# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A.** The **State** of **Nebraska** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Family Support Waiver

**C. Type of Request: new**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

◉ **3 years** ○ **5 years**

☐ **New to replace waiver**

Replacing Waiver Number:

**Base Waiver Number:**

**Amendment Number** (if applicable):

**Effective Date:** (mm/dd/yy)

**Draft ID:** **NE.024.00.00**

**D. Type of Waiver** *(select only one):*

Regular Waiver

**E. Proposed Effective Date:** (mm/dd/yy)

01/01/24

**PRA Disclosure Statement**

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so

that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This request is for a new waiver to provide a home and community-based services family support program which will provide support to children through age 21 with intellectual and developmental disabilities and their families.

Purpose:
The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a menu of services and supports intended to allow children with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. Services encourage and promote the full vision of the HCBS Final Settings Rule requirements. DDD encourages services, which are participant-directed as well as offered by an agency provider, to ensure the maximum flexibility for the participants served under this waiver.

Participant-directed services, delivered by independent providers, are services directed by the participant, their legal representative, or family/advocate. Participant-directed services are intended to give the participant more control over the type of services received, as well as control or choice of the direct providers of those services.

Services that are not participant-directed are delivered by agency providers.

All services provided directly to the participant by either independent or agency providers are habilitative in nature and provide habilitative training with the exception of Respite services, which are non-habilitative by design.

During the initial and annual service planning process Service Coordinators will offer all participants the option to choose between the provider-managed or participant-directed service delivery models. All participants are assumed to be capable of self-direction with or without a freely chosen program representative. Participants who choose participant-direction may self-direct all services with the exception of Day Supports. Opportunities for participant-direction include budget authority and employer authority (common law employer) based on service definitions. Services eligible for employer authority will include the opportunity for participants to set wage rates within a meaningful range (between minimum wage and the maximum service rate less employer taxes). On or before July 1, 2024, DHHS will contract with a qualified contractor/vendor through a competitive procurement process to provide Financial Management Services (FMS) for all participants who choose participant-direction. Prior to the FMS, DHHS will perform provider enrollment and provider monitoring activities.

Goals and Objectives:
To offer participants an array of services, which focus on choice, independence, employment, community inclusion, and integration to meet the needs and wants of the participant by:
• Encouraging the use of community-based services rather than institutionalized care in an Immediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for participants whose needs can be met by community-based developmental disability providers.
• Promoting a high quality of service delivery in community-based services, which supports inclusion, integration, employment, and choice.
• Expanding participant direction of services.
• Providing an opportunity for participants to transition from school-based programs to adult services, thus ensuring the continuation of skill development.

Organizational Structure and Service Delivery:
DDD, a Division within the Single State Medicaid agency, will administer the Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Family Support waiver, which will serve up to 850 children through age 21.

Designated DHHS personnel and a provider screening and enrollment vendor enroll all agency and independent providers as Medicaid providers. Specialized DHHS personnel, DD Surveyors, certify DD provider agencies. DDD supports the free choice of participants and their legal representatives to select from the available pool of agency-based and independent providers to deliver services and supports, with assistance as needed provided by DDD service coordination. DDD service coordination is funded as a Medicaid State Plan targeted case management service. Designated DDD personnel complete the initial level of care (LOC) evaluations, and LOC reevaluations. Services are prior authorized by DDD personnel, as the individualized budget is capped at $10,000 per Neb. Rev. Stat. §68-1530.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the state's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

**C. Statewideness.** Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
  *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
*Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:**

**A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

**1.** As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

**2.** Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

**3.** Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

**1.** Informed of any feasible alternatives under the waiver; and,

**2.** Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

The public input process for this waiver application is done in accordance with 42 CFR 441.304(f). The following strategies are used to secure public input for this waiver application:

Specific to Tribal Notice, the public comment period allows at least 30 days for comment before the anticipated submission date and per the Nebraska State Plan, includes written 30 day notification to all federally-recognized Tribal Governments which maintain a primary office or majority population within the State in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs, and Urban Indian Organizations. The Tribal Notice for this waiver application was distributed on INSERT DATE. The Tribal Notices are available through DHHS Division of Medicaid and Long Term Care (DHHS-MLTC) and DHHS-DDD.

To reach all stakeholders, the public notice is both electronic and non-electronic to ensure people without computer access have the opportunity to provide input. A public notice seeking public comment indicates the waiver application in its entirety is posted on the DHHS public website and is also available upon request in hard copy via mail, email, or by phone. The public can go to or call a local DHHS office or the DHHS-DDD Central Office to request a hard copy. Public comments can be provided via the internet, e-mail, fax, U.S. mail, or phone calls. Phone numbers, FAX numbers, e-mail addresses and staff names are provided on the DHHS public website and in the written notice.

DHHS-DDD conducted presentations via webinar on INSERT DATE and INSERT DATE and in person on INSERT DATE. During the public comment period from INSERT DATES, DHHS solicited input through: virtual and telephonic opportunities with tribal representatives; waiver participants; families; guardians; advocates; providers; the DHHS public website; and non-electronic public notice in the Omaha World Herald, a newspaper with statewide circulation.

The state provided statements of public notice and public input procedures. DHHS's public website contained public notice; the draft waiver application; a link to e-mail questions or comments; and a contact and address to mail comments.

A summary of INSERT NUMBER comments received during public comment is listed below. INSERT SUMMARY

**J. Notice to Tribal Governments**. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Green

**First Name:** Tony

**Title:** Director, Division of Developmental Disabilities

**Agency:** Nebraska Department of Health and Human Services

**Address:** P.O. Box 98947

**Address 2:** 301 Centennial Mall South

**City:** Lincoln

**State:** **Nebraska**

**Zip:** 68509

**Phone:** (402) 471-6038 **Ext:** ☐ **TTY**

**Fax:** (402) 471-8792

**E-mail:** Tony.Green@nebraska.gov

**B.** If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Nebraska**

**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

DHHS.MedicaidSPA@nebraska.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:** Bagley

**First Name:** Kevin

**Title:** Director, Division of Medicaid and Long-Term Care

**Agency:** Nebraska Department of Health and Human Services

**Address:** P.O. Box 95026

**Address 2:** 301 Centennial Mall South

**City:** Lincoln

**State:** **Nebraska**

**Zip:** 68509-5026

**Phone:**

(402) 471-2135 **Ext:** ☐ **TTY**

**Fax:**

(402) 471-9092

**E-mail:**

Kevin.Bagley@Nebraska.gov

## Attachments

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The state assures that this waiver will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Developmental Disabilities

*(Complete item A-2-a).*

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

a) The functions performed by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD): DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and Quality Improvement (QI) activities. A provider screening and enrollment vendor performs enrollment of qualified providers and executes Medicaid provider agreements under the oversight of the Division of Medicaid and Long-Term Care (MLTC), which is the Medicaid agency.

b) The document utilized to outline the roles and responsibilities related to waiver operation: The Nebraska State Medicaid Plan Section A1-A3, approved March 6, 2014, effective Jan 1, 2014. (NE 13-0030-MM4) outlines designation and authority.

c) The methods employed by the designated State Medicaid Director in the oversight of these activities: The State Medicaid Director is the Director of MLTC. Oversight is a collaborative effort among designated personnel within MLTC and DDD. Designated Administrators from MLTC and DDD have regularly scheduled meetings to review discovered and/or anticipated issues; direct remediation and proactive activities; and strategically plan for collaborative alignment of Nebraska's Medicaid HCBS waivers.

Oversight methods include but are not limited to review of reports of provider non-compliance, coordinating corrective action measures with DDD service coordination and DD surveyors as necessary and appropriate. MLTC prepares or reviews statistical and financial data for CMS reports in collaboration with DDD. MLTC personnel attend the quarterly DDD QI Committee meetings as an active participating member and meet with DDD personnel to review program and client issues as necessary and appropriate. Monthly, MLTC tracks the use of Medicaid funding on the use of Medicaid HCBS waiver funding relative to the budgeted amounts; monitors expenditures and budget projections; reviews the development, renewal, or amendments of HCBS waivers; and has final approval and electronic submittal authority. They also review the cost neutrality formulas developed in collaboration with DDD and submit claims quarterly for federal funds for allowable activities administered or supervised by DDD.

The frequency of the oversight is related to the oversight activity or collaborative projects and tasks, and ranges from monthly budget activities to annual reporting activities.

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

A Quality Improvement Organization (QIO)-like entity is the contracted entity that performs the duties and tasks associated with the mortality reviews.

A provider screening and enrollment vendor is the contracted entity who performs 1) Qualified provider enrollment and 2) Execution of the Medicaid Provider Agreement. In conjunction with designated DHHS personnel, and within established timeframes, the provider screening and enrollment vendor electronically enrolls prospective independent and agency providers, conducts first-time or annual background checks, provides on-line and phone enrollment assistance to prospective providers, provides notice to the provider of approval or denial, and completes 5-year revalidation of provider status. The provider screening and enrollment vendor does not complete wage negotiation with the provider.

On or before July 1, 2024, DHHS will contract with a qualified vendor to provide Financial Management Services (FMS) to participants who choose self-directing. The contractor will:

1. Maintain a separate account for each participant's participant-directed budget.
2. Track and report participant funds, disbursements, and the balance of participant funds.
3. Process and pay invoices for goods and services approved in the service plan.
4. Assist the family or participant in managing and directing the disbursement of funds in the participant-directed budget.
5. Facilitate staff employed by the participant by performing employer responsibilities as the participant's agent, such as assisting in verifying employee citizenship status, collecting and processing timesheets, processing payroll, withholding Federal, state, and local tax, and making tax payments to appropriate tax authorities.
6. Perform fiscal accounting and report expenditures to the participant, family, and state authorities.

Prior to the FMS, DHHS will perform provider enrollment and provider monitoring activities.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DDD is responsible for assessing the performance of the QIO-like entity.

MLTC is responsible for assessing the performance of the contracted provider enrollment vendor.

DHHS is responsible for assessing the performance of the Financial Management Services.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The provider enrollment vendor submits monthly reports to MLTC Data Analytics Team. The Data Analytics Team in Medicaid reviews the information supplied by the vendor monthly to compare data against contract deliverables. The data, such as monthly average days to enrollment is utilized to address sub-assurances. The data submitted monthly covers both functions performed by the contracted entity.

The state reviews the monthly Nebraska Quality Mortality Report prepared by the QIO. All systematic quality improvement recommendations and/or follow up actions made by the Mortality Review Committee will be reviewed by the assigned DDD representative.

DHHS will assess the performance of the FMS vendor through an annual contract review, annual performance audit, monthly report reviews and annual participant/representative surveys.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **Participant waiver enrollment** | ☒ | ☐ |
| **Waiver enrollment managed against approved limits** | ☒ | ☐ |
| **Waiver expenditures managed against approved levels** | ☒ | ☒ |
| **Level of care evaluation** | ☒ | ☐ |
| **Review of Participant service plans** | ☒ | ☐ |
| **Prior authorization of waiver services** | ☒ | ☐ |

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **Utilization management** | ☒ | ☒ |
| **Qualified provider enrollment** | ☒ | ☒ |
| **Execution of Medicaid provider agreements** | ☒ | ☒ |
| **Establishment of a statewide rate methodology** | ☒ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☒ | ☐ |
| **Quality assurance and quality improvement activities** | ☒ | ☒ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**

***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

***For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application.*** *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

***Where possible, include numerator/denominator.***

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements.**
**Numerator = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements;**
**Denominator = Number of setting assessments completed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Electronic Database**

| **Responsible Party for data collection/generation***(check* | **Frequency of data collection/generation***(check* | **Sampling Approach***(check each that applies):* |
|---|---|---|

| *each that applies):* | *each that applies):* | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of QI Committee meetings held by the Division of Developmental Disabilities (DDD). N = Number of QI Committee meetings held by DDD. D = Number of QI Committee meetings scheduled.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Electronic Database**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of mortality reviews in which DDD determined Mortality Review Committee (MRC) took appropriate action. Numerator: Number of mortality reviews in which DDD determined MRC took appropriate action. Denominator: Total number of mortalities reviewed by the MRC.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Electronic Database**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Nebraska's population centers are clustered in the eastern portion of the state and the distribution of waiver openings and execution of provider agreements reflect the disproportionate distribution of the population. Therefore, the State does not measure the uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver and does not measure equitable distribution of waiver openings in all geographic areas.

Quarterly off-site file reviews are conducted by the DDD quality team. One hundred percent of the data available to report on these performance measures are analyzed by the DDD quality team. The DDD quality team conducts its reviews to ensure activities are being applied correctly, and reviews and remediation activities are completed as assigned.

The DDD quality team is responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory personnel. This information is summarized and reviewed by the DDD QI Committee (QI Committee) quarterly.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems, which allow for systematic oversight of services across the state by the QI Committee, while ensuring utility of the information at the local service coordination level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The QI Committee minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues which have been identified and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

The QI Committee receives reports and information and provides/shares feedback and support to the service districts. DDD makes all meeting minutes and reports available to the Medicaid Director for their review.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The participant's DDD Service Coordinator (SC) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

The Service Coordinator is responsible for in-person, on-site monitoring of participant health and welfare, and monitoring of the implementation of the person-centered service plan. Service coordination also monitors to ensure a participant resides in and receives services in a setting, which meets the HCBS regulations and requirements. Please see Appendix D QI-b-i for additional information on monitoring and methods of correction.

By statute, providers must report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of participants that are not required to be reported by law, the Protection and Safety personnel share this information with DDD service coordination and DHHS DD Surveyors within 24 hours of receipt. DHHS personnel triage/review the information and make a determination whether to do a complaint investigation or handle it in another manner.

The database for incidents is a state-mandated web-based case management system used for incident reporting and the database allows DDD to review and aggregate data in various formats. Quarterly, agency providers submit a report to DDD detailing the incidents in the quarter and actions taken both on a participant and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the QI Committee. The QI Committee determines the need for systemic follow-up and additional areas requiring probing or DDD management intervention.

Grievances, complaints, questions, or concerns are responded to by designated DDD program personnel. The DDD Director or DDD program personnel work with participants, the general public, service coordination, providers, legislators, or advocacy groups to address the grievance/complaint.

As part of their discovery processes, all Service Coordinator Supervisors are required to conduct a review of services coordination activities on an on-going basis as outlined in the approved DDD standard operating procedures. These reviews ensure all service coordination activities are being applied correctly. The review responses are documented in an electronic data system. Indicators that do not meet standards require remediation/supervisory follow-up. Threshold concerns are reviewed with the local DDD Service District Administrator and brought to the attention of DDD Central Office as needed. This information is summarized and reviewed by the DDD QI Committee quarterly. The summarized data for the service plan review are also shared with service coordination personnel at the local service coordination level.

MLTC is responsible for ensuring effective oversight of the enrollment broker. DDD works in collaboration with MLTC to identify processes and expectations of the enrollment broker that are not met as required. DDD analyzes data from MLTC to report on the performance measures. As problems are discovered with provider enrollment screenings or processing, DDD meets with the MLTC representative responsible for the enrollment broker contract to implement corrective actions.

Annual monitoring of agency provider settings is conducted by the DDD quality team. Providers who are found to be out of compliance or not progressing towards a plan for compliance with HCBS setting requirements are sent a results letter and given a set timeframe in which they are required to submit a remediation plan and supporting documents. Once the provider submits the remediation plan, it has a set timeframe in which to become compliant. Written communication to the provider states that failure to respond timely to requests for plans or documentation will be considered non-compliant and could result in a termination of all services in that setting.

The DDD quality team is responsible for scheduling the QI Committee meetings. If a meeting is cancelled, the DDD quality team is responsible for rescheduling.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☐ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☒ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☒ | Autism | 0 | 21 | ☐ |
| | ☒ | Developmental Disability | 0 | 21 | ☐ |
| | ☒ | Intellectual Disability | 0 | 21 | ☐ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | ☐ |
| | ☐ | Serious Emotional Disturbance | | | |

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

For individuals continuing in Special Education beyond their 21st birthday, eligibility may continue until the Special Education services end. In Nebraska, a student is entitled to complete their final year, rather than leaving school on their 21st birthday. The waiver authorization end date is the individual's high school graduation date and their 21st birthday.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

DDD personnel who determines the eligibility and the Developmental Disabilities (DD) Service Coordinator who provides case management, tracks waiver participants to determine when the participant will become ineligible for the waiver.

At the annual, but no later than the semi-annual person-centered Individual Support Plan (ISP) meeting the participant, family, Service Coordinator, and other team members will discuss the need for adult DD services, based on the participant's person-centered life goals, skills, abilities, needs, and the availability of non-DD services and supports.

If it is determined that adult DD services will best meet the person's needs, prior to the participant aging out of the Family Support waiver, the standard process for Priority Four for the Developmental Disabilities Adult Day waiver offer will be followed.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is** *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

*Specify:*

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

An individual budget amount is capped at $10,000 per Neb. Rev. Stat. §68-1530.

Participants receiving services from the Family Support Waiver are expected to have additional support from the parent, guardian, legally responsible individual, the family, natural supports, and from other public services, such as Medicaid State Plan, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and any other benefits they should qualify for that will ensure the health and welfare of the participant, as based on the person-centered service plan.

**The cost limit specified by the state is** *(select one)*:

◉ **The following dollar amount:**

Specify dollar amount: 10000

**The dollar amount** *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The annual budget amount of $10,000 was established Neb. Rev. Stat. §68-1530.

The service year begins with the effective date of the participant's approved person-centered service plan. During the development of the person-centered service plan, all potential sources for meeting the needs of the participant will be explored, such as private insurance, other federal programs, Medicaid State Plan, EPSDT, other state and local programs as well as non-paid support provided by family, friends as well as other natural supports who have been identified in their circle of support.

When a participant experiences a change in need after waiver eligibility is established, there is no additional waiver funding available for the Family Support Waiver, the following safeguards would be applied;
- The participant is assisted in locating and obtaining other non-waiver services to assist in meeting their needs; or
- The participant may be referred to apply for another waiver to accommodate the participant's needs.

Any applicant denied entrance onto the Family Support Waiver is offered the opportunity to request a Fair Hearing, as provided in Appendix F-1.

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 895 |
| **Year 2** | 975 |
| **Year 3** | 975 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | 850 |
| **Year 2** | 850 |
| **Year 3** | 850 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

| Purposes | |
|---|---|
| **Crisis** | |
| **Risk of Placement** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Crisis

**Purpose** *(describe):*

The purpose of this reserved capacity category is to support a child and the family unit who are in a crisis situation due to the child's tendency to self-injure, injure their siblings, and other family members.

**Describe how the amount of reserved capacity was determined:**

Reserved capacity is based on the historical needs of state wards and approval of funding by the Nebraska legislature. The State believes the number of slots reserved will meet the projected need.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 10 |
| Year 2 | 10 |
| Year 3 | 10 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Risk of Placement

**Purpose** *(describe):*

The purpose of this reserved capacity category is to support a child who is at risk for placement outside of their family home or at risk for placement into juvenile detention centers or into other institutional-type settings.

**Describe how the amount of reserved capacity was determined:**

Reserved capacity is based on the historical needs of state wards and approval of funding by the Nebraska legislature. The State believes the number of slots reserved will meet the projected need.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 5 |
| Year 2 | 5 |

| Waiver Year | Capacity Reserved |
|---|---|
| Year 3 | 5 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ○ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ◉ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

All persons who meet eligibility criteria as defined in Nebraska Revised Statute §83-1205 will be assessed for Medicaid HCBS Waiver level of care and placed on a statewide data registry. This statewide data registry is for all individuals who have been determined eligible for services on any of Nebraska's developmental disabilities waivers. The date used to establish a person's placement on the statewide data registry is the date of application from which eligibility for developmental disabilities in Nebraska was originally established.

For year one of implementation of the Family Support Waiver, 850 individuals currently on the statewide data registry will be identified for entrance to the Family Support Waiver based on the criteria as defined in Neb. Rev. Stat. §68-1532. Additional individuals on the statewide data registry who meet this criterion will be placed on the Family Support Waiver waitlist. For year two and moving forward, individuals on this waitlist are prioritized for entrance to the Family Support Waiver based on the criteria as defined in Neb. Rev. Stat. §68-1532. The priorities set forth in Neb. Rev. Stat. §68-1532 are as follows:

1. Responding to the need of disabled children and family units in crisis situations in which the disabled child tends to self-injure or injure siblings and other family members;
2. Responding to the needs of disabled children who are at risk for placement in juvenile detention centers, other institutional settings, or out-of-home placements;
3. Responding to the needs of disabled children whose primary caretakers are grandparents because no other family caregivers are available to provide care;
4. Responding to the needs of families who have more than one disabled child residing in the family home; and
5. Responding to the needs of all other persons by the date of application.

If there is a change in a person's needs, they may contact DDD and request that an assessment of an immediate crisis be completed. Persons who are assessed to be in an immediate crisis and the crisis cannot be resolved in another way shall be prioritized the highest on the statewide data registry. An immediate crisis due to situations that threaten the life and safety of the individual or members of the family, or the child is at risk of placement outside of the family home is defined by the following criteria:

1. Behavioral challenge is such that the person is seriously injuring/harming self or
2. Injuring siblings in the family home, or
3. Injuring other family members in the family home, or
4. Law enforcement or child welfare contact involvement where the child is at risk of being placed outside of the family home.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Waiver Phase-In/Phase-Out Schedule**

Based on Waiver Proposed Effective Date: 01/01/24

**a. The waiver is being** (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

**b. Phase-In/Phase-Out Time Schedule.** *Complete the following table:*

**Beginning (base) number of Participants:** 300

**Phase-In/Phase-Out Schedule**

**Waiver Year 1**

**Unduplicated Number of Participants: 895**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jan | 300 | 0 | 300 |
| Feb | 300 | 0 | 300 |
| Mar | 300 | 250 | 550 |

**Waiver Year 2**

**Unduplicated Number of Participants: 975**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jan | 850 | 0 | 850 |
| Feb | 850 | 0 | 850 |
| Mar | 850 | 0 | 850 |

**Phase-In/Phase-Out Schedule**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Apr | 550 | 0 | 550 |
| May | 550 | 250 | 800 |
| Jun | 800 | 50 | 850 |
| Jul | 850 | 0 | 850 |
| Aug | 850 | 0 | 850 |
| Sep | 850 | 0 | 850 |
| Oct | 850 | 0 | 850 |
| Nov | 850 | 0 | 850 |
| Dec | 850 | 0 | 850 |

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Apr | 850 | 0 | 850 |
| May | 850 | 0 | 850 |
| Jun | 850 | 0 | 850 |
| Jul | 850 | 0 | 850 |
| Aug | 850 | 0 | 850 |
| Sep | 850 | 0 | 850 |
| Oct | 850 | 0 | 850 |
| Nov | 850 | 0 | 850 |
| Dec | 850 | 0 | 850 |

**Waiver Year 3**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jan | 850 | 0 | 850 |
| Feb | 850 | 0 | 850 |
| Mar | 850 | 0 | 850 |
| Apr | 850 | 0 | 850 |
| May | 850 | 0 | 850 |
| Jun | 850 | 0 | 850 |
| Jul | 850 | 0 | 850 |
| Aug | 850 | 0 | 850 |
| Sep | 850 | 0 | 850 |
| Oct | 850 | 0 | 850 |
| Nov | 850 | 0 | 850 |
| Dec | 850 | 0 | 850 |

**c. Waiver Years Subject to Phase-In/Phase-Out Schedule**

| Year One | Year Two | Year Three |
|---|---|---|
| ☒ | ☐ | ☐ |

**d. Phase-In/Phase-Out Time Period**

| | Month | Waiver Year |
|---|---|---|
| Waiver Year: First Calendar Month | Jan | |
| Phase-in/Phase-out begins | Mar | 1 |
| Phase-in/Phase-out ends | Jun | 1 |

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.** **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

**2. Miller Trust State.**

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

  *Select one*:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  *Specify:*

•Former Foster Care Children (435.150)
•Infants and Children Under Age 19 (435.118)
•Pregnant Women (435.116)
•Parent/Caretaker Relative (435.110)
•Reasonable Classification (435.222)
•Children Eligible under Title IV-E Foster Care and Adoption Agreements (435.145)
•Children under 19 with Non-IV-E Adoption Assistance (435.227)
•Optional Targeted Low Income Children (435.229)
•TMA (1925)
•Breast or Cervical Cancer Treatment Group (1902(a)(10)(A)(ii)(XVIII))
•Deemed Newborns (435.117)
•DAC (1634(c))
•Pickle (435.135)
•1619(b) recipients
•Medicaid expansion (42 CFR 435.119)

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

☐ **A special income level equal to:**

*Select one*:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☒ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

*Select one*:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

*Specify:*

Recipients who are medically needy with spenddown: The State will use the actual maximum monthly allowable ICF/IID rate to reduce an individual's income to an amount at or below the medically needy income limit (MNIL) for persons who are medically needy with a Share of Cost.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's

income:

**i. Allowance for the needs of the waiver participant** (*select one*):

◉ **The following standard included under the state plan**

*Select one*:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

◉ **Other standard included under the state Plan**

*Specify:*

• Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL
• Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

*Specify:*

○ **Other**

*Specify:*

**ii. Allowance for the spouse only** (*select one*):

◉ **Not Applicable**
○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in**

**§1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance** (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  *Specify:*

**iii. Allowance for the family** (*select one*):

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  *Specify:*

- ○ **Other**

  *Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

*Specify formula:*

◉ **Other**

*Specify:*

• Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL
• Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
◉ **The state does not establish reasonable limits.**
○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

○ **Other**
*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DDD personnel perform the initial evaluation of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) institutional level of care are required to have a Bachelor's degree in education, psychology, social work, sociology, human services, or a related field and professional experience in services or programs for persons with intellectual or other developmental disabilities.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Individuals who are deemed to require ICF/IID institutional level of care are enrolled in and maintained on (pursuant to reevaluation) this waiver.

The following waiver eligibility criteria, which are the same as the state's ICF/IID level of care criteria, are assessed to initially determine, or evaluate, whether an individual needs services through the waiver.

a. Self-care in six activities of daily living;
b. Receptive and Expressive Language;
c. Learning;
d. Mobility;
e. Self-direction;
f. Capacity for Independent Living;
g. Social Skills and Personality; and
h. Economic Self-sufficiency.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The ICF/IID level of care assessment tool for waiver evaluation and reevaluation is a state-mandated, evidence-based, assessment tool that is used for all ages and is comparable to the ICF/IID Utilization Review assessment tool completed for institutional ICF/IID placement. Both tools note skills, abilities, preferences, and needs, including health needs, means of communication, and behavioral concerns.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the

evaluation process, describe the differences:

An initial evaluation and an annual reevaluation of waiver eligibility are conducted by DD personnel.

The initial evaluation process is conducted by DD personnel interviewing the participant, family, school personnel, or others as applicable.

The same criteria, three of eight limitations, are required at the reevaluation. The process for the annual reevaluation includes a review of the ICF/IID level of care assessment tool; the service plan; and Medicaid eligibility status. A Service Coordinator (SC) or a designee from DD, will complete the applicable tool by working directly with the participant, family, guardian, provider, etc.

As a last step, DD personnel provide notification of the annual ICF/IID level of care reevaluation to the participant, their family, and their service plan team. When eligible, the participant is maintained on the waiver. When the participant is not eligible, because they do not meet ICF/IID level of care, the participant is removed from the waiver and the waiver case is closed.

Participants who are determined not eligible for waiver services receive written notification of their ineligibility via a Notice of Determination and are then eligible for a Fair Hearing under the state regulations when they believe the eligibility determination was made in error or the ICF/IID level of care determination is not accurate.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  *Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  *Specify the qualifications:*

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

DDD has an internal policy that outlines timelines to ensure reevaluations are completed in a timely manner. Personnel who complete reevaluations utilize the web-based case management system, which are components of case management to ensure timely reevaluations of waiver eligibility. DDD personnel run electronic reports to determine when reevaluations are conducted timely and review findings at monthly supervision meetings

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Initial evaluation and annual reevaluation for ICF/IID level of care are maintained electronically by DDD in an electronic record for each participant. The electronic records are permanently maintained in a web-based case management system.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

***The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of new waiver applicants with a reasonable indication of need for whom an evaluation for LOC was provided. Numerator = Number of new waiver applicants with a reasonable indication of need for whom an evaluation for LOC was provided. Denominator = Number of new waiver applicants with a reasonable indication of need.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Electronic Database**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c.** ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of initial/annual LOCs in which LOC criteria were appropriately applied according to the approved waiver. Numerator = Number of initial/annual LOCs in which LOC criteria were applied according to the approved waiver; Denominator = Number of initial/annual LOC determinations.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level with +/- 5% margin of error |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Annual reevaluation of waiver eligibility is completed for all (100%) waiver participants.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The state monitors level of care (LOC) evaluations and reevaluations, and takes action to address discovered individual problems, which may include failure to complete LOC evaluations/reevaluations, failure to follow established timelines, inaccurate determinations, and missing or incomplete documentation.

Monthly quality assurance reports are electronically generated for access by DDD personnel and are reviewed at both the field office and central office levels to ensure continued Medicaid and DD waiver eligibility for participants. DDD Personnel, Service Coordinators (SC), and Service Coordination Supervisors (SCS) review reports and take appropriate action as needed on individual cases. These positions are responsible for the initial waiver eligibility determinations and they complete a LOC assessment when a funding offer is available for a new participant. When there are issues identified with LOC evaluations involving personnel performance (whether a DD personnel, SC or SCS), the personnel will be retrained. When the personnel find issues with participant's maintaining their eligibility, they are responsible for correcting the issue such as facilitating activities for recertification of Medicaid, correcting a service authorization to change or end DD waiver services, completing a LOC assessment, etc.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nebraska waiver participants are afforded choice among waiver services as well as between waiver services and institutional care and this information is provided by the participant's Service Coordinator. Information about Nebraska's DDD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the participant in understanding DDD waiver services, funding of their services, and their roles and responsibilities. Choice of ICF/IID or waiver services is documented on a waiver consent form which also explains the right and process to appeal.

A signature for consent, documenting the waiver participant's choice to receive community-based waiver services over services in an institutional setting, is obtained upon initial determination of waiver eligibility and is kept in the participant's electronic waiver file. When guardianship or legal status changes, the Service Coordinator must obtain a new, signed consent.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The waiver consent form is kept in the participant's electronic file maintained by DDD personnel. The records are maintained permanently in electronic files by DDD personnel.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on an ongoing basis:

- Oral language assistance services such as interpreters;
- Written materials are translated in several languages, such as applications, brochures, due process, and the Notice of Decision;
- If there is a need for written material(s) to be translated, a request can be made from service coordination or others to DDD Central Office.
- Second language hiring qualifications;
- Availability of translators, including sign language;
- Language line is available and used statewide; and
- Website is available in several languages.

# Appendix C: Participant Services

## C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service | | |
|---|---|---|---|
| **Statutory Service** | **Respite** | | |
| **Other Service** | **Assistive Technology** | | |
| **Other Service** | **Child Day Habilitation** | | |
| **Other Service** | **Community Integration** | | |
| **Other Service** | **Day Supports** | | |
| **Other Service** | **Environmental Modification Assessment** | | |
| **Other Service** | **Family and Peer Mentoring** | | |
| **Other Service** | **Family Caregiver Training** | | |
| **Other Service** | **Home Modifications** | | |
| **Other Service** | **Homemaker** | | |
| **Other Service** | **Independent Living** | | |
| **Other Service** | **Participant Directed Goods and Services** | | |
| **Other Service** | **Personal Emergency Response System (PERS)** | | |
| **Other Service** | **Supported Family Living** | | |
| **Other Service** | **Transportation** | | |
| **Other Service** | **Vehicle Modifications** | | |

# Appendix C: Participant Services

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

Respite

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 09 Caregiver Support | 09011 respite, out-of-home |
| **Category 2:** | **Sub-Category 2:** |
| 09 Caregiver Support | 09012 respite, in-home |
| **Category 3:** | **Sub-Category 3:** |

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

Respite is a non-habilitative service that is provided to participants unable to care for themselves and is furnished on a short-term, temporary basis for relief to the usual unpaid caregiver(s) living in the same private residence as the participant. Respite includes assistance with activities of daily living (ADL), health maintenance, and supervision.

Respite includes the cost of camp fees.

Respite may be provided in the caregiver's home, the provider's home, or in community settings.

Respite may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Respite is limited to no more than 240 hours per annual budget year. Unused Respite cannot be carried over into the next annual budget year.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Respite provided in an institutional setting requires prior approval by DDD and is authorized only when no other option is available.

Respite is reimbursed at an hourly rate.

Any use of respite, when the participant is awake or asleep over eight hours within a 24-hour period is not reimbursable.

Respite requires the provider to use Electronic Visit Verification (EVV).

Federal financial participation must not be claimed for the cost of room and board except when provided as a part of respite care furnished in a facility approved by DDD and not a private residence.

Transportation during the provision of Respite is included in the rate. Non-medical transportation to the site at which Respite begins is not included in the rate. Non-medical transportation from the site at which Respite ends is not included in the rate.

Respite is not available to the usual unpaid caregiver(s) for employment or attending classes, or in lieu of Child Day Habilitation, Supported Family Living, or childcare responsibilities of the usual unpaid caregiver.

Respite must not be provided during the school hours set by the local school district for the participant. Regular school hours and days apply for a child who receives home schooling.

Respite must not be provided concurrently with other HCBS waiver services.

Respite must not be provided by any independent provider who lives in the same private residence as the participant or is a person legally responsible for the participant.

A Respite provider or provider staff must not provide respite to children and adults (18 years and older) at the same time and location, unless approved by DDD Central Office.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver service.

**Service Delivery Method** *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DD Agency |
| Individual | Independent Individual – Non-Habilitative Services |
| Agency | Independent Agency- Non-Habilitative Services |
| Agency | Independent Respite Care Service Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

DD Agency

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Non-Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency- Non-Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is verified through the annual or biennial DDD certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Independent Respite Care Service Agency

**Provider Qualifications**

**License** *(specify):*

175 NAC Health Care Facilities and Services Licensure.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Assistive Technology

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

Assistive Technology is equipment or a product system such as devices, controls, or appliances, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of participants and be necessary to ensure participants' health, welfare, and safety. The use of assistive technology enables participants who reside in their own homes to increase their abilities to perform activities of daily living in their home, or to perceive, control or communicate with the environment they live in, thereby decreasing their need for assistance from others as a result of limitations due to disability.

All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

Assistive Technology includes the equipment or product system as well as:

a. Services consisting of purchasing or leasing assistive technology devices for participants.

b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

c. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan.

d. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant.

e. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive Technology may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

DDD may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of the product. This assessment will be funded by the Environmental Modification Assessment service; as such, it will be reimbursed separately.

Assistive Technology is limited to devices, controls, or appliances to assist the participant to perceive, control, or communicate with the environment they live in.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Assistive Technology is reimbursed per item directly to the Medicaid enrolled provider or the manufacturer.

Providers cannot exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) must apply the same discount to the participants who would otherwise qualify for the discount.

Damaged, stolen or lost items not covered by insurance or warranty may be replaced once every two years.

The services under this Waiver are limited to additional services not otherwise covered under the Medicaid State Plan, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Individual – Non-Habilitative |
| Agency | Independent Agency – Non-Habilitative |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Non-Habilitative

**Provider Qualifications**

**License** *(specify):*

Electricians must be licensed in accordance with Neb. Rev. Stat. §§81-2106 - 2118. Plumbers must be licensed in accordance with Neb. Rev. Stat. §§18-1901 - 1919.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency – Non-Habilitative

**Provider Qualifications**

**License** *(specify):*

Electricians must be licensed in accordance with Neb. Rev. Stat. §§81-2106 - 2118. Plumbers must be licensed in accordance with Neb. Rev. Stat. §§18-1901 – 1919.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Child Day Habilitation

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04020 day habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

Child Day Habilitation is a habilitative service that provides teaching and staff supports to meet the age-appropriate needs of a child due to a disability or special health conditions. Child Day Habilitation takes place in the community, separate from the participant's private family residence, in a provider setting approved, registered, or licensed by the Nebraska Department of Health and Human Services. Participants receiving Child Day Habilitation must be integrated into the community to the greatest extent possible.

Child Day Habilitation activities and environments are designed to teach adaptive skills and build positive social behavior while meeting the child's additional needs related to a disability or special health conditions. Child Day Habilitation includes individually tailored teaching to assist with the acquisition, retention, or improvement in adaptive skill development not yet mastered in daily living activities, inclusive community activities, and the social and leisure skill development necessary which will lead to more independence and personal growth to live in the most integrated setting appropriate to their needs. Services also include the provision of supplementary staffing necessary to meet the child's exceptional care needs in a childcare setting. Child Day Habilitation includes the provision of personal care, health maintenance activities, supervision, and protective oversight beyond what is normally provided to children without disabilities or special health conditions.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Child Day Habilitation may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Child Day Habilitation is available for participants living in their private family residence who are under 21 years of age.

Participants receiving Child Day Habilitation cannot receive Community Integration.

The rates for this service do not include the basic cost of childcare unrelated to a child's disability. The "basic cost of childcare" means the rate charged by and paid to a childcare center or individual provider for children who do not have special needs. Regular childcare is expected to cover the care and supervision provided to children whose parents have elected to work or attend school and must arrange for someone else to take on those responsibilities in absentia. The cost of regular childcare is the responsibility of the participant's parents and is separated from the cost of habilitative services and staff supports due to the child's disability or special health condition. This is done by determining the cost of routine childcare and analyzing historical claims payment for the service to establish a rate that covers the exceptional physical, medical, or personal care needs required by the participant.

Child Day Habilitation only covers necessary services and supports associated with the child's physical, medical, personal care, or behavioral needs not included in regular childcare. Regular childcare and its cost paid by parents do not cover the medically necessary services needed to address disability and special health care conditions. Cost sharing is payment made for a covered service and is usually in the form of a co-insurance, co-payment, or deductible.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Child Day Habilitation is reimbursed at an hourly rate.

Transportation during the provision of Child Day Habilitation is included in the rate. Non-medical transportation to the site at which Child Day Habilitation begins is not included in the rate and is the parents' responsibility. Nonmedical transportation from the site at which Child Day Habilitation ends is not included in the rate and is the parents' responsibility.

Child Day Habilitation cannot be provided by a legally responsible member of the participant's family.

Child Day Habilitation may be provided by a relative who is not legally responsible for the participant.

This service cannot be provided during school hours set by the local school district for the participant. This limitation includes any, and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives home schooling.

The services under this Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Individual – License-Exempt Family Child Care Home – Habilitative Services |
| Individual | Independent Individual – Licensed Family Child Care Home I or II – Habilitative Services |

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency – Licensed Child Care Center – Habilitative Services |
| Individual | Independent Individual – In-Home Child Care Provider – Habilitative Services |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Child Day Habilitation**

**Provider Category:**
Individual
**Provider Type:**

Independent Individual – License-Exempt Family Child Care Home – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

In accordance with 392 NAC 1 Childcare and 391 NAC Children's Services Licensing.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.
All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - Have four or more years of professional experience in the provision of age-appropriate habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Child Day Habilitation**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Licensed Family Child Care Home I or II – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

In accordance with 391 NAC Children's Services Licensing

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the NAC, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Age appropriate habilitation training or relevant experience;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency staff in combination with designated provider enrollment broker.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider enrollment broker, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Child Day Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency – Licensed Child Care Center – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

In accordance with 391 NAC Children's Services Licensing

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid;
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Child Day Habilitation**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – In-Home Child Care Provider – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements as defined by the Department;
- Have necessary education and experience, and provide evidence upon request:
  - Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - Have four or more years of professional experience in the provision of age-appropriate services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Community Integration

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04020 day habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Community Integration is a habilitative service that provides formalized teaching, person-centered activities, and staff supports for the acquisition, retention, or improvement in self-help, behavioral skills, and adaptive skills that enhance social development. Habilitative activities are designed to foster greater independence, community networking, and personal choice.

Community Integration provides an opportunity for the participant to practice skills taught in therapies, counseling sessions, or other settings to plan and participate in regularly scheduled community activities. Community Integration includes supports furnished in the community. Community Integration includes assistance with activities of daily living (ADL), health maintenance, and supervision.

Individual programs must be specific, and measurable, and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system

Community Integration may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

This service may be authorized in combination with Day Supports service in the same person-centered service plan, but the service may not be provided and billed for concurrently.

Participants may not perform paid work activities or unpaid work activities in which others are typically paid but may perform hobbies in which minimal money is received, or volunteer activities.

Participants receiving Community Integration cannot receive Child Day Habilitation.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Community Integration is reimbursed at an hourly rate. The Community Integration provider is in the community, providing a combination of habilitation, supports, protective oversight, and supervision to bill in hourly units.

Transportation required in the provision of Community Integration is included in the rate. Non-medical transportation to the site at which Community Integration begins is not included in the rate. Non-medical transportation from the site at which Community Integration ends is not included in the rate.

This service cannot be provided during school hours set by the local school district for the participant. This limitation includes any, and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives home schooling.

Community Integration services may be provided by a relative but not a person legally responsible for the participant.

A Community Integration service provider or provider staff must not provide community integration to children and adults (18 years and older) at the same time and location. If Community Integration is provided to a child and adult at the same time and location there must be documentation in the person-centered service plan.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DD Agency |
| Individual | Independent Individual – Habilitative Services |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Integration**

**Provider Category:**

Agency

**Provider Type:**

DD Agency

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS, the provider screening and enrollment vendor, to ensure revalidation is completed annually, and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Integration**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - Have four or more years of professional experience in the provision of age-appropriate services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting a person with IDD; OR
  - Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS, the provider screening and enrollment vendor, to ensure revalidation is completed annually, and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Day Supports

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04020 day habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Day Supports is a habilitative service offering habilitative activities in a provider-owned or controlled non-residential setting. Day Supports provides person-centered activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral skills, and adaptive skills to enhance social development. Day Supports activities assist in developing skills in performing activities of daily living, and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Day Supports focuses on enabling the participant to attain or maintain their maximum functional level and must be coordinated with, but may not supplant, any physical, occupational, or speech therapies listed in the person-centered service plan. In addition, the services and supports may reinforce but not replace skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

Individual programs must be specific, and measurable, and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Day Supports may not be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

This service may be authorized in combination with Community Integration service in the same person-centered service plan, but the service may not be provided and billed for concurrently.

Day Support may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan and within the participant's approved annual budget.

Day Support is reimbursed at an hourly rate. The Day Support provider must be in the day site or community setting, providing a combination of habilitation, support, protective oversight, and supervision to bill in hourly units.

Transportation required in the provision of Day Support is included in the rate. Non-medical transportation to the site at which Day Support begins is not included in the rate. Non-medical transportation from the site at which Day Support ends is not included in the rate.

This service cannot be provided during school hours set by the local school district for the participant. This limitation includes any, and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives home schooling.

Documentation must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver services, or Vocational Rehabilitation programs.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DD Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Day Supports**

**Provider Category:**

Agency

**Provider Type:**

DD Agency

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS, the provider screening and enrollment vendor, to ensure revalidation is completed annually, and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental Modification Assessment

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17990 other |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

An Environmental Modification Assessment is a functional evaluation with the participant to ensure the health, welfare, and safety of the participant or to enable the participant to integrate more fully into the community and to function in the participant's private home (not provider owned or leased, operated or controlled), or in the participant's family's home, when living with their family.

The on-site assessment of the environmental concern includes an evaluation of the functional necessity, the determination of the provision of appropriate assistive technology, home, or vehicle modification for the participant, and the need for the modification to ensure cost effectiveness.

Environmental Modification Assessment may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The amount of prior authorized services is based on the participant's need as documented in the participant's person-centered service plan, and within the participant's approved annual budget.

Environmental Modification Assessment is reimbursed per assessment.

Providers must not exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) must apply the same discount to the participants who would otherwise qualify for the discount.

Environmental Modification Assessment may be provided by a relative but not a person legally responsible for the participant.

The services under this Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Individual - Non-habilitative service |
| Agency | Independent Agency – Non-habilitative service |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Modification Assessment**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual - Non-habilitative service

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.
All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant;
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
- Ensure all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation; and
- Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Modification Assessment**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency – Non-habilitative service

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be authorized to work in the United States;
- Not be a person legally responsible for to the participant;
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
- Ensure all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation; and
- Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Family and Peer Mentoring

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 09 Caregiver Support | 09020 caregiver counseling and/or training |
| **Category 2:** | **Sub-Category 2:** |
| 13 Participant Training | 13010 participant training |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

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

The outcome of this service is to support the participant, the family, or both in enhancing their knowledge and skills in understanding of available resources found in their local or surrounding community and how to access those resources. By knowing how to navigate available resources will assist the participant and their family in reaching the participant’s goals and outcomes they have set for themselves.

Family and Peer Mentoring may be not self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The amount of prior authorized services is based on the participant’s need as documented in the person-centered service plan, and within the participant’s approved annual budget.

Family and Peer Mentoring is billed at an hourly rate.

Providers of this service cannot mentor their own family members.

Providers of this service cannot mentor other unpaid caregivers who reside in the family home.

Transportation during the provision of Family and Peer Mentoring is included in the rate. Non-medical transportation to the site at which Family and Peer Mentoring begins is not included in the rate. Non-medical transportation from the site at which Family and Peer Mentoring ends is not included in the rate.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan, including EPSDT, or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency – Non-Habilitative |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family and Peer Mentoring**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency – Non-Habilitative

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation;
  - o Basic first aid; and
  - o Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Family Caregiver Training

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| 09 Caregiver Support | 09020 caregiver counseling and/or training |

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

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

This service is intended to assist the unpaid caregiver in understanding and addressing the participant's needs by building upon their own skills and knowledge to become more proficient in assisting the participant in reaching their life goals.

Family Caregiver Training service may address such areas as:
1. Understand the disability of the participant supported;
2. Achieve greater competence and confidence in providing supports;
3. Develop or enhance key parenting strategies;
4. Other areas so that the unpaid caregiver can most effectively support the participant's desired goals and outcomes as described in the person-centered service plan.

Family Caregiver Training service must be necessary in order to achieve the expected outcomes identified in the participant's person-centered service plan and must be directly related to the role of the unpaid caregiver in supporting the participant in areas specified in the person-centered service plan. All training for the caregiver who provides unpaid support to the participant must be included in the participant's service plan.

Family Caregiver Training includes payment available for registration and training fees associated with formal instruction in areas relevant to the participant needs identified in the service plan. Payment is not available for the costs of travel/transportation, meals, and overnight lodging to attend a training event or conference.

Family Caregiver Training may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Educational and training programs, workshops and conferences registration costs for unpaid caregiver is limited up to $500.00 per annual budget year.

This service may not be provided in order to train or educate paid caregivers.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan, including EPSDT, or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency – Non-Habilitative |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family Caregiver Training**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency – Non-Habilitative

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation;
  - o Basic first aid; and
  - o Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Home Modifications

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Home Modifications are physical adaptations to the participant's private home or to the family's home, when living with their family. Home modifications are necessary to ensure the health, welfare, and safety of the participant, or necessary to enable the participant to function with greater independence in their own participant-directed private home or in the family's home, thereby decreasing their need for assistance from paid and natural supports because of limitations due to disability.

Home Modifications are provided within the current foundation of the residence. Such modifications may include, but are not limited to, the installation of ramps, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems necessary to accommodate the modifications. Adaptations adding to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Approvable adaptations do not include adaptations or improvements to the home of general utility, and are not of direct medical or remedial benefit to the participant. The participant's home must not present a health and safety risk to the participant other than what is corrected by the approved home adaptations. Home Modifications will not be approved to adapt living arrangements for a residence owned or leased, operated or controlled by a provider of waiver services.

Home Modifications may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

DDD may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the adaptation to ensure cost-effectiveness and quality of the product. This assessment will be funded by the Environmental Modification Assessment service and will be reimbursed separately.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Proof of renter's insurance or homeowner's insurance may be requested.

Evidence of application to secure government-subsidized housing through the U.S. Department of Housing and Urban Development or other Economic Assistance programs may be requested.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

Home Modifications may be provided by a relative but not a person legally responsible for the participant.

The services under this Waiver are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency, Department of Education, companies for specialized equipment, supplies, and home repair. |
| Individual | Independent Individual – Non-Habilitative |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Modifications**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency, Department of Education, companies for specialized equipment, supplies, and home repair.

**Provider Qualifications**

**License** *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

**Certificate** *(specify):*

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

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must ensure all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons must make or oversee all modifications.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Home Modifications**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Non-Habilitative

**Provider Qualifications**

**License** *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

**Certificate** *(specify):*

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

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must ensure all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons must make or oversee all modifications.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

# Appendix C: Participant Services

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Homemaker

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08050 homemaker |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Homemaker service is the performance of the general household activities, such as meal preparation, laundry services, errands, and routine household care, when the person regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. This service does not include direct-care or supervision.

Homemaker may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Homemaker cannot be provided to participants receiving Independent Living.

Homemaker cannot duplicate or replace other supports available to the participant, including natural supports.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Homemaker is reimbursed at an hourly rate.

Homemaker requires the provider use Electronic Visit Verification (EVV).

Transportation is not included in the reimbursement rate.

Homemaker cannot be provided by any individual independent provider or agency staff member who lives in the same private residence as the participant, or is a person legally responsible for the participant.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Individual |
| Agency | Independent Agency/Company |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be age 19 or older and authorized to work in the United States;
- Not be an individual independent provider or agency staff member who lives in the same private residence as the participant;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Homemaker**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency/Company

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be authorized to work in the United States;
- Not be an individual independent provider or agency staff member who lives in the same private residence as the participant;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Independent Living

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |

**Category 3:** **Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

Independent Living is provided in the participant's private home, not in a residence owned or leased, operated or controlled by a provider. The participant lives alone or with housemates and is responsible for rent, utilities, and food.

Independent Living is a habilitative service providing individually tailored intermittent supports for a waiver participant, which assists with the acquisition, retention, or improvement in skills related to living in their own private home and community.

Independent Living includes adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores as well as, eating and the preparation of food, community living and activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. Providers of Independent Living generally do not perform these activities for the participant, except when not performing the activities poses a risk to the participant's health and safety.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Independent Living may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Independent Living is available for participants who are 19 years and older.

Independent Living is provided in the participant's private home, not a provider-owned or leased, operated or controlled residence.

Independent Living may be provided to one, two, or three participants, based on the participants' assessed needs.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Independent Living is provided to an awake participant who requires less than 24-hours of support a day.

Independent Living is reimbursed at an hourly rate.

The rate structure for this service is determined based on the group size. Group sizes of one, two, or three are based on the participant's assessed needs.

Independent Living requires the provider use Electronic Visit Verification (EVV).

Participants receiving Independent Living cannot have an active service authorization for Respite.

Participants receiving Independent Living cannot receive Supported Family Living.

Transportation required in the provision of Independent Living is included in the rate. Non-medical transportation to the site at which Independent Living begins is not included in the rate. Non-medical transportation from the site at which Independent Living ends is not included in the rate.

Independent Living may be provided by a relative but not a legally responsible individual or guardian of the participant.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district for the participant. Regular school hours and days apply for a child who receives home schooling.

This service shall not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Individual – Habilitative Services |
| Agency | DD Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Independent Living**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:

- Complete all provider enrollment requirements;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

## C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Independent Living**

**Provider Category:**

Agency

**Provider Type:**

DD Agency

**Provider Qualifications**

**License** *(specify):*

No license is required

**Certificate** *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is verified through the annual or biennial DD certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed every five years.

# Appendix C: Participant Services

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Participant Directed Goods and Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17990 other |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

| Category 4: | Sub-Category 4: |
|---|---|
| | |

This service will be implemented upon implementation of the FMS which will occur on or before 7/1/2024.

Participant Directed Goods and Services include equipment, supplies, items, or services that enables the participant to maintain or increase independence and promote opportunities for community living and inclusion.

Participant Directed Goods and Services must provide a direct benefit to the participant, address an identified need in the participant's person-centered service plan and the specific equipment, supplies, item, or service that are purchased under this service must be documented in the person-centered service plan.

Participant Directed Goods and Services may not be used for the following:
- Personal items not related to the participant's intellectual disability or developmental disability;
- Experimental or prohibited treatments;
- Co-payment for medical services, over-the-counter medications, or homeopathic services;
- Training provided to paid or unpaid caregivers;
- Cost of travel, meals, and overnight lodging to attend training or conference;
- Entertainment activities, including vacation expenses, food, and drink/alcohol, tobacco/nicotine products, movie tickets, subscriptions, televisions and related equipment, and other items as determined by DDD;
- Expenses related to routine daily living, including groceries, rent or mortgage payments, utility payments, home maintenance, gifts, pets/animals, insurance, vehicle maintenance or any other transportation-related costs, self-employment/business related expenses, and other items determined by DDD; or
- Equipment, supplies, item, or service that are excluded from receiving Federal Financial Participation, including but not limited to room and board payments.

Participant Directed Goods may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The amount of prior authorized Participant Directed Goods and Services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Providers of this service shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

This service shall not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan, including EPSDT, Vocational Rehabilitation, or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Vendor Financial Management Services |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Participant Directed Goods and Services**

**Provider Category:**

Agency

**Provider Type:**

Vendor Financial Management Services

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

The Participant/Representative and/or FMS should ensure that only competent qualified providers of goods and services with the appropriate expertise, training, and background are paid with waiver funds.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Personal Emergency Response System (PERS)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

PERS is an electronic device, which enables participants to secure help in an emergency. The participant may also wear a portable PERS to allow for mobility. The system is connected to the participant's telephone and programmed to signal a response center once a PERS is activated.

The provision of PERS includes:
1. Instruction to the participant about how to use the PERS device;
2. Obtaining the participant's or authorized representative's signature verifying receipt of the PERS unit;
3. Ensuring response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days per week;
4. Furnishing a replacement PERS unit when needed to the participant within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Updating a list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensuring monthly testing of the PERS unit; and
7. Furnishing ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the participant in the use of PERS devices, as well as to provide for system performance checks.

Personal Emergency Response System (PERS) may not be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Personal Emergency Response System (PERS) cannot be authorized for a participant who resides in a residence that is provider-owned or leased, operated or controlled.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

PERS is reimbursed as a monthly rental fee or as a one-time installation fee.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency. |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Emergency Response System (PERS)**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency.

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider of this service must ensure all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant;
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
- Complete all provider enrollment requirements;
- Ensure response is provided 24 hours per day, seven days per week;
- Furnish replacement PERS unit within 24 hours of malfunction of original unit;
- Ensure monthly testing of PERS unit; and
- Update responder contacts semi-annually.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

# Appendix C: Participant Services

## C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supported Family Living

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Supported Family Living is provided to the participant in the participant's private family home, not in a provider owned or leased, operated or controlled setting. The participant lives with relatives in their private family home.

Supported Family Living is a habilitative service providing individually tailored intermittent teaching and supports to assist with the acquisition, retention, or improvement in skills related to living in their own private home and community.

Supported Family Living includes adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, as well as eating and the preparation of food, community living and activities, transportation, and the social and leisure skill development necessary to enable the participant to live in their family home while meeting their need as identified in the person-centered service plan. Providers of Supported Family Living generally do not perform these activities for the participant, except when not performing the activities poses a risk to the participant's health and safety.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Supported Family Living may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Supported Family Living is provided to an awake participant who requires less than 24-hours of support a day.

Supported Family Living may be provided to one, two, or three participants, based on the participants' assessed needs.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Supported Family Living is reimbursed at an hourly rate.

The rate structure for this service is determined based on the group size. Group sizes of one, two, or three are based on the participant's assessed needs.

Supported Family Living requires the provider use Electronic Visit Verification (EVV).

Participants receiving Supported Family Living cannot receive Independent Living.

Transportation required in the provision of Supported Family Living is included in the rate. Non-medical transportation to the site at which Supported Family Living begins is not included in the rate. Non-medical transportation from the site at which Supported Family Living ends is not included in the rate.

Supported Family Living may be provided by a relative but not a person legally responsible for the participant.

This service cannot be provided during school hours set by the local school district for the participant. This limitation includes any, and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Agency – Habilitative Services |
| Individual | Independent Individual – Habilitative Services |
| Agency | DD Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Supported Family Living**

**Provider Category:**
Individual

**Provider Type:**

Independent Agency – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

In accordance with 391 NAC Children's Services Licensing.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Supported Family Living**

**Provider Category:**

Individual

**Provider Type:**

Independent Individual – Habilitative Services

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

No certification is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider of this service must:
- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - Have four or more years of professional experience in the provision of age-appropriate services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting a person with IDD; OR
  - Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation of provider is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Supported Family Living**

**Provider Category:**

Agency

**Provider Type:**

DD Agency

**Provider Qualifications**

**License** *(specify):*

No license is required.

**Certificate** *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system and electronic visit verification.

A provider delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation;
  - Basic first aid; and
  - Complete other DHHS trainings upon request;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is verified through the annual or biennial DD certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Transportation

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Transportation is a service designed to foster greater independence and personal choice. Transportation enables participants to gain access to waiver services, community activities, and resources, as specified by the participant's service plan. Transportation is not intended to replace formal or informal transportation options, like the use of natural supports.

Transportation may be self-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

This service does not include transportation to medical appointments available under the Medicaid State Plan or other federal and state transportation programs.

This service does not include transportation to the site at which Child Day Habilitation begins and from the site at which Child Day Habilitation ends and is the primary caregiver's responsibility.

Transportation is provided for a waiver participant to get to and from a location only using the most direct route.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Transportation is reimbursed per mile or cost of a bus pass.

Transportation may be provided by a relative but not a person legally responsible for the participant.

Agency provider mileage rate must not exceed the rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176 multiplied by three.

Individual provider mileage rate is paid at the mileage rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176.

The public transportation rate must not exceed purchase price by the public.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual – Individual Transportation Provider |
| Agency | Agency - Certified Commercial Carrier/Common Carrier |
| Agency | Agency - Public Service Commission Exempt Transportation Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

Individual – Individual Transportation Provider

**Provider Qualifications**

**License** *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484

**Certificate** *(specify):*

No certificate is required.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Ensure drivers possess a current and valid driver's license;
- Maintain the minimum vehicle insurance coverage as required by state law;
- Ensure drivers have not had their driver/chauffeur's license revoked within the past three years;
- Be age 19 or older and authorized to work in the United States; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Agency - Certified Commercial Carrier/Common Carrier

**Provider Qualifications**

**License** *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484.

**Certificate** *(specify):*

Certificate of Authority issued by the Nebraska Public Service Commission. Neb. Rev. Stat. §§75-301 - 322

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Ensure drivers possess a current and valid driver's license;
- Maintain the minimum vehicle insurance coverage as required by state law;
- Ensure drivers have not had their driver/chauffeur's license revoked within the past three years
- Meet and adhere to all applicable employment standards established by the hiring agency; and
- Be age 19 or older and authorized to work in the United States.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Agency - Public Service Commission Exempt Transportation Provider

**Provider Qualifications**

**License** *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484.

**Certificate** *(specify):*

Certificate to operate as a public transit authority issued by the Nebraska Department of Transportation

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Ensure drivers possess a current and valid driver's license;
- Maintain the minimum vehicle insurance coverage as required by state law;
- Ensure drivers have not had their driver/chauffeur's license revoked within the past three years;
- Meet and adhere to all applicable employment standards established by the hiring agency; and
- Be age 19 or older and authorized to work in the United States.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Vehicle Modifications

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 2:** | **Sub-Category 2:** |
| | |

**Category 3:** **Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:** **Sub-Category 4:**

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are specified by the person-centered service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The following are specifically excluded:

1. Adaptations or improvements to the vehicle of general utility, and are not of direct medical or remedial benefit to the participant.
2. Purchase or lease of a vehicle.
3. Purchase of existing adaptations or adaptations in process.
4. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
5. Adaptations to automobiles or vans owned or leased, operated or controlled by providers of waiver services.

Vehicle may not be self-directed

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

DDD may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service, and will be reimbursed separately.

The amount of prior authorized services is based on the participant's need as documented in the person-centered service plan, and within the participant's approved annual budget.

Proof of vehicle insurance may be requested.

Providers must not exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) must apply the same discount to the participants who would otherwise qualify for the discount.

When the vehicle is leased, the modification is transferrable to the next vehicle.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver services.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Independent Agency/Business; Department of Education Vocational Rehabilitation Assistive Technology Partnership; Companies for Specialized Equipment; Businesses for Vehicle adaptions. |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Vehicle Modifications**

**Provider Category:**

Agency

**Provider Type:**

Independent Agency/Business; Department of Education Vocational Rehabilitation Assistive Technology Partnership; Companies for Specialized Equipment; Businesses for Vehicle adaptions.

**Provider Qualifications**

**License** *(specify):*

All vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

**Certificate** *(specify):*

All vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

**Other Standard** *(specify):*

All providers of waiver services must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider of this service must ensure all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons must make or oversee all modifications.

All providers of waiver services must have computer skills and access to the technology needed to navigate the state-mandated web-based case management system.

A provider of this service must:
- Complete all provider enrollment requirements;
- Be authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

**Frequency of Verification:**

The program compliance is completed annually by DHHS and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination to waiver participants is provided by the Nebraska Department of Health and Human Services Division of Developmental Disabilities.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement of obtaining background and/or criminal history is outlined in Neb. Rev. Statute 83-1217(9) and below in this waiver, DDD uses the term “background checks” to refer to criminal history investigations, background investigations, and abuse and other registry screenings.

a) The types of positions for which such investigations must be conducted: The background checks are conducted by DHHS staff or a vendor under contract with DHHS, upon a request initiated by an independent provider or certified DD agency. All waiver providers who will provide direct contact services and supports, and any household member of an independent provider or agency-associated individual contracted provider, if services will be provided in the provider’s home, undergo the background checks. Certified DD agency providers must complete annual background checks on each employee or contractor associated with the DD agency that has direct contact with participants served by the agency. Initial background checks must be initiated by certified DD agency providers and annually thereafter to verify a staff person or associated individual contracted provider is not on the background check and registry lists. Employees who provide direct support services may not work alone with participants until the results of the background checks are reviewed by the provider.

b) The scope of such investigations: The state and federal registry checks consist of a review of the following:

1. Nebraska State Patrol Sex Offender Registry.
2. DHHS Adult Protective Services (APS) and Child Protective Services (CPS) Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse, and if applicable, verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states.

c) The process for ensuring that mandatory investigations have been conducted: On-site surveys, or certification review activities, conducted annually or biennially by DHHS staff ensure that required background checks have been conducted by the DD agency provider. Provider management personnel are interviewed and a sample of records is reviewed to confirm that background checks were completed on all employee and associated individual contracted providers. In addition, DHHS staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities and the frequency is based on the provider’s certification status, which is either a one-year certification or a two-year certification. In addition, DHHS staff review records to ensure that certified providers are in compliance with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Background checks are completed initially for each individual independent provider that has direct contact with participants as a part of the Medicaid enrollment process and are completed prior to an approval and authorization to deliver waiver services. Background checks are completed annually for each individual independent provider that has direct contact with participants. Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Once the background checks are completed on potential independent providers, the contracted vendor notifies DHHS staff by e-mail and electronically transfers the enrollment data. The vendor will notify DHHS if a potential provider fails a screening or background check and designated DHHS staff will issue a denial letter to the potential provider. The electronic enrollment data contains the verification and dates that the abuse registry checks were completed and is stored in perpetuity.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable):

In this waiver, DDD uses the term “background checks” to refer to criminal history investigations, background investigations, and abuse and other registry screenings.

a) The entity (entities) responsible for maintaining the abuse registry: The DHHS Adult Protective Services (APS) and Child Protective Services (CPS) Central Registries are maintained by employees of DHHS.

b) The types of positions for which abuse registry screenings must be conducted.
State service coordination employees and all waiver providers who will provide direct contact services and supports, and any household member of an independent provider or agency-associated individual contracted provider if services will be provided in the provider’s home undergo the background checks listed in C-2-a above and the following registry checks:

1. Nebraska State Patrol Sex Offender Registry
2. DHHS APS and CPS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse and if applicable, verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states

The background checks are conducted by DHHS staff or a vendor under contract with DHHS, upon a request initiated by an independent provider or certified DD agency. Initial background checks must be initiated by certified DD agency providers and annually thereafter to verify a staff person or associated individual contracted provider is not on the background check and registry lists. Employees who provide direct support services may not work alone with participants until the results of the background checks are reviewed by the provider. Background checks on state service coordination employees are completed prior to the first day of employment.

c) The process for ensuring that mandatory screenings have been conducted.
On-site surveys, or certification review activities, conducted annually or biennially by DHHS staff ensure that required background checks have been conducted by the DD agency provider. Provider management personnel are interviewed, and a sample of records is reviewed to confirm that background checks were completed on all employees and associated individual contracted providers. In addition, DHHS staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities, and the frequency is based on the provider’s certification status, which is either a one-year certification or a two-year certification. In addition, DHHS staff review records to ensure that certified providers are in compliance with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Background checks are completed initially for each individual independent provider that has direct contact with participants as a part of the Medicaid enrollment process and is completed prior to an approval and authorization to deliver waiver services. Background checks are completed annually for each individual independent provider that has direct contact with participants. Independent provider background check compliance is completed annually, and the provider enrollment vendor ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Once the background checks are completed on potential providers, the contracted vendor notifies DHHS staff by e-mail and electronically transfers the enrollment data. The vendor will notify DHHS if a potential provider fails a criminal history investigation, background investigation, or abuse and other registry screenings, and designated DHHS staff will issue a denial letter to the potential provider. The electronic enrollment data contains the verification and dates that the background checks were completed and is stored in perpetuity. A provider agreement is not issued prior to the completion of the criminal history investigations, background investigations, and abuse and other registry screenings.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (●) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A legally appointed guardian and a legally responsible relative of a waiver participant cannot provide services to a waiver participant. A legally responsible relative is the parent of a minor child or the spouse of the waiver participant.

Non-legally responsible participant relatives may provide services. Any potential provider meeting general and specific service standards has the right to be a provider. Non-legally responsible participant relatives may provide services as specified in the service definitions, scope, and limitations in accordance with provider standards outlined in Appendix C-1/C-3. The services non-legally responsible participant relative providers may provide include: Assistive Technology, Child Day Habilitation, Community Integration Environmental Modification Assessment, Home Modifications, Homemaker, Independent Living, Respite, Supported Family Living, and Transportation.

Provider agencies may hire participant relatives to provide waiver services when the relative is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure claims are submitted only for services rendered and for the services, activities, and supports specified in the service plan.

The State makes payment to non-legally responsible participant relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any non-legally responsible participant relative provider must only be made when the service provided is not a function the relative would normally provide for the participant without charge as a matter of course in the usual relationship among family members; and the service would otherwise need to be provided by a qualified provider. The provision of services by the non-legally responsible participant relative is determined through documented team discussion during the planning process, on a case-by-case situation by the participant's person-centered service plan team. The provision of services is monitored by the participant's state DDD Service Coordinator.

When services are delivered monthly, Service coordination personnel monitor, at a minimum on a quarterly basis, services are furnished and paid as specified in the service plan.

To ensure the provision of services is in the best interest of the participant, the person-centered service plan must be developed and monitored by a Service Coordinator without a conflict of interest to the relative provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Designated DDD personnel ensure payments are made only for services rendered by prior authorizing all services based on the participant's needs and by reviewing submitted billing documentation.

Determination the above circumstances apply is determined by the participant and their team and verified during enrollment of the potential independent provider.

The State does not make payments to members of the participant's immediate household for Home Modifications, Homemaker, and Respite services; to a legally responsible relative or guardian; or for activities or supervision for which a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) which are available to the participant.

The following controls are employed in the state-mandated web-based case management system to ensure payments are made only for services rendered:

1. The need for the service is documented in the service plan;
2. The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
3. DHHS personnel have prior authorized each waiver service to be delivered;
4. At the time services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to electronic recording of time in and time out and habilitation data;

5. A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
6. An Explanation of Payment is issued electronically; and
7. Edits are in place in the electronic systems.

○ **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers have the opportunity to enroll as waiver service providers. DD waiver services are provided by agencies, which successfully completed an enrollment process through DHHS and through the contracted enrollment provider broker.

The enrollment and certification requirements and procedures, and established timeframes are readily available to prospective DD agency providers on the DHHS public website.

Information for becoming an independent provider can be obtained from the waiver participant or DHHS personnel as well as on the DHHS public website.

Separate Agency Provider Orientation and Independent Provider Orientation are offered monthly and presented by DDD Central Office.

The participant interviews the potential provider to determine whether the provider will meet their needs. The potential provider is referred to DHHS personnel for enrollment. All willing and qualified independent providers can enroll.

On or before July 1, 2024, DHHS personnel and a vendor under contract with DHHS are responsible for enrolling independent providers as waiver providers. Within two business days of receipt of a referral, DHHS personnel enter the referral into the provider data management system for the enrollment process. An application number needed for access to the vendor web portal for enrollment is generated and a referral packet is sent to the potential provider. The referral packet includes billing information, the MC-19 Service Provider Agreement, an application number, and instructions on how to use the contracted vendor's web portal to enroll. The referral cover letter advises the potential provider of the need to provide verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states. Verifications of education/experience, CPR/First Aid, proof of age and a driver's license (as applicable) are also required. The completed MC-19 and all verifications, including out of state background checks must be uploaded into the vendor's web portal before the provider can enroll. The potential provider completes the enrollment process with the contracted vendor on line or, when requested, on paper. The vendor notifies the referring DHHS personnel by e-mail and electronically transfers the enrollment data to DHHS. Within ten business days, DHHS personnel notify the prospective independent service provider and complete the approval process.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.***

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**# & % of new enrolled licensed/certified providers that met licensure/certification standards and adhere to other standards prior to providing waiver services. N = # of new enrolled lic/cert. providers that met lic/cert., and other standards prior to providing waiver services. D = # of reviewed new enrolled lic/cert. providers providing waiver services.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and** | ☐ **Other** |

| | | |
|---|---|---|
| | **Ongoing** | Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**# & % of enrolled licensed/certified providers providing waiver services that met required licensure/certification standards at certification review. N = # of enrolled lic/cert providers providing waiver services that met required licensure/certification standards at certification review. D = # of all lic/cert providers due for certification review providing waiver services that were reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**# and % of new enrolled non-licensed/non-cert providers that initially met rq'd provider standards, specified in the waiver, prior to providing wvr svcs. N=# new enrolled non-licensed/non-cert providers that initially met provider standards, specified in the waiver, prior to providing wvr services. D=# all new non-licensed/non-certified providers providing services that were reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**# and % of enrolled non-licensed/non-certified providers providing waiver srvs that met provider standards as specified in the waiver at annual screening. N= # of enrolled non-lic/non-cert providers providing wvr srvs that met provider standards as specified in the wvr at annual review. D= # of all non-lic/non-cert providers providing srvs that had an annual screening that were reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#&% of licensed/certified providers providing waiver services who met training requirements as specified in state regs and the waiver at the cert review. N: # lic/cert providers providing waiver services who met training requirements as specified in state regs and the waiver at the cert review. D: # of reviewed lic/cert providers who had cert review.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**# & % of enrolled non-licensed/non-certified providers who met the training requirements as specified in state regs and approved waiver at their annual review.**
**N: # of enrolled non-licensed/non-certified providers who met the training requirements as specified in state regs and approved waiver at their annual review.**
**D: # of reviewed non-lic/non-cert providers that had their annual review.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Activities for the determination of compliance with the above sub-assurances and performance measures are completed by DHHS staff and a vendor under contract with DHHS. The sample size for this review is determined by:

1. Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR
2. Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

Monitoring of the delivery of services is conducted by the Service Coordinator, with input from the participant and/or representative when, applicable.

Enrollment of qualified providers is completed by DHHS staff and the contracted vendor. DHHS has the ultimate responsibility for enrolling qualified providers and the execution of Medicaid provider agreements. Each DD agency provider is certified prior to delivering waiver services in accordance with state regulations and re-certified annually or biennially, based on the provider's certification status.

All providers of waiver services must be Medicaid providers, as described in the Title 471 regulations, and adhere to the same general conditions and standards. The provider enrollment broker ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not constitute employment.

Once DHHS approves the provider (Medicaid provider agreement and authorizations in place), web-based training for the provider is available, based on the provider type (independent or agency) and service type. Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

The CBS QI committee meets quarterly and reviews the CBS Quarterly QI Report. Recommendations are made for action by appropriate parties, including DHHS-DD management, members of the committee, and other DHHS staff. The QI activities of DHHS-DD and results of reports are communicated by DHHS to provider organizations, the DHHS-DD Advisory Committee, the Nebraska DD Planning Council, and to participants, families, and other interested parties. See Appendix H for additional information on the State's quality improvement strategies.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the local and state levels have been developed to discover whether the Qualified Providers waiver assurance is being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that are aggregated and analyzed to measure the overall system performance.

The quality management strategies for addressing individual problems related to qualified providers are completed at the local level.

When an issue with performance of an independent provider is identified, the Financial Management Service contractor will collaborate with the SC, state agency representatives, and the participant and family to remedy the issue. The participant and/or their family may address the provider or may ask for assistance in addressing the concerns or issues with the provider. The issue, discussion, and resolution are documented and retained in the state-mandated web-based case management system.

The Service Coordinator (SC) is responsible for facilitation and development of the person-centered service plan and then monitoring the implementation of each person-centered service plan in its entirety quarterly or when services are not provided monthly, monitoring will occur on a monthly basis instead of quarterly in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session. The monitoring data is documented and retained in the state-mandated web-based case management system.

Monitoring mechanisms include:
1. A review of all components of the person-centered service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the person-centered service plan is necessary; and
3. A semi-annual review of the person-centered service plan by the SC and the service plan team. The team reviews progress, implementation of the person-centered service plan, and the need for any revisions to the service plan.

Waiver participants and/or their families may ask for assistance from their SC in communicating to their independent providers their expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC may increase monitoring activities, participate in discussions with the participant, family, and provider, provide talking points, facilitate revisions to the person-centered service plan, or, upon direction from the participant and their family, terminate the authorizations for that provider.

When a pattern of inappropriate or inaccurate claims is detected, a referral is made to the DHHS Program Integrity Unit.

The quality management strategies for reviewing qualified providers are completed at the state level. The CBS QI Committee meets on a quarterly basis and reviews aggregate data for local, district, or statewide monitoring and certification to identify trends related to specific individual and agency providers and recommends resolutions and/or changes that will support service improvement.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

The total annual dollar budget limit of $10,000 per participant was established by Nebr. Rev. Stat. §68-1530 and will only be adjusted if additional funding is provided through legislative appropriation.

Participants are notified in writing, per a mail notice by DDD personnel of their individual budget amount as well as the dollar limits of waiver services at the time of the initiation of DD waiver services and in the development of the person-centered service plan.

Participants who are 21 years of age or younger and still eligible to receive services through IDEA shall have a portion of their daily support and supervision needs covered by the Department of Education, EPSDT. The waiver does not fund HCBS waiver services during school hours.

When a participant experiences a change in need after waiver eligibility is established, as there are no additional waiver funding available for the Family Support Waiver, the following safeguards would be applied;
1. The participant is assisted in locating and obtaining other non-waiver services to assist in meeting their needs; or
2. The participant may be referred to apply for another waiver to accommodate the participant's needs.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The state employs another type of limit.
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

1. At the time of submission of this waiver application, all settings, including private homes, will be monitored through monthly reviews of person-centered plans by Services Coordinators with participants and at annual and semi-annual review meetings facilitated by Services Coordinators.

2. Nebraska's monitoring efforts will occur at the individual, provider, and state levels. All settings, including private homes, are continually monitored through monthly reviews of person-centered plans with participants and at annual review and semi-annual meetings facilitated by service coordinators, which include Home & Community-based Services (HCBS) settings criteria in the monitoring process.

Monitoring efforts at the individual level include a review of person-centered service plans. Relevant forms include indicators of compliance with the HCBS final rule. DDD will ensure that service delivery system staff continue to receive training on person-centered planning philosophy and practice, including the empowerment of the individual to fully understand the range of options available to them and their rights in making individual choices. Training will emphasize an individual's right to select where they live and to receive services from the full array of available options, including services and supports in their own or family homes. The trainings will include curricula on supporting informed choice and identifying areas that providers must address. Guidance will be provided to service coordinators on how to educate individuals about person-centered philosophy and practice, which supports federal HCBS setting requirements. It will also include rights, protections, person-centered thinking, and community membership.

Monitoring efforts at the provider level for all provider-owned, operated, or controlled settings include ensuring current providers maintain compliance. Licensing, certification, and/or service delivery system staff will be critical to ensuring compliance of providers. Strategies to ensure ongoing compliance will include:
1. Ongoing licensing inspections and certification reviews by appropriate staff; and
2. Ongoing HCBS setting compliance monitoring to ensure that settings continue to comply with the HCBS regulations.

At the State level, DDD will ensure staff members are appropriately trained on the HCBS regulations and expectations. DDD works with Department of Public Health (DPH) licensure and certification staff to reduce duplication of effort in each Division's survey process.

DDD staff will conduct ongoing monitoring for all provider-owned, operated, or controlled settings through the use of file reviews and also through the annual provider review process, to assure continuous monitoring and improvement. All provider-owned, operated, or controlled settings are monitored for all parts of the HCBS Final Rule. This will include determining sample sizes to ensure providers are complying with HCBS regulations on an ongoing basis.

DDD staff will also actively monitor the provision of services and supports identified in the participant service plan at a frequency and intensity which ensures needs are met and that any necessary revisions to the service plan are completed. This includes monitoring individual private homes, non-licensed settings, and anywhere services are received.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

Individual Support Plan, hereafter referred to as person-centered service plan.

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  *Specify qualifications:*

DD Service Coordination is provided as Targeted Case Management under the Medicaid State Plan.

The qualifications of a Service Coordinator are:

1. Bachelor's Degree in education, psychology, social work, sociology, human services, or a related field.
2. Experience in services or programs for persons with intellectual or other developmental disabilities.
3. Ability to: mobilize resources to meet participant needs; communicate effectively to exchange information; develop working relationships with participants, their families, interdisciplinary team members, agency representatives, and independent providers; analyze behavioral and habilitative data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) program rules, policies, and procedures;
and organize, evaluate, and address program/operational data.
4. Knowledge of current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities and community-based programming to support people to live their best life; person-centered thinking and person-centered planning; case management; provision of habilitation; positive behavioral supports; and statutes and regulations pertaining to delivery of HCBS waiver services for participants.

☐ **Social Worker**

*Specify qualifications:*

☐ **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant.

The participant's Service Coordinator provides support to the participant and their family to actively lead in the development of their person-centered service plan. The participant and their family also have the option to direct their Service Coordinator to facilitate the service plan development meeting so the participant may actively participate as a team member.

a) The supports and written information which are made available to the participant to direct and be actively engaged in the service plan development process:
DDD requires and promotes a person-centered approach to services. Prior to the service plan meeting(s), the Service Coordinator works with the participant and their family to coordinate invitations for their service plan meetings, dates, times, and locations. The process of coordinating invitations includes whom to invite, times and locations of convenience to the participant and their family, and the inclusion of remote meetings for some teammates when feasible to enhance full and active engagement for all.

Information is available for review prior to the development of the person-centered service plan meeting includes but is not limited to available resources providing an overview of services, fact sheets for NE Medicaid HCBS Waivers developed by DDD Central Office, person-centered tools to assist in identifying needs, personal goals, service preferences, and identification of health and safety risks.

Service planning teams are comprised of people who know and care about the participant. The participant and their family, the Service Coordinator, service provider(s), and other persons chosen by the participant (e.g., advocates, natural supports, and friends) participate in the service plan process or parts of the process.

The process provides necessary information and support to ensure the participant and family direct their service plan meeting to the maximum extent possible and is empowered to make informed choices and decisions. The planning process reflects the cultural considerations and communication needs of the participant and the family. The participant is encouraged and assisted to participate in every aspect of their service planning meeting as fully as they are able and choose to do so.

The participant and their family direct the development and updates the person-centered service plan, and others sign to indicate their participation and agreement in supporting the participant in developing a person-centered service plan according to their hopes and dreams in living the life they choose for themselves.

b) The participant's authority to determine who is included in the process:
Persons involved in the planning process will be determined by the participant and their family, but must at least include the participant and their representatives of their prospective DD provider(s), and the Service Coordinator. The participant may raise an objection to a particular provider representative and the service plan team must attempt to accommodate the objection while allowing participation by provider representatives.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Who develops the plan, who participates in the process, and the timing of the plan:
Persons eligible for waiver services have a person-centered service plan developed prior to the authorization of the initial service package and annually thereafter. Service planning begins immediately following approval of the waiver slot with an Individual Family Meeting (IFM) with the participant and their family. The purpose of this pre-service planning meeting is to gather information by using person-centered tools and practices in discovering what is important to and important for the participant and what supports they need to be safe and healthy while leading the life of their choosing. This meeting is also the opportunity for the Service Coordinator to explain, answer questions and share information and resources about the available service array, including provider options. After the IFM is held, the team meets to develop the service plan using the same person-centered tools and practices. This person-centered service plan is individually tailored to address the unique preferences and needs of the participant. The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies and supports, including paid and unpaid support to be provided to assist the participant in achieving their personal goals for a good life.

Members in the planning process are determined by the participant and their family, but must at least include the participant and their Service Coordinator, and DD agency provider representatives when agency-directed services are provided or independent provider(s) when participant-directed services are provided. The Service Coordinator is responsible for scheduling concurrent remote and/or in-person service plan meetings, coordinating, and documenting the service plan meetings, and facilitating the participation of all team members at the request of the participant and/or their family. The Service Coordinator elicits and records facts and information from other team members, advocates with the participant, encourages team members to explore differences, and discovers areas of agreement so consensus can be reached. This is accomplished by the team using a person-centered approach and methodologies, such as Charting the LifeCourse. The Service Coordinator documents the service plan and the specific responsibilities of each team member regarding the implementation of services, supports, and strategies, and adheres to the electronic processes for service plan development and authorization. Meetings are scheduled at a time and place which accommodates the needs of the participant and their family. Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all team members. The participant or any other team member of the team may request a team meeting at any time.

Each participant and their family also direct, with support as needed, their semi-annual service plan meeting. The purpose of the semi-annual service plan meeting is to review the implementation of the annual person-centered service plan, document the participant's future plans and personal goals, explore how the team can assist the participant to achieve those goals, determine the information needed to develop appropriate supports for achieving the participant’s future plans, assign responsibility for gathering information, and review any other issues impacting the participant in achieving to living the life they want.

b) The types of assessments, which are conducted to support the service plan development process, including securing information about participant needs, preferences, goals, and health status:
The person-centered service plan must identify the needs, goals, and preferences of the participant and specify how those needs, goals, and preferences will be addressed. To accomplish that, assessments to evaluate the participant’s strengths, abilities, and areas needing growth to support the person-centered service plan development are determined by the team. These may include, but are not limited to, the participant and family self-reporting, psychiatric reports, psychological reports, assessments conducted by the Education System, and information from a provider that assesses the participant’s skills and abilities (e.g., developmental stages, vocational, medication administration, home living skills, communicative intent of behavior, etc.).

Health and welfare are addressed through a variety of assessments, which may be completed by the provider, Service Coordinator, Education System, and Medical Professionals. Assessments include but are not limited to, the ICF/IID institutional level of care assessment tools, multidisciplinary reports, Individual Education Plan reports, medical evaluations, health screens, health assessments, and incident reports.

c) How the participant is informed of the services available under the waiver:
The participant and their family are informed of available services under the waiver prior to the initial service plan development and annually thereafter at the IFM meeting.

The Service Coordinator provides to each participant and their family for informed choice that includes, but is not limited to, an introduction to services; the roles and responsibilities of the participant, service coordination, and provider; and service definitions. The information also includes information about rights, responsibilities, and risks; developing a

person-centered service plan; finding providers, resources of approved and available providers; and Participant Guide for Self-Direction that provides information related to services offered under the waiver program; the participant rights and obligations; due process rights; providers' roles and responsibilities, for applicable participant-directed service options – how to hire, fire, and direct providers; and claims review and verification processes.
General information regarding service planning and service options are also available on the DHHS public website, within the Division of Developmental Disabilities tab, and by contacting DD Central Office. However, the primary source of information for participants and families is received directly from service coordination, both verbally and in written form, when requested as described above, prior to entry into waiver services and annually thereafter.

d) How the plan development process ensures the service plan addresses participant goals, needs (including health care needs), and preferences:
Prior to waiver entrance, the participant, along with family and a team develop a detailed person-centered service plan based on a person-centered planning approach, tools, provided information, and information gathered from assessments. The service plan reflects the participant's strengths, abilities, personal goals, and identifies the needs and personal preferences, and specifies how those needs, personal preferences will be addressed, and the assignment of responsibilities. This includes the identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by natural supports, other Medicaid programs, as well as other non-Medicaid resources. The person-centered service plan also includes the following as appropriate:

1. Personal goals and outcomes;
2. Employment goals and strategies when the youth is at least 14 years of age;
3. Health and welfare related to medical, including medication, allergies, nutritional and/or other health risk factors;
4. Review of critical incidents and action needed or already taken to reduce the risk of future critical incidents;
5. Adaptive devices, including support and protective devices;
6. Finances and money management;
7. Identification of paid providers and/or non-paid providers, such as informal or natural supports, and a plan to locate needed provider(s) when applicable;
8. Description and schedule of strategies, services, and supports to be provided;
9. Identification of the budget, the projected monthly cost/utilization of services and supports to be provided, along with services and support to be provided by other non-DD funded resources; and
10. Back-up plan, for when an emergency should occur, if there is a community-wide emergency (e.g., requiring evacuation, to take cover, electricity goes out, etc.) and for each participant-directed service, in the event, participant-directed services aren't provided as scheduled. The backup plan may include provider staff or other natural supports. When the plan includes provider staff, back-up staff must be chosen by the participant, documented in the participant's service plan, and must meet all provider qualifications.

The person-centered service plan indicates how the participant, family, and team believe the plan will meet the health and safety needs of the participant. These needs may be met by a combination of DD agency services/supports, participant-directed supports, natural supports, services/supports from other DHHS programs, and other services/supports from other non-Medicaid sources. If it is determined the needs cannot be met under the current plan without posing a threat to the health and safety of the participant, the participant and their family and team will re-consider the appropriateness of the service array. This may require referral to other services or programs and the development of an alternate plan.

e) How waiver and other services are coordinated:
The person-centered service plan is the focal point of coordinating services under various programs beyond this waiver, including the Medicaid State Plan services, natural supports, as well as other resources for which they may qualify for. The person-centered service plan addresses the participant's and their family's specific needs while working towards achieving and maintaining a good quality of life as determined by their outcomes related to social life, career, relationships, community involvement, health and wellness, finances, life-long learning, advocacy, as well as any other preferences.

The Service Coordinator is responsible for coordination and oversight of the delivery of effective services for participants and their families through assessment, person-centered planning, service plan development, referral(s), and monitoring services. The Service Coordinator provides information about referrals and resources to the participant. The Service Coordinator may make direct referrals and coordinate related activities to help a participant obtain needed habilitation services, medical, social, employment, or other programs and services.

f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The person-centered service plan document identifies the services and supports, the schedule of delivery of services and supports, and the responsibilities to implement the plan. The Service Coordinator completes service reviews and follow-up activities with the participant and family, providers, or other entities to ensure the service plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes necessary in the person-centered service plan and service arrangements. The Service Coordination Supervisor reviews and approves the annual person-centered service plan to ensure it addresses the participant's goals, needs (including health care needs), and preferences in supporting each participant in achieving their life goal(s).

DD agency provider representatives and/or the participant's independent providers must participate in the development of the person-centered service plan. The participant and their family may choose not to invite their independent provider(s) to the person-centered service plan meeting but then is responsible to communicate their applicable services and supports, schedule of delivery of services and supports, and providers' responsibilities to implement the plan to the independent providers following each service plan meeting.

The Service Coordinator is responsible for reviewing the implementation of the plan by observing and documenting observations on the service review form. Service reviews are completed quarterly within the calendar year and are scheduled at the discretion of the Service Coordinator. The Service Coordinator may also complete a service review at the request of the participant and family or other team member or at any other time when the Service Coordinator determines it is necessary to monitor the service delivery.

g) How and when the plan is updated, including when the participant's needs change:
At a minimum, the team comes together annually to develop the person-centered service plan, and semi-annually to review the service plan. The person-centered service plan is updated during the semi-annual service plan meeting. When circumstances occur or needs change, the person-centered service plan may be updated following discussion and agreement via in-person, remote, electronic, or written communication. DDD does not utilize temporary or interim service plans; any changes to the service plan are done formally and with full team participation.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Information from various assessments conducted and from person-centered tools used during the planning process are reviewed to identify any potential risks. Through the development process, the participant, their family, Service Coordinator, the provider, and other team members develop strategies to identify, address and reduce identified risks. To mitigate any identified risk, supports and strategies are personally designed to meet the participant's needs, align with health risk screening tools when applicable, and are documented during the annual person-centered service plan meeting. These supports and strategies are reviewed again at the six-month semi-annual meeting and updated as needed.

A back-up plan is required in each participant's person-centered service plan. The need for and type of back-up is discussed at the person-centered service plan meeting and documented in the service plan. Consideration is given to the natural support(s) which may be available to fill in and the availability of other enrolled providers who could deliver services. Multiple independent providers may be enrolled as back-up or substitute providers. When the DD agency provider is selected, back-up arrangements are described in the provider's policies and procedures. Each DD agency provider has on-call or substitute staff available when a staff person fails to appear for work. All back-up staff must be chosen by the participant, documented in the participant's service plan, and must meet all provider qualifications.

DD providers are also expected to have disaster plans developed and documented so provider personnel are aware of expectations during such a time. Such plans should include where services should be provided when a disaster occurs, what necessary materials or equipment are needed for specific health or behavioral needs, what to do or where to go if there is a community-wide emergency, and who needs to be contacted in cases of emergency.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for participants with intellectual or developmental disabilities are voluntary, both for the participant and the provider. Choice of providers and services is based on mutual consent. Nebraska has regulations and processes in place to ensure participants are provided information about DD services and providers to facilitate informed decisions. DHHS offices are located throughout the state to provide a statewide system of service coordination. The DHHS public website includes information about DDD's responsibilities, service coordination, services funded by DHHS programs, certified DD agency providers, and non-certified independent providers as well as links to other resources for participants and families.

The Service Coordinator provides the participant and their family with information about and website addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD agency providers, and non-certified independent providers.

Information about local community services and supports, and how to access available services are provided to participants, who are determined to be eligible for DD services, at the time of eligibility determination and ongoing thereafter at the person-centered service plan meetings and more frequently as needed.

Service Coordination personnel may assist the participant to arrange interviews with potential providers. The Service Coordinator may assist the participant to arrange tours of potential DD agency providers. Participants often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select independent providers for participant-directed services.

When the participant is considering assistive technology (AT), home modifications, or vehicle modifications, the Service Coordinator authorizes an approved provider to complete an Environmental Modification Assessment, defined in Appendix C1/C3 to ensure the request is functionally necessary, appropriate, based on the service definition of the applicable service, and is cost-effective.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health and Human Services (DHHS) is the State Medicaid Agency for Nebraska, and the Division of Developmental Disabilities (DDD) is a division within the Medicaid agency. At a minimum, the team, facilitated by the DDD Service Coordinator, comes together annually to develop the person-centered service plan, and semi-annually to review the person-centered service plan. The person-centered service plan is updated during the semi-annual service plan meeting, and when circumstances occur and/or needs change the person-centered service plan may be updated following discussion and agreement via an in-person, electronic, or written communication.

All functions related to person-centered service plan approval are completed by DDD personnel. All annual service plans are read and reviewed by the designated Service Coordinator Supervisor upon receipt from the Service Coordinator.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the

appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare: The Service Coordinator is responsible for in-person, on-site monitoring of the participant's health and welfare, as well as monitoring of the implementation of the person-centered service plan. The Service Coordinator also monitors to ensure the participant resides and/or receives services in a setting, which meets the HCBS regulations and requirements.

b) The monitoring and follow-up method(s) used:
Service Coordination monitoring is designed to provide support to the participant and their families and allows for frequent communication through secure emails, phone calls, remote and face-to-face visits, both at their homes and at service provision sites. In addition, on-site monitoring of the provision of services is completed at least quarterly within the calendar year and is scheduled at the discretion of the Service Coordinator. A standardized DDD template is used by Service Coordinators whenever they are conducting monitoring.

At least quarterly within the calendar year, a review of all components of the service plan is conducted to ensure:
1. Delivery of services, supports, and strategies in accordance with the service plan;
2. Effectiveness of habilitation programming for habilitative services;
3. Access to waiver and non-waiver services identified in the service plan;
4. Free choice of provider(s);
5. Determination services meet participant needs;
6. Effectiveness of back-up plans, when applicable and utilized;
7. Health and welfare;
8. Review of paperwork, such as financial records or medication records; and
9. Other as applicable, i.e., physical nutritional management plans, adaptive devices, etc.

When services are not delivered monthly, monitoring of health and welfare will occur on a monthly basis instead of quarterly.

Follow-up and remediation process for issues discovered during on-site monitoring:
Observations made during monitoring or "in passing" are documented. Concerns are discussed with the provider working with the participant. When at any time it is noted supports or services are not being provided as noted in the service plan, the Service Coordinator works directly with the provider staff to reach a resolution. Anytime a concern is noted on the monitoring form, follow-up is required. Follow-up occurs with the provider on how to provide a resolution or address the concern noted on the monitoring form. The follow-up may occur by phone, secure email, remotely, or in-person. The Service Coordinator documents the follow-up completed on the monitoring form and in the service coordination case notes. When the issue is not resolved, the Service Coordinator completes a review and sends it to the agency provider staff supervisor, or to the independent provider and the participant, and to the Service Coordinator's supervisor. A written response is requested within 14 days from receipt of the review.

When a written response is received, the Service Coordinator reviews it to ensure the action taken will correct the problem. When the response is deemed inadequate or no response is received, the Service Coordinator contacts the person to whom the review was sent to find out the status of the response. When the response is still inadequate, the Service Coordinator sends the written documentation of noted concerns to the Service Coordinator Supervisor where both review the issue and determine the necessity of contacting the Manager of the agency provider staff or the participant and independent provider responsible for making changes or corrections to alleviate the concerns. A response from the provider within 14 days is requested when the issue has not been resolved. When a response is received, the Service Coordinator Supervisor and Service Coordinator review the response to ensure it meets the expectations in correcting the problem. When no response or an inadequate response is received, the Service Coordinator Supervisor sends the written documentation of noted concerns to the Service District Administrator (SDA) or their designee.

The SDA or designee contacts the administration of the agency provider or the participant and independent provider to develop a mutually agreed-upon plan of action. When no resolution is achieved, or when trends show the problems are recurring (such as "no ongoing habilitation provided," "programs not implemented as written," "programs not implemented at all," etc.) the SDA or designee informs the DDD Central Office of the problems and works with Central Office personnel to determine what steps will be taken. Central office personnel may provide consultation/technical assistance to the participant and independent provider, to the agency provider, refer an agency provider to DHHS -DDD Surveyors to perform a focused certification review specific to the delivery of services to a participant or provider setting or initiate the complaint process described in Appendix F as necessary.

During agency certification reviews conducted by DHHS DD Surveyors, the service plan is reviewed using the Core Sample Record Audit. Certification reviews are conducted annually, biennially, or more frequently as determined by DHHS management.

In addition, the person-centered service plan is reviewed at least semi-annually and updated annually to determine whether the plan developed and implemented by the team continues to meet the participant's needs. Areas reviewed include but are not limited to health and welfare, safety, habilitation, community involvement, and personal goals. The person-centered service plan identifies services, supports, interventions and strategies to be provided by the DD agency providers as well as services provided by independent providers of DD services.

When non-compliance issues are identified with the agency provider that cannot be resolved, DDD management may make a referral to DHHS surveyor personnel. The types of possible actions range from citing a deficiency to termination of the agency provider certification. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of improvement addressing the issues cited for those participants identified in the sample as well as address the issue cited on a system level within the agency provider. As for independent providers, action is taken to prevent billing for services until they come into compliance or termination by Medicaid.

The information derived from observing the implementation of the person-centered service plan and review of the person-centered service plan is entered into a database. Designated DHHS personnel have access to the database and may query the data to identify problems and trends.

Should immediate safety concerns be evident, the concern is expressed verbally to appropriate personnel to prevent the participant or others from being harmed. When it is necessary for the Service Coordinator to intervene to ensure the health and/or safety of the participant, such incidents are immediately discussed with the Service Coordinator’s Supervisor. Suspected abuse or neglect is reported to DHHS Adult Protective Services and Child Protective Services as appropriate. The Service Coordinator documents health and safety concerns in a case note and completes an incident report as necessary. Please refer to Appendix G for a detailed description of DDD’s critical incident management system.

c) The frequency with which monitoring is performed:
Service coordination verifies, through ongoing monitoring and review of services and supports provided continue to be effective. The Service Coordinator monitors the implementation of each person-centered service plan. This oversight has long been a part of the regulations, policies, and expectations regarding the role of service coordination in monitoring. In-person and on-site monitoring are conducted quarterly for each participant receiving waiver services. When services are not delivered monthly, monitoring of health and welfare will occur monthly instead of quarterly. Ongoing in-person and on-site monitoring are conducted when there are reported health and safety concerns, reports of abuse or neglect and/or when requested by a team member, or any other time when the Service Coordinator determines it is necessary to monitor the delivery of services. During each monitoring of the review of service, the Service Coordinator may choose to scrutinize only those items that surfaced as concerns during the previous monitoring to check that the concerns have been remediated. However, the Service Coordinator has the ultimate and ongoing responsibility to ensure the person-centered service plan implementation, health and welfare, safety, environmental factors, personal well-being, and issues related to community integration are adequate to meet the needs of the participant.

Concerns are reviewed with the local Service District Administrator and brought to the attention of DDD Central Office administration as needed.

Service Coordinators will make monthly contact with all participants on their caseload, as well as team members on an as needed basis, to make sure that services are provided as outlined in the person-centered service plan. This monitoring will continue when services are provided less than monthly.

**b. Monitoring Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

***The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of service plans reviewed which reflect the participant's goal(s). Numerator = number of service plans reviewed which reflect the participant's goal(s); Denominator = number of service plans reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**Number and percent of service plans reviewed that reflect the participant's assessed needs (including health and safety risk factors). Numerator = number of service plans reviewed that reflect the participant's assessed needs (including health and safety risk factors); Denominator = number of service plans reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed whose person-centered plans were**

**reviewed and revised on or before the annual review date. Numerator = number of participants reviewed whose person-centered plans were reviewed and revised on or before the annual review date. Denominator = number of participants reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed whose person-centered plans were revised, as needed, to address changing needs. Numerator = number of participants reviewed whose person-centered plans were revised, as needed, to address changing needs; Denominator = number of participants whose person-centered plan required a change due to a participant's changing needs that were reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**# and % of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-centered plan. N = # of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-centered plan. D = # of participants reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed whose case management files document an annual choice of waiver services. Numerator = number of participants reviewed**

**whose case management files document an annual choice of waiver services.**
**Denominator = number of participants whose case management files were reviewed.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed whose case management files document an annual choice of waiver providers. Numerator = number of participants reviewed whose case management files document an annual choice of waiver providers. Denominator = number of participants whose case management files were reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level with +/- 5% margin of error |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Service Coordinator Supervisor reviews the online initial service plan for each waiver participant to ensure it meets the waiver and regulatory standards. The process was developed to also ensure the service plan is completed in accordance with timelines and to aggregate the results to identify issues at various levels of DDD.

The Service Coordinator reviews assessment information, the participant's personal goals, and the service plan to determine if the services defined flow from the assessments and personal goals.

To allow for increased state oversight of the service review process, the responses are entered into a quality database. The database allows DDD personnel responsible for quality reviews to access the information and create aggregated reports to look at the performance of individual service coordinators and analyze systemic trends. DDD Central Office Quality personnel annually conducts off-site file reviews of a representative sample at a confidence interval of 95% with a +/- 5% margin of error to check service plan documentation. The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

In addition to the ongoing monitoring of the service plan, the Service Coordinator monitors the implementation of each service plan in its entirety quarterly or monthly when services are not delivered monthly, which may involve specific areas of the service plan within each service review.

Monitoring/service review mechanisms include:
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team when a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the service coordinator and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Monitoring is completed quarterly or monthly when services are not delivered monthly and additionally when there are reports of abuse or neglect, health and safety concerns, at the request of the participant or any other team member, or any time when the Service Coordinator determines it is necessary to monitor the service delivery.

To allow for state oversight of the monitoring process, responses on the monitoring forms are entered into a web-based database. This allows individual Service Coordinators to track issues, which are yet unresolved and provide aggregate information for Service Coordinator Supervisors, Quality personnel, and the DDD Central Office personnel. The information is useful for looking at the performance of individual Service Coordinators and providers, as well for identifying any area-wide issues. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during monitoring, the participant's Service Coordinator documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the participant, provider(s) of services, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the service review form as well as whether the issues were resolved within the timeline.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☒ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

## E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant.

On or before July 1, 2024, DHHS will procure Financial Management Services (FMS) as a contracted administrative activity to support participants who choose self-direction.

a) The nature of the opportunities afforded to participants: This option is available to every eligible participant. A participant may appoint a representative who may or may not be their legal representative, to assist them in self-directing their services (referred to as “representative”).

Participants are educated annually about Freedom of Choice, which includes the participant-directed model. Participant direction provides everyone with the opportunity to exercise choice and control over the self-directed services they receive and the employees they hire (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their budget) will be spent (budget authority.)

Under the participant-directed option, the participant is the common law employer of the qualified employees they directly hire. The FMS vendor acts as the fiscal/employer agent to the common law employer. This vendor is responsible for managing the receipt and distribution of the participant’s self-directed budget funds, processing and paying the participant’s qualified employee, providing orientation at the time of enrollment with the FMS vendor, and ongoing training and support to the participant and their employees.

b) How participants may take advantage of these opportunities: Two options are available to participants:
Employer Authority. This authority allows participants to recruit, hire, manage, and dismiss employees. Participants may draw from friends, family, or others that they recruit. The FMS ensures that Federal, State, and local employment taxes and insurance related to household employment and payroll are implemented accurately and timely. According to IRS regulations, the employer must be designated.
Budget Authority. This approach permits participants to manage an Individual Budget to purchase permissible items that enhance their independence and reduce their reliance on human assistance. The FMS pays invoices for the approved goods and services. This model also allows the participant to move funds among services and goods and services based on their needs.

The costs of administrative services provided by the FMS contractor is based upon a per-member-per-month (PMPM) rate and are not deducted from the person’s individual budget. Under this model, the participant or representative can:
1. Elect the participant-directed option.
2. Recruit and hire a qualified employee.
3. Provide required and participant-specific training to the qualified employee(s).
4. Determine the qualified employee’s work schedule and how and when the qualified employee should perform the required tasks.
5. Supervise qualified employees’ daily activities.
6. Evaluate the qualified employees’ performance.
7. Review, sign, and submit qualified employee’s time sheets to the FMS contractor
8. Discharge the qualified employee when necessary.
9. Work to develop an emergency backup plan to ensure staffing.
10. Notify the Service Coordinator of any changes in service needs.

Service Coordinators assist the participant upon request with information or links to information related to self-direction, including the benefits and responsibilities of self-directing some of their services. Service Coordinators will provide written educational materials regarding self-direction to participants upon request. These materials will also be provided during the annual service planning process to ensure unbiased information is being provided.

Service Coordinators will receive training in self-direction. Service Coordinators will also be provided with a side-by-side comparison of the two service delivery models to review with the participant if they have any questions. Service Coordinator activities related to self-direction include:
1. Introduce the participant to self-direction.
2. Describe the benefits of the model.
3. Develop the service plan.
4. Explain general rights, risks, responsibilities, and the participant’s right to choose the participant-directed model.

5. Assist in determining if a Program Representative is desired and/or needed by the participant.
6. Provide or link the participant/representative with program materials in a format they can use and understand.
7. Explain to the participant the roles and supports that will be available. Ensure that the participant/representative knows how and when to notify the Service Coordinator of any operational or support concerns or questions.
8. Notify the FMS of concerns regarding potential issues which could lead to a participant's disenrollment.
9. Apprise the participant of their right to a Fair Hearing.

Offering the participant or representative with information about self-direction to include:
1. The benefits of self-direction, and responsibilities of all involved parties, including the participant, the representative, and the FMS.
2. Work with the FMS to resolve issues specific to the participant-directed experience.

c) The entities (e.g., support brokers, case management, financial management services entities) that play a role in supporting participants who direct their services and types of support that they provide: DHHS will procure the services of a qualified FMS contractor through a competitive bid process and will contract with the selected vendor as an administrative activity.

The FMS vendor:
1. Acts as a bank and receives, disburses, and tracks public funds on behalf of the participant;
2. Monitors the participant's use of public funds, including any underage/overage, in accordance with the person's approved spending plans;
3. Develops and manages a customer service system for participants/representatives (e.g., provides a toll-free phone, TTY, and fax numbers);
4. Provides information in alternate formats and provides foreign and American Sign Language interpreter services;
5. Manages a customer service system that receives, tracks, and resolves inquiries and links with all mandatory reporting systems;
6. Conducts and analyzes the results of satisfaction surveys;
7. Conducts paper and/or web-based budget reporting;
8. Assists the participant/representative in enrolling into the participant-directed system by assisting with the completion and submission of employee's employment forms and maintaining copies in the appropriate files;
9. Collects, processes, and maintains qualified employees' time sheets;
10. Processes returned payments (i.e., payroll checks or invoice payments) in accordance with state unclaimed property law;
11. Generates required financial reports for State and local government, as required;
12. Implements fiscal accountability and participant protections (e.g., incident/mandatory reporting related to fiscal issues), and implementation of internal controls related to all vendor tasks); and
13. Processes and pays invoices for approved participant-directed goods and services.

# Appendix E: Participant Direction of Services

## E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) The information about self-direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction: Information about self-direction opportunities is available to participants who are currently receiving DD waiver services as well as to anyone entering DD waiver services. Information is provided verbally and through written materials and website addresses by the Service Coordinator and is provided to the participant prior to entrance to DD waiver services and prior to the annual service plan meeting to allow sufficient time for the participant to weigh the pros and cons of self-direction and obtain additional information as necessary. Information about self-direction opportunities is available in reference materials developed by DDD, the DHHS public website, and other public communications, such as information from the Nebraska Department of Education about post-high school opportunities and information developed through the Nebraska Developmental Disabilities Council.

Reference materials developed by DDD include descriptions of available DD waiver services, guidance for deciding if self-direction is right for a participant, guidance for finding, enrolling, and managing independent providers for participants who self-direct services, and guidance for providers on authorizations and submitting claims.

The DHHS public website also includes information about DDD responsibilities, service coordination, services funded by DHHS and DDD, certified DD agency providers, and non-certified independent providers, as well as links to other resources for participants, families, and any interested persons.

Reference materials developed by DDD are utilized as training tools and post-training reference guides for participants and their support systems.

The participant may ask their Service Coordinator about the available service delivery models during routine home visits. Information about self-direction is also available on the DHHS DDD public website. DHHS and DDD are available to answer questions and provide technical assistance.

b) The entity or entities responsible for furnishing this information: The Service Coordinator provides basic information to the participant about self-direction.
Service Coordinators are primarily responsible for developing the person-centered service plan and the spending plans. Service Coordinators will continue to manage their traditional duties (develop the person-centered service plan, ensure the service plan is effectively implemented, and monitor the health and welfare of the participant.

c) How and when this information is provided on a timely basis: The information is provided during the initial service planning and annually thereafter.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participants who self-direct may appoint a non-legal representative (program representative) to assist them with self-directing their services. The participant's abilities and desires will determine the extent of the assistance. The Service Coordinator is responsible for developing the person-centered service plan. All employer-related responsibilities remain with the participant receiving services, with the assistance of their program representative and/or FMS, and the Service Coordinator. The representative may not be a paid service provider.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| **Transportation** | ☐ | ☒ |
| **Supported Family Living** | ☒ | ☒ |
| **Participant Directed Goods and Services** | ☐ | ☒ |
| **Independent Living** | ☒ | ☒ |
| **Homemaker** | ☒ | ☒ |
| **Respite** | ☒ | ☒ |
| **Home Modifications** | ☐ | ☒ |
| **Family Caregiver Training** | ☐ | ☒ |
| **Environmental Modification Assessment** | ☐ | ☒ |
| **Community Integration** | ☒ | ☒ |
| **Child Day Habilitation** | ☒ | ☒ |
| **Assistive Technology** | ☐ | ☒ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

On or before July 1, 2024, DHHS will procure the services of a qualified vendor through a competitive process to provide FMS as a contracted administrative activity. The FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable State and local labor, employment tax, employees' compensation insurance and Medicaid program rules, as required.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

On or before July 1, 2024, DHHS will procure the services of a qualified vendor through a competitive process to provide FMS as a contracted administrative activity. The FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable State and local labor, employment tax, employees' compensation insurance and Medicaid program rules, as required.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

*Specify:*

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

*Specify:*

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Administrative Services (AS) State Accounting is responsible for systematically reviewing on a regular basis activities of state agencies and departments to determine adequate internal controls exist within all agencies, including DHHS, to assure proper accounting methods are employed, per Neb. Rev. Stat. §81-111(4). AS State Accounting approves a required internal control plan for financial reporting that is implemented, tested, and monitored by DHHS, which includes pre-audit functions. DHHS has an Internal Audit Division to perform internal audits along with assisting DHHS personnel in the event of a State or Federal audit.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Case management in Nebraska is performed by DDD Service Coordinators (SCs) and all DDD Service Coordinators are qualified to provide self-direction guidance. In addition to basic new Service Coordinator training, Service Coordinators receive training on available participant-directed services, such as the types/definitions of services, limits on services, authorization codes and rates, billing guidelines, budget projecting, and the referral process for enrollment of independent providers. Service Coordinators also receive all reference materials developed by DDD as training tools. Service Coordinators provide information to those who self-direct DD waiver services listed in E-1-g.

The Service Coordinator provides reference materials developed by DDD with the participant to assist the participant in understanding their responsibilities in self-direction, including hiring, training, and dismissing a provider, as well as assisting the participant to recognize potential abuse and neglect situations. The Service Coordinator informs the participant of the amount of funding available and develops the monthly budget with the participant. When determining the rate for an independent provider, the participant is informed of their annual funding allocation and the maximum rates to be considered for each service, based on the potential independent provider's experience and training, the participant's needs, and the tasks the potential provider will perform. When the participant has not chosen their provider(s), DDD personnel may provide a list of currently enrolled independent providers for the participant to consider, and help the participant interview a potential provider when the participant requests assistance. The Service Coordinator is informed by DDD Central Office when the provider is enrolled and authorized to provide services to the participant. When requested, the Service Coordinator will assist the participant in communicating their expectations to the independent provider, including when and how the services will be delivered, and addressing any performance issues, which may arise.

The duties of a Service Coordinator include introducing the participant to self-direction, describing the model's benefits, and assisting with the development of the person-centered service plan, participant-directed information will be distributed to the participant/representative during their annual person-centered service planning process. Service Coordinators will receive training in self-direction and be provided with a side-by-side comparison of the two service delivery models to review with the participant if they have any questions. Service Coordinator activities related to self-direction include:

1. Introduce the participant to self-direction.
2. Describe the benefits of the model.
3. Develop the service plan.
4. Explain general rights, risks, responsibilities, and the participant's right to choose the participant-directed model.
5. Assist in determining if a Program Representative is desired and/or needed by the participant.
6. Provide or link the participant/representative with program materials in a format they can use and understand.
7. Link the participant with the FMS for completion of the necessary paperwork to enroll in this program.
8. Explain to the participant the roles and supports that will be available.
9. Ensure the participant/representative knows how and when to notify the Service Coordinator of any operational or support concerns or questions.
10. Notify the FMS of concerns regarding potential issues which could lead to a person's disenrollment.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Vehicle Modifications** | ☐ |
| **Transportation** | ☐ |
| **Supported Family Living** | ☐ |
| **Personal Emergency Response System (PERS)** | ☐ |
| **Participant Directed Goods and Services** | ☐ |
| **Independent Living** | ☐ |

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Homemaker** | ☐ |
| **Respite** | ☐ |
| **Home Modifications** | ☐ |
| **Family and Peer Mentoring** | ☐ |
| **Family Caregiver Training** | ☐ |
| **Environmental Modification Assessment** | ☐ |
| **Day Supports** | ☐ |
| **Community Integration** | ☐ |
| **Child Day Habilitation** | ☐ |
| **Assistive Technology** | ☐ |

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

Selection of an advocate is voluntary, and an advocate may be chosen by the participant when the participant does not have a guardian. The responsibilities and extent of involvement in decision-making by the advocate are determined by the participant and documented in the service plan. The advocate must be 19 years of age or older and can be an involved family member or trusted friend of the participant. The advocate works with the participant to make sure their wishes and needs as desired are being fulfilled. The advocate is authorized by the participant to assist them in making informed decisions and cannot assume legal responsibilities. A person interested in becoming an advocate is screened by the participant, with assistance from their Service Coordinator when desired, to ensure the advocate demonstrates a strong commitment to the participant's wellbeing and is interested in and able to carry out responsibilities as agreed upon with the participant. The Service Coordinator provides monitoring to ensure the advocate functions as agreed upon with the participant and in the best interest of the participant as part of monitoring the service plan. When the advocate serves their own interests rather than those of the participant, the Service Coordinator may advise the participant and their service plan team to consider a change of advocate or, when no other advocate can be identified, advise a transfer to agency provider services. In egregious cases, DDD may report the concerns identified through Service Coordinator monitoring as suspected abuse, neglect, or exploitation of a vulnerable adult.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

DD waiver services are voluntary services for the participant and the provider(s). Each participant can choose services and the provider(s ) to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD service providers are DD waiver service providers. The participant may choose provider-managed services that may better meet the participant's health and safety needs. The provider-managed waiver services are delivered by certified DD agency providers and the team process is utilized to assist the participant to choose DD waiver services and providers to best meet the participant's needs. Participants can change waiver services without a gap in the provision of services.

Participants or representatives who self-direct can opt to transfer from self-direction to the traditional model at any time. Participants who voluntarily terminate this option will ordinarily be effective the first day of the month, except in cases of emergency. The FMS vendor, the Service Coordinator, and the DDD will assist the participant in ensuring a seamless transition or emergency transfer to a traditional personal care agency to prevent interruption of services (if applicable).

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

DD state regulation allows DDD to deny or end funding of specific services when:
1. A participant's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF/IID level of care;
2. The participant has failed to cooperate with or refused the services funded by DDD; or
3. The participant's service plan has not been implemented.

The decision to end funding of participant-directed services may be based on the Service Coordinator monitoring, review of the service plan, critical incident reports, and assessment of risk to the participant and community, or complaint investigations conducted by DHHS personnel. The participant may choose provider-managed services that may better meet the participant's health and safety needs. The provider-managed waiver services are delivered by certified DD agency providers and the team process is utilized to assist the participant to choose DD waiver services and providers to best meet the participant's needs. Participants can change waiver service delivery models without a gap in the provision of services.

Participants who demonstrate an inability to manage the duties related to self-direction will be required to select a representative to assist them with their responsibilities. If the participant is unable or refuses to choose a representative, they must transfer to the traditional model. The FMS contractor, the Service Coordinator, and the DDD will assist the participant in ensuring a seamless transition. The Service Coordinator or the FMS must develop a report to DHHS outlining the reasons for requesting to transfer the participant from self-direction to traditionally delivered services involuntarily. Issues such as the inability to manage funds or services, the inability/unwillingness to maintain safe staffing reports, the inability to provide a safe work environment for the FMS staff and employees, and the inability to keep the spending plan within the budget.

Allegations of abuse, neglect, and exploitation must be reported to Adult Protective Services and the Medicaid Fraud Control Unit. The FMS will also enter an incident report. All paid and natural support must be outlined in each participant's service plan. The Service Coordinator is responsible for overseeing each participant's program implementation, health, and welfare. The Service Coordinator will ensure that no break in vital services will occur and that a timely revision of the person-centered service plan occurs. Notify the participant of their right to a Fair Hearing.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 638 |
| **Year 2** | | 638 |
| **Year 3** | | 638 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of

participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state’s method to conduct background checks does not vary from what is described in Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☐ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individual budget amount (IBA) is $10,000 as defined in Neb. Rev. Stat. §68-1530.

The methodology for establishing the amount of the participant-directed budget is the same as for provider-managed services, as fully described in Appendix C-4-a of this waiver.

The assigned IBA constitutes a limit on the overall amount of services, which may be authorized in the person-centered service plan. The IBA is the total annual funding amount available to the participant per their waiver year. The budget amount does not change if a participant chooses to self-direct services or if services are provided by an agency provider.

Participant information, service rates, and other information on participant-directed services are located on the Department's website at www.dhhs.ne.gov. This information is accessible to participants, stakeholders, providers, and the general public.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant's budget is a set amount of $10,000 per Nebr. Rev. Stat. §68-1530. The participant is notified in writing by DDD of their set IBA as well as the dollar limits of waiver services at the time of initiation of DD waiver services and prior to the development of the person-centered service plan. The participant is also notified of their service authorizations, prior to services being delivered. The written notice is mailed, which includes fair hearing rights information. Questions about the right to a fair hearing are directed to the Service Coordinator or the Service Coordinator's Supervisor. Additionally, DDD Central Office personnel are available to respond to participant questions regarding fair hearing rights and any other aspect of waiver implementation.

The participant may propose changes in their service authorizations at any time, by contacting the Service Coordinator. By utilizing the budget functions of the state-mandated web-based case management system, the overall impact of the proposed change is calculated and the participant is able to compare the proposed changes in their service authorizations to their current budget. Budget amounts won't increase, as the limit to the budget has been set by legislation. The Service Coordinator is responsible for updating the person-centered service plan.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

# Appendix E: Participant Direction of Services

## E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards have been established to prevent the premature depletion of the participant's budget or address potential service delivery problems associated with budget over-utilization. DDD is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The state-mandated web-based case management system tracks budget utilization and provides monthly reports for service coordination, management, and administrative personnel.

DDD and the vendor of the state-mandated web-based case management system has developed rules within the system to highlight possible over-utilization. When potential over-utilization is identified, the participant and Service Coordinator discuss and manage adjustments to the monthly authorized amounts and the annual individual budget amount when necessary.

Likewise, providers contact participants and Service Coordinators when services are under-utilized. The Service Coordinator may follow-up with monitoring, a meeting with appropriate parties, referrals to another qualified DD waiver service provider, participant education, provider re-education, to ensure the participant's health and safety are not at risk.

# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant.

Participants are advised of their appeal rights at the time of initial eligibility by the Department of Health and Human Services Division of Developmental Disabilities (DDD) Disability Services Specialist and annually thereafter by their Service Coordinator (SC) at the time of the Individual and Family Meeting or annual service plan meeting. At the annual Individual and Family or annual service plan meeting, the participant is given a Notice of Rights and Obligations to read and sign. Hearing rights are also printed on the Notice of Decision.

Participants receive and have the opportunity to dispute a Notice of Decision in any of the following circumstances:
1. The applicant is determined ineligible for NE Medicaid HCBS DD waiver services;
2. The applicant is not given the choice of Medicaid HCBS DD waiver services as an alternative to institutional care;
3. The participant’s choice of providers is denied;
4. Services to the participant are denied, suspended, reduced, or terminated; or
5. Final Setting Rule compliance.

Participants may also appeal any action, inaction, or failure to act with reasonable promptness because:
1. Their application is denied;
2. Their application is not acted upon with reasonable promptness;
3. Their assistance or services are suspended;
4. Their assistance or services are reduced;
5. Their assistance or services are terminated;
6. Their form of payment or services is changed to be more restrictive; or
7. They think the Department's action was erroneous.

When issued, the Notice of Decision includes information about the Request for a Fair Hearing, and advises participants of their right to a hearing, the method by which to obtain a hearing, and that they may represent themselves or use an attorney, friend, or other spokesperson. This information is also posted on the DHHS public website at: www.dhhs.ne.gov/developmental_disabilities.

Designated Department of Health and Human Services Division of Developmental Disabilities (DDD) personnel complete and retain the Notice of Decision in N-FOCUS, Nebraska’s electronic local web-based system for claims processing. The Notice of Decision is mailed to the participant at least ten days prior to the action being taken, in accordance with 42 CFR 431.211.

The Notice of Decision includes an advisement that services will continue (or be reinstated) until the outcome of the fair hearing when the participant requests a hearing within ten days of the mailing of the Notice of Decision.

Request for Fair Hearing must be submitted in written hardcopy or electronic form, and submission may be done via mail, email, fax, phone, or in person at any local DHHS office. All Notices of Decision and Requests for Fair Hearing are maintained in electronic form, in accordance with the Records Retention Schedule applicable to DHHS . Fair hearing rights are provided in English and Spanish according to the language on file, which is spoken at home, and may be translated into other languages upon request.

In order to exercise the right to a hearing, the participant must file a petition with DDD. The petition may be made on a form provided by DDD for such purpose, or in another written format, which contains at least the following information:
1. The name and contact information of the petitioner (the participant’s or guardian’s name, address, and phone number, and signature);
2. The specific decision contested;
3. The date of the decision contested; and
4. Any other information the participant wants to be included at the hearing.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (◉) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (◉) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Participants receiving supports through the waiver may register a grievance or complaint with DHHS. Participants are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) The types of grievances/complaints that participants may register: Participants are advised in the annual Notice of Rights and Obligations (received at the annual Individual and Family meeting or annual service plan meeting) that filing a grievance or complaint is not a prerequisite for filing for a Fair Hearing.

Participants receiving supports through the waiver may register the following types of grievances/complaints:

1. Safety, endangerment, or welfare issues;
2. Suspicion of Medicaid fraud;
3. Violations by DDD Medicaid providers of Medicaid regulations, DDD regulations, or DDD policies;
4. Issues related to a participant's Service Coordinator; or
5. Difficulty with DDD Medicaid services or providers .

(b) The process and timelines for addressing grievances/complaints: The grievance/complaint may be submitted via mail, email, fax, phone, or in person at any local DHHS office. A complaint form and email link are listed on the DD web page. DDD also has a central phone number participants can call to file a complaint or to ask questions. Participants can also write a letter and mail or fax it in to DDD. Complaints, questions, or concerns are responded to by designated DDD program personnel. Once the grievance/complaint has been resolved, designated DHHS personnel provide a written notification, when applicable, of the outcome to the complainant. Resolution of the grievance/complaint may involve working with DHHS Division partners, multiple providers, and the participant's service plan team; thus, there is no specified timeframe for the state making resolution and notifying the complainant. Designated DDD personnel are expected to take immediate steps to make a resolution and notification. All grievances/complaints and outcomes are maintained in electronic form, in accordance with the Records Retention Schedule applicable to DHHS.

(c) The mechanisms used to resolve grievances/complaints: The mechanisms for resolving the complaint and preparing the response include, but are not limited to, follow-up by phone, letter, in-person or remote visits with the provider or participant, and referral to another DHHS program (e.g., Child Welfare Services, Adult Protective Services, and Medicaid Fraud Control Unit).

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant.
The Critical Incident Management Process is used to document, track, and analyze critical events/incidents. Reports of incidents may be received from any source.

The Department of Health and Human Services Division of Developmental Disabilities (DDD) defines critical events/incidents requiring an incident report to DDD as situations that may adversely affect the physical or emotional well-being of the participant; alleged or suspected cases of abuse, neglect, or exploitation, or mistreatment; and emergency safety situations requiring the use of emergency safety interventions.

All instances of abuse, neglect, or exploitation must be reported to appropriate authorities to conduct a follow-up action. Appropriate authorities include DHHS-Division of Child and Family Services (Adult Protective Services, Child Protective Services), DHHS-Division of Public Health (for certified providers), and Law Enforcement.

DHHS maintains a toll-free hotline available at all times for reporting suspected or alleged abuse, neglect, and exploitation of children and vulnerable adults. This number is posted on the DHHS public website.

For vulnerable adults age 18 and older, abuse, neglect, and exploitation are defined in the Adult Protective Services Act, Neb. Rev. Stat. §§28-348 - 28-387. Neb. Rev. Stat. §28-372 specifies persons are required to make a report to DHHS or the appropriate law enforcement agency when abuse, neglect, or exploitation of a vulnerable adult is suspected or alleged. Regulations on Adult Protective Services can be found in Title 463 Nebraska Administrative Code (NAC)

Guidelines for mandatory reporting for abuse, neglect, and exploitation for the adult/aged population can be found on the DHHS website at http://dhhs.ne.gov/Pages/Adult-Protective-Services.aspx.

For children, age 18 and younger, abuse and neglect are defined in the Child Protection and Family Safety Act, Neb. Rev. Stat. §28-710. Neb. Rev. Stat. §28-711 requires any person to make a report to DHHS or the appropriate law enforcement agency when abuse or neglect of a child is suspected or alleged.
1. Maltreatment of children constituting abuse or neglect is further defined in Title 390 of NAC.
2. Medical neglect of a handicapped infant constituting abuse or neglect is further defined in Title 390 NAC.

Guidelines for mandatory reporting for abuse, neglect, and exploitation of children can be found at http://dhhs.ne.gov/Pages/Child-Abuse.aspx

For all participants in Medicaid HCBS DD waiver services, DHHS state regulation defines and prohibits provider use of: physical restraint except as specified; chemical restraint; mechanical restraint; aversive stimuli; corporal punishment; seclusion; physical, emotional, and verbal abuse; denial of basic needs; discipline; implementation of an intervention on a participant by another participant; or other means of intervention that result in or are likely to result in physical injury to the participant.

Providers, Service Coordinators or the FMS must report the following types of incidents to DDD in DDD’s web-based case management system:
• Actual or Potential Airway Obstruction
• Allegation, Suspicion, or Actual Events of Abuse, Neglect, or Exploitation of a Child or a Vulnerable Adult
• Communicable Disease
• Death of a Participant
• Emergency Situations
• Fall with Significant Injury
• Fatal 5 conditions (aspiration, dehydration, gastroesophageal reflux disease, severe constipation/bowel obstruction, sepsis, first time seizure or seizure lasting longer than 5 minutes)
• Incidents Involving Emergency Personnel Requiring Emergent Response
• Infestations
• Injuries of Unknown Origin Raising Suspicion
• Injury Requiring Medical or Nursing Interventions beyond First Aid
• Medication Errors
• Misconduct not Involving Law Enforcement
• Missing Person(s)

- PRN Psychotropic Medication Usage
- Property Damage
- Suicide Attempts
- Swallowing Inedible Items
- Unplanned Hospital/Emergency Room/Urgent Care Visit
- Use of Emergency Safety Interventions
- Use of Restraint or Prohibited Practices
- Vehicle Accident

A verbal report must be made by the provider to DDD upon becoming aware of the incident. Written incident reports must be submitted using the state-mandated web-based case management system within 24 hours of the verbal report to DDD.

Incident reports recorded in the DDD's web-based case management system are analyzed for any type of event in which abuse, neglect, or exploitation is either suspected or substantiated. This includes incidents/events that may not initially be considered to be critical, but after review or investigations, are found to have resulted in abuse, neglect, or exploitation.

Quality Improvement Organization (QIO)-like entity staff reviews all incidents in which abuse, neglect or exploitation is either suspected or substantiated. QIO-like entity staff will work with Service Coordination and/or provider staff as needed to remediate any issues to ensure appropriate resolution activities are occurring to mitigate the incident and ensure the health and safety of the participant.

The web-based case management system is also used to record all participant deaths. After receiving notification of a death, the QIO-like entity Mortality Review Nurse will triage the death to determine if the mortality review needs to be expedited due to the death being due to alleged or suspected abuse/neglect, exploitation, or criminal acts, was sudden and unexpected, or could be due to a lack of standard medical or clinical care. Expedited mortality reviews are to be completed within 45 calendar days following the triage.

If, during the mortality review triage process or review of death related information, the QIO-like entity Mortality Review Nurse discovers potential signs of abuse, neglect, or exploitation, designated DDD personnel will be informed to make them aware of any immediate concerns that might need to be addressed. All expedited mortality reviews and any non-expedited mortality reviews that require medical discretion will have a second-level review completed by the QIO-like entity Mortality Review Physician. All unexpected and unexplained deaths will be referred for review by the Mortality Review Committee. The Mortality Review Committee will forward any systemic quality improvement recommendations and/or follow-up actions to designated DDD personnel.

Agency providers must submit an aggregate report of incidents the provider has reported to DDD on a quarterly basis. The report must be received by DDD no later than 30 calendar days after the last day of each quarter. The report must include a compilation, analysis, and interpretation of data, and evidentiary examples to evaluate action taken to address critical incidents to reduce the number of incidents over time.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from and reporting of abuse, neglect, and exploitation is provided to each participant when entering DD waiver services and annually thereafter by their Service Coordinator (SC). This information is also available on the DHHS public website. Training is available to the public, including participants, family members, and providers on the DHHS public website.

The participant's assigned Service Coordinator must provide information on participant rights to the participant when entering DD waiver services and annually thereafter.

Additional information on abuse/neglect is available on the Nebraska Department of Health and Human Services website (dhhs.nebraska.gov). Participants and their family members may be directed to those websites for additional resources.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receipt of an incident report, a Service Coordination Supervisor (SCS) reviews the report to determine the appropriate response, which depends on the nature and severity of the incident. All critical incidents that include a significant health and safety concern or law enforcement contact requires follow-up action from the Service Coordinator. The type of follow-up and timeline for completion is decided in consultation between the Service Coordinator and Service Coordination Supervisor.

Agency providers must complete an investigation of each reported incident. A written summary of the agency provider's investigation and action taken must be submitted via the state-mandated web-based case management system to DDD within 14 calendar days of the initial report of the incident. Timeframes for conducting and completing the investigation and informing the participant of the results of an internal investigation completed by the agency provider must be specified in the provider agency policies and procedures, and cannot exceed 14 calendar days. Any incidents reported by an agency provider involving suspected or alleged abuse, neglect, or exploitation, use of emergency safety intervention, or any other situation where violation of the participant's rights may have occurred must also be reviewed by the agency provider's rights review committee.

The DHHS Division of Children and Family Services (DHHS-CFS) Protection and Safety Unit maintains the toll-free hotline available at all times for reporting of alleged or suspected abuse, neglect, and exploitation of children and vulnerable adults. All reports of suspected or alleged abuse, neglect, or exploitation are screened immediately and shared with law enforcement within 24 hours of receipt.

Reports of alleged or suspected abuse, neglect, or exploitation of children or vulnerable adults are reviewed by CFS personnel with specialized training in intake and screening. Screening criteria includes definitions of abuse, neglect, and exploitation of a vulnerable adult outlined in the Adult Protective Services Act, Neb. Rev. Stat. §§28-348 - 28-387 and definitions of child abuse and neglect outlined in the Child Protection and Family Safety Act, Neb. Rev. Stat. §28-710. Reports of suspected or alleged abuse, neglect, or exploitation that do not meet statutory definitions will not be accepted for investigation by CFS.

When CFS personnel have screened a report of suspected or alleged abuse, neglect, or exploitation, the determination to accept or not accept a report for investigation and the prioritization of accepted reports are reviewed by a CFS supervisor to ensure screening criteria are applied accurately.

Accepted reports are prioritized and assigned for investigation. Reporting parties are notified by the CFS personnel taking the report whether the report will be accepted and assigned to CFS for investigation or if the report will not be accepted for investigation.

Investigations for Abuse/Neglect/Exploitation of a Vulnerable Adult
Investigations of alleged or suspected abuse, neglect, or exploitation of vulnerable adults are performed by CFS personnel specializing in adult protective services. Accepted reports are categorized in three priorities. Investigations for all priority levels must be completed within 60 days of the report being accepted for investigation, unless there is alleged or suspected financial exploitation, which requires the investigation be completed within 90 days.
• Priority One – includes reports indicating a vulnerable adult is in immediate danger of death or life-threatening or critical harm. Face-to-face contact must be made with the victim within eight hours from the time the report was accepted for investigation. When CFS personnel are unable to respond within the specified timeframe, they must notify law enforcement of the emergent nature of the reported abuse, neglect, or exploitation and request immediate response, and CFS personnel must make face-to-face contact with the alleged victim within 24 hours of law enforcement contact. CFS personnel may work simultaneously with law enforcement when requested.
• Priority Two – includes reports indicating a vulnerable adult is in danger of serious, but not life-threatening or critical harm. Face-to-face contact by a CFS personnel must be made with the victim within five calendar days of the date of the report was accepted for investigation.
• Priority Three – includes reports indicating a vulnerable adult is in danger of harm that is serious, but not less serious than Priority One or Two reports. Face-to-face contact by APS personnel or law enforcement must be made with the victim within ten calendar days of the date of the report was accepted for investigation.

Investigations for Abuse/Neglect of a Child
Investigations of allegations of abuse or neglect of children are performed by DHHS-CFS personnel specializing in child protective services. Since both law enforcement agencies and DHHS-CFS have statutory obligations pertaining to child abuse/neglect cases, one agency may take the primary responsibility for some investigations and some investigations may

initially be a joint effort.

Accepted reports are categorized in three priorities. Investigations for all priority levels must be completed within 30 days. When necessary, a plan will be developed and implemented to provide safety for the child during the investigation. Exceptions to the timelines for initial contact with the alleged victim may be made based on the involvement or request of law enforcement, inability to locate the alleged victim, inability to identify the alleged victim, or parental refusal to allow children to be interviewed. When law enforcement makes first contact with an alleged victim, this contact may be used as the initial contact with the alleged victim(s) when it occurs after the report is accepted for investigation and it is clear in law enforcement reports the alleged victim was seen and immediate safety concerns were addressed.
• Priority One– These are reports that may be life threatening and require immediate response. Contact must be made with the alleged victim(s) within 24 hours from the time the report was accepted for investigation. When CFS personnel are unable to respond, they must notify law enforcement of the emergency nature of the report and request law enforcement respond immediately.
• Priority Two – Contact must be made with the alleged victim(s) within five calendar days from the date and time the report was accepted for investigation.
• Priority Three – Contact must be made with the alleged victim(s) within ten calendar days from the date and time the report was accepted for investigation.

Provider reports of alleged or suspected abuse, neglect, or exploitation to the CFS Protection and Safety Unit not accepted for investigation are electronically submitted within 24 hours of receipt to DHHS. DHHS reviews each report upon receipt to determine what action should be taken. Actions taken may include the completion of a complaint investigation by DHHS, depending on the nature and circumstances of the incident. These reports are also reviewed by the assigned Service Coordinator and Service Coordinator Supervisor to assess the participant's safety and the need for any revision to the participant's service plan to address the reported incident.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDD is responsible for overseeing the reporting of and response to critical incidents. All critical incidents are entered into the state-mandated web-based case management system and are subject to DHHS review and analysis at any time. DDD reserves the right to request additional review of any critical incident. There may be immediate follow-up of individual events.

CFS personnel are also responsible for the oversight of critical incident management. At least annually, CFS provides to DDD information about reports of abuse, neglect, or exploitation involving DD waiver service participants made to CFS. Data is obtained and analyzed on waiver participants involved in reports of alleged or suspected abuse, neglect, or exploitation. The data includes demographic information, types of abuse/neglect reported, and the findings of investigations.

CFS and DDD collaborate to identify strategies to reduce the number of critical incidents and to coordinate on both a system-wide and participant-specific basis. Examples of these strategies include training of CFS personnel about the Medicaid HCBS DD waivers, and training of DDD personnel about abuse, neglect, and exploitation and the functions of CFS.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this

oversight is conducted and its frequency:

The State does not permit the use of restraints by any provider of any waiver service. Services, such as Respite, Child Day Habilitation, Community Integration, and Day Supports include components of supervision that ensure each participant receives person-centered services from a qualified provider to maintain the participant's health, safety, and welfare along with dignity and respect.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for the certification of agency providers. Surveyors from the Public Health Division conduct initial and ongoing certifications, which include on-site scheduled and unscheduled reviews.

All providers of DD of waiver services are required to report any use of emergency safety intervention and prohibited use of physical, mechanical, or chemical restraint to DD through the state-mandated web-based case management system. Possible actions taken by DHHS are outlined in G-1.

DDD Service Coordinators are responsible for participant monitoring, which includes monthly contact and quarterly on-site observation of service delivery. They are positioned to identify the potential use of prohibited restraints and would report such findings to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also in effect to identify and adress inappropriate consideration or use of any type of restraint.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Participants in DD waiver services are entitled to the same human and legal rights guaranteed to all citizens as outlined in federal and state laws and constitutions. These rights include, but are not limited to, right to be treated with dignity and respect, right to privacy, right to autonomy, freedom of choice, freedom of access to other people, places, and activities, and freedom of movement.

The State does not permit the use of restrictive interventions by any provider of any waiver service. Services, such as Respite, Child Day Habilitation, Community Integration, and Day Supports include components of supervision that ensure each participant receives person-centered services from a qualified provider to maintain the participant's health, safety, and welfare along with dignity and respect.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for the certification of agency providers. Surveyors from the Public Health Division conduct initial and ongoing certifications, which include on-site scheduled and unscheduled reviews.

All providers of DD of waiver services are required to report any use of emergency safety intervention and prohibited use of physical, mechanical, or chemical restraint to DD through the state-mandated web-based case management system. Possible actions taken by DHHS are outlined in G-1.

DDD Service Coordinators are responsible for participant monitoring, which includes monthly contact and quarterly on-site observation of service delivery. They are positioned to identify the potential use of prohibited restrictive interventions and would report such findings to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also in effect to identify and address inappropriate consideration or use of any type of restrictive intervention.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving. Seclusion is prohibited.

The State does not permit the use of seclusion by any provider of any waiver service. Services, such as Respite, Child Day Habilitation, Community Integration, and Day Supports include components of supervision that ensure each participant receives person-centered services from a qualified provider to maintain the participant's health, safety, and welfare along with dignity and respect.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for the certification of agency providers. Surveyors from the Public Health Division conduct initial and ongoing certifications, which include on-site scheduled and unscheduled reviews.

DDD Service Coordinators are responsible for participant monitoring, which includes monthly contact and quarterly on-site observation of service delivery. They are positioned to identify the potential use of seclusion and would report such findings to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also in effect to identify and address inappropriate consideration or use of any type of restrictive intervention of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DD provider agencies have ongoing responsibility to ensure medications administered by provider staff are provided in compliance with applicable state statutes and regulations, including the Medication Aide Act, Neb. Rev. Stat. §§71-6718 - 71-6743, and 172 NAC. These statutes and regulations do not govern self-administration of medication or administration of medication by a caregiver or service provider not employed or subcontracted by a certified DD provider agency. Participants choosing to self-direct DD waiver services by employing independent providers are responsible for all oversight of medication provision by the providers the participants employ.

Medications administered by certified DD provider agencies may be administered by a medical professional acting within their scope of practice, or by a certified medication aide as delegated by a licensed medical professional who is permitted to administer medication and delegate medication administration within their scope of practice.

Medical professionals prescribing medication to participants are responsible for monitoring participant medication regimens. The medical professional prescribing medication determines the frequency of their monitoring, based on the circumstances, including the participant's diagnoses and current condition, the type of medication, the length of time the medication is prescribed, other medications the participant is prescribed, monitoring for the intended effect of the medication, or other factors.

Monitoring the appropriateness of each medication individually and in relation to other prescribed medications is the responsibility of the medical professional who prescribes each medication and the pharmacist who fills the prescriptions.

DD agency providers must maintain a medication administration record (MAR) for all participants receiving medications administered by the provider. These records must be kept in the state-mandated web-based case management system.

DD providers monitor administration of medication through documenting and reporting relevant information whenever the participant receives medical attention or treatment with provider support to the participant and the medical professional delegating responsibility for medication administration to a licensed medication aide (if applicable). Relevant information includes:
- Inappropriate storage conditions for medications;
- Adverse reactions or side effects to medications experienced by the participant;
- Medication administration errors; and
- Observation of the symptoms the medication is prescribed to treat.

Licensed medical professionals whose scope of practice allows delegation of medication administration are responsible for monitoring medication administration by medication aides, at a frequency determined by the delegating medical professional and the DD agency provider. Delegation is based on the willingness and ability of the participant to be involved in management of their own care, the stability of the participant's condition, the experience and competency of the medication aide, and the level of nursing judgment required for medication administration. The licensed medical professionals are employees of the DD provider agency or professionals who have entered into a contract with the DD provider.

Delegating medical professional and DD provider agency monitoring may include observation of the administration of medication or treatment, review of records relating to medication provision or treatment, review of incident reports related to medication or treatment errors, retraining medication aides, and ongoing observation.

DD agency providers must have policies and procedures for the provision of medications in compliance with applicable state regulation. This includes policies and procedures for internal quality improvement including frequency of QI monitoring. The agency provider QI monitoring includes review of medication errors to identify inappropriate or concerning practices, and follow-up action to reduce or prevent medication administration errors, such as retraining medication aides, review of provider procedures or practices, or disciplinary action.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

DHHS is responsible for oversight of DD agency provider compliance with all state statutes and regulations applicable to medication administration. The administration of medication is a regulated activity as a method to ensure participant medications are managed and administered appropriately. DHHS monitors the administration of medications through review of DD agency provider policies and procedures during the initial certification process and on-site certification review activities.

When DHHS personnel finds policies and procedures do not comply with regulatory requirements, such as an insufficient QI system, inadequate incident reporting and follow-up, etc., the prospective agency provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit.

During on-site certification review, which may be unannounced or scheduled, service delivery and agency systems are reviewed. A random sample of participants served by the agency provider is chosen based on the total number of participants in the provider's services. From this certification review, DHHS personnel assess whether participants are receiving medication from medication aides in accordance with physician orders and applicable state statute and regulation. When this evaluation identifies any inappropriate or prohibited practices, DHHS cites deficient practice, and the provider agency must submit a formal plan of improvement addressing citations. The plan of improvement must be approved by DHHS, and when the plan is insufficient, the provider must correct the plan and resubmit.

Medication aides must be certified through DHHS and recertified as required by Neb. Rev. Stat. §§71-6718 – 71-6743. Medication aides may participate in the physical act of medication provision and related documentation as delegated by a licensed medical professional. Unlicensed persons, including medication aides, may assist with monitoring therapeutic effects of medication, under some conditions.

DHHS Division of Public Health (DPH) oversees the regulatory requirements for certification of medication aides through maintenance of the Medication Aide Registry. The training requirements for certification of medication aides, outlined in 172 NAC, include DPH approved medication aide examinations and procedures. The competency exam must assess the competency standards identified in 172 NAC. These topics include:

1. Maintaining confidentiality;
2. Compliance with a participant's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five "rights" (provides the right medication, to the right participant, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in the application of medication procedures;
8. Compliance with limitations and conditions under which a medication aide may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Compliance with every participant's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Upon successful completion of a medication aide training course, the applicant for certification must pass a competency test in order to be placed on the Medication Aide Registry. All medication aide certifications expire two years from the date of issue and the applicant must renew their registration to continue to be on the Medication Aide Registry.

DHHS personnel are responsible for ongoing monitoring of the performance of medication aides employed by the certified agency providers. When a complaint involving the performance of a medication aide is received by the DHHS, the MAR information for medication administered by the medication aide is reviewed for compliance with the state statute and regulation. When DHHS discovers a medication aide is not performing their duties in compliance with the state statute and regulation, the medication aide is removed from the Medication Aide Registry.

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Certified DD agency providers are responsible for monitoring medication administered by provider employees and ensuring medication is administered in compliance with applicable state statutes and regulations, including the Medication Aide Act, Neb. Rev. Stat. §§71-6718 - 71-6743 and 172 NAC.

Any certified DD agency provider staff or subcontractor administering medication to participants must be a licensed medical professional or a certified medication aide.

When a participant is able to self-administer their medication, the agency provider is not responsible for the administration of or monitoring of these medications. The participant must meet the following criteria to be considered capable of self-administration of medication:
• Participant is 19 years of age or older;
• Participant is capable of completing the physical act of taking or applying a dose of a medication;
• Participant is capable of taking or applying the medication according to a prescription or recommended protocol;
• Participant has the capacity to observe and monitor for desired effects, side effects, interactions, and contraindications of the medication, and take appropriate action based on those observations;
• Participant receives no assistance in any way from another person for any activity related to medication administration.

The service plan team must evaluate a participant's ability to self-administer medication and determine the level of assistance needed for medication administration.

For participants without the capability and capacity to make informed decision about medications and for whom there is no caretaker, a licensed medical professional must accept responsibility for direction and monitoring of medication administration. The Nurse Practice Act, Neb. Rev. Stat. §38-2201 – 38-2238 and 172 NAC outlines the medical professional’s responsibility and accountability for nursing actions delegated, directed, or assigned to be performed by others, and all requirements for documentation and oversight.

DHHS state regulation specifies direction and monitoring of medication administration by medication aides will be completed on an ongoing basis. The DD agency provider must have policies and procedures in place for monitoring medication administration by medication aides.

**iii. Medication Error Reporting.** *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  *Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Medication errors are any errors in the five “rights” of medication provision, or inaccurate or incomplete documentation of medication name, dose, route, or time administered.

Medication errors must be reported to the person responsible for directing and monitoring administration of medication.

Medication errors that result in injury, serious illness, hospitalization, or death must be reported as critical incidents to DDD and are monitored and reviewed through the required incident reporting process described in section G-1 of this appendix.

Medication errors suspected to be abuse or neglect must be reported to CFS or law enforcement, as well as to DDD as a critical incident.

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DHHS is responsible for oversight of DD agency provider compliance with all state statutes and regulations pertaining to medication administration. The administration of medication is a regulated activity as a method to ensure participant medications are managed and administered appropriately. DHHS monitors the administration of medications through review of DD agency provider policies and procedures during the initial certification process and on-site certification review activities.

When DHHS personnel finds policies and procedures do not comply with regulatory requirements, such as an insufficient QI system, inadequate incident reporting and follow-up, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit.

During on-site certification reviews, which may be unannounced or scheduled, service delivery and agency systems are reviewed. A random sample of participants served by the provider is chosen based on the total number of participants in the provider's services. From this certification review, DHHS personnel assess whether participants are receiving medication from medication aides in accordance with physician orders and applicable state statute and regulation. When this evaluation identifies any inappropriate or prohibited practices, DHHS cites deficient practice, and the agency provider must submit a formal plan of improvement addressing citations. The plan of improvement must be approved by DHHS, and when the plan is insufficient, the provider must correct the plan and resubmit.

DPH oversees the regulatory requirements for certification of medication aides through maintenance of the Medication Aide Registry. The training requirements for certification of medication aides, outlined in 172 NAC, include DPH approved medication aide examinations and procedures. The competency exam must assess the competency standards identified in 172 NAC.

Upon successful completion of a medication aide training course, the applicant for certification must pass a competency test in order to be placed on the Medication Aide Registry. All medication aide certifications expire two years from the date of issue and the applicant must renew their registration to continue to be on the Medication Aide Registry.

DHHS personnel are responsible for ongoing monitoring the performance of medication aides employed by the certified agency providers. When a complaint involving the performance of a medication aide is received by the DHHS, the MAR information for medication administered by the medication aide is reviewed for compliance with the state statute and regulation. When DHHS discovers a medication aide is not performing their duties in compliance with the state statute and regulation, the medication aide is removed from the Medication Aide Registry.

DDD monitors medication errors resulting in injury, serious illness, or hospitalization through the critical incident monitoring process outlined in section G-1.

Data from monitoring completed by DHHS through certification review and complaint investigation and monitoring completed by DDD through critical incident reporting is reviewed by the DDD QI Committee at least semi-annually. Data is used to identify trends or patterns and to make recommendations of improvement strategies.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**# and % of participants reviewed who received information/education about how to identify & report abuse, neglect exploitation & other critical incidents. N: # of participants reviewed who received info/education about how to id & report abuse, neglect exploitation & other critical incidents; D: # of participants reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**# & % of abuse, neglect, exploitation (ANE) and unexplained death incidents that were reported by provider in the incident management system as required by DD policies and approved waiver. Numerator: # of ANE & unexplained death incidents that were rptd by prvdr in the incident mgt system as required by DD policies and approved waiver. D: # of ANE & unexplained death incidents reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error. |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DDD policies. N = Number of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DDD policies. D = Number of reportable incidents reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>5% confidence Level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**# and % of substantiated abuse/neglect/exploitation (ANE) & unexplained death critical incidents (CI) reviewed where the CI resolution was completed as required by DDD policies. N: # of substantiated ANE & unexplained death critical incidents reviewed where the CI resolution was completed as required by DDD policies. D: # of substantiated ANE & unexplained death critical incidents reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of new service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect. Numerator- Number of new service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect Denominator- Total number of new service coordinators.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of critical incident trends where systemic intervention was implemented. Numerator: Number of critical incident trends where systemic intervention was implemented. Denominator: Number of critical incident trends.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#&% of incident reports regarding use of unallowable restraint that document an investigation & actions were taken to address incident in accordance with DDD policies. N:# of incident reports re use of unallowable restraint that document an investigation & actions were taken to address the incident in accordance with DDD policies.D:# of incident reports re use of unallowable restraint reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

**Performance Measure:**
**Number and percent of service plans reviewed that are free from evidence of use of restraint, rights restrictions, or seclusion. Numerator: Number of service plans reviewed that are free from evidence of use of restraint, rights restrictions, or seclusion. Denominator: Number of service plans reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of case management files reviewed where the participant's health care status was assessed at the initial or annual review. Numerator = Number of case management files reviewed where the participant's health care status was assessed at the initial or annual review. Denominator = Number of case management files reviewed.**

**Data Source** (Select one):
**Record reviews, off-site**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% confidence level with +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Strategies employed by DHHS to discover and identify problems or issues within the waiver program including provider responsible and timelines are summarized in sections G-1-b, G-1-d, G-1-e, G-2-a-ii, G-2-b-ii, G-3-b-ii, G-3-c-iii, and G-3-c-iv.

The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DDD has processes in place to address specific problems upon discovery.

Providers are required by state statute to report any suspected or alleged abuse, neglect, or exploitation of participants to CFS and/or law enforcement. Reports of alleged or suspected abuse, neglect, or exploitation of participants made to CFS that do not meet statutory definitions of abuse, neglect or exploitation are shared with DHHS within 24 hours of receipt. DHHS personnel review the information and determine what action should be taken.

Critical incidents are reported through the state-mandated web-based case management system. DDD reviews a sample of reportable incidents for compliance with state policies. These findings are trended and analyzed to determine what remediation to apply.

In addition, agency providers submit a report quarterly to DDD summarizing critical incidents for the quarter and actions taken on both a participant and provider-wide level to address the issue and decrease the likelihood of future incidents. A summary of all quarterly reports sent by the providers on their critical incidents and actions taken are compiled into a report reviewed quarterly by the DDD QI Committee. The DDD QI Committee determines the need for systemic follow-up and additional areas requiring investigation or DDD administrative intervention.

Data is summarized and reviewed by the DDD QI Committee quarterly. The summarized data from service plan reviews is shared with service coordination personnel. The implementation data summary is shared with service coordination, providers, and DDD Central Office personnel.

Providers are required by state statute to report any suspected or alleged abuse, neglect, or exploitation of participants to CFS or law enforcement. Reports of alleged or suspected abuse, neglect, or exploitation of participants made to CFS that do not meet statutory definitions of abuse, neglect or exploitation are shared with DHHS within 24 hours of receipt. DHHS personnel review the information and determine what action should be taken.

The critical incidents are reported through the state-mandated web-based case management system, which allows DDD to review and aggregate data related to reported critical incidents. Quarterly, agency providers submit a report to DDD summarizing critical incidents for the quarter and actions taken on both a participant and provider-wide level to address the issue and to decrease the likelihood of future incidents. A summary of all reported critical incidents and actions taken are compiled into a report reviewed quarterly by the DDD QI Committee. The DDD QI Committee determines the need for systemic follow-up and additional areas requiring investigation or DDD administrative intervention.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | Specify:<br><br>Semi-Annually or more often as determined by the DDD Director |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 3)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The stated purpose of the Medicaid Home and Community-Based Services (HCBS) Waivers quality improvement (QI) strategy is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a system of quality management and improvement strategies.

The DDD QI Strategy uses an evidence-based tiered approach, which includes a number of activities and processes at both the local and state levels. This system has been developed to discover whether the federal waiver assurances are being met, to remediate identified problems, and to carry out quality improvement.

The DDD quality improvement (QI) efforts for DDD waiver services are coordinated through the DDD Quality Improvement (QI) Committee comprised of (at a minimum), representatives from DDD Central Office, DHHS Medicaid (MLTC), and DDD Service Coordination. The QI Committee meets at least quarterly and reviews data and reports including, but not limited to, statewide monitoring, critical incidents, complaints and investigations, Medicaid HCBS waiver performance measures, service utilization, post-payment claims, and certification surveys to identify trends and consider statewide changes to support service improvement.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems allowing for systematic oversight of services across the state by the QI Committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes of QI Committee quarterly meetings document review of reports and data, identification of areas of concern, and recommendations and assignment of tasks for remediation, both to address identified issues and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

The QI Committee receives reports and information and provides/shares feedback and support to the DDD service districts. DDD makes all meeting minutes and reports available to the Medicaid Director for their review.

DDD Central Office personnel design and monitor services, including specific performance related to service and remediation. Discovery methods under DDD Central Office are expenditure and utilization monitoring; technical assistance; professional research, observation and insight; and analysis of data sources.

The DDD QI personnel provide systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under QI include reviewing electronic participant data, conducting file reviews, National Core Indicators (NCI) participant surveys, and oversight of field office supervisory efforts. For reviews completed using a representative sample, the sample size is determined by using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

Both DDD Central Office and QI personnel are involved in discovery related to, complaints, incident reports, and data collection and analysis. In addition to DDD Central Office and QI personnel, a contracted QIO-entity is also involved in the discovery, data collection, and reporting related to mortality review. The contracted QIO-like entity compiles and produces reports related to mortality reviews, which are analyzed by DDD personnel, DDD administration and the QI Committee. QI reports include data from mortality review, appeals, supervisory file review, Central Office file review, critical incident, state-mandated web-based case management system reports, post-payment claims, and service authorizations. These reports are compiled by DDD personnel and analyzed by the DDD administration and the QI Committee at least annually and as needed. When a provider is cited during certification review or complaint investigation and it is determined a plan of improvement is required, DHHS personnel monitor the plan of improvement to assure completion.

In order to assure protections, services, and supports on a systems level, DHHS has established a formal certification and review process in accordance with state regulations and Medicaid HCBS waiver requirements for provider agencies offering DD waiver services. This certification process includes certification and service reviews of certified agency providers and programs by DHHS surveyors in accordance with a one-year or two-year certifications issued by DHHS. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths, in services provided on a statewide level. In order to ensure continued certification as an agency provider of DD waiver services, when providers are cited during certification review or complaint investigations,

a formal plan of correction may be required to ensure remediation of circumstances leading to citation that must be addressed. On an ongoing basis, critical incidents and complaints associated with certified providers, which have been reported to DDD, are reviewed and appropriate levels of follow-up are conducted.

Quality improvement for the purpose of statewide systemic program enhancement occurs through a variety of activities, including:
• Training and staff development may be offered or required for DDD personnel to remediate identified issues, inform and educate staff on changing regulations, policies, procedures, etc., and to provide opportunities for continued staff growth and education.
• Development of policy and operational guidelines to revise or clarify existing program expectations, or communicate new program expectations as needed for continuous program improvement.
• Development of informational materials, including written guidance for DDD personnel and providers and reference materials for current or prospective participants and the public.
• Researching national trends and best practices in the field of developmental disabilities and applying information gathered to continuous quality improvement activities or recommendations.
• Remediation of specific issues by DDD personnel. DDD personnel involved in remediation activities may vary, depending on the nature and scope of the identified issue.
• The DDD QI Strategy outlines a structured process for continuous assessment, monitoring, measuring, and evaluating operational and person-centered outcomes of DD waiver service delivery. The QI Strategy also outlines DDD collaboration with other DHHS divisions and the Governor’s Advisory Committee on Developmental Disabilities for continuous quality improvement.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☒ **Annually** |
| ☐ **Other**<br>Specify: | ☒ **Other**<br>Specify:<br>More frequently as determined by DDD. |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DDD is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. The DDD Director and DDD personnel are responsible for coordinating the development, implementation and monitoring of any system design changes. The DDD Director works closely with the DDD QI Committee to assure the appropriate identified priority system issues are developed, implemented, and monitored to assure system change occurs. Annual data is aggregated and compared to the previous baseline evidence to determine if the identified system change is effective. System design change recommendations will be made available to MLTC before implementation.

As described in section H-a-i of this waiver, DDD has in place a QI system including monitoring for issues and remediation of identified concerns. In turn, this process leads to system improvement. This is an ongoing, circular system with components of design, discovery, remediation, and operational improvement. DDD QI personnel, in consultation with the DDD Director, review the QI strategies on an ongoing basis, but no less frequently than quarterly, to adjust program outcomes, determine the need to modify data sources and to develop other methods to evaluate progress and services.

DDD QI personnel fulfill the lead role in guiding this improvement along with input from DDD service coordination, DDD Central Office personnel, and other divisions of DHHS. Specific activities are as follows:

a. Process of Aggregating Data and Monitoring Data Trends
The majority of waiver Performance Measure data is aggregated through queries from the state-mandated web-based case management system and electronic records where data is entered directly by the worker or reporter.

For data not entered directly into a system, data is derived from individual source documents such as audits of files or certification reports and manually tabulated as necessary.

In addition to Medicaid HCBS DD waiver performance measure data, the following data points are monitored on a quarterly basis:
- Service coordination timelines;
- Wait list management and timelines;
- Service authorizations; and
- Prevention of incidents.

b. Report Formats
Quality reports include mortality review data, appeals data, supervisory file review data, critical incident data, electronic participant data system reports, post-payment claims data, and service authorization data. These reports reflect information via graphs, tables, and narratives. QI Committee minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

c. Communicating Results
Aggregate data is shared through the QI Committee with DDD administration, service coordination, and other stakeholders. Data reports are submitted as requested to CMS representatives. Quality data is presented at stakeholder meetings (e.g., Nebraska Association of Service Providers, DD Council, DD Advisory Committee, and DHHS HCBS stakeholder meetings).

d. Using Data for Implementing Improvement
Data is reviewed on at least a quarterly basis through the QI Committee. Appropriate recommendations, action plans, and follow-up are documented in the QI Committee minutes.

e. Assessment of the Effectiveness of the QI Process
Evaluations of the effectiveness of the QI process are done by analyzing remediation activities, determining if timelines and outcomes are being met, and the success level in addressing the original concern. Effectiveness is also measured through the relevancy of collected data in providing useful information on the timeliness and quality of services provided through waiver services; data is not collected for its own sake but rather to measure areas requiring maintenance of effort or improvement in service operations and delivery.

The DDD administration is responsible for coordination of monitoring and analysis of system design changes.

The administration works in conjunction with the QI Committee and the DDD personnel to develop methods of evaluation when implementing system design changes. The QI Strategy goals define the outcome desired as a function of the system change and to allow the gathering of data and other information related to the state of affairs prior to the system change.

In cases where this is not practicable, efforts are made to develop alternate strategies to capture information post hoc allowing a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies was the decision to utilize a contracted vendor web-based case management system for budgeting, case management, and reporting incidents. The use of the web-based application and electronic records has improved the methods of data collection and aggregation.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality improvement (QI), program management, and administrative personnel in DDD evaluate the effectiveness of the waiver QI system on an ongoing basis. Quality improvement strategies stratify information for each respective waiver for all services funded by DDD. MLTC oversees the implementation of the Medicaid State Plan and all identified State Plan system issues are relayed to MLTC personnel responsible for services under the Medicaid State Plan. System design change recommendations will be made to MLTC before implementation.

The evaluation of DDD's QI strategy involves assessing the effectiveness of the system in improving the quality of services as well as comparing the system to best practices. When efforts to improve the quality of services are not effective, additional analyses are conducted to identify weaknesses in the current QI strategy. These analyses aid in identifying potential changes to improve the efficacy of the overall system. In addition, the QI Committee provides an additional review of the effectiveness of the QI strategy and makes recommendations for improvement.

The QI strategy is evaluated on various levels in a systematic basis. Information reviewed by the QI Committee is reviewed to assess the reliability and thus, validity of the information being presented each time a committee meeting is held.

There is also a self-correcting nature based on strategies used to effect systems change. As the QI strategy has become more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

Just as the assumption is that services can always be improved, the same concept also holds with the QI strategy. Efforts are continually made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements, and eliciting additional feedback from agencies and providers regarding QI issues. New technology also leads to system changes and improvements in QI strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed, which may lead to new strategies.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):***

○ **No**

◉ **Yes** *(Complete item H.2b)*

**b. Specify the type of survey tool the state uses:**

○ **HCBS CAHPS Survey :**
◉ **NCI Survey :**
○ **NCI AD Survey :**
○ **Other** *(Please provide a description of the survey tool used):*

## *Appendix I: Financial Accountability*

### *I-1: Financial Integrity and Accountability*

***Financial Integrity.*** *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

*Financial accountability and integrity are joint responsibilities of the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) with assistance from, Medicaid and Long-Term Care (MLTC), and the DHHS Financial Services unit.*

*DDD is responsible to ensure the integrity of the service authorization and claims processes. DDD staff authorizes services using a state-mandated web-based case management system which edits individual claims, suspends inaccurate claims, and tracks the participant's utilization of waiver services.*

*The DDD Program Accuracy Specialists are responsible for conducting the post-payment reviews quarterly. A random sample of all paid claims processed in the prior month will be reviewed each quarter. The Raosoft calculator will be used to determine the sample size needed to ensure a representative sample of paid claims is reviewed.*

*For the post-payment reviews, all paid claims are included in the population from which the random sample is drawn. Any claim processed in the prior month can become part of the sample and is equally likely to be selected. Claims for all services are audited in the same manner. Onsite reviews are not conducted for claims reviewed with this process.*

*When overpayments are discovered, the provider is contacted and given the opportunity to provide additional information to substantiate their claim. The additional information is reviewed and the provider is notified of findings, which can include the requirement to initiate repayment of funds.*

*The state-mandated web-based case management system identifies inaccurate authorizations, claims and trending data, and DDD supervisory and management personnel utilize this data to determine follow-up with service coordination personnel to correct errors in service authorizations or conduct monitoring activities to determine whether authorizations are sufficiently linked to service delivery. This data may also lead DDD personnel to conduct financial reviews of provider claims when concern is raised through monitoring, certification activities by DHHS Surveyors, or complaint investigations.*

*The DHHS Financial Services unit operates the cost allocation plan, prepares and monitors budget projections for MLTC and DDD, prepares federal and state reports as required, and prepares the CMS-64 reports.*

*a) Describe the requirements concerning the independent audit of provider agencies: DD agency providers are required to contract with a certified public accountant for an annual independent audit of financial operations. The scope of this independent audit includes a review of the accounting systems of the agency in order to assess whether the financial statements provide an accurate representation of its financial position and are free from material misstatement.*

*Audit reports are submitted to DDD and are reviewed by an analyst for any audit findings or exceptions, which might affect State payments by or for the provider. Agency providers are also required to submit a cost report if the total revenue is 1.5 million dollars or more for the operating year.*

*Agency providers with annual operating budgets of less than $1.5 million are not required to provide an audit report. However, these providers are required to retain financial and statistical records to support and document all claims.*

*Services delivered by independent providers, rather than agency providers do not require an independent audit. Independent providers are required to retain financial and statistical records to support and document all claims.*

*b) Describe the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope, and frequency of audits: Claims for all services are audited in the same manner. Medicaid HCBS DD waiver providers submit billings through a state-mandated web-based case management system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including electronic recording of time-in and time-out, program data records, or other documentation as determined by DDD must be available to DDD upon request. The provider must maintain electronic or paper records and documentation in sufficient detail to allow DDD program accuracy personnel to verify delivery of service to participants as certified on the electronic claim.*
*Audits of provider claims may be conducted in response to concerns raised by a review of electronic data, trending reports, complaints, or certification reviews. DDD central office personnel will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider claim, electronic recording of time-in and time-out, service authorizations, electronic service utilization data, and the service plan. When issues are found which may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or*

*the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.*

*DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried monthly to track trends in costs and service use by area, provider and statewide. These quality assurance activities are not a random sample review. They refer to reports that the Division produces internally that track/trend service utilization and for internal control of compliance to service limitations in the waiver*

*Nebraska does not review all claims. For its quality assurance activities, Nebraska reviews a statistically valid random sample.*
*• Post-audit activities associated with audits of provider claims occur as needed.*
*• Post-audit activities associated with quality assurance activities occur quarterly.*
*• Post-audit activities associated with the monthly queries to track trends occur as needed.*
*• Post-audit activities associated with Financial Services tracking occurs as needed.*
*• Post-audit activities associated with Auditor of Public Accounts audits occur annually.*

*Financial Services track the use of Medicaid funding and provide monthly updates on the use of Medicaid HCBS DD waiver funding relative to the budgeted amounts. This aids DHHS-DD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.*

*c) Describe the agency (or agencies) responsible for conducting the financial audit program: The Nebraska Auditor of Public Accounts (APA) and DHHS are responsible for conducting these financial audits. The APA is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. The APA conducts the audits on an annual basis.*

*The state uses an Electronic Visit Verification System. The following services are subject to EVV:*
*• Supported Family Living*
*• Independent Living*
*• Respite*
*• Homemaker*

*Providers are required to use the EVV system. EVV data collected is used to monitor the State's financial integrity and accountability as an element of the post payment review processes.*

## *Appendix I: Financial Accountability*

### *Quality Improvement: Financial Accountability*

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

***a. Methods for Discovery: Financial Accountability Assurance:***
***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

***i. Sub-Assurances:***

***a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

***Performance Measures***

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to*

*analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

***Performance Measure:***
***Number and percent of paid claims reviewed that were paid in accordance with the reimbursement methodology specified in the approved waiver. Numerator = Number of paid claims reviewed which were paid in accordance with the reimbursement methodology specified in the approved waiver. Denominator = Number of paid claims reviewed.***

***Data Source*** *(Select one):*
***Record reviews, on-site***
*If 'Other' is selected, specify:*

| ***Responsible Party for data collection/generation*** *(check each that applies):* | ***Frequency of data collection/generation*** *(check each that applies):* | ***Sampling Approach****(check each that applies):* |
|---|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** | ☐ ***100% Review*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** | ☒ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☒ ***Representative Sample***<br>*Confidence Interval =*<br>*95% confidence level with +/- 5% margin of error* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*Specify:* | |

***Data Aggregation and Analysis:***

| ***Responsible Party for data aggregation and analysis*** *(check each that applies):* | ***Frequency of data aggregation and analysis****(check each that applies):* |
|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** |
| ☐ ***Sub-State Entity*** | ☒ ***Quarterly*** |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***Number and percent of paid claims reviewed that were supported by documentation that services were rendered. Numerator: Number of paid claims reviewed that were supported by documentation that services were rendered. Denominator: Number of paid claims reviewed.***

***Data Source*** *(Select one):*
***Record reviews, on-site***
*If 'Other' is selected, specify:*

| ***Responsible Party for data collection/generation*** *(check each that applies):* | ***Frequency of data collection/generation*** *(check each that applies):* | ***Sampling Approach****(check each that applies):* |
|---|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** | ☐ ***100% Review*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** | ☒ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☒ ***Representative Sample***<br>*Confidence Interval =*<br>*95% confidence level with +/- 5% margin of error* |

| | | |
|---|---|---|
| ☐ ***Other*** *Specify:* | ☐ ***Annually*** | ☐ ***Stratified*** *Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other*** *Specify:* |
| | ☐ ***Other*** *Specify:* | |

***Data Aggregation and Analysis:***

| ***Responsible Party for data aggregation and analysis*** *(check each that applies):* | ***Frequency of data aggregation and analysis****(check each that applies):* |
|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** |
| ☐ ***Sub-State Entity*** | ☒ ***Quarterly*** |
| ☐ ***Other*** *Specify:* | ☐ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other*** *Specify:* |

***b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

***Performance Measures***

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

***Performance Measure:***
***Number and percent of paid claims reviewed that were paid in accordance with the rate methodology specified in the approved waiver. Numerator = Number of paid claims reviewed that were paid in accordance with the rate methodology specified in the approved waiver. Denominator = Number of paid claims reviewed.***

***Data Source*** *(Select one):*
***Record reviews, on-site***
*If 'Other' is selected, specify:*

| ***Responsible Party for data collection/generation*** *(check each that applies):* | ***Frequency of data collection/generation*** *(check each that applies):* | ***Sampling Approach****(check each that applies):* |
|---|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** | ☐ ***100% Review*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** | ☒ ***Less than 100% Review*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** | ☒ ***Representative Sample***<br>*Confidence Interval =*<br>*95% confidence level with +/- 5% margin of error* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*Specify:* | |

***Data Aggregation and Analysis:***

| ***Responsible Party for data aggregation and analysis*** *(check each that applies):* | ***Frequency of data aggregation and analysis****(check each that applies):* |
|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** |
| ☐ ***Sub-State Entity*** | ☒ ***Quarterly*** |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***ii.*** *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

*Quarterly off-site file reviews are conducted by DHHS-DD program accuracy staff (PAS). This review is conducted on a sample of files to ensure activities are being applied correctly, and that reviews and remediation activities are completed as assigned. The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%. PAS are responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory staff. This information is summarized and reviewed by the DHHS-DD Quality Improvement Committee (QIC) quarterly.*

*An independent statewide single audit of DHHS is conducted by the State APA office on an annual basis following each state fiscal year (July 1 - June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DHHS-DD staff responds to findings related to review of randomly selected participant waiver files.*

*The APA reviews the waiver files for compliance with the state's regulations. The APA reviews the State's electronic information systems for inclusion of the waiver consent form, service plan, and waiver evaluation or reevaluation worksheets. The APA office also reviews the electronic claim and service authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the service plan documentation. Please see Appendix I-1, I-2-b, I-2-d, I-3, and I-5 for additional information on strategies employed by the state for checks and balances and discovery of systemic issues.*

***b. Methods for Remediation/Fixing Individual Problems***

***i.*** *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

*The participant's DHHS-DD Service Coordinator (SC) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.*

*Participants are notified in writing or electronically of the authorized funding amount at the time of choosing a provider and in the development of the service plan. Checks and balances described in sections I-1, I-2, and I-3 are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The participant's SC authorizes the services. When discrepancies are found, designated DHHS-DD staff take action to correct errors in the authorization, such as correcting the provider, service type, service amount, and/or dates of services. A pre-audit of all provider claims is completed to assure the accuracy of coding and claim.*

*The continuing efforts are to oversee and refine the formal design and implementation of quality improvement systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local service coordination level. Quarterly reporting has been developed to ensure regular review of the results of the various QI functions. The report shows an empirical data review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.*

***ii. Remediation Data Aggregation***

***Remediation-related Data Aggregation and Analysis (including trend identification)***

| ***Responsible Party****(check each that applies):* | ***Frequency of data aggregation and analysis*** *(check each that applies):* |
|---|---|
| ☒ ***State Medicaid Agency*** | ☐ ***Weekly*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***c. Timelines***

*When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.*

◉ ***No***

○ ***Yes***

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.*

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (1 of 3)*

***a. Rate Determination Methods.*** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*Information about payment rates is made available verbally and in writing to waiver participants and providers by state DHHS staff. The waivers and rates are posted on the DHHS public website. Using the normal budgeting and appropriation process, rates are increased or decreased at the direction of the Nebraska Legislature through the biennial budget process. Public comments on rates are made through the legislative budget public hearing process. A biennial (two-year) state budget is submitted to the Legislature by the governor based on budget requests and the Governor's budget priorities. The budget recommendation comes as a bill that is introduced by the Speaker of the Legislature at the request of the governor. Appropriations bills routinely are referred to the Appropriations Committee. This committee holds public hearings with interested parties. Hearing notices are published in the Legislative Journal. The notice of committee public hearing, when published, includes the date, time, location, and legislative bill number(s). Interested entities and the general public are given the opportunity to comment regarding the preliminary recommendations, as well as letters or written communication are accepted by committees during a bill's public hearing. The Nebraska Legislature appropriates funding for services, specifying the percentage or specifying how a special appropriation is to be spent.*

*Reimbursement is based on Fee-For-Service rates for all services with the exception of Assistive Technology, Environmental Modification Assessment, Home Modification, Vehicle Modification, and Personal Emergency Response System (PERS) Services. Current and historical fee schedules are available to the public at the following url: https://dhhs.ne.gov/Pages/DD-Provider-Rates-and- Fee-Schedules.aspx. First year rates for new services are based on utilization of similar services in other waiver programs or experience in other states that operate similar waivers with similar services. Successive year rates show a 2% increase as the Nebraska legislature typically provides the budget for the increase.*

*The methodology for estimating the direct labor cost and all factors in the rate model are explained below:*
*1. Direct Labor Cost:*
*The cost of direct labor for each service is based on the staffing requirements for the service and the classification of the employee. For each classification, an appropriate employment classification from the 2016 Bureau of Labor Statistics (BLS) was selected. Most of the services use the classification of Social and Human Service Assistants for direct-care staff. Wages are inflated from the BLS data using the Consumer Price Index to account for inflation from the time when this data was collected to the anticipated implementation of this rate model.*
*2. Employee Related Expenses (ERE):*
*This includes costs associated with employees of DD agency providers. These costs include FICA, retirement, unemployment compensation, health/dental/life insurance, and short and long-term disability insurance. The ERE factor is based on actual costs in general ledger (GL) data submitted by providers.*
*3. Availability Factor:*
*This factor compensates agency providers for paid direct-care staff time for non-billable activities including recordkeeping, reporting, training, and meetings. Additionally, it also compensates agency providers for paid time off for direct staff (holidays, sick, vacation) and overtime hours. The factor is based on payroll data submitted by a representative sample of DD service providers for Nebraska state fiscal year 2016 and a training survey administered to the PAG.*
*4. Mileage:*
*This factor compensates providers for mileage while transporting the participant as part of waiver services. The rate is based on the 2018 rate published by the Internal Revenue Service for reimbursement of employees for personal vehicle usage.*
*5. Program Support:*
*This factor is intended to cover the supports around direct-care specific to the provision of services (as opposed to general and administrative expenses). Examples include clinical supports, nursing costs, and rent/maintenance associated with a building used for the delivery of service. It does not include costs for staff who have direct contact with the waiver participant as these costs are accounted for in the direct labor cost component. This factor was estimated based on GL data submitted by providers.*
*Rent expenses included in the rate model were categorized based on how they were recorded in the GL data. For buildings that housed both program activities and support staff, the expense was split into program support and administration.*
*6. Administration:*
*This factor is intended to cover general and administrative expenses for the providers. These include indirect costs such as rent/depreciation, salaries and benefits, and background checks for staff for functions such as human resources, finance and accounting, and quality improvement. This factor was estimated based on GL data submitted by providers.*

*Other services have rate structures to accommodate service delivery one-on-one or in a group setting. This structure*

*provides waiver participants the flexibility to purchase the services in a group setting at a lower cost. Independent Living, and Supported Family Living services are structured with both individual and group rates. Rates for these services are adjusted by changing the assumed staffing ratio for direct labor based on the setting.*

*The service rates do not differ geographically. The state considered the need for rate differences by geographical region in the 2018 rate study and concluded that this was not necessary.*

*Rates established in accordance with this methodology may be adjusted at the direction of the Nebraska State Legislature.*

*The following services use an alternative rate methodology:*
*Environmental Modification Assessment, Home Modification and Vehicle Modification, Assistive Technology, and Personal Emergency Response System are provided at a market rate and approved on a per-case basis.*

*Reimbursement for Transportation service is based on the Nebraska standard for mileage reimbursement, pursuant to Neb. Rev. Stat. § 81-1176.*

*To ensure rates remain consistent with the provisions of §1902(a)(30)(A), DDD monitors utilization of waiver services on a monthly basis via reporting. This reporting calculates many of the statistics required on the CMS 372 reports and provides assurance the cost neutrality requirement of the waiver are being met. DDD intends to review rates paid to providers annually. The review will determine the number of providers, both independent and agency, providing services in the Metropolitan Statistical Areas within Nebraska and compare this figure to prior years to identify trends in provider availability. In addition, DDD will review on an annual basis the number of participants served on the waiver, including new participants, and the reserve capacity slots utilized for new entrants.*

***b. Flow of Billings.*** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

*Billings flow from providers to the State's claims translator and downloaded to the State's electronic local web-based service system, N-FOCUS, which is a component of MMIS., Services are prior authorized and sent electronically to the provider in a state mandated web-based case management system.*

*Service data, including the time at which services begin and end and the service delivery location, is recorded in the attendance module and a claim is generated through the state mandated web-based case management system by providers and are electronically submitted for claims processing following the delivery of services.*

*During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services are authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher, which is then sent to the state's accounting system, EnterpriseOne (formerly the Nebraska Information System or NIS).*

*All claims are routed through the State's electronic local web-based service system, a recognized component of MMIS, and are subsequently sent to EnterpriseOne, the accounting system for the State of Nebraska.*
*The program under which a claim is paid is stored on each individual service authorization and electronically transferred to the claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to EnterpriseOne. The state's electronic local web-based service system stores the timestamp and user ID for all new or updated information related to this process.*

*Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the EnterpriseOne. Claims are processed on a daily basis.*
*Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.*
*The state collects overpayments to Medicaid providers pursuant to 471 NAC § 3-003.06. The Medicaid Financial Responsibility (MFR) unit of DHHS Financial Services is responsible for processing and collecting overpayments for Medicaid provider claims.*

*An overpayment is established when a claim is revised in the state-mandated web-based case management system to lower the number of billable units. This revision can be done by either the provider or the state. The claim revision generates an overpayment in the N-FOCUS system, which creates an Accounts/Receivables (A/R) account to monitor the collection of the overpayment. A demand letter is sent to the provider to provide notification of the establishment of the A/R. The provider may remit payment via check or have the A/R satisfied via recoupment from future payments.*

*Collections made via both check/cash remittance and recoupments are recorded to the general ledger and account for federal funds in claims for Federal Financial Participation (FFP).*

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (2 of 3)*

***c. Certifying Public Expenditures*** *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

***Select at least one:***

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state*

*verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## *Appendix I: Financial Accountability*

### *I-2: Rates, Billing and Claims (3 of 3)*

***d. Billing Validation Process.*** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

*a) Claims for payment are made only when the participant was eligible for a Medicaid waiver payment on the date of service.*
*DD waiver services must be prior authorized before payment is made. Authorizations are based upon a determination by designated DHHS-DD staff that the participant meets waiver eligibility criteria, that the services are identified in the approved service plan, and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.*

*b) Claims for payment are made only when the service was included in the participant's approved service plan. The authorization and payment process includes the following steps:*
*1. Waiver eligibility of the participant is determined.*
*2. Waiver services are identified in the person-centered service plan.*
*3. Waiver service authorization, also known as the budget authorization, is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.*
*4. Authorization is entered into in a state mandated web-based case management system used for budget authorization, claims processing, and case management and then sent to the state's electronic local web-based service system.*
*5. Upon verification through the state mandated web-based case management system, claims are electronically submitted to state's electronic local web-based service system for processing. Edits in the state mandated web-based case management system verify participant and provider eligibility, dates of service, units of service, and rates.*
*6. Claims are generated based on service data entered by providers.*

*c) Claims for payment are made only when the services were provided.*
*DD waiver providers submit billings through a state mandated web-based case management system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including electronic recording of time-in and time-out, program data records, or other documentation as determined by DHHS-DD must be available to DHHS-DD staff upon request. An electronic signature is acceptable.*

*The billing validation process verifies that the participant was eligible for Medicaid waiver payment on the date of service.*

*The state collects overpayments to Medicaid providers pursuant to 471 NAC § 3-003.06. The Medicaid Financial Responsibility (MFR) unit of DHHS Financial Services is responsible for processing and collecting overpayments for Medicaid provider claims.*

*An overpayment is established when a claim is revised in Therap to lower the number of billable units. This revision can be done by either the provider or the state. The claim revision generates an overpayment in the NFOCUS system which creates an Accounts/Receivables (A/R) account in NFOCUS to monitor the collection of the overpayment. A demand letter is sent to the provider to provide notification of the establishment of the A/R. The provider may remit payment via check or have the A/R satisfied via recoupment from future payments. Collections made via both check/cash remittance and recoupments are recorded to the general ledger and account for federal funds in claims for Federal Financial Participation (FFP).*

***e. Billing and Claims Record Maintenance Requirement.*** *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (1 of 7)*

***a. Method of payments -- MMIS*** *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  *Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal*

*funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are not made through an approved MMIS.***

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

*Describe how payments are made to the managed care entity or entities:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (2 of 7)*

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

*On or before July 1, 2024, the state will procure a FMS vendor. The FMS will make payments for participants exercising self-direction on Transportation, Supported Family Living, Participant Directed Goods and Services, Independent Living, Homemaker, Respite, Home Modifications, Family Caregiver Training, Environmental Modification Assessment, Community Integration, Child Day Habilitation, and Assistive Technology when furnished by independent providers not affiliated with a DD agency. The FMS vendor acts as the fiscal/employer agent to the common law employer. The vendor will be responsible for managing the receipt and distribution of the participant's self-directed budget funds, processing and paying the participant's qualified employee, providing orientation at the time of enrollment with the FMS vendor, and ongoing training and support to the participant and their employees. The FMS vendor will be monitored by Administrative Services (AS) State Accounting and DHHS Internal Audit Division through systematic reviews, internal control plan requirements, and internal audits.*

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care*

*entities.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (3 of 7)*

***c. Supplemental or Enhanced Payments.*** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (4 of 7)*

***d. Payments to state or Local Government Providers.*** *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

*Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is an independent Medicaid HCBS DD waiver provider of Assistive Technology, Home Modifications, Vehicle Modifications, and Environmental Modification Assessment, and receive the same rates as all providers for those services.*

*In Nebraska, some agency providers are public providers established by County Commissioners under interlocal agreements. Both private and public agency providers deliver the same DD waiver services, and the payment to these public providers does not differ from the amount paid to private providers.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (5 of 7)*

***e. Amount of Payment to State or Local Government Providers.***

*Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

*Describe the recoupment process:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (6 of 7)*

***f. Provider Retention of Payments.*** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (7 of 7)*

***g. Additional Payment Arrangements***

***i. Voluntary Reassignment of Payments to a Governmental Agency.*** *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

*Specify the governmental agency (or agencies) to which reassignment may be made.*

***ii. Organized Health Care Delivery System.*** *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

***iii. Contracts with MCOs, PIHPs or PAHPs.***

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  *Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  *In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (1 of 3)*

***a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

☐ ***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (2 of 3)*

***b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

*Check each that applies:*

☐ ***Appropriation of Local Government Revenues.***

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

☐ ***Other Local Government Level Source(s) of Funds.***

*Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

## *Appendix I: Financial Accountability*

### *I-4: Non-Federal Matching Funds (3 of 3)*

***c. Information Concerning Certain Sources of Funds.*** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  *Check each that applies:*

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  *For each source of funds indicated above, describe the source of the funds in detail:*

## *Appendix I: Financial Accountability*

### *I-5: Exclusion of Medicaid Payment for Room and Board*

***a. Services Furnished in Residential Settings.*** *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

***b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.*** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

***Do not complete this item.***

## *Appendix I: Financial Accountability*

### *I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver*

***Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*** *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)*

***a. Co-Payment Requirements.*** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

***i. Co-Pay Arrangement.***

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

*Specify:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)*

***a. Co-Payment Requirements.***

***ii. Participants Subject to Co-pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)*

***a. Co-Payment Requirements.***

***iii. Amount of Co-Pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)*

***a. Co-Payment Requirements.***

***iv. Cumulative Maximum Charges.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)*

***b. Other State Requirement for Cost Sharing.*** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

*Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:*

## *Appendix J: Cost Neutrality Demonstration*

### *J-1: Composite Overview and Demonstration of Cost-Neutrality Formula*

***Composite Overview.*** *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

***Level(s) of Care: ICF/IID***

| *Col. 1* | *Col. 2* | *Col. 3* | *Col. 4* | *Col. 5* | *Col. 6* | *Col. 7* | *Col. 8* |
|---|---|---|---|---|---|---|---|
| *Year* | *Factor D* | *Factor D'* | *Total: D+D'* | *Factor G* | *Factor G'* | *Total: G+G'* | *Difference (Col 7 less Column4)* |
| *1* | *9404.00* | *13429.00* | *22833.00* | *199587.00* | *8645.00* | *208232.00* | *185399.00* |
| *2* | *8568.28* | *13697.58* | *22265.86* | *203578.74* | *8817.90* | *212396.64* | *190130.78* |
| *3* | *8964.00* | *13971.53* | *22935.53* | *207650.31* | *8994.26* | *216644.57* | *193709.04* |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (1 of 7)*

***a. Number Of Unduplicated Participants Served.*** *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

***Table: J-2-a: Unduplicated Participants***

| *Waiver Year* | *Total Unduplicated Number of Participants (from Item B-3-a)* | *Distribution of Unduplicated Participants by Level of Care (if applicable)* |
|---|---|---|
| | | *Level of Care:* |
| | | *ICF/IID* |
| *Year 1* | *895* | *895* |
| *Year 2* | *975* | *975* |
| *Year 3* | *975* | *975* |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (2 of 7)*

***b. Average Length of Stay.*** *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

*Average length of stay on the waiver is based off of Adult Day Waiver of year four of 372 report that was submitted. The submitted report covered dates between 3/1/2020-2/29/2021.*

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (3 of 7)*

***c. Derivation of Estimates for Each Factor.*** *Provide a narrative description for the derivation of the estimates of the following factors.*

***i. Factor D Derivation.*** *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

*Factor D is based off of the most recent 372 report submitted for year four of the Adult day waiver (dates: 3/1/2020 - 2/29/2021). Our baseline was 372 data that was submitted and the subsequent years reflect a 2% increase.*
*The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year. This waiver does not cover the cost of prescribed drugs and therefore Factor D does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.*

***ii. Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Factor D' is based on actual acute care expenditures for individuals on the waiver in Waiver year 4. The data source is paid claims for fee for service expenditures and capitation payments made to managed care organizations for dates of service between 3/1/2020 to 2/29/2021. The average cost for acute care for this year was $13,429. Price increases of 2.0% were included for each year.*

*The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year.*

*This waiver does not cover the cost of prescribed drugs and therefore Factor D' does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.*

***iii. Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*The average cost of institutional care per ICF-DD recipient was based on actual expenditures in waiver year three for dates between 3/1/2020 to 2/29/2021. The average cost for this year was $199,587. Price increases of 2% were included for each year.*

*The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year.*

***iv. Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Factor G' is based on actual acute care expenditures for individuals in an ICF-DD in waiver year three for dates between 3/1/2020 to 2/29/2021. The average cost for acute care for this waiver year was $8,645. Price increases of 2% were included for each year.*

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (4 of 7)*

***Component management for waiver services.*** *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

| *Waiver Services* | |
|---|---|
| *Respite* | |
| *Assistive Technology* | |
| *Child Day Habilitation* | |
| *Community Integration* | |
| *Day Supports* | |
| *Environmental Modification Assessment* | |
| *Family and Peer Mentoring* | |
| *Family Caregiver Training* | |
| *Home Modifications* | |
| *Homemaker* | |
| *Independent Living* | |
| *Participant Directed Goods and Services* | |
| *Personal Emergency Response System (PERS)* | |
| *Supported Family Living* | |
| *Transportation* | |
| *Vehicle Modifications* | |

# *Appendix J: Cost Neutrality Demonstration*

## *J-2: Derivation of Estimates (5 of 7)*

***d. Estimate of Factor D.***

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 1***

| *Waiver Service/ Component* | *Unit* | *# Users* | *Avg. Units Per User* | *Avg. Cost/ Unit* | *Component Cost* | *Total Cost* |
|---|---|---|---|---|---|---|
| ***Respite Total:*** | | | | | | ***666950.00*** |
| *Respite - Agency* | *Hour* | *200* | *25.00* | *29.39* | ***146950.00*** | |
| *Respite - Independent* | *Hour* | *400* | *80.00* | *16.25* | ***520000.00*** | |
| ***Assistive Technology Total:*** | | | | | | ***2342.00*** |
| *Assistive Technology* | *Occurrence* | *1* | *1.00* | *2342.00* | ***2342.00*** | |
| ***Child Day Habilitation Total:*** | | | | | | ***584912.50*** |
| *Child Day Habilitation - Agency* | *Hour* | *150* | *25.00* | *12.99* | ***48712.50*** | |
| *Child Day Habilitation - Independent* | *Hour* | *400* | *70.00* | *19.15* | ***536200.00*** | |
| ***Community Integration Total:*** | | | | | | ***1653900.00*** |
| *Community Integration - Agency* | *Hour* | *200* | *50.00* | *12.99* | ***129900.00*** | |
| *Community Integration - Independent* | *Hour* | *400* | *200.00* | *19.05* | ***1524000.00*** | |
| ***Day Supports Total:*** | | | | | | ***183750.00*** |
| *Day Supports - Agency* | *Hour* | *250* | *70.00* | *10.50* | ***183750.00*** | |
| ***Environmental Modification Assessment Total:*** | | | | | | ***12000.00*** |
| *Environmental Modification Assessment* | *Occurrence* | *12* | *1.00* | *1000.00* | ***12000.00*** | |
| ***Family and Peer Mentoring Total:*** | | | | | | ***75000.00*** |
| *Family and Peer Mentoring* | *Hour* | *100* | *15.00* | *50.00* | ***75000.00*** | |
| ***Family Caregiver Training Total:*** | | | | | | ***25000.00*** |

| | |
|---|---|
| ***GRAND TOTAL:*** | ***8416187.00*** |
| ***Total Estimated Unduplicated Participants:*** | ***895*** |
| ***Factor D (Divide total by number of participants):*** | ***9404.00*** |
| ***Average Length of Stay on the Waiver:*** | *290* |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Family Caregiver Training | Occurrence | 50 | 1.00 | 500.00 | 25000.00 | |
| **Home Modifications Total:** | | | | | | 33000.00 |
| Home Modifications | Occurrence | 10 | 1.00 | 3300.00 | 33000.00 | |
| **Homemaker Total:** | | | | | | 600645.00 |
| Homemaker - Agency | Hour | 100 | 75.00 | 20.32 | 152400.00 | |
| Homemaker - Independent | Hour | 350 | 90.00 | 14.23 | 448245.00 | |
| **Independent Living Total:** | | | | | | 949350.00 |
| Independent Living - Agency | Hour | 50 | 150.00 | 42.88 | 321600.00 | |
| Independent Living - Independent | Hour | 100 | 250.00 | 25.11 | 627750.00 | |
| **Participant Directed Goods and Services Total:** | | | | | | 375000.00 |
| Participant Directed Goods and Services | Occurrence | 250 | 15.00 | 100.00 | 375000.00 | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | 620.00 |
| Personal Emergency Response System (PERS) -Installation (One-time) Fee | Occurrence | 5 | 4.00 | 31.00 | 620.00 | |
| **Supported Family Living Total:** | | | | | | 2951767.50 |
| Supported Family Living - Agency | Hour | 150 | 65.00 | 39.33 | 383467.50 | |
| Supported Family Living - Independent | Hour | 350 | 300.00 | 24.46 | 2568300.00 | |
| **Transportation Total:** | | | | | | 201950.00 |
| Transportation - Agency | Mile | 200 | 500.00 | 1.97 | 197000.00 | |
| Transportation - Independent | Mile | 50 | 150.00 | 0.66 | 4950.00 | |
| **Vehicle Modifications Total:** | | | | | | 100000.00 |
| Vehicle Modifications | Occurrence | 10 | 1.00 | 10000.00 | 100000.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8416187.00 |
| **Total Estimated Unduplicated Participants:** | 895 |
| **Factor D (Divide total by number of participants):** | 9404.00 |
| **Average Length of Stay on the Waiver:** | 290 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 7)

***d. Estimate of Factor D.***

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 2***

| *Waiver Service/ Component* | *Unit* | *# Users* | *Avg. Units Per User* | *Avg. Cost/ Unit* | *Component Cost* | *Total Cost* |
|---|---|---|---|---|---|---|
| ***Respite Total:*** | | | | | | ***680460.00*** |
| *Respite - Agency* | Hour | 200 | 25.00 | 29.98 | ***149900.00*** | |
| *Respite - Independent* | Hour | 400 | 80.00 | 16.58 | ***530560.00*** | |
| ***Assistive Technology Total:*** | | | | | | ***2342.00*** |
| *Assistive Technology* | Occurrence | 1 | 1.00 | 2342.00 | ***2342.00*** | |
| ***Child Day Habilitation Total:*** | | | | | | ***596527.50*** |
| *Child Day Habilitation - Agency* | Hour | 150 | 25.00 | 13.25 | ***49687.50*** | |
| *Child Day Habilitation - Independent* | Hour | 400 | 70.00 | 19.53 | ***546840.00*** | |
| ***Community Integration Total:*** | | | | | | ***1694900.00*** |
| *Community Integration - Agency* | Hour | 200 | 50.00 | 13.25 | ***132500.00*** | |
| *Community Integration - Independent* | Hour | 400 | 200.00 | 19.53 | ***1562400.00*** | |
| ***Day Supports Total:*** | | | | | | ***187425.00*** |
| *Day Supports - Agency* | Hour | 250 | 70.00 | 10.71 | ***187425.00*** | |
| ***Environmental Modification Assessment Total:*** | | | | | | ***12000.00*** |
| *Environmental Modification Assessment* | Occurrence | 12 | 1.00 | 1000.00 | ***12000.00*** | |
| ***Family and Peer Mentoring Total:*** | | | | | | ***75000.00*** |
| *Family and Peer Mentoring* | Hour | 100 | 15.00 | 50.00 | ***75000.00*** | |
| ***Family Caregiver Training Total:*** | | | | | | ***25000.00*** |
| *Family Caregiver Training* | Occurrence | 50 | 1.00 | 500.00 | ***25000.00*** | |
| ***Home Modifications Total:*** | | | | | | ***33000.00*** |

| | |
|---|---|
| ***GRAND TOTAL:*** | ***8354071.90*** |
| ***Total Estimated Unduplicated Participants:*** | ***975*** |
| ***Factor D (Divide total by number of participants):*** | ***8568.28*** |
| ***Average Length of Stay on the Waiver:*** | *300* |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Home Modifications | Occurrence | 10 | 1.00 | 3300.00 | 33000.00 | |
| **Homemaker Total:** | | | | | | 612540.00 |
| Homemaker - Agency | Hour | 100 | 75.00 | 20.73 | 155475.00 | |
| Homemaker - Independent | Hour | 350 | 90.00 | 14.51 | 457065.00 | |
| **Independent Living Total:** | | | | | | 968300.00 |
| Independent Living - Agency | Hour | 50 | 150.00 | 43.74 | 328050.00 | |
| Independent Living - Independent | Hour | 100 | 250.00 | 25.61 | 640250.00 | |
| **Participant Directed Goods and Services Total:** | | | | | | 150000.00 |
| Participant Directed Goods and Services | Occurrence | 250 | 6.00 | 100.00 | 150000.00 | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | 632.40 |
| Personal Emergency Response System (PERS) -Installation (One-time) Fee | Occurrence | 5 | 4.00 | 31.62 | 632.40 | |
| **Supported Family Living Total:** | | | | | | 3010920.00 |
| Supported Family Living - Agency | Hour | 150 | 65.00 | 40.12 | 391170.00 | |
| Supported Family Living - Independent | Hour | 350 | 300.00 | 24.95 | 2619750.00 | |
| **Transportation Total:** | | | | | | 205025.00 |
| Transportation - Agency | Mile | 200 | 500.00 | 2.00 | 200000.00 | |
| Transportation - Independent | Mile | 50 | 150.00 | 0.67 | 5025.00 | |
| **Vehicle Modifications Total:** | | | | | | 100000.00 |
| Vehicle Modifications | Occurrence | 10 | 1.00 | 10000.00 | 100000.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8354071.90 |
| **Total Estimated Unduplicated Participants:** | 975 |
| **Factor D (Divide total by number of participants):** | 8568.28 |
| **Average Length of Stay on the Waiver:** | 300 |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (7 of 7)*

***d. Estimate of Factor D.***

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to*

*automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 3***

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Respite Total:** | | | | | | **694020.00** |
| Respite - Agency | Hour | 200 | 25.00 | 30.58 | **152900.00** | |
| Respite - Independent | Hour | 400 | 80.00 | 16.91 | **541120.00** | |
| **Assistive Technology Total:** | | | | | | **2342.00** |
| Assistive Technology | Occurrence | 1 | 1.00 | 2342.00 | **2342.00** | |
| **Child Day Habilitation Total:** | | | | | | **608422.50** |
| Child Day Habilitation - Agency | Hour | 150 | 25.00 | 13.51 | **50662.50** | |
| Child Day Habilitation - Independent | Hour | 400 | 70.00 | 19.92 | **557760.00** | |
| **Community Integration Total:** | | | | | | **1728700.00** |
| Community Integration - Agency | Hour | 200 | 50.00 | 13.51 | **135100.00** | |
| Community Integration - Independent | Hour | 400 | 200.00 | 19.92 | **1593600.00** | |
| **Day Supports Total:** | | | | | | **191100.00** |
| Day Supports - Agency | Hour | 250 | 70.00 | 10.92 | **191100.00** | |
| **Environmental Modification Assessment Total:** | | | | | | **12000.00** |
| Environmental Modification Assessment | Occurrence | 12 | 1.00 | 1000.00 | **12000.00** | |
| **Family and Peer Mentoring Total:** | | | | | | **75000.00** |
| Family and Peer Mentoring | Hour | 100 | 15.00 | 50.00 | **75000.00** | |
| **Family Caregiver Training Total:** | | | | | | **25000.00** |
| Family Caregiver Training | Occurrence | 50 | 1.00 | 500.00 | **25000.00** | |
| **Home Modifications Total:** | | | | | | **33000.00** |
| Home Modifications | Occurrence | 10 | 1.00 | 3300.00 | **33000.00** | |
| **Homemaker Total:** | | | | | | **626775.00** |

| | |
|---|---|
| **GRAND TOTAL:** | **8739899.50** |
| **Total Estimated Unduplicated Participants:** | **975** |
| **Factor D (Divide total by number of participants):** | **8964.00** |
| **Average Length of Stay on the Waiver:** | 300 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Homemaker - Agency | Hour | 100 | 75.00 | 21.41 | 160575.00 | |
| Homemaker - Independent | Hour | 350 | 90.00 | 14.80 | 466200.00 | |
| **Independent Living Total:** | | | | | | 987575.00 |
| Independent Living - Agency | Hour | 50 | 150.00 | 44.61 | 334575.00 | |
| Independent Living - Independent | Hour | 100 | 250.00 | 26.12 | 653000.00 | |
| **Participant Directed Goods and Services Total:** | | | | | | 375000.00 |
| Participant Directed Goods and Services | Occurrence | 250 | 15.00 | 100.00 | 375000.00 | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | 645.00 |
| Personal Emergency Response System (PERS) -Installation (One-time) Fee | Occurrence | 5 | 4.00 | 32.25 | 645.00 | |
| **Supported Family Living Total:** | | | | | | 3071220.00 |
| Supported Family Living - Agency | Hour | 150 | 65.00 | 40.92 | 398970.00 | |
| Supported Family Living - Independent | Hour | 350 | 300.00 | 25.45 | 2672250.00 | |
| **Transportation Total:** | | | | | | 209100.00 |
| Transportation - Agency | Mile | 200 | 500.00 | 2.04 | 204000.00 | |
| Transportation - Independent | Mile | 50 | 150.00 | 0.68 | 5100.00 | |
| **Vehicle Modifications Total:** | | | | | | 100000.00 |
| Vehicle Modifications | Occurrence | 10 | 1.00 | 10000.00 | 100000.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8739899.50 |
| **Total Estimated Unduplicated Participants:** | 975 |
| **Factor D (Divide total by number of participants):** | 8964.00 |
| **Average Length of Stay on the Waiver:** | 300 |