *Lack of Provision to Address Changes in Need*

   There is no published standard or provision to allow for a new ICAP to be completed due to changes in a person's needs.

Implementation of Exception Funding That Circumvents OAP

The DDD has developed and implemented methods of funding supports and services that are outside of the OAP, as follows:

1. *Medical Risk and Behavioral Risk Services Funding*

   The DDD has set rates for "Risk Services" that require prior approval by the Department. There are two types of risk services which the Division has established daily payment rates: Medical Risk and Behavioral Risk[11].

   Neither the definitions nor the criteria one must meet to be eligible for this funding appear in regulation. There are no regulations that govern the provision of these services and there are no published standards that must be met to receive payment to provide them. The rates and service codes[12] are found in Appendix B of this report.

   Both types of risk services are funded at a daily rate regardless of the individual's ICAP score or correlated funding level— outside of the OAP and without a described process that must be followed to receive such funding. The Division originally created these service types/funding authorizations for people with needs that providers could not meet with OAP funding. Providers, rather than individuals and their guardians, request risk service funding. Equitable access to such funding is not afforded as individuals and their guardians are not informed that they may request risk service funding. Funding that is authorized is not based on consistently applied assessments and there is no due process to appeal when such funding is denied.

2. *Exception Funding*

   A second funding exception to the OAP-generated funding amounts for individuals is titled "Exception to the Individual Budget Amount (IBA)". In this

[11] The definitions of Behavioral Risk and Medical Risk services can be found in the DDD 2015 Draft Waiver at: http://dhhs.ne.gov/developmental_disabilities/Documents/DDACDraftRenewalApplication7.15.15.pdf. See pages 71-73 for Behavioral Risk, pages 92-95 for Medical Risk, and pages 138-143 for risk mitigation assurances.

[12] Note: the Behavioral Risk service is incorrectly titled "Behavioral Health Services". This appears to be a typographical error.

case, the Department has published a process to access the funding, which is commonly called "exception funding" among providers and team members. As described in the flowchart in Appendix C, and documents in Appendix D and Appendix E, an exception funding request is submitted after a person's interdisciplinary team identifies their needs that cannot be met with the person's current funding authorization. The community service provider completes the "Request for Exception to the IBA" form and submits it to a dedicated e-mail address for such requests, along with copies to the service coordinator and his or her supervisor.

Designated DDD staff review the document. If all approve, funding is authorized in the electronic billing system. If the request is denied, ultimately by the Administrator of Resources, the service provider, Service Coordinator, and Service Coordination Supervisor are notified. A revised request may be submitted and the process of review is repeated. Individuals and their guardians are not notified of the decision and there is no notification of the due process right to appeal the denial of exception funding.

Other Effects of Funding on Inclusion

The OAP uses the ICAP to calculate a person's funding. The score equates to a level from 1 to 11, which designates an hourly or daily rate for services. The types of services funded and related restrictions affect inclusion on individual and systems levels.

1. *Restrictions on Where Services are Provided*

   Some service categories require that services (habilitation) be provided in a particular setting. For example, residential supports are provided in a "group home", "in-home", "companion-home", or in an "extended family home." The setting in part dictates the hourly and daily rates that will be paid to support a person. These rates include only the cost of service provision. Room and board is paid by the person separate from the habilitation rate. Dictating the setting in which supports are provided affects inclusion— a group home is a segregated and isolating setting where only people with disabilities may live.

2. *Restrictions/Limits on Services That can be Provided in a Given Day*

   Funding rules do not allow a provider to bill for more than one type of service for a person on a given day. This means that a person requiring supports on a job for part of the day cannot be funded for any other service for the remainder of the day. The person must be without supports or the provider must provide supports without being funded to do so. There is a disincentive to provide supports for employment when such supports are for only part of a day. While full-time employment is generally the goal, it is more common for people to seek part-time

employment at least initially. This funding rule is a deterrent to seek employment when supports are provided for only part of a day.

3. *Impact of The ICAP Score on an Individual's Ability to Access the Community*

The ICAP determines a service score that ranges from level 1 (score of 1 to19—total personal care and intense supervision) to a level 11 (score of 90 or over—infrequent or no assistance for daily living.) This score is translated into a service level that correlates to staff-to-individuals served ratios and an hourly funding amount for each level. These hourly rates are determined by the number of individuals for which a provider will need to bill to provide a single staff. For example, at a service level of 3 the rate is set to reimburse one staff for providing supports to two individuals. Each individual is then assigned an annual individual budget that is derived from a complex formula recommended under a contract with Navigant following a lengthy study of the cost of providing specific waiver services in Nebraska. Individuals can then use this budget to purchase supports. The budgeted funds cannot be used to purchase supports at a lower service level (staffing ratio) than that determined by the ICAP score. For example, an individual with a service level of 5 (a 1:3 ratio) cannot purchase services at a level 1 rate in order to access the community with support by a single staff. The individual may only purchase services that would require him or her to access the community with a staff and 2 additional individuals. This requirement severely impacts a provider's ability to provide supports that are individualized and ensure community inclusion. Table 3 illustrates other scenarios for staff ratios based on the person's service level score.

Table 3: Service Levels and Staff Ratios

Service Level	Staff Ratio
1	1:1
2	1:1.5
3	1:2
4	1:2.5
5	1:3
6	1:3.5
7	1:4
8	1:5
9	1:6
10	1:7
11	1:8

Effects of Regulations on Inclusion of Individuals with Developmental Disabilities

The workgroup identified regulations that contribute to segregation and adversely affect inclusion. The primary regulations governing community-based services are Title 404 of the Nebraska Administrative Code (NAC). The workgroup also reviewed Title 175, Chapter 3, "Regulations and Standards Governing Centers for the Developmentally Disabled".

Nebraska Regulations Title 404 Review

DD Services Funded by Medicaid Waivers

By using Medicaid waivers, states are able to capture Federal Fund Participation (FFP) to match state dollars. States establish a number of waiver "slots" in the waiver application. A "slot," effectively, is a person. States must identify how many people they will serve in each year of the waiver— generally a five-year period. By committing to serve "X" number of people given "X" number of slots, the State must ensure that state matching dollars are available. Title 404 NAC 3-003.02 "Determination of Eligibility for HCB Waiver Services" states that "The individual is eligible if s/he meets eligibility requirements initially and on an ongoing basis. This determination is made annually by the Department. An individual who is eligible for waiver services will receive services if a slot and funds are available." A state cannot allow slots to be unallocated because of a lack of state matching funds. DDD does not publish slot utilization information to show that all slots are always assigned to a person.

Core Requirements for Specialized Providers of Services

This chapter includes certification standards service providers must meet. Regulations noted to interfere with community inclusion and individual choice include:

Nebraska regulation 404 NAC 4-003.05 requires a prospective provider to "consider the safety of all individuals in the decision to accept new individuals to service or the location for the services." There is currently no provision for people to choose with whom they will live. Exercising choice is a basic element of community inclusion.

Nebraska regulation 404 NAC 4-004.04A, B, and C, "Required Training" states that providers are required to train staff in "Individual rights, in accordance with state and federal laws." The DDD does not currently review each provider's curricula to ensure that it includes this requirement. Each provider is responsible for identifying applicable laws and incorporating them into staff training. Documents interpreting the HCBS Final Rule convey expectations that people have rights to choose where and with whom to live and work, privacy assurances (including keys to the home/bedrooms), as well as access to food and personal resources, including money. In practice, providers vary greatly in their application of state and federal laws related to individual rights. Greater

understanding and education about rights will support inclusion as people and staff supporting them recognize that inclusion itself is an individual right.

1. *Individual Support Options and Provider-Operated/Controlled Service Option*

   Title 404 NAC Chapter 5 governs services provided under the Individual Support Options (ISO) for adults with developmental disabilities. The services provided under these regulations can be continuous or intermittent and can cover 24 hours per day. Regulations in Title 404 NAC 5-002.01 state that "there must be flexibility of services that change, as the person changes, without the individual having to move elsewhere for services."

   Title 404 NAC Chapter 6 governs services under the Provider Operated/Controlled Community Based Residential and Day Service Option. Under this option, services are provided in settings that are controlled or operated by the provider, regardless of who owns or leases the property. A setting under this option must "have no more than three individuals with developmental disabilities residing in the setting; be operated as a single setting and demonstrate that each residence operates independently; and be staffed when the residence offers continuous services."

   There is no provision in regulations governing provider-controlled/operated settings to require flexibility of services that change as the person changes without the individual having to move elsewhere for services. This disparity affects inclusion. For additional comparisons, see Table 4.

   An analysis of these requirements reveals both subtle and drastic differences for the provision of services specific to the type of setting in which they are delivered. These differences may very well affect people's lives and the need to make such distinctions is not apparent.

   The ISO calls for services to be person-centered. There is no such language in the Provider-Controlled Option. The ISO speaks of "freedom, a meaningful life, participation in the community, living as a member of the larger community, and the provision of well-planned and proactive opportunities to determine the type and amount of support desired." The Provider-Controlled Option speaks to more foundational expectations— freedom from abuse and neglect, daily opportunities to make choices and participate in decision making, and people experience being a part of the community.

   It is unclear why these distinctions are necessary. It is clear that distinguishing between two types of service options with exclusive provisions for services based on the characteristics of the setting in which they are provided sends a message of differential expectations about inclusion.

Table 4: Comparisons between Individual and Provider-Controlled/Operated Options

Individual Support Option	Provider-Controlled/Operated Option
Person-centered	Individuals are free from abuse, neglect, mistreatment, and exploitation
Demonstrate the individual is in charge of his/her services and supports	Health, safety, and well-being of the individual is a priority
Promote the freedom for an individual to live a meaningful life and participate as a member of the community as any other citizen	Individuals are treated with consideration, respect, and dignity
Promote the individual's rights and autonomy	Individuals' preferences, interests, and goals are honored
Promote the use of generic services, natural supports, and options	Individuals have daily opportunities to make choices and participate in decision making
Assist the individual in acquiring, retaining, and improving the skills and competence necessary to live successfully in his/her residence and as a member of the larger community	Activities are meaningful and functional for each individual
Promote well-planned and proactive opportunities for the individual and his/her family to determine the type and amount of support desired with meaningful direction from the individual, the individual's family or guardian (where appropriate) and the proposed or current provider (as appropriate and desired)	Services are directed towards maximizing the growth and development of each individual for maximum community participation and citizenship
	Individuals live in a manner that is most inclusive
	Individuals experience being part of the community
	Individuals are able to express their wishes, desires, and needs

2. *Community Supports Program (CSP)*

Title 404 Chapter 9 makes provisions to "offer alternatives to the traditional model of services available through the DDD." This is Nebraska's offering of "self-directed" services. Under the program, people and/or their families select their own support providers who are screened and contract with the department directly. The amount of hourly payment to the contractor is set by the DDD. This service can be authorized alone or in conjunction with specialized supports from traditional service providers. Services and supports offered under the CSP include non-staff and environmental supports, Personal Emergency Response System (PERS), Assistive Technology and Supports, and Home and Vehicle modifications. Additionally, Respite, Community Living and/or Day Supports may be selected.

Hourly caps on the contractor's payment set by the Department have not been reviewed to determine whether they affect the person's ability to use their Individual Budget Amount (and how) and whether such caps affect use of or access to the program. Quality assurance is measured by participant experience.

Licensing Standards

Regulations in Title 175 NAC Chapter 3 comprise licensing standards for "Centers for the Developmentally Disabled" (CDD). These centers are defined as "any residential facility, place, or building, not licensed as a hospital, which is used to provide accommodation, board, training, advice, counseling, diagnosis, treatment, care, including medical care when appropriate, or services primarily or exclusively to four (4) or more persons residing in the facility who are developmentally disabled, which term shall include those persons suffering from mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions which require care similar to the care required for persons suffering from such aforementioned conditions. The term, 'Center for the Developmentally Disabled,' shall include a group residence." Other than a change to increase licensing fees in 2004, the regulations have remained the same since 1984.

There are numerous regulations and standards in this chapter that call into question the nature of the CDD as an HCBS setting in which waiver services may be funded/provided. A few notable standards include:

- Physical plant requirements such as "dining and recreation square footage requirements for each resident", the provision of "a room for the house manager or house parents", "artificial lighting specifications with minimum foot candles or lumen per square foot rating at an elevation of 30 inches above the floor", and "automatic fire alarm systems"

- Staffing standards bear no relevance to the current funding methodology and individualized funding expectations, i.e., staff-to-individual ratios are dictated based on time of day— with required ratios ranging from 1:4 to 1:10 depending on the time of day and the characteristics of the people supported

- Rights of residents include provisions for restraints that are no longer allowed under Title 404 regulations

These standards can be seen as a formula for the creation of institutional settings that ultimately affect the inclusion of people in community life.

System Constructs

The workgroup identified a number of existing DDD systems that could be strengthened to monitor and provide support for increased community inclusion.

Service Coordination

Workgroup members reported a void in advocacy that has occurred because of changes in service coordinators' roles. Some of those changes, including the removal of responsibility for accepting referrals and determining eligibility, have already been discussed. The service coordinator remains responsible for monitoring the individual's services and reporting and ensuring resolution of concerns affecting quality of life—including inclusion in community life. The workgroup agreed that a service coordinator's role to promote community inclusion could be strengthened by:

1. Addressing high turnover rate of service coordinators
2. Limiting the ratio of service coordinator to people served (caseload size)
3. Ensuring that the length and depth of contact time is sufficient to ensure that service coordinators can develop a relationship with the person
4. Enhancing service coordinators' skills in person-centered planning process
5. Considering how to remove perceived conflict of interest when service coordinators are employees of the agency responsible for level of care and funding decisions
6. Permitting service coordinators to advocate for individuals, even when their opinion differs from DDD administrative decisions, so that the person and the system as a whole can benefit from such advocacy

Quality Review Teams

In accordance with the Developmental Disability Services Act, the DDD must provide for the establishment of at least one Quality Review Team for each developmental disability service area designated by the Department. The teams are responsible for conducting on-site visits of people receiving residential services, assessing quality of life, and making recommendations to improve quality of services. When assessing quality of life, the Quality Review Teams consider the extent to which people:

- Are able to exercise choice and control regarding the type and provider of services they receive and the daily activities in which they are engaged
- Are treated with respect and dignity by service providers
- Have access to necessary services, equipment, and support

- Are able to participate in activities and events that maximize community integration and inclusion

Quality Review Teams perform in an advisory capacity to the DDD. Statute prohibits any employee of a governmental agency from serving on a Quality Review Team. For a number of years Quality Review Teams were organized and overseen under contracts with outside entities— an advocacy agency and a private consultant. The DDD recently opted to administer Quality Review Teams itself.

Each Quality Review Team is required to provide a quarterly and annual report of its findings. At the time this report was written, the DDD had not been fielding Quality Review Teams and no reports of findings were available.

The HCBS Final Rule calls for an assessment of all settings in which community-based waiver services are provided. There are hundreds of residential and day service settings across the state. Self-assessments of settings where four or more people reside have been completed by service providers. The DDD is assessing day service settings itself.

A more objective means of assessing settings than those currently being conducted would be to use Quality Review Teams. Conflicts of interest with self-assessment or with the DDD completing assessments would be removed.

DDD Transition Plan

The DDD has submitted a transition plan to implement the provisions of the HCBS Final Rule discussed earlier. At the time this report was written, CMS had not yet reviewed and approved Nebraska's plan[13]. With the long delay in getting approval from CMS, DDD has begun implementation of its plan. Self-assessment by providers has begun and day service settings are being reviewed by the DDD. Implementation thus far has included:

1. *Provider Self-Assessment of Residential Settings*

   In February 2015, the DDD requested that all providers complete a self-assessment of residential settings pursuant to the transition plan. A copy of the assessment is found in Appendix G.

   The assessment does not capture the intent of the HCBS rule. Results are unlikely to yield useful information about people's experiences in terms of community inclusion, or how settings affect inclusion adversely or in positive ways.

[13] "Transition Plan to Implement the Settings Requirement for Home and Community-Based Services Adopted by CMS on March 17, 2014 for Nebraska's Home and Community-Based Waivers", December 1, 2014. Available at http://dhhs.ne.gov/Documents/Transition-Plan-Final.pdf

Provider staff completing the assessment were not advised of its purpose. The DDD sent the Self-Assessment to providers on January 16, 2015, with a submission deadline of February 5, 2015. In the introductory information, the DDD stated that it would be providing a document in early January, titled "Protection of Community Characteristics by Existing Nebraska Statutes and Regulations Governing Developmental Disability Services", and would coordinate a webinar in early February to review and discuss any questions or concerns with providers. No such document was disseminated and no webinar was held by the DDD.

The DDD communication states that "most of the characteristics identified by CMS were already incorporated into the Nebraska Administrative Code with the Title 404 revisions to Community Based Services Regulation for Individuals with Developmental Disabilities in 2011". The regulations were promulgated in 2011— three years before the CMS Final Rule was adopted and before interpretive standards and exploratory questions for guidance were made public.

The DDD determined that the size of the setting dictated whether or not a self-assessment was required. Only settings with four or more residents were assessed, although setting size is not the sole criterion for determining whether a setting meets the standard as an HCBS setting under the Final Rule.

There is no identified plan to complete integrity checks of provider's responses to assessments. Without education on heightened expectations it cannot be said that provider staff used common standards in completing the assessments.

Questions posed do not measure the inclusive, integrated nature of the setting and supports currently provided. For example, there are no questions directly related to what is occurring— such as whether the person is employed or active in the community outside the residential setting. Another question, "Are the individuals living at this address experiencing restrictions to accessing the community due to the larger nature of the services setting?" measures only whether or not the number of people living in the setting has an adverse effect on inclusion rather than other factors that affect inclusion such as staffing ratios or personal characteristics of the people living together.

Literal interpretation of the rule and exploratory questions may set a low bar for expectations of what constitutes inclusion. Tom Pomeranz, a national expert in the field of developmental disabilities, recently addressed a group of professionals working for providers of developmental disabilities services in the Midwest. Dr. Pomeranz suggested that the CMS exploratory questions pertaining to "roommates" should be interpreted to mean "housemates" in that people should choose who they live with— not who they share a room with. The DDD provider self-assessment asks, "Are individuals allowed to change roommates?" Most service providers have worked to identify residences that afford people the option of having their own bedrooms. The question posed

implies that people should have choice of roommates, rather than choice of people with whom they will share their home.

2. *Self-Advocate/Family Surveys*

   In the transition plan the DDD states it will revise its survey "to provide information regarding the community nature of residential settings." No such information was provided with surveys when sent to individuals, families, and guardians. Without education about the new standards, respondents could not answer questions using the proper context for response.

3. *Reviews of Non-Residential Settings*

   The transition plan states that the DDD will conduct site reviews and compliance surveys, use participant experience surveys and self-advocate/family surveys, review service coordination monitoring tools and provider self-assessments, and hold stakeholder meetings to gain information to assess day service settings. In January 2015, the DDD requested from providers a list of day service settings operated, including the address and the "capacity" of the setting. DDD has reportedly visited a number of day service settings. There are no published measures against which the settings will be assessed. Questions posed in the CMS exploratory questions for non-residential settings include questions about the setting's physical plant, such as barriers preventing entrance to areas in the setting. Other questions ask about whether people are assigned to be with a particular group or can opt to choose to take part in activities elsewhere, both in and outside of the setting. As with residential settings, without identifying the expectations, it is not possible to measure whether settings meet them.

Recommendations to Support Increased Inclusion: Systems Change, Development, and Innovation

The workgroup made recommendations to address barriers to inclusion in the areas covered by this report and identified innovative practices that should also be implemented.

Recommendations Related to Eligibility for DD Services

Eligibility Criteria

- Remove regulatory reference to primary diagnosis
- Collect statistical data on reasons people are found ineligible
- Publish aggregated data on those found eligible and ineligible as well as the reasons for such determination
- Develop expertise in the behavioral health and developmental disabilities service systems to meet the needs of people with a dual diagnosis

Eligibility Determination Instrument

- Review differences between the SIB-R and EDI-A or EDI-C in measuring substantial functional limitations
- Analyze possible effects of use of the SIB-R on eligibility findings
- Research eligibility tools used by other states
- Ensure that assessments measure all seven substantial functional limitations outlined in statute

Eligibility Determination Process

- Ensure that accurate data on eligibility/ineligibility for services and funding is maintained
- Follow regulation to have Service Coordination accept referrals and provide support throughout the eligibility determination process
- Publish up-to-date information about use of waiver slots and numbers of people receiving supports funded by state general funds alone

Recommendations Related to DD Funding

Following are recommendations to address findings of the workgroup. While it is anticipated that the DDD would take the lead in making systems changes, input of all stakeholders should be sought to develop a collaborative approach to promoting inclusion.

1. *Develop Protocols for the OAP Process*

   - Provisions for people to be involved in the completion of the assessment that will determine their funding
   - Standardized and required training for anyone who will act as an informant
   - Methods to address inter-rater discrepancies
   - Provisions to allow review of the completed tool by those for whom the individual signs a release of information
   - Information about how measures on the tool are weighted to affect the overall score equated to funding
   - Due process rights for individuals to resolve concerns with assessment results
   - Instructions for completing a new assessment when the person experiences a significant change in need and on a regularly scheduled basis/at regular intervals

2. *Funding Exceptions to OAP*

   - Publish information in regulations about how to apply for exception funding and the supports to be provided with such funding
   - Consider use of pilot projects, as outlined in statute, to develop high quality supports for people whose needs cannot be met within OAP
   - Determine supports and services that cannot be provided with the person's OAP-determined funding and incorporate weighted measures into the funding formula to remove exceptions over time
   - Ensure that individuals and their guardians are afforded due process in the denial of any exception funding

3. *Other Funding Recommendations*

- Remove artificial, setting-specific constraints on funding; describing the supports to be provided rather than the setting in which they may be provided
- Remove funding constraints that may unintentionally inhibit inclusion— such as the inability to fund two types of day/employment/community inclusion services in a day
- Determine how people may use their Individual Budget Amount to purchase supports that may be provided at a staffing ratio that is lower than the OAP may dictate

Recommendations for Regulation Revision

- Identify regulations that conflict with or do not support the expectation and outcome that all services and supports be provided in an inclusive manner
- Consider repealing regulations for licensing of Centers for the Developmentally Disabled
- Develop Nebraska's interpretative standards of the exploratory questions about HCBS services and settings and incorporate such standards into regulation
- Monitor the implementation of changes required under the HCBS Final Rule in community-based services
- Set benchmarks for and measure outcomes correlated to inclusion, such as employment, relationships with unpaid community members, and involvement in community organizations and activities
- Measure the use of the Individual Support Option in enhancing community inclusion and determine methods to expand access to and use of this option over supports that are provider-controlled/operated
- Study the Community Supports Program to determine its effectiveness in supporting community inclusion, how self-directed services could be made available to more people, how service coordination oversight of such supports should be provided, and how community support providers should receive training to provide supports
- Provide training and education on new regulations and interpretive standards to individuals, providers, and other stakeholders

Recommendations for Existing DDD Constructs

1. *Service Coordination*

    - Seek an independent assessment of service coordination to assess service coordinators' roles, turnover rates, job expectations, policies and procedures, and an overall assessment of service coordination's role in promoting inclusion

    - Present the report publicly to solicit feedback and recommended systems changes

2. *Quality Review Teams*

    - Use the Quality Review Teams as outlined in statute to conduct an independent assessment to determine the extent to which people experience community inclusion in everyday life

    - Revise statutes to enable Quality Review Teams to assess the provision of day habilitation settings and services

3. *Transition Plan*

    - The DDD must set standards and then make efforts to educate people with developmental disabilities, their guardians, providers, and other stakeholders on requirements of the HCBS Final Rule

    - Reassessment of settings and practices should be completed after expectations are clearly understood

    - Quality Review Teams should be utilized to assess and monitor inclusion and inclusive practices, some of which are specifically called for in the HCBS Final Rule

4. *Development and Innovation*

    - An Initiative To Support The Employment Of People With Developmental Disabilities

        There is no question that having a job is one of the best ways to be a part of one's community. At work we develop skills and competencies, establish relationships and connections with others, and earn money that enables us to take part in recreational and other community activities. So that people with developmental disabilities may be afforded these experiences, the Workgroup recommends that Employment First be established in Nebraska.

Employment First is a framework for systems change that is based on the premise that all citizens, including people with disabilities, are capable of full participation in integrated employment and community life. Nebraska is one of only a few states that do not have an Employment First initiative. Nebraska's Association of People Supporting Employment First (APSE) has been calling for Employment First legislation for some time.

At least two studies have been published by Protection and Advocacy agencies assessing implementation of Employment First. Nebraska should look to these experiences to plan for success and avoid pitfalls experienced elsewhere. The HCBS Final Rule could play a significant role in boosting an Employment First initiative.

It its study, Washington's Protection and Advocacy agency identified that prevocational services isolated people and so could not continue to be funded under the new HCBS rule. Funding and service authorizations were noted to be barriers to supporting people to advance in work or careers. Washington's Protection and Advocacy agency recommended swifter and more definitive action, including using the HCBS transition plan to phase out prevocational services and improving provider accountability through performance-based contracting tied to person-centered outcomes.

Iowa's Protection and Advocacy agency found similar concerns with segregated work facilities and stated their perception that such "facilities did little to actively build skills, move individuals forward, or shake the illusion of security such institutions create."[14] Iowa's Protection and Advocacy agency recommended various actions be taken by the Department of Human Services, Iowa Medicaid Enterprises, Vocational Rehabilitation, providers, schools, and individuals with disabilities and their families. Such recommendations included developing a 10-year Olmstead plan, improving rate setting for employment services, and collecting data on outcomes.

The workgroup strongly recommends the passage of Employment First legislation and created an initial draft bill to support this intent, found in Appendix H of this report.

The Work Innovation and Opportunity Act (WIOA) includes provisions specific to employment for people with disabilities that should be incorporated into Nebraska's employment initiatives. APSE supports

[14] Disability Rights Iowa, December 2014, "Stalled on the Road to Olmstead Compliance", available at http://disabilityrightsiowa.org/wp-content/uploads/2015/03/StalledFinalReport-12-13-14.pdf

the federal legislation, passed in 2014, because it includes provisions to divert transition-age youth "from a path of segregated, sub-minimum wage services to competitive, integrated employment."[15] The Act calls for use of Vocational Rehabilitation (VR) funds for pre-employment transition services for any youth eligible for (or potentially eligible for) VR services. The National Center on Leadership for the Employment and Economic Advancement of People with Disabilities (LEAD) recently sponsored a webinar[16] to provide guidance on implementation of WIOA. The presentation encouraged states to submit for approval a "Combined State Plan" that engages stakeholders, including employers, the workforce development system, education, VR, the mental health service delivery system, intellectual and developmental disability service delivery system, adult education and literacy, the Social Security Ticket to Work program, and nonprofit disability organizations.

The workgroup recommends that the DDD actively participate in Nebraska's implementation of WIOA, collaborating with VR, the Department of Labor, and community partners across the state to ensure that provisions of the law are enacted.

Data on outcomes achieved through these efforts must be maintained and made public to ensure accountability and direct future planning. Youth exiting the public schools with jobs that were secured and sustained with supports funded by WIOA should be able to expect that DDD funding, if needed, will be able to be used for continued job support. Because WIOA prohibits payment of subminimum wage to people with significant disabilities who are under the age of 24, the DDD and its providers will need to be poised and ready to ensure that DDD can provide funding for needed supports when youth leave the public schools. In addition, the DDD could benefit from the learning and experience of VR and schools in their endeavors to link youth with jobs during the period of transition from school to adult life. Together, VR and the DDD should develop state experts in customized employment to enhance employment options for individuals with disabilities.

- *Develop Opportunities for Pilot Projects as Discussed in the Developmental Disability Services Act*

  The DDD is permitted by statute to fund pilot projects of high quality, cost-effective services provided by specialized programs. The workgroup recommends the use of this vehicle to call for proposals for creative and innovative methods of promoting inclusion. Service providers could try new methods to promote inclusion (particularly in the area of employment) that might not be possible under existing funding

[15] Association of People Supporting Employment First available at http://www.apse.org/resources
[16] Available at http://www.leadcenter.org

and service authorization constraints. Other options could develop methods of promoting community inclusion for specific groups of people who may not be well-served in the traditional habilitation model of supports. For example, supports could be offered under a pilot project for community inclusion of a person with autism who has sensory integration or social interaction concerns or for a person with cerebral palsy who may just need environmental supports. Traditional habilitative interventions may not even be necessary.

- *Performance Measurement and Data Analysis*

  The workgroup expressed concern with the lack of reliable data for everything ranging from eligibility determinations to data on employment and community integrated experiences of people supported by the system. Nebraska is one of only a handful of states that do not participate in the National Core Indicators (NCI) project. While Nebraska participated in the project in its infancy by collecting data that helped to establish the validity and reliability of the project, its connection and commitment to the project waned before it was fully implemented. Data collection and analysis is greatly needed in order to guide DDD decision making. Advocacy groups need data to identify systems-level issues that require revision and lawmakers need data to understand how their decisions and leadership make a difference for people supported by tax dollars. It is recommended that action be taken to ensure that data is collected and made publicly available.

While the Inclusion Coalition did not specifically discuss this issue, there are at least two subpopulations of people with developmental disabilities who fall into the void when it comes to advocacy and oversight assurances for community inclusion.

The first is the population of children with developmental disabilities who are state wards and are not funded by the developmental disabilities system. Many of these children live in out-of-home placements, funded by Child Welfare dollars, with no real oversight of their services except that which may be provided by a DD service provider. The children often have very high needs (which is why, sometimes, they are not living in their family home or in a foster home) and are, essentially, being raised by shift staff. This group was the subject of a State Ward Permanency Pilot studied by The Foster Care Review Office (FCRO) under LB905 (2014). The report reveals numerous concerns and “pressing systemic issues” found by the FCRO. Youth falling into this category may very well be some of the most isolated people with developmental disabilities in our state, and attention is needed to ensure that there is proper monitoring and oversight to provide not only necessary protections but also the assurance of community inclusion.

A second group about which there was some discussion among the workgroup is the population of people with developmental disabilities who have been admitted to nursing facilities (NF). A comment made by one workgroup member who regularly visits a Lincoln NF highlights the need to look at data on this group. He said that he was surprised by the large number of people with developmental disabilities who reside at the facility. While it is true that people with nursing care needs might be appropriately living at an NF, this anecdotal report suggests that review of data related to those with developmental disabilities living in the state should be undertaken.

A Preadmission Screening and Resident Review (PASRR) process is required when people with developmental disabilities (as well as those with mental illness) are to be admitted to a NF. Currently, the state of Nebraska contracts with Ascend Management Innovations to complete screening and evaluations of people being admitted to NFs.

A Senate Health, Education, Labor, and Pensions (HELP) Committee report states that between 2008 and 2012 there was an 8.77% increase in the number of people under 65 living in NFs in Nebraska[17]. At the time, Nebraska was eligible for, and has since applied for, the Balancing Incentive Payment program (BIP) which allows a 2% enhancement to the Federal Medical Assistance Percentage (FMAP) for making enhancements to its Medicaid program. Nebraska uses Money Follows the Person (MFP) grant funds to pay costs for transition from institutional settings such as NFs to the community. It is recommended that data reports be sought and reviewed to determine whether the state's efforts to provide home and community-based services for people who wish to move from institutions are utilized and effective. Following such an analysis, a plan to address any identified continued segregation and isolation should be developed with state leadership and advocacy organizations.

The workgroup came together just as initiatives related to the nature of home and community-based services, settings, and employment for people with developmental disabilities gained heightened attention on a national level. The work of the people who served on the workgroup commissioned by Disability Rights Nebraska was broad and extensive. The workgroup focused on discussing broader systems-level issues and gave attention to minute details in specific areas such as eligibility and funding. This report has provided a summary of the workgroup's discussion, ideas, and recommendations for addressing barriers to inclusion for all people with developmental disabilities in our state. Whether change is achieved by collaboration, legislative mandate, or other means, it is necessary. The efforts of many partners will be required to bring about change so that people with disabilities truly can enjoy a life of inclusion—"the good life"— in Nebraska's communities.

[17] Senate Health, Education, Labor, and Pensions Committee, 2013, "Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act", available at http://www.help.senate.gov/newsroom/press/release/?id=909ecec1-4c87-4891-8314-7b35e5316a35

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LIST OF APPENDICES

A. Developmental Disability Eligibility Presentation

B. Developmental Disability Specialized Service Rate

C. Individual Budget Amount Exception Flowchart

D. Individual Budget Amount Exception Request Form

E. Individual Budget Amount Exception Request Instructions

F. Service Provider Guidance

G. Provider Self-Assessment Survey for Residential Settings

H. Possible Employment First Legislation

Appendix A: Developmental Disability Eligibility Presentation

Eligibility Determination for Adults and Children with Intellectual and Related Developmental Disabilities

Division of Developmental Disabilities

Department of Health & Human Services
DHHS
NEBRASKA

Division goals

- Maximize federal funding
  - Must apply for and accept federal Medicaid benefits
  - Benefits from other funding sources within department, State Department of Education, specifically including the Division of Rehabilitation Services and other agencies

Eligibility for Developmental Disabilities (DD) Services

- DD Services = voluntary
  - ≠ entitlement like educational services
- Division of Developmental Disabilities (DDD) determines eligibility following statutory definition of developmental disability (DDSA § 83-1201 to § 83-1226)

Eligibility (continued)

§ 83-1205. Developmental disability, defined

Handout:
What is an intellectual disability (ID)?
What is a developmental disability (DD)?
What is a developmental disability? (Nebraska State Law)

Applying for services

- Anyone can request application for eligibility determination
- Early determinations = best!
- Application
  - Via a referral http://www.dhhs.ne.gov/dip/ded/DDEligibility.htm
  - When making application for services through DHHS on AccessNebraska

Initial eligibility – important information

- Online AccessNebraska application
  - Online application – “ENTER in English”
    or “Ingrese en Espanol”
  - Select “Healthcare/Medicaid Application”
  - Respond to the following questions:
    - Does (applicant) have a physical disability or mental health condition that limits their ability to work, attend school or take care of their daily needs?
    - Does (applicant) need help with activities of daily living (like bathing, dressing and using the bathroom) or live in a medical facility or nursing home?

Application packet

Application packet sent to individual or guardian includes:

- Application and cover letter listing specific required documents with checklist for the applicant's use
- Attestation of US citizenship
- Notice of Rights and Obligations
- Consent to Release Information forms with example
- Definition of developmental disabilities

DD Eligibility tracking

- Timelines incorporated into the process
  - Up to 90 days for applicant to send information
  - 45 day – no info letter or 45 day – incomplete info letter
  - 90 day - no info letter – file goes into inactive status

What DDD does to determine eligibility

- When required information received, or after 90 days, Disability Services Specialist (DSS) assigned
- DSS has up to 30 days to make initial conclusion
- Up to 30 additional days when Division psychologist is consulted or Scales of Independent Behavior – Revised (SIB-R) is administered
  - SIB-R may be administered to assess adaptive skills and determine if substantial functional limitations exist

DD eligibility decision: “Not eligible”

- Notice of Decision (NOD) sent to individual or their guardian
- Due process rights and Request for Informal Dispute Resolution (IDR) and/or Appeal hearing attached to NOD
- 90 days to request an IDR and/or appeal hearing
  - Same DSS represents DDD at IDR and presents information to CB Administrator, Tricia Mason for Tricia’s affirmation or reversal of original decision
  - DD attorney represents DDD at appeal hearings
    - Hearing officer presents record to DDD Director, Jodi Fenner for affirmation or reversal of original decision

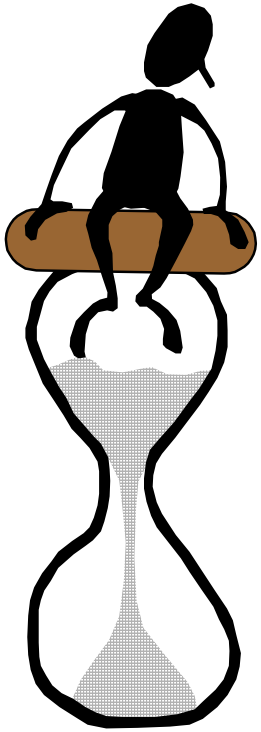
DD eligibility decision: “Eligible for DD services”

- Notice of Decision (NOD) sent to individual or guardian
- Option provided to work with a Service Coordinator (SC)
  - Ability to pay is considered

What happens next?

- Date of need for services is requested and service coordination is available
- If individual is over age 21 and has graduated from a high school on or after September 6, 1993, day services are automatically funded according to § 83-1216.
- Services not available until end of school year in which they turn 21.
  - Division cannot pay for (supplant) services that are available from the educational system.

What is the registry (aka the waiting list)?



- After determined eligible, select date of need = on the ‘registry’
- Receive services when appropriation received from the legislature
- ‘Priority’ funding (rare)

How is funding allocated?

- Once funding is offered and accepted, Inventory for Client and Agency Planning (ICAP) is administered
- Needs revealed in the ICAP translate into Individual Budgeted Amount (IBA)
- IBA = annual amount for participants to choose services that meet their goals and preferences

How do I choose services?

- Once IBA is determined, Service Coordinator (SC) holds individual/family meeting to learn hopes, dreams and needs
  - Discuss options available and craft sample budget for the year
  - Select providers
- Team meeting to develop the IPP (Individual Program Plan) or Individual Service Plan (ISP)

Focus on employment

- Focus on community integration, activities and job experiences in the community
- Provides graduates with more options to live and work in their community
- Funds more job training activities
- Allows for in-home job searching activities
- Allows for home-based businesses

Difference between specialized and non-specialized services

- Specialized services are provided by certified provider agencies
- Non-specialized services are supports provided by independent providers, people hired by the individual and their family – job coaches, companions, housekeepers who are neighbors, college students, friends, etc.

Helpful resource

- Ready Set Go!

  http://readysetgo.site.esu9.org/

Appendix B: Developmental Disability Specialized Service Rates and Service Codes

Appendix c DD Specialized Service Rates as of July 1, 2014

CONTINUOUS RESIDENTIAL	Service Code	Level 1 ICAP: 1-11		Level 2 ICAP: 12-22		Level 3 ICAP: 23-36		Level 4 ICAP: 37-49		Level 5 ICAP: 50-57		Level 6 ICAP: 58-64		Level 7 - 11 ICAP: 65 +	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
EFH Res Hab	4596	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Group Home Res Hab - Asleep Ovrnght	4566	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Group Home Res Hab - Awake Ovrnght*	4566	$ 25.22	$ 487.57	$ 19.74	$ 307.72	$ 16.99	$ 233.17	$ 15.35	$ 193.37	$ 14.25	$ 168.89	$ 13.47	$ 152.41	$ 12.88	$ 140.61
Group Home Res Hab - No Ovrnght**	4566	$ 25.22	$ 285.76	$ 19.74	$ 149.80	$ 16.99	$ 97.21	$ 15.35	$ 70.57	$ 14.25	$ 54.87	$ 13.47	$ 44.65	$ 12.88	$ 37.56
Companion Home Res Hab - Asleep Ovrnght	5617	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Companion Home Res Hab - Awake Ovrnght*	5617	$ 25.22	$ 487.57	$ 19.74	$ 307.72	$ 16.99	$ 233.17	$ 15.35	$ 193.37	$ 14.25	$ 168.89	$ 13.47	$ 152.41	$ 12.88	$ 140.61
Companion Home Res Hab - No Ovrnght**	5617	$ 25.22	$ 285.76	$ 19.74	$ 149.80	$ 16.99	$ 97.21	$ 15.35	$ 70.57	$ 14.25	$ 54.87	$ 13.47	$ 44.65	$ 12.88	$ 37.56
Retirement Residential Services	3225		$ 146.91		$ 77.02		$ 50.46		$ 37.21		$ 29.50		$ 24.54		$ 21.11

*AWAKE Overnight requires and approved exception

*No Overnight needs team approval and IPP documentation that the individual is safe with no overnight staff

CONTINUOUS DAY	Service Code	Level 1 ICAP: 1-11		Level 2 ICAP: 12-22		Level 3 ICAP: 23-36		Level 4 ICAP: 37-49		Level 5 ICAP: 50-57		Level 6 ICAP: 58-64	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
Adult Day Habilitation	7090	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Workstation	2566	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Children's Day Habilitation	2139	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Retirement Day	3225	$ 19.88	$ 73.45	$ 14.36	$ 38.51	$ 11.61	$ 25.23	$ 9.96	$ 18.60	$ 8.85	$ 14.75	$ 8.06	$ 12.27

		Level 7 ICAP: 65-69		Level 8 ICAP: 70-74		Level 9 ICAP: 75-80		Level 10 ICAP: 81-89		Level 11 ICAP: 90+	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
Adult Day Habilitation	7090	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Workstation	2566	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Children's Day Habilitation	2139	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Retirement Day	3225	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56

INTERMITTENT RES & DAY	Service Code	Level 1 - 11 ICAP: 1-90+
		Hourly
In-Home Res Hab	8891	$ 33.20
Companion Services Res Hab	5617	$ 33.20
Integrated Community Employment (ICE)	3227	$ 40.26
Vocational Planning	3728	$ 38.42

RISK SERVICES (require prior approval)	Service Code	Level 1 -11 ICAP: 1-90+
		Daily
Medical Risk Services	8539	$ 519.14
Behavioral Health Services	2541	$ 506.74

SPECIALIZED RESPITE	Service Code	Level 1 -11 ICAP: 1-90+	
		Hourly	Daily
Respite	6089	$ 16.54	$ 132.38

New Rate Methodology - Staff Hours for Assisted Services (Units - Navigant Study Ratios)

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Residential Units	347	231	174	139	116	99
Vocational Units	173	115	87	69	58	49

	Level 7	Level 8	Level 9	Level 10	Level 11	Behavior Risk
Residential Units	87	83	80	79	78	250
Vocational Units	43	35	29	25	22	90

Appendix C: Individual Budget Amount Exception Flowchart

Requests for Exception to the IBA: Flow Chart

After discussion with the team, provider completes exception request document and submits request to DHHS DD Exceptions at DHHS.DDExceptions@nebraska.gov with a copy to the SC and their supervisor.

Exception Request is retrieved from the exceptions email inbox

Exception request including required attached documents are reviewed by the Administrator of Resources, who may review the request with the Service Coordinator, SC supervisor, psychologist, nurse or others as needed.

If Yes

Administrator **approves** exception funding and sends an email with notes to the provider, Service Coordinator, SC supervisor, and Lelia Razey.

In Therap: Lelia Razey adds the exception amount to the IBA to create an applicable IBA. Lelia then emails the SC notifying them the exception has been added.

The Service Coordinator creates the service authorizations (SA) according to the exception approval. Once saved, the SAs appear as a DRAFT for the Supervisor.

The supervisor conducts a review of the SAs, entering approval/rejection notes to the SC in the review section. If information is incorrect or needs additional information, the SC edits and it is sent to the Supervisor again for approval/rejection.

The SAs including the exception funding are forwarded to Lelia Razey for final approval/rejection.

If rejected, the SC is notified and changes must be made to the authorization. If the authorization is approved, it is then forwarded to the provider agency.

If No

Administrator denies exception funding request and sends an email to the provider, Service Coordinator and SC supervisor. A revised request may be submitted.

Revised: 6/11/2014

Appendix D: Individual Budget Amount Exception Request Form

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

Request for Exception to the IBA

☐ **New** ☐ **Renewal** **When does the current exception expire?**

Agency:				
Submitted by:			**Date:**	
Individual Name:			**NFOCUS #:**	
Current Funding:	Day:	Res:	**Annual IPP Date:**	

Section 1.

Reason for exception request:

☐ **Enhanced Medical risk** ☐ **Awake overnight**
☐ **Enhanced Behavioral risk** ☐ **Temporary request (less than plan (IPP) year)**
How long?

For new requests, what support level are you requesting (please consult the rate matrix)?

Section 2.

Current living situation:

Description of behavioral and/or physical health or other concerns:

Strategies currently in place that are effective:

What has the team tried that has failed?

Staffing/supervision levels and explanation of staffing pattern:

What are your proposed changes to day and/or residential services?

How do you expect the proposed changes to meet their needs?

If approved, what change will be made to the service plan (person-entered strategies)?

Section 3.

Was a SNA submitted to request new ICAP?

☐ Yes ☐ No **If yes, date SNA submitted:** Outcome: ☐ Approved ☐ Denied

Has a Team Behavioral Consultation been completed?

☐ Yes ☐ No **If yes, please summarize plan and supports and attach results and recommendations:**

If no, does the team feel one needs to be completed?

☐ Yes ☐ No

Has there been a Risk Assessment completed?

☐ Yes ☐ No **If yes, please attach summary.**

Number of GERs is the past 90 days:

High: Medium: # of law violations: # of police contacts:

Summary of GERs:

Summary of target behaviors (if applicable):

Summary of medical risk (if applicable):

What programs, supports or safety plans are in place?

(Please attach appropriate plan with data for the last 90 days (i.e., nursing plan, health plan, safety plan, functional behavioral assessment, overnight plan, etc.), and other clinical documentation that supports the need.

Section 4.

Plan to decrease support:

Rationale to continue exception funding in spite of decreased behaviors:

Section 5.

Additional Information:

DDD Administrative Notes:

Decision:

☐ Approved ☐ Denied

_____

Signature of Administrative Designee *Date of Decision*

Appendix E: Individual Budget Amount Exception Request Instructions

Division of Developmental Disabilities

Instructions: Request for Exception to the IBA

☐ New ☐ Renewal	When does the current exception expire?
Select if this is a new request or a renewal	Enter the date when a current exception expired

Agency:	Enter the name of the provider making the request			
Submitted by:	Enter the name of the individual making request		**Date:**	Enter the date the form was completed
Individual Name:	Enter the name of the individual served		**NFOCUS #:**	Enter the individual's NFOCUS # (available on the Therap IDF)
Current Funding:	Day: Enter the designated day budget according to the level from the Rate Matrix	Res: Enter the designated residential budget according to the level from the Rate Matrix	**Annual IPP Date:**	Enter the date the last Annual IPP

Section 1.

Reason for exception request: Provide rationale for why the team feels there is an enhanced need that cannot be addressed by the individual's budget amount. Consider the person's current needs and determine if it is medical or behavioral in nature, or perhaps both. Select any of the corresponding boxes below that are relevant

☐ **Enhanced Medical risk**
☐ **Enhanced Behavioral risk**
☐ **Awake overnight**
☐ **Temporary request (less than plan (IPP) year)**

How long? Expected duration. Requests will not be considered for longer than the individual's IPP year.

For new requests, what support level are you requesting (please consult the rate matrix)?

To assist the division with determining the funding requested, please indicate a corresponding funding level according to the rate matrix. For individuals that have currently approve exceptions, the Division will translate that amount into a daily rate for 6-9 months (from July 1, 2014) and in some cases until the end of the IPP plan year (these will be administratively extended until that time, when the administrative exception expires then this form needs to be utilized to request any appropriate continuation).

Section 2.

Current living situation:

Where does the person live? Please include details about the environment including number of housemates and any information about what makes the home work or not work for the individual.

Description of behavioral and/or physical health or other concerns:

Include current diagnoses (both medical and mental health), identified risk behaviors, medical needs, and other concerns. Attach appropriate documents that are applicable to the concerns and needs.

Strategies currently in place that are effective?

While considering the diagnosis, document corresponding supports such as those that are found in a Functional Behavioral Assessment, Behavior Support Plan, Safety Plan, Nursing Care Plans, or other habilitative programs or activities that identify the need and the strategies. What informal supports and natural supports are in place? What informal or natural supports do you plan to increase so to alleviate the need for exception funding?

What has the team tried that has failed?

What has the team implemented that has not been successful? This section should also include the restrictions that are currently in place and justification, as restrictions should only be in place when other methods have been attempted and failed. Please include documentation for informal and natural supports that have been attempted but haven't worked as planned. Also describe how the individual has accessed other benefits for which they may qualify to the maximum extent possible (as applicable) but perhaps haven't met their needs.

Staffing/supervision levels and explanation of staffing pattern:

Include a description of staff supports in the residence and during day services. If requesting overnight awake, please submit the justification for the request, the data that has been collected to justify the requested staff levels (overnight logs, incident reports during the night, etc.) and a plan on how the person is to be supported during overnight hours.

What are your proposed changes to day and/or residential services?

This includes information regarding what changes will be made *for* the individual. What programs or activities will you add to the current plan? With additional funding, what will you be able to provide that you were not able to provide previously? How will supports be provided? If increased funding will be used to enhance staff supports to reduce or eliminate a restriction, this would be the place to include information on what that plan might be to meet that goal.

How do you expect the proposed changes to meet their needs?

What do you hope will be the outcome of planned implementation of changes? Given the plan that the provider will implement, which behavioral or medical concerns do you anticipate will decrease?

If approved, what change will be made to the service plan (person-entered strategies)?

What specific outcome statements, habilitation goals, activities and supports will address the need identified by the team? Please include both formal and informal supports.

Section 3.

Was a SNA submitted to request new ICAP? Questions to ask about whether an SNA might be more appropriate than exception funding. 1) Does the team believe that the individual's current budget amount determined through the Objective Assessment Process meets their needs? 2) After the team has reviewed the current ICAP, does the assessment appear to be an adequate reflection of the individual's abilities and needs? 3) Will a short term funding increase assist the team to meet the needs long term? If the team answers yes to all three of these, then a SNA might be an appropriate first step before an exception request. The Service Coordinator completes the SNA with the input from the team and approval of the guardian.

☐ Yes ☐ No **If yes, date SNA submitted:** Outcome: ☐ Approved ☐ Denied

Has a Team Behavioral Consultation been completed?

☐ Yes ☐ No **If yes, please summarize plan and supports and attach results and recommendations:**

How long ago was TBC involved? What was the outcome? What TBC recommendations were implemented? Which were not implemented and why? If recommendations were implemented and are not successful and it has been a year since TBC was involved with the team, then a new request for a consult should be considered by the team.

Has there been a Risk Assessment completed?

☐ Yes ☐ No **If yes, please attach summary.**

Please attach the risk assessment document.

If no, does the team feel one needs to be completed?

☐ Yes ☐ No Does the team believe the individual needs a current risk assessment? Justification to request the assessment should be included.

Number of GERs is the past 90 days:

High: Medium: # of law violations: # of police contacts:

Summary of GERs:

For individuals with behavioral related GERs, please include a summary of target/risk behaviors that have resulted in a GER; there's no need to summarize of every GER (nor do copies need to be attached), but the intensity, type and frequency of GERs should be discussed here. If there was significant law enforcement contact, court appearances as a result, psychiatric hospitalizations, etc., those should be discussed here. If there is property damage, please describe the severity. For individuals with medically related GERs, please include hospital visits with or without admission including summary of injury or if for mental health, choking, fracture, concussion, laceration, or other incident requiring immediate medical intervention. Include the number of Emergency Safety Interventions. If known, include number of Adult Protective Service (APS) reports.

Summary of target behaviors (if applicable):

Include a description of target behaviors with antecedents and how those behaviors are addressed through a positive behavioral support plan.

Summary of medical risk (if applicable):

Include health risk screen scores and information if completed (it is strongly encouraged to complete a new HRS with a request). If your exception request is primarily due to a recent hospitalization, indicate your plan to follow physician orders.

What programs, supports or safety plans are in place?

(Please attach appropriate plan with data for the last 90 days (i.e., nursing plan, health plan, safety plan, functional behavioral assessment, overnight plan, etc.), and other clinical documentation that supports the need.

If any of these plans are currently in place, please attach them with the request.

Section 4.

Plan to decrease support:

Because exception funding is likely restrictive in some way to the individual, how will the team plan to decrease support and staff supervision over the plan year? What criteria will you put into place so that you as the provider know you are ready to decrease support and or supervision? These efforts should be documented in the ISP and support plans as applicable including the individual's safety plan.

Rationale to continue exception funding in spite of decreased behaviors:

This question is designed for clinical staff to provide their opinion on why exception funding should be continued even when the individual has decreased risk behaviors or decreased need for support. This includes information such as the risk versus benefits of maintaining the exception funding and therefore maintaining the same levels of supervision and support to the individual.

Section 5.

Additional Information:

Include any additional information that may not have captured under other questions.

DDD Administrative Notes:

This area will include any notes made by the decision-maker. It may include notations about limits to the funding such as "less than" what is requested by the provider, but will include the amount approved and the duration. If the request is denied, a rationale will be included. It may include: the team should consider an SNA, there is not enough information provided to support the request, request is not appropriate (other funding supports can be accessed to meet the need), the amount requested is in excess to need level described, funding is to not be used for room and board or clothing, etc.

Decision:

☐ Approved ☐ Denied

_____

Signature of Administrative Designee *Date of Decision*

Appendix F: Service Provider Guidance

Attachment A to the FY14-15 General Services Contract

State of Nebraska
Department of Health and Human Services
Division of Developmental Disabilities

Specialized Service Provider Guidance to:

Authorizations
Billing Guidelines
Service Definitions
Claims Processing

Effective July 1, 2014

Table of Contents

Section I – Introduction Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) is within the Nebraska Department of Health and Human Services. DDD is responsible for the system of supports in Nebraska for persons eligible for developmental disability services. DDD provides the funding for services and oversight of specialized community-based providers.

Throughout this guide, any reference to "an individual" means an individual receiving services/supports funded through the Division of Developmental Disabilities.

Services funded through the Division of Developmental Disabilities include:

- Service Coordination – assisting the individual/guardian and their family to develop person-centered plans for meeting the individual's needs and personal goals.
- Day Habilitation - these services may be integrated in the community at large or provided at a provider operated location. These may include:
  - Vocational Planning, Integrated Community Employment, Workstation and Day Habilitation – training and supports designed to assist in becoming employed. Services may range from to teaching job skills prior to becoming employed, assisting in acquiring a job, and supporting a person in a community integrated job.
  - Day Habilitation (for adults), Day Habilitation (for children), and Retirement services and support to provide opportunities during the day that are not vocationally based for adults, children and older adults who may prefer retirement activities.
- Residential Habilitation – these services may be provided in the individual's own home, the family home or at a provider operated home. All must be integrated in the community at large. These may include:
  - Companion Home, In-Home, Extended Family Home (EFH), Group Home and Retirement – training and supports designed to assist the individual in acquiring independent living skills.
- Respite – services to provide occasional relief to a non-paid caregiver that lives with the individual receiving services.

There are specific eligibility requirements an individual must meet in order to be eligible for services through the Division of Developmental Disabilities. Eligibility is determined by DDD staff and funding is not authorized until eligibility is determined. Additionally, the amount of funding for services that a person is eligible for is determined by the objective assessment process which determines the individual's abilities and needs. Currently in Nebraska, individuals who have been determined eligible may receive day/vocational services once they've completed the school year, at a Nebraska high school, in which they turn age 21. In certain situations, individuals may be eligible for other services such as residential habilitation services and respite services. Funding is authorized by DDD staff.

In addition, individuals must make every effort to become eligible and maintain eligibility for the Medicaid Waiver applicable for the funding that has been offered to the individual. This includes, but is not limited to, remaining in school with an active Individualized Education Plan (IEP) until the end of

the school year in which the individual turns 21 years of age, ensuring an annual physical is completed and maintaining financial eligibility for Medicaid.

Each individual receiving services through the Division of Developmental Disabilities is required to apply for and accept any federal and state benefits they may be eligible for (i.e. Social Security benefits, Medicaid benefits), and complete a financial assessment that determines their ability to pay (ATP) for the cost of the services received. For youth under age 19, the parents' (biological or adoptive) ability to pay must be assessed. The ATP is payable by the individual (or their parents/guardian) directly to the Department of Health and Human Services. Individuals may also have a share of cost (SOC) to be eligible for Medicaid. The SOC is assigned to the provider that provides the mostly costly service and that amount is deducted from the provider's monthly reimbursement. The provider is then responsible for collecting the SOC amount from the individual/guardian.

Section II - Service Authorization

DDD utilizes a web-based electronic case management system called Therap Services, LLC (Therap). Service authorizations are completed by Service Coordination in Therap then entered into NFOCUS. The Service Coordinator will send the approved service authorization to the specialized provider and the provider should review the service authorization for accuracy before acknowledging.

If the service authorization is inaccurate, the provider should contact the Service Coordinator for revisions. If accurate, acknowledge the service authorization for the authorization to be activated. The service authorization is not complete and cannot be billed towards until the provider has acknowledged it.

Step by step instructions, including screen shots, for receiving and acknowledging a Service Authorizations may be found at: http://www.therapservices.net/nebraska/.

Section III – Billing Guidelines for Specialized DD Services

Services and supports must be delivered as documented in each individual's person-centered plan, which may also be referred to as a service plan, Individual Support Plan (ISP), Individual Program Plan (IPP), or Individual and Family Support Plan (IFSP), hereafter referred to as IPP. The type and amount of service and/or support, the location and schedule for delivery of the services and/or supports, and the person or agency responsible for the delivery of the service and/or support must be documented in the IPP.

Services billed must be provided in accordance with all statutory, regulatory, and contract requirements and in accordance with the approved Home and Community Based Services (HCBS) Medicaid Waivers.

Payments by DDD are not made for room and board, the cost of facility maintenance, upkeep and improvement. When applicable, room and board is the responsibility of the individual and is paid directly to the provider. If services are provided in a provider owned and controlled setting, the provider is responsible for the cost of home and service location maintenance, upkeep and improvement.

A specialized provider will only bill for days/hours when the individual is present and receiving habilitative services/supports. There will no longer be "leave days" or "therapeutic days". The only days which should be noted on a submitted claim is when an individual may be in the hospital (admitted) and the provider has approval to provide habilitative supports when the individual is hospitalized. The provider will indicate "Hospital Leave" as outlined below.

Continuous Services:

Continuous Services imply that a staff person is available when the individual is present. An individual is not necessarily prevented from having independent/alone time, but during that time staff are expected to respond and be available if needed. The team must ensure that the individual is safe and has the ability to obtain staff assistance independently if needed; this should be documented in the IPP and be based on assessments or demonstrated skills. Daily rates are available for day and residential services if the person receives that service for four or more hours (four hours of day services or four hours of residential services). An individual's overall ICAP score determines the support level (rate) for which the provider will bill. The attached rate matrix (appendix A) allows Service Coordinators to determine how to authorize continuous services for an individual. Services may not be provided or billed outside of the support level the individual falls into on the rate matrix unless an exception has been made by the DDD Deputy Director, or designee, to add funding to the individual's budget to account for an increase in services/supports.

Continuous day services are expected to be available for no less than seven hours per day. Continuous residential services are expected to be available for no less than eleven hours with six hours of overnight. Generally, residential services will begin at 6:00 am each day. Generally, day services are provided between the hours of 7:00 am and 5:00 pm.

Hourly rates are also available for times when the individual might be in that service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Service Coordination will authorize individuals who utilize continuous services for both a daily and hourly rate in accordance with the needs of the individual and the plan developed by the IPP team. Should an individual not anticipate the need for hourly services throughout the year, one day of daily rate service will be converted to hourly services in anticipation of an unplanned utilization of hourly services. This will allow providers to be "pre-authorized" for an hourly rate in the event that there is a need without over-authorizing services beyond the individual's budget. The Service Coordinator will then make adjustments throughout the budget year as needed.

Examples: Group Home, EFH, Companion Home, Day Habilitation, and Workstation

Intermittent Services:

Intermittent Services imply that that staff support is provided as needed. Intermittent services are authorized in accordance with the needs and preferences of the individual, but cannot exceed the annual Individual Budget Amount. An individual may be independent in many regards, but need staff support to provide teaching/training in regards to specific skills. There are only hourly rates for this service and it is not dependent on what support level the individual falls into on the rate matrix. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Examples: In-Home Habilitation, Vocational Planning, Integrated Community Employment and in some cases, Companion Home (the old 'supported residential')

When providing continuous and intermittent services to the same individual:

1. An individual CAN have continuous residential and intermittent day occurring on the same day (or vice versa).
2. They CANNOT use continuous residential AND intermittent residential on the SAME day IF the provider is going to bill the daily rate for residential services.
3. They CANNOT use continuous day AND intermittent day on the SAME day IF the provider is going to bill the daily rate for day services.
4. If they use both continuous day and continuous residential on any given day, they CANNOT use a non-specialized supports in addition as there will not be funding available in their budget to accomplish this.

Exceptions to the Individual Budget Amount:

Exceptions may be requested utilizing the approved "Request for Exception to the IBA" form available from the specialized provider website. Instructions on how to complete the form are also available along with a flow-chart explaining how exceptions are requested and entered into Therap. All exceptions to the IBA (to add dollars to an individual's budget to provide additional support) must be prior approved by the DDD Deputy Director, or designee. Exceptions may be time limited and documentation and rationale must be provided before a request will be considered. DDD requires clinical assessment or documentation to justify that an individual's budget amount is insufficient to meet their needs.

Billable activities:

1. Habilitation training provided and direct support of ongoing service needs as specified in the person's current IPP;
2. Individualized job development and support on behalf of the individual as specified in the person's current IPP;
3. Attendance and participation at the person's interdisciplinary team meetings;
4. Documentation of information supporting the agency staffs' performance of activities that are specified in the person's current IPP; and
5. For days when an individual might be hospitalized but also received services prior to admission or after discharge, the services must be claimed at the hourly rate. Daily rates do not apply on days when an individual is either admitted to or discharged from the hospital. A maximum of seven (7) hours per day is allowable for the days an individual is hospitalized.
6. Time when an individual is transported by a provider may be billed.

Unbillable Activities:

1. Staff meetings, agency-wide staff training, habilitation plan/training program research and development, supervisory/administrative activities, staff paid leave time, ancillary support activities not involving the participation of the individual (e.g., shopping for supplies, building cleaning, maintenance, etc.);
2. Any time periods where other paid services (e.g., Personal Assistance Services, Speech Therapy, Physical Therapy, Counseling/Therapy sessions, etc.) are provided concurrently in a provider owned and controlled location.
3. For a child (individual under 21 years of age), time periods the child is to be attending school – generally 8:00 a.m. to 3:00 p.m. or the operational hours of the school.
4. Paid staff time providing only general care and supervision to the person during the delivery of continuous services.
5. If an individual's IPP identifies a specialized provider as being the party responsible for assisting the individual to schedule and attend an annual physical examination and that individual loses or has a gap in their waiver eligibility due to an expired annual physical examination, then the federal matching funds that are unable to be acquired by the DDD will be reduced from the provider payment until the individual becomes waiver eligible.

6. Payment for services cannot go, directly or indirectly, to members of the individual's immediate family or to their guardian. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Record Keeping/Documentation:

Providers are required to keep records in accordance with 404 NAC 4-004.09A and any contract requirements. At a minimum documentation must include:

1. For continuous services a daily record of attendance for each individual receiving services must be maintained. This record should include the total hours attended including transportation if the provider is claiming that time. Lack of appropriate documentation may result in funds being recouped for times when service provision/attendance cannot be confirmed via documentation.
2. For intermittent services a record of the actual time an individual is served must be maintained. Lack of appropriate documentation may result in funds being recouped for times when service provision/attendance cannot be confirmed via documentation.
3. Data related to the habilitation and supports provided for each individual receiving services must be maintained. Lack of appropriate documentation may result in funds being recouped for times when habilitation cannot be confirmed via documentation.
4. Staff time/pay records including: employee name, dates and time periods worked, individuals served, work activities engaged in if not providing the direct services as outlined in the IPP, and signature of staff and supervisor.

Service Requirements:

Day Services

1. Generally, day services are provided between 7:00 am and 5:00 pm, Monday – Friday. Knowing that individuals may have weekend or evening jobs which require supports from a specialized provider, the IPP team should identify and document any special circumstances.
2. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed. For instance, if a provider leaves a provider setting to pick up an individual they may not bill for that time; as soon as the individual enters the vehicle with the staff to the time when the individual is dropped off at their service delivery site, that time may be billed. The provider should document transportation time if the provider chooses to bill for this time.
3. For continuous day services, if the individual is present and served for more than four hours, the provider will bill at the daily rate for day services in accordance with the identified service level for the individual, unless there is an approved exception. The hourly rate is only claimed if the individual is present for fewer than four hours or is absent part of the day due to a hospitalization.
4. Intermittent day services are only billed at the hourly rate. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).
5. Continuous day services are expected to be available for no less than seven hours per day. Providers that opt to provide only four hours per day of continuous day services in order to bill the daily rate will be out of compliance with this guidance and may be found to be in breach of

the General Services Contract between DHHS – DDD and the provider agency. The duration for which an individual attends any given service will be determined by their identified outcomes and needs as documented in the IPP; the team will be responsible for determining and documenting the frequency, i.e. days of the week and hours each day, etc., of the service and the type of habilitation that will occur. In addition, the IPP will identify the type and intensity of supervision that shall occur while the individual is receiving services.

Residential Services

1. Continuous residential services are expected to be available for no less than eleven hours with six hours of overnight. Generally, for the purposes of residential services each new day will begin at 6:00 am.
2. The IPP will identify the type and intensity of supervision that shall occur while the individual is receiving residential services. Should the team believe awake overnight staff is required for an individual the need, rationale, and expectations must be included in the individual's current IPP and DDD Central Office prior approval is required for payment for overnight awake residential services.
3. Staff must be available when the individual is present in a continuous residential setting. An individual is not necessarily prevented from having independent/alone time, but during that time staff are expected to respond and be available if needed. The team must ensure that the individual is safe and has the ability to obtain staff assistance independently if needed; this should be documented in the IPP and be based on assessments or demonstrated skills.
4. If an individual is served residentially in an Extended Family Home (EFH), group home or continuous companion home, providers may now bill for weekend days, when the individual is ill and cannot/should not attend day services, if the day service is closed in observation of a holiday, or if during a regular school year a child is unable to attend school due to it not being in session. The individual must receive habilitation during these times and those habilitative programs should be identified in the IPP, and the provider must document the habilitation provided. The habilitation may be recreational, vocational or residential in nature depending on the individual's preferences and needs.
    a. If the provider serves an individual for both day and residential services, then the provider would utilize the authorized daily or hourly rates for day services and residential services.
    b. If the individual receives day services from a different provider than they receive residential services, then the residential provider will bill the appropriate daily or hourly rate for day services on weekend days.

Hospital Leave and Billing on Days of Hospital Admittance/Discharge

1. Any habilitation services provided to an individual during a hospitalization must be approved by the DDD Deputy Director, or designee. The provider must request the ability to bill during a hospitalization within 48 hours of initial hospitalization. The request should be made to: DHHS.DDExceptions@nebraska.gov with a copy to the individual's Service Coordinator and their supervisor.
2. Providers will note on their billing documents that the service provided during this time as "hospital leave" or "HL" on the submitted claim.
3. For days when an individual might be hospitalized but also received continuous services prior to admission or after discharge, the services must be claimed at the hourly rate. Daily rates for

the service type do not apply for the service that is being provided at the time the individual is either admitted to or discharged from the hospital. For instance, an individual wakes up at 6:00 am and the provider supports the person for two hours residentially prior to going to attending day services. The individual attends a full day of day services but an incident occurs at 8:00 pm which results in being admitted to the hospital. The provider would bill the daily rate for the day services provided and five hours of residential services. If the individual was hospitalized at 10:00 am, then the provider would bill two hours of residential services and two hours of day services. A maximum of seven (7) hours per day at the hourly rate is allowable for the days an individual is hospitalized.

Section IV – Service Definitions

Day Habilitation Services

Intermittent:

- Integrated Community Employment – Adult and Child (child, summer only) – 3227
- Vocational Planning – Adult and child (child, summer only) – 3728

Continuous:

- Adult Day Habilitation – 7090
- Child Day Habilitation (summer only) – 2139
- Workstation Habilitation Services – Adult and child (child, summer only) – 2566

Integrated Community Employment - 3227

Integrated community employment (ICE) service is intermittent formalized training and staff supports - needed by an individual to acquire and maintain a job/position in the general workforce at or above the state's minimum wage. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the individual service plan. ICE services are person-centered and team supported to address the individual's particular needs for ongoing or intermittent habilitation, throughout stabilization services and extended integrated community employment services and supports.

ICE services include habilitation that is outcome based and focused to sustain paid work by individuals and is designed to obtain, maintain or advance employment. Intensive direct habilitation will be designed to provide the individual with face to face instruction necessary to learn explicit work-related responsibilities and skills, as well as appropriate work behavior.

ICE services enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Support may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

ICE services are primarily provided away from the home, in a non-residential setting, during typical working hours and conducted in a variety of work settings, particularly work sites where persons without disabilities are employed. Discreet habilitation in preparation for leaving the residential setting during working hours is allowed. Intermittent face to face individualized habilitation is provided to assist the individual in maintaining employment. Habilitation goals and strategies must be identified in the service plan and specify in a measurable manner, the services to be provided to meet the preferences and needs of the individual.

ICE services may include a customized home-based business. Habilitation services may be delivered in a customized home based businesses in participant directed companion homes.

ICE services do not include employment in group settings such as workstations or enclaves, classroom settings, or provider owned and controlled fixed site day habilitation. In addition, it does not include services provided in provider-controlled residential environments such as group homes or extended family homes.

When integrated community employment services are provided at a work site where persons without disabilities are employed, payment is made to the provider only for the supervision and training required by individuals receiving waiver services as a result of their disabilities but does not include payment for the employer's supervisory activities rendered as a normal part of the business setting.

Stabilization is ongoing habilitation services needed to support and maintain an individual in an integrated competitive employment site or customized home-based employment. Stabilization supports are provided when the staff intervention time required at the job site is 20% - 50% of the individual's total work hours. Staff intervention includes regular contacts with the individual or on behalf of the individual to determine needs, as well as to offer encouragement and advice. Staff is intermittently available as needed to the individual during employment hours. Goals and strategies needed for the individual to maintain employment must be identified in the individual plan.

Extended ICE services are provided to persons who need ongoing intermittent support to maintain employment and when the staff intervention time required at the job site is less than 20% of the individual's total work hours. The provision of extended ICE is limited to the work site, including home-based business sites. Staff supports must include at a minimum, twice monthly monitoring at the work site. Extended ICE services must identify the services and supports needed to meet the needs of the individual in the service plan.

Prior to learning to access transportation independently, transportation between the individual's place of residence and the employment site is a component of vocational planning habilitation services and the cost of this transportation is included in the rate paid to providers.

Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for training that is not directly related to an individual's integrated community employment services

Limits on the amount, frequency, or duration of this service:

- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.
- ICE stabilization services require at least 40 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue reimbursement at the ICE rate as long as the minimum total number of hours worked for the last three months (including the current month) is more than 120 hours of work (or an average of 40 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 40 hours of employment per month.
- Extended ICE services are time limited. Extended integrated community employment services require at least 80 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue payment for the extended ICE services as long as the minimum total number of hours worked for the last three months (including the current month) is more than 240 hours of work (or an average of 80 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 80 hours of employment per month. The provider may claim extended integrated community employment services for up to 24 months in order for the individual to meet their personal and career goals.
- Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment. No more than two individuals may participate in a home-based business at the same participant-directed companion home.
- Children between the ages of 18-21 years may only utilize this service during the summer when school is not in session.
- DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Vocational Planning Habilitation Services – 3728

Vocational planning habilitation services focus on enabling the individual to attain work experience through career planning, job searching, and paid and unpaid work experience with the goal or outcome of vocational planning being integrated community employment. Services are furnished as specified in the service plan.

Vocational planning habilitation services are formalized training and staff supports which take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting where individuals without disabilities work or meet together. Discreet habilitation focused on job searching or in preparation for leaving the residential setting during typical working hours is allowed. Direct training and supports will be designed to provide the individual with face to face instruction necessary to learn work-related responsibilities, work skills, and appropriate work behavior.

Vocational planning services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion and personal accomplishment in the working community. Habilitation may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives. Vocational planning habilitation services also include personal care and protective oversight and supervision when applicable to the individual. The habilitative services, supports, and strategies are documented in the service plan and delivered based on the service plan.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Vocational planning habilitation services may include career planning that is person-centered and team supported to address the individual's particular needs to prepare for, obtain, maintain or advance employment. Habilitation services with focus on career planning includes development of self-awareness and assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Assessment of skills, abilities, and needs is a person-centered team responsibility that engages all team members to support an individual in identifying a career direction and developing a plan for achieving integrated community employment at or above the state's minimum wage. The outcome is documentation of the individual's stated career goals and career direction and strategies for the acquisition of skills and abilities needed for work experience in preparation for integrated community employment. Establishment of career goals may not take place at the same time as other vocational planning activities.

Habilitation services with focus on career planning and strategies for implementing career goals may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

Vocational planning habilitation services may include job searching designed to assist the individual or on behalf of the individual to locate a job or development of a work experience on behalf of the individual. Job searching may take place in the individual's private residence, in integrated community settings, or in provider staff office areas. Job searching may not take place in a fixed-site facility in the areas where other individuals are receiving continuous day habilitation services. Job searching with the individual will be provided on a one to one basis to achieve the outcome of this service.

Vocational planning habilitation services may include work experiences that are paid part-time employment, workstations or enclaves, or unpaid experience such as volunteering, apprenticing, interning, job shadowing, etc. A work experience takes place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, with the focus on attaining the outcome of integrated community employment. Habilitation provided during a work experience may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

Prior to learning to access transportation independently, transportation between the individual's place of residence and the employment site is a component of vocational planning habilitation services and the cost of this transportation is included in the rate paid to providers.

Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services.

Vocational planning habilitation services may take place in conjunction with integrated community employment services, workstation habilitation services, community inclusion day habilitation, or other day activities.

Limits on the amount, frequency, or duration of this service:

- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.
- Some components of vocational planning habilitation services are time-limited. Establishment of career goals through career planning may not exceed three months. If the outcome of career planning is not reached within three months, a team meeting must be held to change the service plan. Unpaid work experiences must lead to paid employment and are therefore time-limited. Work experiences for which the general population is paid to perform may not last beyond six months. Volunteering to provide services and supports in an integrated community setting for which the general population does not get paid to perform are not considered to be a work experience and are not time-limited.
- No more than three individuals may participate in the same paid or unpaid work experience at the same time.
- Children between the ages of 18-21 years may only utilize this service during the summer when school is not in session.
- DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Adult Day Habilitation Services – 7090

Day habilitation services are formalized training and staff supports that take place in a non-residential setting separate from the individual's private residence or other residential living arrangement. Day Habilitation services are scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living and employment. Day habilitation services may be prevocational in nature or may be provided to individuals not currently seeking to join the general work force. Activities and environments are designed to foster the

acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living.

Day Habilitation may be delivered in integrated community settings or in provider owned and operated settings. Staff support is continuous, that is staff are present at all times the individual is present. The provider may operate a location where individuals come to check-in prior to participating in integrated activities and/or to participate from a variety of daily activities, some which may be prevocational in nature or related to greater community living. Provider owned and controlled settings may also allow for individuals who are experiencing short-term medical or behavioral crisis a location to participate in activities that are outside the residence.

Prevocational activities prepare an individual for paid or unpaid work experiences and competitive employment. When compensated, individuals may be paid at less than 50 percent of the minimum wage. Habilitation may include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are generally not job-task oriented but instead are directed at underlying habilitative goals, such as attention span and motor skills, and not explicit employment objectives.

The activities, services, supports, and strategies are documented in the service plan, and the frequency and duration for which the services are delivered will be based on the IPP. Day Habilitation services will focus on enabling the individual to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, habilitation services may reinforce skills taught in therapy, counseling sessions, or other settings. Habilitation also includes personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the IPP.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

For individuals with degenerative conditions, Day Habilitation services may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Meals provided as part of these services do not constitute a full nutritional regiment and as applicable, physical nutritional management plans must be implemented as documented in the service plan. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Individuals that choose Day Habilitation may also choose Community Living and Day Supports, but these services may not be billed during the same period of the day.

Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

Limits on the amount, frequency, or duration of this service:

- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Child Day Habilitation Services - 2139

Day habilitation services are formalized training and staff supports that take place in a non-residential setting separate from the individual's private residence or other residential living arrangement. Day Habilitation services only take place during times when a child is not attending school due to school not being in session (i.e., summer breaks and/or scheduled school holidays, in-service days, etc.). These services are scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living and employment. Day habilitation services may be prevocational in nature or may be provided to individuals not currently seeking to join the general work force. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living.

Day Habilitation may be delivered in integrated community settings or in provider owned and operated settings. Staff support is continuous, that is staff are present at all times the individual is present. The provider may operate a location where individuals come to check-in prior to participating in integrated activities and/or to participate from a variety of daily activities, some which may be prevocational in nature or related to greater community living. Provider owned and controlled settings may also allow for individuals who are experiencing short-term medical or behavioral crisis a location to participate in activities that are outside the residence.

Prevocational activities prepare an individual for paid or unpaid work experiences and competitive employment. When compensated, individuals may be paid at less than 50 percent of the minimum wage. Habilitation may include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are generally not job-task oriented but instead are directed at underlying habilitative goals, such as attention span and motor skills, and not explicit employment objectives.

The activities, services, supports, and strategies are documented in the service plan, and the frequency and duration for which the services are delivered will be based on the IPP. Day Habilitation services will focus on enabling the individual to attain or maintain his or her maximum functional level and must

be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, habilitation services may reinforce skills taught in therapy, counseling sessions, or other settings. Habilitation also includes personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the IPP.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

For individuals with degenerative conditions, Day Habilitation services may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Meals provided as part of these services do not constitute a full nutritional regiment and as applicable, physical nutritional management plans must be implemented as documented in the service plan. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Individuals that choose Day Habilitation may also choose Community Living and Day Supports, but these services may not be billed during the same period of the day.

Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

<u>Limits on the amount, frequency, or duration of this service:</u>

- The amount of authorized services is the individual’s approved annual budget and is provided based on the individual’s preferences to the extent possible, and as documented in the service plan.
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.
- DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.
- Day habilitation services are provided to individuals not currently seeking to join the general work force or participate in Vocational Planning services, Workstation Habilitation services, or Integrated Community Employment Supports – Individual Employment Support. Day Habilitation services do not provide payment of services that are vocational in nature.

Workstation Habilitation Services – 2566

Workstation habilitation services are formalized training and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills which takes place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting where individuals without disabilities work or meet together. Discreet habilitation in preparation for leaving the residential setting during typical working hours is allowed.

Workstation habilitation services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion, inclusion, and personal accomplishment in the working community. This day habilitation service also includes personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. The habilitative services, supports, and strategies are documented in the IPP and delivered based on the service plan.

Workstation habilitation services are delivered continuously and provide paid work experiences in preparation for competitive employment. Habilitation may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

<u>Limits on the amount, frequency, or duration of this service:</u>

- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- Children between the ages of 18-21 years may only utilize this service during the summer when school is not in session.
- If a child receives this service, DDD will not authorize developmental disabilities services for the hours a child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Residential Habilitation Services

Intermittent:

- Companion Home – Adult and Child – 5617
- In Home – Adult and Child - 8891

Continuous:

- Companion Home – Adult and Child - 5617
- Extended Family Home – Adult and Child - 4596
- Group Home – Adult and Child - 4566

Companion Home Residential Habilitation - 5617

Companion home services consist of residential habilitation delivered as formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation may also include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

Companion home residential habilitation services may be delivered intermittently or continuously. A companion home may be an apartment, a house, a condominium, or a townhouse which the individual owns or rents. The provider of residential habilitation services in a companion home must be able to document that the individual freely choose their residential setting and housemates and that the lease or mortgage is under the control of the individual. The owner or lessee of the property must be unrelated, directly or indirectly, to the provider of services.

For continuous companion home residential habilitation services, the provider staff must be present and awake during the times that individuals are present and awake. The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. As applicable, when the individual does

not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

When the provider claims for overnight awake or overnight asleep staffing, the staff must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Companion home residential habilitation may be delivered intermittently. Community based DD provider staff is intermittently in the home to deliver face to face habilitation to the person receiving services. Intermittent companion home residential habilitation services are based on the individual's preferences and assessed needs, and must be documented in the service plan.

Limits on the amount, frequency, or duration of this service:

- Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.
- Payment for residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.
- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences, to the extent possible, as documented in the service plan.
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.
- Children between the ages of 18-21 may utilize this service if they live in their own home.

In-Home Residential Habilitation - 8891

Residential habilitation is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation may also include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present.

Residential Habilitation services provided to a participant living in his/her family home are called in-home residential habilitation services and are intermittent services. Community based DD provider

staff is intermittently available to deliver habilitation to the person receiving services in the family home or in the community. Training and supports are designed to provide the individual with face to face habilitation.

Limits on the amount, frequency, or duration of this service:

- Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.
- Payment for residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.
- The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- The provision of residential habilitation cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation, or Medicaid State Plan services. Residential habilitation services will not duplicate other services provided through this waiver.

Extended Family Home Residential Habilitation - 4596

Extended family home residential habilitation service is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight as applicable to the individual as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.
Residential Habilitation services provided in a single family home setting are called extended family home (EFH) residential habilitation services. EFH residential habilitation services are delivered as an employee of the DD provider agency or under a subcontract with a DD provider agency and are continuous services. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

EFH residential habilitation services are services provided in a setting where the individual and the EFH provider resides and the EFH provider is on-site and immediately available at all times to the individual

receiving services, including during the individual's sleep time. The EFH provider must be present and awake during the times the individual is present and awake.

Overnight staffing is built into the overnight awake and overnight asleep rate for Extended Family Home residential habilitation. The EFH provider may be sleeping, unless awake overnight supervision or assistance is required as documented in the individual's program plan, and must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan.

Limits on the amount, frequency, or duration of this service:

- An EFH may qualify as a supported living option. It must be a residence for no more than two individuals with DD, owned or leased by the subcontractor providing supports. The individual is his/her own payee or representative payee and pays room and board directly to the EFH provider. The agency must not own the residence when the EFH provider is engaged as a subcontractor or employee of the agency.
- Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement.
- Payment for residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.
- The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.
- The provision of residential habilitation cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation, or Medicaid State Plan services. Residential habilitation services will not duplicate other services provided through this waiver.

Group Home Residential Habilitation – 4566

Group home residential habilitation services are formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support

professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

Group home residential habilitation services are continuous services and are delivered in provider operated or controlled settings, such as a home with three or less individuals with DD, or a licensed Center for persons with Developmental Disabilities (CDD) with four or more individuals with DD. Rental agreements with and payment for room and board to a DD provider must be treated as landlord-tenant agreements and all applicable state and local laws must be followed.

Staff must be present and awake during the times that individuals are present and awake. The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. When the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

When the provider claims for overnight awake or overnight asleep staffing, the staff must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

The method by which the cost of room and board is excluded from payment for residential habilitation is specified in Appendix I-5.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of residential habilitation services and the cost of this transportation is included in the rate paid to providers of residential habilitation services.

Day habilitation and intensive behavioral interventions are not components of this service.

<u>Limits on the amount, frequency, or duration of this service:</u>

- Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.
- Payment for residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

- The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan, also called the individual and family support plan (IFSP), individual program plan (IPP), or individual support plan (ISP).
- This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Retirement Services

Retirement Day and Residential - 3225

Retirement services are available to individuals who are of the typical retirement age. Participants of this service have chosen to end employment or participation in day habilitation services or are no longer able to be employed or participate in day habilitation services due to physical disabilities or stamina. Retirement services are structured services consisting of day activities and residential support. Retirement services are provided in a home setting or community day activity setting and may be provided as a day service or a residential service. Retirement services may be self-directed or provider controlled. The outcome of retirement services is to treat each person with dignity and respect, and to the maximum extent possible maintain skills and abilities, and to keep the person engaged in their environment and community through optimal care and support to facilitate aging within the person's home and community.

Retirement services and supports are designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits, establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Active supports must be furnished in a way which fosters the independence of each individual. Strategies for the delivery of active supports must be person centered and person directed to the maximum extent possible and is identified in the IPP.

Retirement services and supports may include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the IPP.

Retirement services may be provided as a continuous or intermittent service. Continuous day service activities are provided for five or more hours per day and delivered in a non-institutional, community setting that may include people without disabilities. Retirement day settings cannot be set up or operated by a DD provider in communities where an existing community senior center or facilities

geared for people who are elderly, such as an adult day care center are available. DD provider-operated retirement day settings must be made available to people without disabilities.

Continuous retirement residential supports are provided for five or more hours per day and may be provided in a supported living companion homes or provider operated residences. A supported living companion home has no more than two other individuals with developmental disabilities and is under the control and direction of the individual(s). The home or residence must be in an integrated community setting.

When retirement services are delivered in a provider operated residence, there must be staff on-site or within proximity to allow immediate on-site availability at all times to the individual receiving services, including during the individual's sleep time. Staff must be available to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety and security, and to provide activities to keep the person engaged in their environment.

The personal living space and belongings of others must not be utilized by others receiving retirement services. When retirement services are delivered in residences, only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized, and when retirement services are delivered to two or more individuals, different residences must be utilized on a rotating basis.

Transportation into the community to shop, attend recreational and civic events, go to the senior center, adult day care center, or other community activities is a component of retirement services and is included in the rate to providers. It shall not replace transportation that is already reimbursable under the Medicaid non-emergency medical transportation program. The IPP planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by the provider is not intended to replace generic transportation or to be used merely for convenience.

Limits on the amount, frequency, or duration of Retirement services:

- The amount of authorized services for retirement services may not be determined using the objective assessment process.
- Payments for retirement services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.
- Meals provided as part of retirement services and supports do not constitute a "full nutritional regimen" (3 meals per day).
- Payment for retirement services does not include payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant.
- Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

- Retirement day supports cannot duplicate or replace existing natural supports, senior centers, adult day care centers, or other community activity centers in the communities in which the person resides.
- The provision of this service cannot overlap with or supplant other state or federally funded services such as, but not limited to, respite services, Vocational Rehabilitation services, residential habilitation, or Medicaid State Plan services. This service will not duplicate other services provided through this waiver.

Specialized Respite Services

Respite – 6089

Respite is the temporary, intermittent relief to the usual non-paid caregiver(s) from the continuous support and care of the individual to allow the caregiver to pursue personal, social, and recreational activities such as personal appointments, shopping, attending support groups, club meetings, and religious services, or going to entertainment or eating venues, and on vacations. Components of the respite service are supervision, tasks related to the individual's physical and psychological needs, and social/recreational activities. Services are provided on a short-term basis because of the absence or need for relief of those unpaid persons who normally provide care for the individual. These services may be provided in the individual's living situation and/or in the community.

Limits on the amount, frequency, or duration:

- Respite is available only to those individuals who live with their usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual.
- Payment for respite does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Respite cannot be provided by members of the individual's immediate household.
- Respite services cannot be used as adult/child care while the parents work or attend school.
- The amount of authorized services for respite services is not determined using the objective assessment process.
- All waiver services and providers must be prior authorized within the following guidelines:
    1. The tasks and interventions to be performed to meet the needs of the individual are documented in the IPP.
    2. For respite services, a unit is defined as an hour, or if eight or more hours are provided in a calendar day, a day. Respite cannot exceed 30 days per individual budget year;
    3. Unused respite hours are not carried over into the next waiver year; and
    4. Respite funding is available from one DHHS program source only.
- Federal financial participation is not claimed for the cost of room and board.

Section V – Claims Processing

Please read the billing instructions carefully. Inaccurate or incomplete billing documents will cause a delay in payment as your billing document will be returned to you for revision.

Providers can only claim for services provided during the period shown on the Service Authorization.

The preprinted Form DHHS-5N, "N-FOCUS Health and Human Services Billing Document" (aka preprints) must be used. You should submit all completed preprints via secure email to DDD to DHHS.DDBillingDocs@nebraska.gov or via Secure Communication (S-Comm) in Therap to the designated DDD Central Office employee assigned.

Effective September 1, 2013, the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care implemented changes in the requirements for timely filing of all claims from one year to six months from the date of service. See: http://dhhs.ne.gov/medicaid/Documents/pb1350.pdf for additional information about the six month (180 day) timely filing requirements. No bills will be processed after the 181st day after the service was provided.

The Division has 60 days to pay providers in accordance with the Prompt Payment Act. However, it generally takes approximately 14 business days for payment to be made once a complete and accurate claim is received by DDD. The Division may request additional documentation in order to process a claim. Questions about payments that have not been received within 14 business days may be directed to DDD Central Office.

Appendix A: DD Specialized Service Rates as of July 1, 2014

CONTINUOUS RESIDENTIAL	Service Code	Level 1 ICAP: 1-11		Level 2 ICAP: 12-22		Level 3 ICAP: 23-36		Level 4 ICAP: 37-49		Level 5 ICAP: 50-57		Level 6 ICAP: 58-64		Level 7 - 11 ICAP: 65 +	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
EFH Res Hab	4596	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Group Home Res Hab - Asleep Ovrnght	4566	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Group Home Res Hab - Awake Ovrnght*	4566	$ 25.22	$ 487.57	$ 19.74	$ 307.72	$ 16.99	$ 233.17	$ 15.35	$ 193.37	$ 14.25	$ 168.89	$ 13.47	$ 152.41	$ 12.88	$ 140.61
Group Home Res Hab - No Ovrnght**	4566	$ 25.22	$ 285.76	$ 19.74	$ 149.80	$ 16.99	$ 97.21	$ 15.35	$ 70.57	$ 14.25	$ 54.87	$ 13.47	$ 44.65	$ 12.88	$ 37.56
Companion Home Res Hab - Asleep Ovrnght	5617	$ 25.22	$ 353.02	$ 19.74	$ 202.44	$ 16.99	$ 142.52	$ 15.35	$ 111.50	$ 14.25	$ 92.88	$ 13.47	$ 80.58	$ 12.88	$ 71.90
Companion Home Res Hab - Awake Ovrnght*	5617	$ 25.22	$ 487.57	$ 19.74	$ 307.72	$ 16.99	$ 233.17	$ 15.35	$ 193.37	$ 14.25	$ 168.89	$ 13.47	$ 152.41	$ 12.88	$ 140.61
Companion Home Res Hab - No Ovrnght**	5617	$ 25.22	$ 285.76	$ 19.74	$ 149.80	$ 16.99	$ 97.21	$ 15.35	$ 70.57	$ 14.25	$ 54.87	$ 13.47	$ 44.65	$ 12.88	$ 37.56
Retirement Residential Services	3225		$ 146.91		$ 77.02		$ 50.46		$ 37.21		$ 29.50		$ 24.54		$ 21.11

*AWAKE Overnight requires and approved exception

*No Overnight needs team approval and IPP documentation that the individual is safe with no overnight staff

CONTINUOUS DAY	Service Code	Level 1 ICAP: 1-11		Level 2 ICAP: 12-22		Level 3 ICAP: 23-36		Level 4 ICAP: 37-49		Level 5 ICAP: 50-57		Level 6 ICAP: 58-64	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
Adult Day Habilitation	7090	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Workstation	2566	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Children's Day Habilitation	2139	$ 33.09	$ 231.65	$ 23.65	$ 165.55	$ 18.93	$ 132.50	$ 16.10	$ 112.66	$ 14.21	$ 99.44	$ 12.85	$ 89.99
Retirement Day	3225	$ 19.88	$ 73.45	$ 14.36	$ 38.51	$ 11.61	$ 25.23	$ 9.96	$ 18.60	$ 8.85	$ 14.75	$ 8.06	$ 12.27

		Level 7 ICAP: 65-69		Level 8 ICAP: 70-74		Level 9 ICAP: 75-80		Level 10 ICAP: 81-89		Level 11 ICAP: 90+	
		Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily	Hourly	Daily
Adult Day Habilitation	7090	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Workstation	2566	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Children's Day Habilitation	2139	$ 11.84	$ 82.92	$ 10.42	$ 73.00	$ 9.49	$ 66.39	$ 8.81	$ 61.67	$ 8.30	$ 58.13
Retirement Day	3225	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56	$ 7.47	$ 10.56

INTERMITTENT RES & DAY	Service Code	Level 1 - 11 ICAP: 1-90+
		Hourly
In-Home Res Hab	8891	$ 33.20
Companion Services Res Hab	5617	$ 33.20
Integrated Community Employment (ICE)	3227	$ 40.26
Vocational Planning	3728	$ 38.42

RISK SERVICES (require prior approval)	Service Code	Level 1 -11 ICAP: 1-90+
		Daily
Medical Risk Services	8539	$ 519.14
Behavioral Health Services	2541	$ 506.74

SPECIALIZED RESPITE	Service Code	Level 1 -11 ICAP: 1-90+	
		Hourly	Daily
Respite	6089	$ 16.54	$ 132.38

Appendix G: Provider Self-Assessment Survey for Residential Settings

Provider Self-Assessment Survey

Residential Developmental Disability Services

The rule adopted by the Centers for Medicare and Medicaid Services (CMS) on January 16, 2014, related to Home and Community Based Services requires developmental disability services funded by Medicaid HCBS waivers to be provided in integrated community settings. CMS has issued guidance and recommended a list of characteristics be considered in determining whether a service setting meets the requirements for being community based.

Most of the characteristics identified by CMS were already incorporated into the Nebraska Administrative Code with the Title 404 revisions to Community Based Services Regulations for Individuals with Developmental Disabilities in 2011. In addition to setting expectations for person-centered practices, individual choice and integrated services and settings, the Title 404 regulations also include enhanced oversight requirements for provider-operated settings that are now recommended by the CMS guidance. A document entitled Protection of Community Characteristics by Existing Nebraska Statutes and Regulations Governing Developmental Disability Services will be provided in early January that provides an overview of the CMS recommendations, relevant Nebraska statutes/regulations, and the current Division of Developmental Disabilities (DDD) Survey/Certification Team approach to these issues. DDD will then coordinate a LiveMeeting (i.e. a webinar) in early February 2015 to review these issues with specialized providers and to address any related questions or concerns.

As discussed at the Nebraska Association of Service Provider meeting on November 25, 2014, to the extent that CMS guidance recommendations are already addressed in current DDD regulations, we are not necessarily going to address them in this survey. Additionally, we are still awaiting CMS guidance related to day services settings. We appreciate the dedication that Nebraska specialized service providers have to implementing the new HCBS requirements and understand the value of the resources that you are dedicating to this effort. Thus, a separate survey will be sent after CMS issues the anticipated guidance related to day services settings, and we are limiting this survey to items that we believe are necessary to the task of identifying potentially non-compliant residential settings.

DDD has developed a provider self-assessment survey. These questions identify characteristics that are expected to be present in all provider owned and controlled community-based settings and the associated traits that individuals in those settings might encounter.

Please complete this survey for residential locations with ***four or more*** unrelated individuals in residence.

Due to the fact that the 404 regulations already limit the size of provider-owned and controlled residential settings to three or fewer residents, we have established that those settings are compliant under the new HCBS Rule.

Per Title 404, Chapter 6-001.02A:

"Each Residential setting must:

1. Have no more than 3 individuals with developmental disabilities residing at the setting;
2. Be operated as a single setting and demonstrate that each residence operates independently; and
3. Be staffed when the residence offers continuous services."

Provider Agency:		Name of Individual Completing form:
Email address:	Phone Number:	Residential Address:
What is the maximum number of individuals who can be served at this location?		
How many individuals are currently being served at this location?		
Is the location licensed as a CDD under Title 175, Chapter 3?		
Please attach or enclose a picture of the residential setting		

Visual Characteristics of the Setting/Home:
1) Does this setting provide a home environment, or is it clear from appearances and location that it a services setting for people with developmental disabilities? ○ Yes ○ No Optional Comments:
2) Is the setting adjacent to another setting, such as a workshop, another group home, another apartment or any other setting for individuals with disabilities? ○ Yes ○ No Optional Comments:
3) Is the setting in a commercial area, non-residential in character? ○ Yes ○ No Optional Comments:
4) Is the setting an apartment or home developed with special finance (ie HUD), with **only** individuals with disabilities in residence? ○ Yes ○ No Optional Comments:
5) Is the setting located in the same building as an educational program or school? ○ Yes ○ No Optional Comments:
6) Is the setting located in a residential area with private residences not owned by the provider? ○ Yes ○ No Optional Comments:
7) Is the setting located in a rural setting? ○ Yes ○ No Optional Comments:

Home/Community Characteristics Particularly Susceptible to Infringement in Larger Living Environments:
1) Are individuals living at this address experiencing a true community home or is this being impaired by the larger nature of the services setting? ○ Yes ○ No Optional Comments:
2) Do the individuals have their own bedrooms? ○ Yes ○ No Optional Comments:
3) If individuals share bedrooms, are they able to choose their roommate? ○ Yes ○ No Optional Comments:
4) Are individuals allowed to change roommates? ○ Yes ○ No Optional Comments:
5) Do individuals have full access to the whole house, such as kitchen, dining area, laundry and comfortable seating in shared areas? ○ Yes ○ No Optional Comments:
6) Is there adequate space to allow individuals to keep food of their choice in the kitchen? Is the refrigerator large enough to accommodate their needs? ○ Yes ○ No Optional Comments:
7) Is the home accessible to meet the physical needs of the individuals living there, including no steps or barriers for those with mobility issues? All areas, including showers, sinks, and appliances should be accessible for use by all people living at the setting. ○ Yes ○ No Optional Comments:
8) Are individuals able to decorate their own space as they wish, i.e., can they hang their own pictures and pick their own curtains/bedding? ○ Yes ○ No Optional Comments:
9) Are individuals able to decorate the common areas of the home, if they wish? ○ Yes ○ No Optional Comments:

Access to the Community:
1) Are the individuals living at this address experiencing restrictions to accessing the community due to the larger nature of this services setting? ○ Yes ○ No Optional Comments:
2) Do individuals have options for day services other than those provided by the residential provider?

	○ Yes ○ No Optional Comments:
3)	Are individuals given information about community activities? (Festivals, religious activities, concerns, sporting events, movies, etc.) ○ Yes ○ No Optional Comments:
4)	Do individuals regularly shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community as the individual chooses? Are they supported to attend if they so choose? ○ Yes ◉ No Optional Comments:
5)	Is public transportation accessible from the setting? (For example, a public bus stop is nearby) ○ Yes ○ No Optional Comments:
6)	If there is no public transportation available, is there other transportation available to take individuals to non-health related appointments, shopping, etc.? ○ Yes ○ No Optional Comments:

Right to dignity and privacy:
1) Are staff available to assist individuals privately? For example, if the individual needs help with hygiene, toileting? ○ Yes ○ No Optional Comments:
2) If an individual has a complaint, do they know how to make complaints anonymously? ○ Yes ○ No Optional Comments:
3) Is health information about individuals kept in a secure and private location? Is private information kept in confidence, with personal records, medications, etc., being stored in a way that it is accessible only to those who need it – including the individual? ○ Yes ○ No Optional Comments:
4) Is health information about individuals kept in a secure and private location? Is private information kept in confidence, with personal records, medications, etc., being stored in a way that it is accessible only to those who need it – including the individual? ○ Yes ○ No Optional Comments:
5) Are supports and/or adaptations available for individuals who need them? ○ Yes ○ No Optional Comments:
6) Is the furniture arranged as individuals prefer and does the arrangement assure privacy and comfort? ○ Yes ○ No Optional Comments:
7) Can the individual close and lock the bedroom door? ○ Yes ○ No Optional Comments:
8) Can the individual close and lock the bathroom door? ○ Yes ○ No Optional Comments:
9) Do staff and or other residents always knock and receive permission prior to entering a bedroom or bathroom? ○ Yes ○ No Optional Comments:
10) Do staff use a key to enter private spaces under limited circumstances agreed upon by the individual? ○ Yes ○ No Optional Comments:
11) Do the individuals have comfortable places for private visits with family and friends? Is the furniture arranged to support small group conversations? ○ Yes ○ No Optional Comments:

12) Does the individual have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement?

○ Yes ○ No

Optional Comments:

13) Does the individual know his/her rights regarding housing and when s/he could be required to relocate?

○ Yes ○ No

Optional Comments:

Appendix H: Possible Employment First Legislation

Statement of purpose.

The Nebraska Legislature finds that the benefits of meaningful and competitive work have significance and importance to all working-age individuals, including persons with disabilities. Work is a fundamental component to establish and maintain quality of life, individual productivity, and a means to exercise freedoms and choices available to all citizens. Living with a disability does not mean a person does not also have abilities.

Recent federal initiatives also drive the notion that Nebraskans with disabilities have opportunities to actively enter the workforce just as those without disabilities. The federal Workforce Innovation and Opportunity Act (WIOA), effective in 2016, builds upon past federal/state initiatives in which Nebraska has engaged, such as the Ticket to Work program, to further make this an expected reality.

Nebraskans with disabilities should have every opportunity to engage in competitive employment. Yet a significant number of Nebraskans with disabilities are unemployed, underemployed, working in agency programs featuring segregated environments, or working in sheltered workshops. These situations are too often accepted as the inevitable outcome of living with a disability.

Research and practice have demonstrated repeatedly that people with disabilities can and do obtain jobs in the competitive workforce and integrated work environments. People with disabilities can use their abilities when a good employment match is found, and when the employee has access to appropriate, responsive supports including, but not limited to, customized employment services.

It shall be the policy that agencies providing services to working-age persons with disabilities have an obligation to assist and support persons with disabilities to secure competitive employment in integrated work environments. Employment in the general workforce is the first and preferred outcome in the provision of publicly funded services for all working age citizens with disabilities, regardless of level of disability. Employment opportunities in fully integrated work settings shall be a priority and the first option explored in service planning for working-age persons with disabilities.

Definitions.

As used in this section, unless the context otherwise requires:

"Competitive employment" means work in the competitive labor market, that is performed on a full-time or part-time basis in an integrated setting and for which a person with a disability is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Disability" means, with respect to an individual: an individual with a disability as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

"Integrated setting" means with respect to an employment outcome, a setting in the community in which persons with disabilities interact with persons without disabilities, other than those providing services to persons with disabilities, to the same extent that persons without disabilities in comparable positions interact with their community.

"Working-age" means persons age 16 and older employed or permitted to work in any employment as defined in section 48-301.

Employment first policy.

It is hereby declared to be the policy of this State that competitive employment in an integrated setting shall be considered a priority and shall be the first option offered when planning for or providing services to persons with disabilities who are of working-age. All state agencies that provide services and support to persons with disabilities shall follow this policy and ensure that it is effectively implemented in their programs and services. Nothing in this Act shall be construed to limit or disallow any disability benefits to which a person with a disability who is unable to be employed as contemplated by this Act would otherwise be entitled. Nothing in this Act shall be construed to require any employer to give preference to hiring persons with disabilities.

Implementation of policy by state agencies.

All state agencies shall coordinate efforts and shall collaborate within and among such agencies to ensure that state programs, policies, procedures and funding support competitive employment in integrated settings for persons with disabilities who are of working age. All state agencies are required to adopt measurable goals and objectives to assess progress in implementing this Act as well as adopt measures to collect program data. All state agencies shall regularly collect and share data and information across systems in order to demonstrate progress toward full implementation of and compliance with this Act.

State agencies are authorized to adopt rules and regulations to implement this Act.

All appropriate state agencies shall seek out and apply for federal funding to the maximum extent possible to implement this Act.

Establishment of Employment First Advisory Council.

The Employment First Advisory Council is created. The council shall be appointed by the Governor, comprised of individuals from a variety of disciplines who are knowledgeable in disability issues including the employment of people with disabilities, be selected to be representative of the geographical and cultural diversity of the state and to reflect gender fairness. The council shall consist of thirteen voting members.

Powers and duties of the Employment First Advisory Council.

The focus of the council shall be to increase the number of Nebraskans with disabilities achieving competitive integrated employment. The commission shall work collaboratively with state agencies that provide services to assist Nebraskans with disabilities to become employed. The council shall review measurable goals, objectives, and other data as requested of each relevant state agency to ensure the purpose of this Act is fulfilled. All state agencies shall fully cooperate with and provide data and information to assist the council in carrying out its duties.

The council shall prepare an annual report to the Governor and members of the Nebraska legislature detailing progress toward achieving the purpose and implementation of this Act. All state agencies shall cooperate with the council on the creation and dissemination of the report. The report also shall identify barriers to achieving the outcomes along with the effective strategies and policies that can help realize the employment first initiative.

Membership and Operation of the Employment First Advisory Council.

The members shall include four members who are persons with disabilities who are not state employees, one member who is experienced with employment service programs for persons with disabilities and who is not a state employee, a representative of the Department of Labor, a representative of Nebraska Vocational Rehabilitation, a representative of the Nebraska Department of Education, a representative of the Nebraska Division of Behavioral Health, a representative of the Division of Developmental Disabilities Services, one member with an interest and background in disability advocacy, a representative of the One Stop system, and a representative of the Nebraska Department of Veteran's Affairs.

The initial members of the council shall be appointed for staggered terms of one, two, or three years. All subsequent appointments shall be made for terms of three years. Any vacancy on the council shall be filled in the same manner in which the original appointment was made and shall last for the duration of the term vacated. Appointments to the council shall be made within ninety days after the operative date of this act. The council shall select a chairperson, a vice-chairperson, and such other officers as it deems necessary.

The Commission shall hold regularly scheduled business meetings at least once in each quarter, at such times as the chairperson deems necessary, or at the request of a majority of the members of the council. Members of the council shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.