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.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Appendix A.3: Updated to reflect duties related to the additional services in Appendix C.
Appendix A.6: Addition of NCI-AD.
Appendix A.7: Updated to reflect duties related to the additional services in Appendix C.
Appendix A.QIS.a: One performance measure removed due to duty no longer being delegated to contracted entity. One performance measure removed because it is covered in Appendix D.
Appendix A. QIS.b: Language related to remediation has been updated.

Appendix B-1: Maximum age limit has been removed.
Appendix B-2: Individual cost limit has been changed from Institutional Cost Limit to No Cost Limit.
Appendix B-3: Unduplicated Number of Participants has been increased.
Appendix B-3: Selection of Entrants to the Waiver section has been updated to align with Title 480 NAC.
Appendix B-4: The Medicaid eligibility groups served in the waiver have been updated.
Appendix B-5: The box for “SSI standard” has been unchecked in sections b and d and the “other” options have been selected.
Appendix B-6.b: The responsibility for performing evaluations and reevaluations has been changed.
Appendix B-6.c: Qualifications for individuals performing initial evaluation have been revised.
Appendix B-7: Language has been updated.
Appendix B. QIS.b: Language related to remediation has been updated.

Appendix C-1/C-3: Appendix C-1/C-3: The following services have been added: Supported Employment – Individual; TBI Adult Day Health Services; TBI Personal Care; TBI Respite Care; Assistive Technology; Caregiver Training; Chore; Community Connections; Home Delivered Meals; Home Modifications; Non-Medical Transportation; Personal Emergency Response System (PERS); Supported Employment – Follow Along; TBI Companion; and Vehicle Modifications.
Appendix C-1/C-3: Language for service specific provider standards has been updated.
Appendix C-1/C-3: The Assisted Living service has been renamed TBI Supported Residential Living.
Appendix C-2: Updated to reflect elements related to additional services and provider types, including relatives and legal guardians being allowed to receive payment for providing waiver services.
Appendix C-2.a: Language has been updated.
Appendix C.QIS a: Performance measures have been added to reflect the use of non-licensed, non-certified providers as applicable to the addition of services.
Appendix C.QIS.a: The performance measure related to provider training has been updated to reflect training of service providers instead of training of Service Coordination and Resource Development staff.
Appendix C. QIS.b: Language related to remediation has been updated.
Appendix C-5: Updated to reflect approved HCB Settings Waiver Transition Plan.

Appendix D-1.a: Case Manager qualifications have been revised.
Appendix D-1.c: Language has been updated.
Appendix D-1.d. Language has been updated.
Appendix D-1.e: Language has been updated.
Appendix D-1.f: Language has been updated.
Appendix D-1.g: Language has been updated.
Appendix D-2.a. Language has been updated.
Appendix D. QIS.b: Language related to remediation has been updated.

Appendix F: Language has been updated throughout all sections.

Appendix G-1.b: Language has been updated and QIO-like entity added to process.
Appendix G-1.c: Language has been updated.
Appendix G-1.d; Language has been updated.
Appendix G-1.e. Language has been updated.
Appendix G-2.a.b.c: Language has been updated to reflect additional services and providers other than TBI Supported Residential Living (formerly Assisted Living).
Appendix G-3: Language has been updated.
Appendix G.QIS.a: One performance measure was changed to include the QIO-like entity’s review of incident reports. Language was clarified in two performance measures. One performance measure was removed due to duplication with other performance measures.
Appendix G. QIS.b: Language related to remediation has been updated.

Appendix H: Language in all sections was updated to provide clarification.

Appendix I-1: Updated language to reflect addition of services.
Appendix I-2: Updated language in all sections to reflect addition of services.
Appendix I-3.a: The method of payment option related to MMIS will be changed due to the addition of services.
Appendix I-3.d: The "payment to state or local government providers" section will change due to the addition of services.
Appendix I-3.e: The first box in this section is checked.
Appendix I-5.b: Language has been updated.
Appendix I.QIS.a: One performance measure was removed because of duplication with other performance measures.
Appendix I. QIS.b: Language related to remediation has been updated.

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*):

Traumatic Brain Injury

C. Type of Request: renewal

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**

Original Base Waiver Number: NE.40199
Waiver Number:NE.40199.R05.00
Draft ID: NE.010.05.00

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

Regular Waiver

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

10/01/23

Approved Effective Date: 10/01/23

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:

Participants must have a medical diagnosis of a traumatic brain injury which is defined as a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

○ **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.

Purpose:

The Traumatic Brain Injury (TBI) Waiver was established to provide adults and aged adults with TBI community options for services and supports related to their care needs. The TBI Waiver provides participant-centered waiver services to strengthen and support informal and formal services to meet the unique cognitive and behavioral needs of each participant in their home or a TBI assisted living facility.

Organizational Structure and Service Delivery Methods:

The Nebraska Department of Health and Human Services (DHHS), Division of Developmental Disabilities (DDD), operates the HCBS TBI Waiver. DDD completes eligibility screening and nursing facility level of care determinations for potential waiver participants.

DHHS, the Single State Medicaid agency, contracts with community partners to provide services coordination (case management). These activities include but not limited to developing the person-centered plan, completing service authorization, approving claims, monitoring services delivery, and participating in quality assurance reviews.

DHHS contracts for provision of services coordination with Independent Living Centers for adults with disabilities. State requirements are developed for every waiver service. Resource development staff review individual and agency provider requirements to confirm the providers meet waiver requirements on an annual basis and with some enrollment functions completed by the Provider Enrollment Broker. Independently enrolled individual waiver providers deliver services. This creates additional options for services delivery in the rural and frontier areas of Nebraska. Resource development staff and services coordination staff monitor services delivery.

Goals and Objectives:

The TBI Waiver is based on a person or family-centered, participant-directed philosophy with an emphasis on the use of informal and natural supports in the community.

The goal of this waiver is to rebalance the long-term care system Medicaid costs in the State of Nebraska by offering a community alternative to institutional services for persons with a TBI who meet the nursing facility level of care. This will allow participants to remain at home and prevent institutionalization.

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 renewal is done in accordance with 42 CFR 441.304(f). The following strategies are used to secure public input for the 40199 renewal:

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. Per the Nebraska State Plan, Tribal Governments have 30 days to respond or comment to a proposed state plan amendment, waiver, or demonstration from the date the required notice is submitted. The Tribal Notice for the 40199 renewal was distributed on April 10, 2023, with responses being requested through May 10, 2023. The Tribal Notices are available through the 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 April 13, 2023 and April 21, 2023. An in-person presentation was conducted on April 18, 2023. During the public comment period from April 11, 2023 to May 11, 2023, 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 full waiver application; a PowerPoint summary of proposed changes to the waiver, a link to e-mail questions or comments, and contact and address to mail comments.

A summary of 57 comments received during public comment is listed below. Three comments related to service caps for two services resulted in those caps being removed. Two comments related to provider qualifications resulted in those qualifications being updated.
• 5 comments were related to capacity issue. 1 comment received from a provider expressed appreciation at the opportunity to serve more individuals with TBI. 4 other comments received from stakeholders were questions related to possible transfers from other waivers and increased capacity if needed. Clarification was provided and no changes were made to the waiver.
• 4 comments received from stakeholder agencies and a provider were related to the desire to change the nursing facility level of care criteria for this waiver. Clarification was provided to indicate the criteria is set in state regulations and no changes were made to the waiver.
• 1 comment received from a stakeholder was related to possible funding caps. Clarification was provided to indicate this waiver doesn’t apply an individual cost limit and no changes were made to the waiver.
• 1 comment received from a stakeholder was related to a concern the TBI diagnosis wasn’t being included in the assessment information when the nursing facility level of care is completed. Clarification was provided and no waiver changes were made.
• 12 comments were related to provider training and the development of that training. 3 of these comments were from a provider and 9 were from stakeholders. Clarification was provided and no changes were made to the waiver.
• 29 comments were related to questions regarding additional services added to the waiver. All were from stakeholders. Clarification was provided for the majority of these comments and waiver changes weren’t made. Three comments related to service caps for Supported Employment – Individual and Supported Employment – Follow Along. This resulted in those service caps for those services being eliminated in the waiver application. Two comments related to provider qualifications for Supported Employment – Individual and Supported Employment – Follow Along. This resulted in the provider qualification sections for these services being updated in the waiver application.
• 5 comments were related to questions about waiver service rates. 1 comment was received from a provider. The others were from stakeholders. Clarification was provided and no changes were made to the waiver.

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: 68509-8947

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: N/A

First Name: N/A

Title:

N/A

Agency:

N/A

Address:

N/A

Address 2:

N/A

City:

N/A

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: Colin Large

State Medicaid Director or Designee

Submission Date: Sep 21, 2023

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:

N/A

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 renewal will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan. The state will complete any CMS required milestones as outlined in the HCBS Final Settings Rule Corrective Action 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 is the division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

(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 oversight for Services Coordination contracted entity functions identified in Appendix A.3. in addition to preforming these functions for a some of waiver participants: participant waiver enrollment activities; management of approved limits; monitoring of expenditures; 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 activities. A provider enrollment broker 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 that are 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 staff within MLTC and DDD. Designated Administrators from MLTC and DDD have regularly scheduled meetings to review discovered and/or anticipated issues; direct remediation and/or proactive activities; and strategically plan for collaborative alignment of Nebraska's Medicaid funded HCBS services.

Oversight methods include but are not limited to: reviewing reports of provider non-compliance and coordinating corrective action measures with DDD service coordination, surveyors from Public Health and licensure as necessary and appropriate; preparing or reviewing statistical and financial data for CMS reports in collaboration with DDD; attending the quarterly DDD Quality Improvement (QI) Committee meetings as an active participating member; meeting with DDD staff to review program and participant issues as necessary and appropriate; weekly tracking the use of Medicaid funding on the use of Medicaid HCBS waiver funding relative to the budgeted amounts; and monthly monitoring expenditures and budget projections; reviewing the development, renewal, or amendments of HCBS waivers, with final approval and electronic submittal authority; reviewing the cost neutrality formulas developed in collaboration with DHHS-DD; and submitting 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.:*

Independent Living Centers and Area Agencies on Aging perform all of the following operational and administrative functions for the participants they serve, except where noted:

- Disseminate information concerning the waiver to potential enrollees
- Assist individuals in waiver enrollment
- Develop Person-Centered Plans
- Review participant service plans to ensure that waiver requirements are met
- Perform prior authorization of waiver services
- Conduct utilization management functions
- Recruit providers
- Execute the Medicaid Provider Agreement including negotiating rates for applicable services.
- Complete provider service referrals in the provider enrollment brokerage system for tasks related to completing background checks.
- Conduct training and technical assistance concerning waiver requirements
- Perform supervisory oversight and training of Service Coordination and Resource Development staff
- Monitor and approve claims that are not subject to Electronic Visit Verification (EVV). (Claims subject to EVV can be monitored post payment in the DHHS system.)
- Monitor service provision
- Conduct on-going case management
- Assess and re-assess participant needs, strengths, and priorities
- Complete quality assurance reviews
- Complete established incident reporting process and maintain internal complaint process

Provider Enrollment Broker:
Execute the Medicaid Provider Agreement including all tasks related to completing background checks for all providers.

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

○ **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:

The DHHS Division of Developmental Disabilities has the responsibility for assessing the performance of contracted entities in conducting waiver operational and administrative functions.

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 following methods are used to assess the performance of the contracted entities:
1) Continuous and on-going review of Services Coordination billings and follow up as needed.
2) Continuous and on-going review of complaint and incident reports. Annual data aggregation and analysis.
3) Continuous death reviews of waiver participants to identify risks, trends, and needed actions.
4) Conduct participant/family experience surveys or applicable surveys for satisfaction and outcome needs at the discretion of the department. Current surveying is completed with the National Core Indicators – Aging and Disabilities (NCI-AD) survey.
5) Continuous and on-going monitoring of service expenditures and utilization.
6) Continuous and on-going monitoring of participant enrollment in the waiver.
7) Continuous and on-going Services Coordination office supervisory and DDD quality staff reviews of participant and provider files, remediation, and analysis.
8) Continuous and on-going Services Coordination office supervisory and DDD quality staff reviews review of person-centered plan, health and welfare, choice, financial oversight, qualified providers; remediation and data analysis.
9) Annually present program data aggregation and analysis to the DDD QI Committee for review and recommendation.

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	☒	☒
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:
HCBS Setting Review Tool

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**

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** 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 system

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:

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.

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.

Any contracted services coordination agency is responsible to remediate all identified individual problems identified through its discovery processes in an appropriate and timely manner (45 days). Discovery processes include: inputting data entry; remediating findings of File Reviews, reporting incidents; reporting complaints; and reporting death reviews.

Any contracted services coordination agency is responsible to remediate all identified individual problems identified through its discovery processes in an appropriate and timely manner (45 days). As part of their discovery processes, DDD quality staff conduct reviews of services coordination/resource development files on an annual basis. These reviews ensure all delegated waiver activities are being applied correctly. The review responses are documented in an electronic quality database. Indicators that do not meet standards require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from date of review and be recorded in the electronic quality database. The DDD quality staff monitors to ensure remediation activities are completed as assigned.

DDD quality staff are also responsible for overseeing that all individual problems requiring remediation identified during discovery processes are remediated. This is accomplished by individual follow up/remediation, shared resolution, or quality improvement plans.

Individual follow-up/remediation is an informal plan detailing corrections which must be made created by the services coordination supervisor, in consultation with DDD quality staff as needed. Services coordination supervisors are responsible for documenting remediation activities in the electronic quality database.

Shared Resolution is a formally-defined process, based on proactive partnership, to work with service delivery staff and agencies to resolve and improve instances which (1) reflect performance below expectations that cannot be remediated through technical assistance; (2) indicate a pattern of policy or procedure non-compliance which does not include a participant safety concern; or (3) are identified through formal discovery and determined not egregious as defined in the Quality Improvement Plan process. The Shared Resolution is a plan jointly created with services coordination supervisors and documented by DDD quality staff. The plan details how resolution and results will be monitored and measured. DDD quality staff are responsible for verifying corrections have been made.

The Quality Improvement Plan is a formally-defined process to resolve and improve performance an apparent contract violation or immediate risk to participant health and safety is identified. This remediation is appropriate for these egregious issues as well as when other remediation has been unsuccessful or determined ineffective. The Quality Improvement Plan is a formal plan written by the services coordination supervisory staff using the template provided by the DDD quality team detailing specific, measurable steps, persons responsible, and start and ending dates. The Quality Improvement Plan also details supportive documentation on final follow up. DDD quality staff approve this plan before it is implemented and monitor its progress through completion.

An agency that does not successfully complete the Quality Improvement Plan process or fails to provide delegated functions, may be referred to the DDD contract manager for contract review and possible withholding of payment reimbursement.

In addition to individual remediation, practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their specific agency. Services coordination supervisors use the electronic quality database to run reports of file review and other data to evaluate the agency’s performance. Services coordination supervisors may also use the electronic quality database to perform additional agency specific file reviews. The electronic database enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

Performance measure related data reports developed by the Performance Measure Subcommittee will be shared with services coordination agencies at least quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

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**
	☐ **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**	18		☒

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Participants must have a medical diagnosis of a traumatic brain injury which is defined as a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

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:

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.

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

○ **The following dollar amount:**

Specify dollar amount:

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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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	230
Year 2	230
Year 3	230
Year 4	230
Year 5	230

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	
Year 2	
Year 3	
Year 4	
Year 5	

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).**

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:

Nebraska does not have a waiting list for the Traumatic Brain Injury Waiver and is not expected to require a waiting list due to available slots. In the event that a waiting list is necessary, regulations found at Title 480 NAC outline the priority criteria. Priority is assigned in the following order:
(1) Needs in domains which define NF level of care are so severe that the health and welfare of the participant are jeopardized, but the needs could safely be met with immediate waiver services;
(2) Family/caregivers are in a crisis/high stress situation;
(3) No informal support network is available to meet identified needs;
(4) Inappropriate out-of-home placement is being planned;
(5) No other program is available to meet the needs identified in the referral;
(6) Support services are required to allow the participant to return home; or
(7) A participant with an identified waiver service need of Assistive Technology and Supports or Home Modification lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

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:

Working Disabled under 1619(b)(Social Security Act Section 1619(b),Disabled Adult Children(Social Security Act Section 1634(c), Pickle Category recipients (42 C.F.R. 435.135), Disabled Widow(er)s (42 C.F.R. 435.138), Medicaid expansion (42 C.F.R. 435.119).

• PCR (435.110)
• IV-E (435.145)
• M-CHIP (435.229)
• FFC (1902(a)(10)(A)(i)(IX))
• TMA (1925)
• Breast or Cervical Cancer Treatment Group (1902(a)(10)(A)(ii)(XVIII))
• Reasonable Classification (435.222)
• Medicaid Expansion (42 C.F.R. 435.119)

The addition of the eligibility groups will include TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act and TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act. These changes do not have criteria that are more restrictive and a neutral impact on individuals eligible for the waiver is anticipated.

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 eligible under 1902(a)(10)(A)(ii)(XI) of the Act

Recipients who are medically needy with spenddown: The State will use the actual maximum monthly allowable Special Needs Nursing Facility 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:

○ **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:

(1) For waiver participants receiving TBI Supported Residential Living Services: The State protects the SSI standard.
(2) For participants receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

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:

(1) For waiver participants receiving TBI Supported Residential Living Services: The State protects the SSI standard.
(2) For participants receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

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:

Level of care assessors who perform the initial evaluation of level of care for waiver applicants must possess the following educational and professional qualifications:

A. Education: Baccalaureate or graduate degree in the human services, education, health/medical field or related field; AND

B. Experience: Professional experience in services or programs for persons with disabilities, including physical or intellectual/developmental disabilities, persons with special health care needs, or the aging.

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.

Nebraska uses the same criteria for level of care eligibility in nursing facilities and in this waiver program, with the addition of TBI diagnosis for this waiver.

Regulations found in Title 471 NAC and/or Title 480 NAC define participant eligibility criteria.

Individuals are evaluated based on the following assessment categories:
*Activities of Daily Living - the ability to self-perform bathing, dressing, eating, locomotion, personal hygiene, toileting, and transferring.
*Risk Factors - issues which cause significant impact to the person's life and functional capacity such as behavior, frailty and safety.
*Medical treatment or observation - a medical condition is present which requires observation and assessment to prevent a decline in health status.
*Cognitive Function - memory, orientation, communication and judgment.

The level of care assessor collect the above information on each individual seeking waiver services to determine the functional abilities and care needs of that individual. Individuals who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria.

I. A score of one or more in at least three activities of daily living AND at least one risk factor AND a medical diagnosis of a traumatic brain injury.

II. A score of one or more in at least three activities of daily living AND at least one medical area and intervention AND a medical diagnosis of a traumatic brain injury.

III. A score of one or more in at least three activities of daily living AND at least one area of cognitive limitation AND a medical diagnosis of a traumatic brain injury.

IV. A score of one or more in at least one activity of daily living AND at least one risk factor AND at least one area of cognitive limitation AND a medical diagnosis of a traumatic brain injury.

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 interRAI-HC tool for the waiver evaluation and reevaluation, is used for adult ages and is comparable to the Functional Criteria for Aged/Adults MLTC-14AD assessment tool completed for institutional NF placement. Both tools note Activities of Daily Living (ADL's), Risk Factors, Medical Conditions and Interventions, and Cognitive Function. The participant and family or guardian, and their LOC assessor, or others who are familiar with the participant complete the applicable tool. The state regulations which define what constitutes LOC does not change regardless of which tool is being used.

The interRAI HC is completed on an annual basis. Although the tools are different, reliability and validity testing completed by previous DHHS-MLTC and DDD personnel using a sampling methodology indicates that the outcome of the determinations yielded from the InterRAI HC was the same as the functional criteria of determination yielded from the assessment completed for NF placement.

During the time between 07/01/22 and 3/31/2024, if an individual does not meet the Level of Care criteria based on their initial assessment or reevaluation utilizing the interRAI-HC tool, an additional review utilizing the prior tool (MLTC-14AD) will be performed. This additional review will be completed to verify that an individual does not meet Level of Care criteria based on the prior assessment tool. Should the person qualify under the prior assessment tool (MLTC-14AD), their eligibility will be granted or continued.

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:

The Process for Level of Care evaluation and reevaluation includes an in-person meeting with the participant/guardian and through observation. The level of care assessor must meet in person with the potential participant and legal guardian, if any, initially within 14 days of referral to evaluate Nursing Facility level of care. The visit must be conducted, if possible, at the participant's residence to allow observations of the home situation. The meetings must be held at a date and time convenient to the participant/guardian. Level of Care reevaluations must be completed every 12 months. The process for Level of Care evaluation and reevaluation includes an in-person meeting with the participant/guardian, and an individual with knowledge of the individual's functioning when needed. The adult being assessed shall participate in the assessment. Adults will be assessed by the level of care assessor using the interRAI HC Assessment. The interRAI HC Assessment questions are scored by the level of care assessor during the in-person meeting.

The interRAI HC Assessment includes areas to document information regarding medical conditions and treatments as reported by the participant/guardian and the individual with knowledge of the individual (when applicable). Questions within the interRAI HC Assessments measure the level of independence and support needed for the adult to complete activities of daily living, health conditions and treatments, and risk factors. Other areas assessed includes formal and informal supports, housing, environment, nutritional status, and medication usage.

The assessment evaluates the individual's functional limitations and medical needs as described in Appendix B-6-d and Risk Factors outlined in Appendix D-1-e. Other areas assessed include formal and informal supports, housing, equipment, assistive technology usage and needs, nutritional status, and medication usage.

During the time between 07/01/22 and 3/31/2024, if an individual does not meet the Level of Care criteria based on their initial assessment or reevaluation utilizing the interRAI-HC tool, an additional review utilizing the prior tool (MLTC-14AD) will be performed. This additional review will be completed to verify that an individual does not meet Level of Care criteria based on the prior assessment tool. Should the person qualify under the prior assessment tool (MLTC-14AD), their eligibility will be granted or continued.

The Division will utilize the electronic database system to hold level of care documentation.

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):*

Regulations outlined in Title 480 NAC specify the procedures which ensure timely reevaluations for level of care.

The services coordinator must annually review each participant to assure both continued eligibility and that the well-being of the participant is safeguarded. Reevaluation must take place every 12 months and be documented.

DDD will utilize the electronic database system which contains reports on the participant's level of care and due dates. These reports allow the services coordinator and their supervisor to manage and plan for re-evaluation.

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:

Written documentation of all evaluations and reevaluations are filed in the DDD electronic database system. Nebraska requires this documentation to be maintained for at least six years.

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 eligible applicants with a reasonable indication of need for whom an evaluation for LOC was provided. Numerator = Number of new waiver eligible applicants with a reasonable indication of need for whom an evaluation for LOC was provided. Denominator = Number of new waiver eligible applicants with a reasonable indication of need.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant system data reports

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**

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** 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 and annual Level of Care (LOC) determinations in which LOC criteria were accurately applied. Numerator = number of initial and annual LOC determinations in which LOC criteria were accurately applied; Denominator = number of initial and annual LOC determinations reviewed.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(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** 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**

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** Specify:

Performance Measure:
Number and percent of participants for whom initial or annual Level of Care (LOC) is determined using the appropriate instrument. Numerator = number of participants for whom LOC is determined using the appropriate instrument; Denominator = number of participants for whom LOC is determined that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant data system reports

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:

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.

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.

Activities and processes at the state level have been developed to discover whether the federal level of care 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. DDD is responsible for remediation of all identified level of care individual problems identified through the discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing Level of Care include:

- Reviews of a representative sample of LOC assessments are completed by RN Program Specialists in the DDD Eligibility and Enrollment unit. Interrater reviews are completed by DDD quality staff.
- If a level of care assessment has not been adequately determined, the RN Program Specialist provides the assessor with information concerning corrections needed.
- Reassessment occurs and the required corrections are documented by the assessor on the electronic Level of Care Review tool.
- If the participant is found to be eligible, he/she continues to receive services.
- If the participant is found to be ineligible, the case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
- The DDD Eligibility and Enrollment unit report remediation activities to the DDD Quality Team. The staff document corrections in the electronic case management system. The review documentation must include information that all negative level of care certifications have been resolved correctly.
- If services have been provided for a participant that didn't meet nursing facility level of care, a referral is made to Program Integrity for claims recovery.

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**
	☒ **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 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).

The Services Coordinator explains the service options available under this home and community based waiver. The participant or their guardian are offered the option of accepting Nursing Facility or waiver services as described in the Person-Centered Plan. When the participant or the guardian chooses to accept waiver services, the Services Coordinator obtains the proper signature on the waiver consent form. The consent form must be signed at initial determination and remains valid as long as the waiver case is open. When guardianship or legal status changes, the Services Coordinator must obtain a new, signed consent (for example, an adult's legal guardianship is transferred to another person).

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.

Written documentation of all Freedom of Choice forms (waiver consent) are contained in the participant files at the services coordination agency. Nebraska requires these documents to be maintained for at least six years.

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:

*Language Line is available and used statewide.
*All contracted services coordination agencies are required to provide interpreters when needed to communicate with an individual.

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	Supported Employment - Individual		
Statutory Service	TBI Adult Day Health Services		

Service Type	Service		
Statutory Service	TBI Personal Care		
Statutory Service	TBI Respite Care		
Other Service	Assistive Technology		
Other Service	Caregiver Training		
Other Service	Chore		
Other Service	Community Connections		
Other Service	Home Delivered Meals		
Other Service	Home Modifications		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Supported Employment - Follow Along		
Other Service	TBI Companion		
Other Service	TBI Supported Residential Living		
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:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Employment – Individual is one-to-one support available to a participant who needs assistance to maintain their competitive or customized employment or self-employment, in an integrated work setting in the general workforce. A participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by a person without a disability. Support may be utilized for referring the participant to gain access to an employment network, Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified employment service programs, which provide benefits planning. The outcome of this service is sustained paid employment, which meets personal and career goals in an integrated setting in the general workforce, particularly work sites where persons without disabilities are employed. Personal care services are not a component of this service. Volunteer work is not a component of the service.

Services are provided at the place of the participant's competitive integrated employment site to support the participant in achieving their personally identified goals for refining employment-related skills, and for developing and sustaining a network of positive natural supports. Locations must be non-disability specific and meet all federal standards for home and community-based settings. This service cannot take place in licensed facilities, or any type of facility owned or leased, operated or controlled by a provider of other Medicaid waiver services. Supported Employment –Individual must be provided in an integrated community employment setting unless the support is to maintain a customized home-based business.

Services include activities needed to sustain paid work by a participant and are designed to maintain or advance in employment. When Supported Employment – Individual is provided at a work site where persons without disabilities are employed, payment is made only for the adaptations and coaching required by participants receiving waiver services because of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

The participant's person-centered service plan includes the need for continued job coaching with a written plan to lessen the job coaching.

Monthly summary reports on progress or lack of progress of lessening the job coach must be made available.

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

• This service may be authorized in combination with any, or all, of the following services in the same service plan, but the services may not be provided and billed for concurrently: Community Connections, and Supported Employment –Follow-Along.
• Income from customized home-based businesses is not required to be commensurate with minimum wage requirements with other employment.
• The amount of prior authorized services is based on the participant's need as documented in the service plan.
• Supported Employment – Individual is reimbursed at an hourly unit.
• A provider of Supported Employment – Individual cannot be the employer of the participant to whom Supported Employment – Individual is provided.
• Waiver funds cannot be used to compensate or supplement a participant's wages.
• Transportation required in the provision of Supported Employment – Individual is included in the rate. Nonmedical transportation to the site at which Supported Employment – Individual begins is not included in the rate. Non-medical transportation from the site at which Supported Employment – Individual 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 EducationAct (IDEA). Regular school hours and days apply for a child who receives home schooling.
• For participants 18-21 years of age, documentation is maintained in the file of 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) or the IDEA (20 U.S.C. 1401 et seq.)..
• Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments passed through to users of supported employment programs; or
o Payments for training not directly related to a participant's supported employment program.
• Supported Employment – Individual may be provided by a relative but not 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, HCBS Waiver service, or Vocational Rehabilitation

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	Agency supported employment - agency provider
Individual	Independent supported employment - individual provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:
Agency

Provider Type:

Agency supported employment - agency provider

Provider Qualifications

License *(specify):*

No license required.

Certificate *(specify):*

No certification 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 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; and
  - Basic first aid;
- Be authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All providers must ensure staff working with participants served by the TBI waiver have completed specialized TBI training.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:

Individual

Provider Type:

Independent supported employment - individual provider

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.

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of 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
  - o 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:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All providers of this service must complete specialized TBI training.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

TBI Adult Day Health Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

TBI Adult Day Health Services are structured social, and health activities provided outside of the participant's home. Providers must offer or make available through arrangements with community agencies or individuals, each of the services to meet the identified needs in the participant's person-centered plan and plan specific to TBI Adult Day Health Services.

The services components of TBI Adult Day Health Services include: personal care services, health assessment and nursing services, meal services, recreational therapy, supportive services and other activities.

Transportation is not a component of TBI Adult Day Health and is charged under the transportation service. Physical, occupational and speech/language therapies are not included as components of TBI Adult Day Health. Meals provided as part of this service do not constitute a full nutritional regimen (i.e., 3 meals per day). Relatives/guardians who provide TBI Adult Day Health services are either employees of a licensed adult day health agency or are the owner of a licensed adult day health agency.

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

TBI Adult Day Health Services are provided four or more hours per day, but less than 24 consecutive hours, on a regularly scheduled basis, or as specified in the person-centered plan. TBI Adult Day Health Services may be occasionally provided to a participant for less than four hours in a day when the participant must leave the TBI adult day program due to an emergency. If the participant is still receiving school services, this service cannot be provided during school hours set by the local school district for the participant. The limitations include any and all public education programs funded under the individuals with Disabilities Education Act (IDEA). TBI Adult Day Health Services will not be authorized for the hours set forth in the school district's days and hours of regular attendance.

The services under the Traumatic Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. TBI Adult Day Health services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

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	Licensed Adult Day Service provider according to 175 NAC 5

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: TBI Adult Day Health Services

Provider Category:

Agency

Provider Type:

Licensed Adult Day Service provider according to 175 NAC 5

Provider Qualifications

License *(specify):*

Adult Day Service

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 Statues.

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

The provider must:
•Complete all provider enrollment requirements;
•Ensure that services are provided in an integrated, community-based setting;
•Provide a telephone with assistive devices;
•Ensure there is a written plan for each participant. This is in addition to the person- centered plan. The written plan must be jointly developed with the participant and service coordinator and must include the participant's strengths, needs and desired outcomes as they pertain to TBI Adult Day Health Services, a plan to meet the needs and desired outcomes, and TBI Adult Day Health Services components to be provided;
•Ensure the written plan includes an up-to-date listing of the participant's current medications and treatments, emergency contact information, and special dietary requirements, a description of any limitations to participate in activities, and any recommendations for special therapies;
•Together with the participant and service coordinator, review and revise the plan as appropriate, but at least semiannually. A copy of the plan must be submitted to the participant's services coordinator;
•Employ or contract with a licensed nurse, who will provide the health assessment and nursing services component of the service and supervise activities of daily living as well as activities of daily living training components; and
•Ensure all staff employed by the provider who work with a participant served by the Traumatic Brain Injury Waiver complete specialized TBI training.
•Complete DHHS trainings upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures that revalidations is completed annually, and re-enrollment is completed every 5 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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

TBI Personal Care

HCBS Taxonomy:

Category 1: | **Sub-Category 1:**

08 Home-Based Services | 08030 personal care

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

TBI Personal Care is a service which includes assistance with Activities of Daily Living (ADLs) and/or health-related tasks and may include Instrumental Activities of Daily Living (IADLs) provided in a person's home and other community settings.

This service offers a range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a TBI. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. These services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.

TBI Personal Care may include the supports offered in the companion service if these supports are provided along with assistance with ADLs and/or health related tasks.

TBI Personal Care under the waiver differs in scope and nature from the personal care offered under the State Plan as supervision may be provided. A participant cannot be authorized to receive both services at the same time.

Participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the Services Coordinator performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a monthly basis.

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

General household tasks are limited to those necessary for maintaining and operating the participant's home when they are responsible for the home.

A participant cannot be authorized to receive this service at times that overlap with TBI Companion Service, TBI Adult Day Health, TBI Respite or Non-Medical Transportation Services.

If assistance with ADL's is not needed, this service should not be authorized. This service cannot duplicate provisions of TBI Companion or TBI Chore services if authorized in conjunction.

TBI Personal Care does not include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).

The services under the Traumatic Brain Injury Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. TBI Personal Care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

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	Agency TBI Personal Care provider
Individual	Independent TBI Personal Care provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: TBI Personal Care

Provider Category:

Agency

Provider Type:

Agency TBI Personal Care provider

Provider Qualifications

License *(specify):*

When mandated, Home Health Aide Service license as found in 175 NAC 14.

Certificate *(specify):*

No certificate 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 Statues.

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

Providers must:
•Employ staff who have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Employ staff based on qualifications, experience, and abilities in carrying out personal care services comparable to those who will be authorized;
•Ensure staff working with participants served by the TBI waiver have completed specialized TBI training;
•Require staff use of universal precautions;
•Provide training to staff and provide DHHS with training plans upon request;
•Complete DHHS trainings upon request;
•Ensure availability of caregivers; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: TBI Personal Care

Provider Category:

Individual

Provider Type:

Independent TBI Personal Care provider

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 Titles of the Nebraska Administrative Code and Nebraska State Statues.

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

Providers must:
- Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
- Have qualifications, experience, and abilities necessary in carrying out personal care services comparable to those who will be authorized;
- Complete specialized TBI training;
- Complete DHHS trainings upon request;
- Use universal precautions; and
- Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

TBI Respite Care

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:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

TBI Respite Care is temporary care of a participant with TBI to relieve the usual caregiver from continuous support and care responsibilities. TBI Respite Care may be provided in or out of the participant's home. Out of home respite care may be provided in the following locations: private residence of a respite service provider, licensed assisted living facility, licensed respite facility, or other community settings. Providers must use Electronic Visit Verification when this service is provided in the participant's home.

Federal Financial Participation may not be claimed for room and board when respite is provided in the participant's home or place of residence.

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

TBI Respite Care may not be used to allow the usual caregiver to accept or maintain employment or pursue a course of study designed to fit the caregiver for paid employment or professional advancement. When the need for TBI Respite Care is identified, the amount authorized is based on the assessment of several factors such as the availability of informal support, potential for abuse/neglect, and caregiver health status. No more than 360 hours within the participant's annual eligibility period may be authorized.

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 TBI Respite Care Provider
Agency	Agency TBI Respite Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: TBI Respite Care

Provider Category:

Individual

Provider Type:

Independent TBI Respite Care Provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

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

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

Providers must:
•Never leave the participant alone while providing respite;
•Prepare meals or snacks to comply with participant's dietary needs;
•Use universal precautions;
•Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Complete specialized TBI training;
•Complete DHHS trainings upon request;
•Out of home providers must ensure their home is accessible and safe; and
•Have computer skills and access to the technology needed to navigate the state electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: TBI Respite Care

Provider Category:

Agency

Provider Type:

Agency TBI Respite Care Provider

Provider Qualifications

License *(specify):*

When mandated, 175 NAC Health Care Facilities and Services Licensure

Certificate *(specify):*

Not 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 Cod, and Nebraska State Statutes.
Direct care staff of the respite provider agency must:
•Never leave the participant alone while providing respite;
•Prepare meals or snacks to comply with participant's dietary needs;
•Use universal precautions;
•Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Complete specialized TBI training;
•Complete DHHS trainings upon request;
•Out of home agency providers must ensure their setting is accessible and safe;
•Provide training to staff and provide DHHS with training plans upon request;
•Ensure availability of caregivers; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive technology includes the purchase or rent of items, devices, or product systems to increase or maintain a person's functional status. This service includes designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment.

Renting is generally considered to be on a month-to-month basis or need. Leasing can be for an extended time frame which may not coincide with waiver eligibility periods or may extend beyond waiver eligibility periods. To ensure equipment needs coincide with waiver eligibility periods, the state has chosen to use the term renting.

This service also includes the assessments needed to identify the type of assistive technology necessary to aid the waiver participant. The assessment costs associated with Assistive Technology are not paid for by the waiver. Assessment costs are covered by an administrative contract with the Assistive Technology Partnership within the Nebraska Department of Education.

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

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

Assistive technology supports must be of direct medical or physical benefit to the participant.

Assistive technology supports do not include the leasing of equipment.

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	Specialized equipment and supplies

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:

Specialized equipment and supplies

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. All items and assistive equipment must meet applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nebraska Department of Education Assistive Technology

Frequency of Verification:

Ongoing

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:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Caregiver Training service is person-centered and provides individualized training and education to the unpaid caregiver who provides informal 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.

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 care and support 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

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 person-centered service plan.

Caregiver Training includes payment that is 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.

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.
- 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	Agency Caregiver Training Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Caregiver Training

Provider Category:

Agency

Provider Type:

Agency Caregiver Training Provider

Provider Qualifications

License *(specify):*

No license required.

Certificate *(specify):*

No certification 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.

Providers must employ staff based on qualifications, experience, and abilities in carrying out services comparable to those who will be authorized.

Providers must provide DHHS with training plans upon request.

Complete DHHS trainings upon request.

Have computer skills and access to the technology needed to navigate the state-mandated case management system.

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:

Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Chore activities occur less frequently than services identified under the companion service but assist in ensuring the health and safety of the participant in their own home. Types of assistance furnished may include housekeeping activities such as heavy household chores and care of household equipment, appliances, or furnishings; Minor repairs of windows, screens, steps or ramps, furnishings, and household equipment; and landscaping. Landscaping includes snow and ice removal, mowing, raking, removing trash (to garbage pickup point), pest remediation, and clearing water of drains may also be provided.

These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

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

Mowing is limited to that which is necessary to meet the health and safety of the participant and to meet local codes.

If the participant lives in a rental property, the lease agreement will be reviewed to determine the responsibilities of the landlord to provide repairs or maintenance.

The in-home cleaning does not duplicate light housekeeping covered under the service called TBI Companion.

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	Agency Chore Provider
Individual	Independent Chore Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Agency Chore Provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not 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 Statues.

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

Providers must:
•Employ staff who have the knowledge and abilities required to meet the needs of the participant;
•Complete DHHS trainings upon request;
•Employ staff based on qualifications, experience, and abilities in carrying out services comparable to those who will be authorized;
•Use universal precautions; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:

Individual

Provider Type:

Independent Chore Provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

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

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

Providers must:
•Have the knowledge and abilities required to meet the needs of the participant;
•Have qualifications, experience, and abilities necessary in carrying out services comparable to those who will be authorized;
•Complete DHHS trainings upon request;
•Use universal precautions; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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 Connections

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

04 Day Services | 04070 community integration

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Connections is a service which provides individualized support and assistance to participants to enable them to participate in community or social activities. Services are aimed at helping participants engage or re-engage in preferred community or social activities while fostering greater independence, community networking and personal choice.

Community or social activities include activities in the community at large, including volunteer work. General types of these activities must be documented in the Person-Centered Plan.

This service does NOT include assistance with activities of daily living or assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.

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

A participant cannot be authorized to receive this service at times that overlap with TBI Personal Care, TBI Companion, TBI Adult Day Health, TBI Respite, or Non-Medical Transportation. This service cannot duplicate provisions of these other services if authorized in conjunction.

No more than 360 hours of Community Connections may be authorized within the participant's annual eligibility period.

This service must not overlap with, supplant, or duplicate other comparable services provided through 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	Agency Community Connections Provider
Individual	Independent Community Connections Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Connections

Provider Category:

Agency

Provider Type:

Agency Community Connections Provider

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 Statues.

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

Providers must:
•Employ staff who have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Employ staff based on qualifications, experience, and abilities in carrying out Community Connections services comparable to those who will be authorized;
•Ensure staff working with participants served by the TBI waiver have completed specialized TBI training;
•Require staff use of universal precautions;
•Provide DHHS with training plans upon request;
Complete DHHS trainings upon request;
•Ensure availability of caregivers; and
• Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification and case management system.

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 Connections

Provider Category:

Individual

Provider Type:

Independent Community Connections Provider

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 Titles of the Nebraska Administrative Code and Nebraska State Statues.
All providers of waiver services must adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.
Providers must:
• Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
• Have qualifications, experience, and abilities necessary in carrying out Community Connections services comparable to those who will be authorized;
• Complete specialized TBI training;
• Complete DHHS trainings upon request;
• Use universal precautions; and
• Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification and case management system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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 Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home-Delivered Meals is a service which provides a meal prepared outside the participant's home and is delivered to their home. Home delivered meal providers which meet the definition of a food establishment in Nebraska Revised Statutes 81-2,257.01 must follow regulations and procedures outlined in the above statute, also known as the Nebraska Food Code. A "food establishment" is defined as an operation that stores, prepares, packages, serves, sells, vends, or otherwise provides food for human consumption. It does not include health care facilities (in which assisted living facilities are classified) or nursing facilities. Such facilities are directed by their licensing regulations for food preparation and safety.

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

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

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	Agency home delivered meal provider
Individual	Independently operated home delivered meal provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency home delivered meal provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

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

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

Providers must:
•Deliver meals in a sanitary manner and using methods to maintain proper food temperatures;
•Provide meals which contain at least 1/3 of the recommended daily allowance per meal;
•Make menus available to DHHS; and
•Conform to applicable laws and regulations Nebraska Food Code (Neb.Rev. Stat. 81-2,257.01), 175 NAC

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Independently operated home delivered meal provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

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

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

Providers must:
•Deliver meals in a sanitary manner and using methods to maintain proper food temperatures;
•Provide meals which contain at least 1/3 of the recommended daily allowance per meal;
•Make menus available to DHHS; and
•Conform to applicable laws and regulations Nebraska Food Code (Neb.Rev. Stat. 81-2,257.01), 175 NAC

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Modifications are physical changes to a private residence to accommodate the participant or improve their function.

The Waiver does not cover home modifications considered to be of general utility, standard housing obligations of the participant or homeowner, and which are not of direct medical or remedial benefit. For example, excluded are carpeting, roof repair, sidewalks, storage and organizers, hot tubs, whirlpool tubs, elevators, landscaping, and general home repairs. The Waiver does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the Waiver. Waiver funds may be authorized to assist with adaptations of direct medical or remedial benefit (e.g. ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed for a home under construction which requires special adaptation to the plan (e.g. a roll-in shower), the Waiver may be used to fund the difference between the standard fixture and the modification required to accommodate the participant’s need. Environmental adaptations shall exclude costs for improvements exclusively required to meet local building codes.

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

Adaptations that add to the total square footage of the home are excluded from this benefit 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).

The assessment costs associated with Home Modifications are not paid for by the waiver. Assessment costs are covered by an administrative contract with the Assistive Technology Partnership within the Nebraska Department of Education.

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

The state does not have an annual maximum for each of the components of Home Modifications. This allows flexibility for the participant's needs to be met if a modification is necessary to remain or return home.

The State receives reports on services received by participants which include details on the exact technology or modification received and the cost involved. Service and claims information is also stored in the participant file.

This service does not include durable medical equipment which is required to be provided under the Medicaid State Plan. This service is not available to facility providers.

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	Specialized equipment, supplies, home repair companies.

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:

Specialized equipment, supplies, home repair companies.

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Home modification must be provided in accordance with applicable local and state building codes. Appropriately licensed/certified persons shall make or oversee all modifications. All items and assistive equipment must meet applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nebraska Department of Education Assistive Technology

Frequency of Verification:

Ongoing

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:

Non-Medical 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-Medical Transportation is provided to enable a participant to gain access to waiver and other community services and resources as outlined in the person-centered plan. This service may include accompanying a participant who is unable to travel and wait alone.

Waiver Non-Medical Transportation may not be substituted for the state plan transportation Nebraska is obligated to furnish under the requirements of 42 CFR 440.170 and medical transportation required under 42 CFR §431.53.

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

A participant may be authorized for Non-Medical Transportation if they do not have access to a working licensed vehicle or a valid driver's license; are unable to drive due to physical or cognitive limitation; OR are unable to secure transportation from relatives, friends, or other organizations at no cost.

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 Transportation Provider
Agency	Public Service Commission Exempt Transportation Provider
Agency	Certified Commercial Carrier/Common Carrier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual Transportation Provider

Provider Qualifications

License *(specify):*

Provider must have a valid driver's license per Neb. Rev. Stat §60-484 and have no more than three points assessed against their Nebraska driver's license within the past two years, or meet a comparable standard in the state in which they are licensed to drive.

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 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.

Providers must:
•Use their own personally registered vehicle to transport the participant.
•The provider must maintain the minimum vehicle insurance coverage as required by state law.
•Complete DHHS trainings upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

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):*

No certification is required. Neb. Rev. Stat §75-301-322,291 NAC 3-002.

Other Standard *(specify):*

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

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

Providers must:
•Ensure drivers possess a current and valid driver's license with no more than three points assessed against their Nebraska driver's license within the past two years or meet a comparable standard in the state in which they are licensed to drive.
•Ensure drivers have not had their driver/chauffeur's license revoked within the past three years.
•Complete DHHS trainings upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Certified Commercial Carrier/Common Carrier

Provider Qualifications

License *(specify):*

Provider must have a valid driver’s license Neb. Rev. Stat §60-484.

Certificate *(specify):*

Certification of Authority issued by the Nebraska Public Service Commission. Neb. Rev. Stat §75-301-322,291 NAC 3-002.

Other Standard *(specify):*

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

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

Providers must:
•Ensure drivers possess a current and valid driver's license with no more than three points assessed against their Nebraska driver's license within the past two years or meet a comparable standard in the state in which they are licensed to drive.
•Ensure drivers have not had their driver/chauffeur's license revoked within the past three years.
•Complete DHHS trainings upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device that enables a participant to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a help button is activated. The response center has trained professionals to respond timely when the button is activated. The service includes installation, upkeep, and maintenance of the PERS device.

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

To receive PERS, the participant must have the cognitive and physical ability to use the PERS equipment. Participants need for the device must be jointly determined by the service coordinator and the participant and documented in the person-centered plan.

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	Agency PERS Provider

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:

Agency PERS Provider

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not 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 Statues.

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

Providers must:
•Ensure response is provided 24 hours per day, 7 days per week.
•Furnish replacement PERS unit within 24 hours of malfunction of original unit.
•Ensure monthly testing of PERS unit.
•Update responder contacts semi-annually.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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 Employment - Follow Along

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Employment – Follow-Along is one-to-one intermittent support to enable a participant who is paid at or above the minimum wage to maintain employment in an integrated community employment setting working with other employees who do not have disabilities. Intermittent support may be provided on-site, remotely, and on behalf of or for the participant through phone calls between provider staff and the participant's employer staff, followed up with face-to-face contact with the participant to reinforce and stabilize job placement. Services must be furnished consistent with the participant's service plan.

Supported Employment – Follow-Along includes ascertaining the success of the job placement and when needed, the provision of short-term job skill support at the work site to help maintain employment. Supported Employment – Follow-Along includes the facilitation of natural supports at the work site and advocating with the participant, but only with persons at the employment site (e.g., employers, co-workers, customers) and only for purposes directly related to employment.

Monthly summary reports on progress or lack of progress on job stabilization must be available.

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

• This service may be authorized in combination with any, or all, of the following services in the same service plan, but the services may not be provided and billed for concurrently: Community Connections and Supported Employment –Individual.
• Supported Employment – Follow-Along does not include activities taking place in a group, i.e. work crews or in-service meetings; staff development; department meetings; or any other non-participant-specific activities, such as a job coach completing the work instead of the participant.
• The amount of prior authorized services is based on the participant's need as documented in the service plan.
• Supported Employment – Follow-Along is reimbursed at an hourly rate.
• A provider of Supported Employment – Follow-Along cannot be the employer of the participant to whom they provide Supported Employment – Follow-Along.
• Waiver funds cannot be used to compensate or supplement a participant's wages.
• Transportation required in the provision of Supported Employment – Follow-Along is included in the rate. Nonmedical transportation to the site at which Supported Employment – Follow-Along begins is not included in the rate. Non-medical transportation from the site at which Supported Employment – Follow-Along 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.
• For each participant receiving this service, and on the wait list under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services), documentation must be maintained in the service coordination file. Documentation must include that the participant is on the Vocational Rehabilitation Services wait list, and the service is not available due to the program's wait list.
• Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments passed through to users of supported employment programs; or
o Payments for training not directly related to a participant's supported employment program.
• Supported Employment – Follow-Along may be provided by a relative but not 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, HCBS Waiver service, or Vocational Rehabilitation.

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	Agency supported employment - follow along provider
Individual	Independent supported employment – follow along provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Agency

Provider Type:

Agency supported employment - follow along provider

Provider Qualifications

License *(specify):*

No license required.

Certificate *(specify):*

No certification 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 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; and
  - Basic first aid;
- Be authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All providers must ensure staff working with participants served by the TBI waiver have completed specialized TBI training.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Individual

Provider Type:

Independent supported employment – follow along provider

Provider Qualifications

License *(specify):*

No license required.

Certificate *(specify):*

No certification 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:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of 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
  - o 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:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All providers of this service must complete specialized TBI training.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:

TBI Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

TBI Companion is a service in which supervision and/or social supports are provided in a person’s home and possibly other community settings. This service may include light housekeeping tasks, as well as bill paying, errand service, essential shopping, food preparation, and laundry service.

The provision of companion services does not entail hands-on nursing care.

If assistance with ADLs and/or health-related tasks is needed, this service should not be authorized and another service, such as TBI Personal Care, should be considered.

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

General household tasks are limited to those necessary for maintaining and operating the participant's home when they are responsible for the home.

A participant cannot be authorized to receive this service at times that overlap with as Personal Care, Adult Day Health, Respite or Transportation Services.

If assistance with ADL's and/or health-related tasks is needed, this service should not be authorized and another service, such as Personal Care, should be considered. This service cannot duplicate provisions of TBI Personal Care or TBI Chore if authorized in conjunction.

TBI Companion does not include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).

The TBI Companion services does not include assistance with Activities of Daily Living, heavy household chores, care of household equipment, appliances, or furniture, minor repairs, landscaping, pest remediation, or clearing water of drains.

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 TBI Companion Provider
Agency	Agency TBI Companion Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: TBI Companion

Provider Category:

Individual

Provider Type:

Independent TBI Companion Provider

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 Titles of the Nebraska Administrative Code and Nebraska State Statues.

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

Providers must:
•Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Have qualifications, experience, and abilities necessary in carrying out TBI Companion services comparable to those who will be authorized;
•Have completed specialized TBI training;
•Complete DHHS trainings upon request;
•Use universal precautions; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: TBI Companion

Provider Category:

Agency

Provider Type:

Agency TBI Companion Provider

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 Titles of the Nebraska Administrative Code and Nebraska State Statues.

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

Providers must:
•Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
•Have qualifications, experience, and abilities necessary in carrying out TBI Companion services comparable to those who will be authorized;
•Ensure staff working with participants served by the TBI waiver have completed specialized TBI training;
•Complete DHHS trainings upon request;
•Use universal precautions; and
•Have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers of DHHS staff in combination with designated provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually, and the provider enrollment broker ensures revalidation is completed annually, and re-enrollment is completed every 5 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:

TBI Supported Residential Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

TBI Supported Residential Living services are provided for participants with a medical diagnosis of a traumatic brain injury in a homelike, non-institutional setting and include personal care and supportive services. This includes 24-hour response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security.

The following services are available to the participant: medication administration, transportation, escort services, activities, essential shopping, housekeeping services, laundry services, and personal care services.

Escort service is accompanying or physically assisting a participant who resides in an assisted living facility who is unable to access medical care without supervision or assistance.

Activities are social and recreational programming.

Nursing and skilled therapy services are incidental, rather than integral to the provision of TBI Supported Residential Living services. Payment is not made for 24-hour skilled care. Federal Financial Participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for TBI Supported Residential Living service is described in Appendix I-5.

No therapies are included in the TBI Supported Residential Living service.

TBI Supported Residential Living includes the provision of personal care services and additional billing for personal care services are not allowed. This is prevented by review and approval of all waiver claims. When a participant's residence is noted as TBI TBI Supported Residential Living, any claims for personal care are denied.

Relatives/guardians who provide TBI Supported Residential Living services are either employees of a licensed assisted living facility or are the owner of a licensed assisted living facility.

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

The unit of service is billed at a daily rate.

The TBI Supported Residential Living Services rate includes the provision of five roundtrip medical transportation trips per month. If the participant's service plan reflects the need for more medical transportation, it may be authorized outside of the TBI Supported Residential Living service payment, as a state plan Medicaid service. The TBI Supported Residential Living service does not include medical transportation in excess of 50 miles roundtrip. This also is authorized as a state plan Medicaid service.

The daily rate for each participant is comprehensive and not based on individual services used or not used. The rate is not adjusted and does not depend upon what the individual actually receives. Components may not be billed separately if not all are provided.

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	TBI Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: TBI Supported Residential Living

Provider Category:

Agency

Provider Type:

TBI Assisted Living Facility

Provider Qualifications

License *(specify):*

Provider must be licensed as an Assisted Living Facility by the Nebraska Department of Health and Human Services Division of Public Health. The licensure regulations are found at 175 NAC 4.

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
•Provide a private room with bathroom consisting of a toilet and sink for each participant receiving TBI Supported Residential Living service. Semi-private rooms will be considered on a case-by-case basis and require prior approval of the Department.
•Provide essential furniture, at a minimum, a bed, dresser, nightstand or table, and chair, if a participant does not have those items.
•Supply normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, feminine hygiene products and dental hygiene products.
•Provide privacy in the unit including lockable doors, and access by the participant to the facility and to the individual apartment.
•Provide training to staff and provide DHHS with training plans upon request.
•Complete DHHS trainings upon request.

The TBI Supported Residential Living provider must have a resident service agreement for each participant which includes a lease agreement. The agreement must also include an up-to-date listing of the participant's current medications and treatments, any special dietary requirements, and a description of any limitation to participate in activities. TBI Supported Residential Living staff will, together with the participant and service coordinator, review and revise the resident service agreement as appropriate, but at least annually.

All staff employed by the provider who work with a participant served by the Traumatic Brain Injury waiver must complete specialized TBI training.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff.

Frequency of Verification:

Provider qualifications are verified on an annual basis.

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:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vehicle Modifications are physical changes to an automobile or van to accommodate the participant or improve their function.

Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the 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 that are of general utility, and are not of direct medical or remedial benefit to the participant;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

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

The state does not have an annual maximum for each of the components of Home and Vehicle Modifications. This allows flexibility for the participant's needs to be met if a modification is necessary to remain or return home.

The State receives reports on services received by participants which include details on the exact technology or modification received and the cost involved. Service and claims information is also stored in the participant file.

This service does not include durable medical equipment which is required to be provided under the Medicaid State Plan. This service is not available to facility providers.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of 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	Specialized equipment, supplies, home repair companies.

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:

Specialized equipment, supplies, home repair companies.

Provider Qualifications

License *(specify):*

Not required.

Certificate *(specify):*

Not required.

Other Standard *(specify):*

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Appropriately licensed/certified persons shall make or oversee all modifications. All items and assistive equipment must meet applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nebraska Department of Education Assistive Technology

Frequency of Verification:

Ongoing

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:

Contracted Independent Living Center or Area Agency on Aging staff conduct case management functions on behalf of waiver participants.

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):

Criminal history and/or background investigations are required for:
(a) All Services Coordinator and Resource Development staff
(b) Individual providers
(c) Persons employed by contracting provider agencies. Waiver resource development staff are responsible for completing criminal history checks for individual providers and verify that agencies have completed criminal history checks for their employees. The Medicaid Agency completes criminal history checks for Services Coordination and Resource Development staff.

Regulations found in Nebraska Administrative Code (NAC) Titles 471 and 480 outline the process to ensure criminal history compliance. Individual providers, employees of agency providers and employees of assisted living facility providers must sign a statement approved by DHHS, identifying any record of any felony or misdemeanor convictions and/or pending criminal charges. This must include details, dates, and disposition (e.g., parole, probation, incarceration, fine, community service, etc.). Minor traffic violations must be included only if transportation services are to be provided. If the individual provider will be providing waiver services in their home, the provider must also provide this information for all household members age 13 or older. Assisted living facility providers must obtain this statement at time of hire and at least annually. All agency providers must have a policy that fully states the agency's practice in assuring safeguards are in place to protect the well-being of waiver participants.

For agency providers, the assigned Resource Development staff review the policy of the agency, upon provider enrollment and annually, to determine safeguards are in place to protect the well-being of waiver participants. For assisted living facility providers, this includes review of staff statements of criminal history. Other assisted living facility assurances in this area are provided through Regulation and Licensure, Nebraska Administrative Code (NAC) Title 175.

The Resource Developer must deny or terminate service provider approval immediately if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the participant.

Refusal to sign a release of information is grounds for immediate denial or termination of provider approval. If a report of abuse or neglect concerning a current waiver provider (or household member) as perpetrator is substantiated, staff shall immediately terminate the provider contract and notify the services coordinator.

Program Integrity must review the situation if charges listed above are pending to determine whether the participant's safety is in jeopardy. Criminal history background checks are documented and reviewed by the provider enrollment broker. Quarterly on-site file reviews are conducted by resource developer supervisors. Additionally, DDD quality staff annually conduct off-site file reviews to verify the work of the resource developer supervisors. The combined on-site and off-site file reviews comprise a representative sample of providers.

Information related to criminal history/background investigations related to a provider agreement is stored electronically through the Provider Enrollment Broker's web portal. State retention schedule guidelines require this information to be maintained for 10 years after the last date the provider agreement is in effect.

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):

(a) The Department of Health and Human Services maintains the Adult Abuse Registry and the Child Abuse Registry.
(b) All Services Coordination and Resource Development staff and all independent contractor and agency service providers must be screened against the child and adult abuse central registries. All requests for Service Coordination Agency staff are submitted to identified DHHS staff to conduct the screenings against the registries.
For individual providers and agency provider owners, the provider must complete steps within the Medicaid Provider Screening and Enrollment (PSE) system for their background check to be complete. Providers submit information on the Central Registry website to be screened by DHHS staff against the following registries; DHHS Adult Protective Services Central Registry, and the DHHS Child Central Register of Abuse and Neglect. The PSE vendor screens against the Nebraska Sex Offenders Website, and the License Information System.
Agency providers must have a policy that governs central registry checks for direct service staff under their employment. Regulations within Title 480 NAC state, each agency waiver provider must have a policy to determine how information found via these registries/websites are used for its employees. This policy must ensure no staff person identified through this process poses a danger to the health and safety of any waiver participant. Providers must adhere to regulations within Title 471 NAC provider participation. If the Resource Developer learns that a protective services investigation is in progress, they must review the situation to determine if the participant's safety is in jeopardy. The RD may terminate an existing service provider approval immediately.
(c) The DDD reviews the process for Services Coordination agencies. Resource Development staff within the Services Coordination agencies monitor this process for Medicaid providers.

Providers who are listed on the Adult Protective Services/Child Protective Services registry are ineligible to be a Nebraska Medicaid provider. Individuals identified on the registry will have their enrollment denied or terminated as appropriate.

Provider Screening and Enrollment requirements indicate the registry will be checked at initial enrollment, revalidation, and annually.

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.

The state considers legally responsible individuals to be the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or a spouse. The state does not make payment to these legally responsible individuals.

There are no limits on the types of non-legally responsible relatives/legal guardians who may furnish services as long as they are able to provide the services identified in the person-centered plan. All services may be provided by non-legally responsible relatives/legal guardians. Any potential provider meeting service standards has the right to be a provider. The Services Coordinator ensures payments are made only for services rendered by prior authorizing all services based on the participant's needs. Billing documentation submitted through the Electronic Visit Verification (EVV) solution can be reviewed post-payment in the DHHS system or through the EVV solution. Billing documents for services not required to use EVV are submitted directly to the local contracted Services Coordination Agency. The Services Coordinator monitors on a monthly basis that services are furnished and paid for as specified on the person-centered plan. If a legal guardian is a paid provider, an individual with knowledge about the participant's care will also be contacted to provide monitoring information for those services provided by the legal guardian.

○ **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:

Regulations are published on the Nebraska Department of Health and Human Services website, which are readily available to anyone with internet access. Resource Development staff within the contracted Services Coordination Agencies may publish ads in newspapers for specific types of providers, process initial referral information for potential providers, conduct wage negotiation activities for specific services, and provide enrollment guidance to prospective providers after referring them to the provider enrollment brokerage. Potential providers may apply at any time to become a provider of waiver services. The provider enrollment process consists of completing an in-person interview conducted by Resource Development staff, wage negotiation activities as applicable to each service type, and referral to the provider enrollment brokerage. Once a provider has been determined to have met all the applicable provider criteria, the provider is entered on the automated system as an approved Medicaid waiver provider. The agreements are renewed annually based on continued compliance. This process ensures continuous open enrollment of waiver service providers.

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:
Number and percent of enrolled providers that continue to meet licensure/certification and other standards at annual review. Numerator = Number of enrolled providers that continue to meet licensure/certification and other standards at annual review; Denominator = number of enrolled providers required to be licensed/certified that have had an annual review 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** 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**

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

Performance Measure:
Number and percent of enrolled licensed, certified providers that have had an annual review. Numerator = number of enrolled licensed, certified providers that have had annual review; Denominator = number of enrolled licensed, certified providers 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** 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:

Performance Measure:
Number and percent of new providers that met licensure/certification and other standards prior to furnishing services waiver. Numerator = Number of new providers that met licensure/certification and other standards prior to furnishing services waiver.; Denominator = number of new providers required to be licensed/certified 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** 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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:
Number and percent of new non-licensed/non-certified providers that initially met waiver requirements. Numerator = Number of new non-licensed/non-certified providers that initially met waiver requirements.; Denominator = number of new licensed/certified providers 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** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		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:

Performance Measure:
Number and percent of enrolled non-licensed/non-certified providers that continue to adhere to waiver requirements at annual review. Numerator = Number of enrolled non-licensed/non-certified providers that continue to adhere to waiver requirements at annual review.; Denominator = number of enrolled non-licensed/non-certified providers that had an annual review that 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** 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrolled non-licensed, non-certified providers that have had an annual review. Numerator = number of enrolled non-licensed, non-certified providers that have had annual review; Denominator = number of enrolled non-licensed, non-certified providers 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** 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:

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:
Number and percent of providers of waiver services who met training requirements as specified in DDD policy and in accordance with state requirements and the approved waiver. Numerator = number of providers of waiver services who met training requirements as specified in DDD policy and in accordance with state requirements and the approved waiver; Denominator = number of reviewed providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic data system

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** 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.

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.

Activities and processes at the state level have been developed to discover whether the federal 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 services coordination/resource development agencies are responsible to remediate all identified provider problems identified through the discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing qualified providers include:

1. Review of electronic reports of provider enrollment:
• Qualified providers quality improvement reviews are completed through review of provider enrollment records by DDD quality staff.
• Reassessment occurs and the required corrections are completed.
• If the provider is found to be qualified, the provider continues to provide services.
• If the provider is found to be ineligible, the provider agreement is terminated.
• Services coordination/resource development supervisors report remediation activities to DDD quality staff. DDD quality staff document corrections. The review documentation must include information that all negative qualified provider issues have been resolved correctly.
• If there is a concern that the resource development agency didn't meet performance compliance, they are responsible for a Shared Resolution or Quality Improvement Plan that will demonstrate how the agency will remediate and then determine system improvement.
• The DDD quality staff monitors statewide reviews to ensure review and remediation activities are completed as assigned. Review documentation must include information that all negative provider enrollment issues have been resolved correctly.

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**
	☐ **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 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.

☐ **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, one TBI Supported Residential Living provider has been serving participants on the TBI waiver. That provider has demonstrated compliance with federal HCBS Setting requirements. This has been verified through annual setting assessments completed by the Resource Developer, on-going monitoring by the Services Coordinator, file reviews by DDD staff, and the National Core Indicators Aging and Disability (NCI-AD) results.

With the addition of services to this waiver, service settings will include the TBI Adult Day Health provider settings and participants' private homes.

Any provider of TBI Adult Day Health services will need to demonstrate compliance with federal HCBS setting requirements through settings assessments completed by Resource Developers during initial and annual provider enrollment. This assessment will include an interview, a walk-though of the setting, and a review of policies and procedures. If the setting has the qualities of an institution as defined by CMS, the provider will complete a heightened scrutiny packet, which will be reviewed by DDD to ensure the setting is compliant.

All settings, including private homes, will be monitored through monthly reviews of person-centered plans by Services Coordinators with participants and at 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 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. DDD will use results of initial site assessments to identify those settings requiring further attention to come into compliance with the HCBS settings final rule. The assessment process will identify what modifications are needed and by when. Nebraska will assess providers' progress towards compliance through reports, interviews, and on-site inspections that include information from providers and individuals receiving services. Licensing, certification, and/or service delivery system staff will be critical to ensuring compliance and assuring providers' progress on their provider-level transition plans. Ongoing monitoring and follow-up will ensure compliance is achieved. Once overall compliance is achieved, strategies to ensure ongoing compliance will include:

i. Ongoing licensing inspections and certification reviews by appropriate staff; and
ii. 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 will work with the 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:

Person-Centered 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:

At a minimum, staff who provide Service Coordination for the TBI Waiver are required to have:
•A bachelor's degree in education, psychology, social work, sociology, human services, or a related field; AND
•Professional experience in one of the following fields: long term care, gerontology, rehabilitation, health/disability case management, or health/medical.

Verification of credentials for TCM providers must be kept on file and records retained in accordance with establish DHHS policy (7 years) and provide records upon request

☐ **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.

The participant's Services Coordinator (SC) together with the potential participant, develops the participant's service plan.

a) The supports and written information are made available to the participant to direct and be actively engaged in the service plan development process.

Prior to the service plan meeting(s), the SC works with the participant to coordinate invitations for their service plan meetings, dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant.

Service planning meeting involves people who care about and know the participant. The development process is a collaborative process between the participant and SC that includes people chosen by the participant, provides necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions, and reflect cultural considerations and communication needs of the participant. The participant is present, is encouraged and assisted to participate in every aspect of their service planning as fully as they are able and choose to do so.

The participant, SC, and other individuals chosen by the participant (e.g. advocates, family members, and friends) participate in the service plan process or parts of the service plan process; discuss the participant's goals and needs; develop the service plan; and review and update the service plan throughout the year to support the participant to live the life they want.

b) The participant's authority to determine who is included in the process.

Individuals involved in the planning process will be determined by the participant but must at least include the participant and the SC. Individuals who care about and know the participant may be included dependent upon the participant's choice of who to include in the process.

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 waiver services and annually thereafter.

Service planning is developed in conjunction with the person-centered plan once the initial assessment is completed and reflects the participant's waiver and non-waiver services, needs, goals and preferences. This meeting is also the opportunity for the SC to explain the available service array, including provider and conflict of interest options. The purpose of the meeting is to 1) discuss information gathered about what is important to and for the participant, 2) identify other services or programs and informal supports the participant has available outside of waiver services and 3) identify what supports they need to be safe and healthy while leading the life of their choosing. This person-centered plan is individually tailored to address the unique preferences and needs of the participant.

After the person-centered plan is developed, the waiver and non-waiver services available to the participant shall be discussed to identify providers and authorize services. The person-centered plan will include waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the participant to achieve their future plan, or personal goals.

Members in the planning process are determined by the participant but must at least include the participant and the SC. Informal supports and the prospective waiver provider(s) may be included dependent upon the participant's choice of who to include in the process. The SC is responsible for scheduling, coordinating, and documenting all service plan meetings, and facilitating the participation of all included in the planning process by request of the participant. The SC elicits and records facts and information, advocates for the participant, documents the person-centered service plan and the specific responsibilities of those involved in the planning process with regard to implementation of services, supports, and/or strategies, and adheres to the processes for service plan development and authorized services. Meetings are scheduled at a time and place that accommodates the needs of the participant. Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all involved in the planning process. The participant or those identified in the planning process may request a meeting at any time.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, goals and health status.

The service plan must identify the needs, goals and preferences of the participant and specify how those needs, goals and preferences will be addressed.

In order to accomplish that, the participant's strengths, capacities and areas needing growth to support the service plan development are determined by the participant and the individuals they invited to develop the person-centered plan.

Adults age 18 and older are assessed with the interRAI Home Care Assessment. If there is a change in circumstance prior to the annual level of care assessment, the Home and Community-Based Adult Assessment will be used to document changes in care needs. Health and welfare is addressed through a variety of assessments that may be provided by the family, service coordinator, and/or Medical Professionals.

The interRAI is used to measure the participant's level of independence and support needed for the participant to complete activities including Activities of Daily Living, Instrumental Activities of Daily Living, and risk factors. Supplemental medical information gathered in determining level of care eligibility will inform the planning process and discussions including medical needs; any recent illnesses and recovery; condition or therapeutic changes; and summary reporting of ongoing monitoring. Information from other sources, such as medical records/reports and special education plans may be reviewed. This information guides the development of the person-centered plan.

(c) How the participant is informed of the services that are available under the waiver.

The SC has the primary responsibility to inform the participant of available services under this waiver. Information about available services is shared with the participant from the point of referral through the development of the person-centered plan. The participant is informed of the services that are available through the waiver during the initial plan development and annually during the service-planning meeting. Services Coordinators continue to provide information about services

through monthly monitoring contacts as participants' needs and preferences change. The DHHS website provides further information on waiver services and other resources.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

The person-centered plan must identify the needs and personal preferences of the participant and specify how those needs and personal preferences will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid waiver resources or informal supports. The service plan indicates how the team believes that this plan will meet the health and safety needs of the participant including back up plans. These needs may be met by a combination of waiver services, self-directed supports, natural supports, services/supports from other DHHS programs and other services/supports from other non-Medicaid sources. If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the participant, the team will re-consider the appropriateness of the participant's service array. This may require referral to other services or programs and the development of a revised plan.

(e) How waiver and other services are coordinated.

Coordination of waiver services includes documentation, referral, and follow-up. The SC is responsible for coordination and oversight of the delivery of effective services for participants through assessment, service plan development, referral, and monitoring activities. The participant determines the level of coordination desired. The SC provides information about referrals and resources to the participant. The SC may make referrals and coordinate related activities to help a participant obtain needed services, medical, social, educational providers, or other programs and services. The SC makes referrals to prospective providers selected by the participant for needed services and may schedule appointments for the participant.

The SC completes monitoring and follow-up activities with the participant, providers, or other entities to ensure that the person-centered plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes in the needs or status of the participant that warrant making necessary adjustments in the person-centered plan and service arrangements with providers. When requested, the SC may serve as a liaison for the participant with the service provider and the community.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

The person-centered plan is the document that outlines the outcomes and action steps that reflect the participant's needs, personal preferences, and desired outcomes. The person-centered plan identifies the services to be provided, the amount and frequency of service provision, and the people responsible for the delivery of the services required (i.e. the type of provider). People responsible may include the participant, family members, waiver providers, other providers, informal supports, and the SC. The SC is responsible for monitoring the plan, and this is accomplished through at least monthly contact with the participant/guardian.

The SC may complete ongoing monitoring in the environment that waiver services are provided when there are reports of abuse or neglect, health and safety concerns, at the request of the participant.

(g) How and when the plan is updated, including when the participant's needs change.

Regulations found at Title 480 NAC require the person-centered plan to be modified as the participant's needs change and annually. The plan modification or annual review is also a joint planning process including the participant, SC, and other people chosen by the participant.

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.

Risk is identified through the level of care and functional assessment processes.

The SC must determine the presence and effect of risk factors that impact the health and welfare of the participant. Risk factors are concerns which cause significant impact to the participant's life and functional capacity. To be considered a factor, the risk must be immediate and require a significant intervention (referral, support, or service), either in a facility or as part of an in-home plan.

Risk factors to be considered include but are not limited to:

1. Documented Abuse/Neglect.
2. Socially inappropriate behavior: The participant exhibits a recurring behavior deviant from that which is commonly regarded as acceptable by societal norms. These specific behaviors are wandering, inappropriate sexual behavior, assaultive behavior, and resistance to physical care. This also includes thought impairment such as hallucination, delusion, or suicidal ideation not related to a severe and persistent mental illness.
3. Communication: The participant is unable to communicate information in an understandable manner. Information may be conveyed by any means (examples include but are not limited to: verbally, in writing, sign language, message board). This does not include speaking a language other than English.
4. Continence: The participant is incontinent (that is, unable to control their body to empty the bladder and/or bowel) and is unable to self-manage related needs.
5. Falls: The participant has fallen resulting in injury which required physician treatment or hospitalization.
6. Housing: No safe, accessible, adequate housing. At intake, these factors are of concern in the participant's life. At renewal, the participant would be at risk of these factors recurring in the absence of waiver services.
7. Nutrition or Hydration Concerns: The participant has a history/present diagnosis of dehydration or malnutrition. In absence of diagnosis, the participant does not demonstrate interest/motivation to eat.
8. Lack of informal support: The participant has no network of caring friends/relatives/neighbors/staff or non-waiver providers who are physically, mentally, and psychologically able and willing to provide any care or support.

Strategies to mitigate risk to the participant's health and welfare are incorporated into the person-centered plan, subject to participant needs and unique preferences. The array of Waiver services in this program are designed to mitigate risks. For example, the Personal Emergency Response System (PERS) addresses risk common to vulnerable adults served by this waiver. Other strategies include developing goals and action steps to address identified risks; referral to services/resources to address risks, as well as the actual use of those services/resources.

Back up plans are developed on an individual participant basis to address situations of the unavailability of a provider or informal support; or in the event of a natural disaster or emergency. Back up plans are written into the participant's person-centered plan. The assessments tool informs the Service Coordinator of potential health and safety risk factors. Each participant's person-centered plan is required to have outcomes and action steps which address all needs for ADLs and IADLS, including risk factors. The person-centered plan also is required to address the supports and interventions related to the identified health and safety risks needed to prevent harm to the participant. In addition, all person-centered plans must contain outcomes and action steps which address unavailability of a provider and a plan for what will be done in the event of a natural disaster or emergency. All participants are to be involved in writing the person-centered plan and the identified action steps.

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 eligible for the Traumatic Brain Injury Waiver are voluntary, both for the participant and the provider. Choice of providers and services is based on the choice of the participant. The provider must enroll and meet Medicaid requirements.

Participants have ready access to accessible information about the qualified waiver providers available to furnish the services included in the plan. All provider information is stored electronically in a DHHS system. SCs access the information based on participant needs regarding geographic, hours of operation when services are needed, travel requirements, and past history of service provision. A participant may receive a list of providers upon request from their SC. The participant has the option of recommending a potential provider who is then subject to the provider approval process. The lists are generated by requested county for the service and by the service the participant is authorized to receive. Participants are provided with the list of potential providers during the initial person-centered planning meeting or prior to this meeting upon request.

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):

DDD quality staff conduct records reviews annually that include a review of service plans. A representative sample of service plans with a confidence interval of 95% with +/-5% margin of error for Traumatic Brain Injury waiver participants are reviewed, through the waiver's Person-Centered Plan Review process. This review is conducted by DDD quality staff who are trained on the review tool and have knowledge of waiver regulations, policies, procedures, philosophy, and documentation requirements.

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 responsible for monitoring the implementation of the service plan and participant health and welfare;

Services Coordinators (SC) are responsible for monitoring the implementation of the person-centered plan and updating the person-centered plan as needed when it has been identified the participant's assessed needs have changed. SCs are also responsible for monitoring participant's health and welfare. SCs along with the participant develop a backup plan to ensure the participant's needs are met when the primary provider is not available. Monitoring services includes SC reviewing claims for services rendered. SCs make referrals, as appropriate, to assure participants safety (i.e., additional programs, providers, Adult Protective Services, law enforcement and Licensure). The SC is responsible for monitoring the participant's satisfaction of services.

b.) The following describes the monitoring process;

SCs monitor the person-centered plan by interviewing and observing the participant and their surroundings and interviewing the participant's family members, participant representatives and providers regarding the provision of waiver and non-waiver services including health services. The SC then determines with input from the identified individuals, whether or not the services continue to meet the participant's needs. When there is a change in participant needs the person-centered plan is updated to include a new statement to cover the newly identified participant need. These same methods are used to determine if the participant is choosing the providers they want to provide the needed services and to also monitor the effectiveness of the backup plan when the primary providers are not available. The SC also monitors to ensure the participant resides and/or receives services in a setting that meets the HCBS regulations and requirements.

The SC also encourages the participant's family to monitor service provision. The SC also monitors the usage of services and the cost of services by reviewing provider billing documentation using DHHS systems which contain this information on a regular basis. Services that include personal cares are recorded in an Electronic Visit Verification system. Claims for those services are available to view post-payment in DHHS systems. SC maintains a working relationship with resource development staff persons in regard to provider issues or complaints received, and service gaps and/or barriers in the service area.

During the person-centered plan monitoring process, if an incident or a complaint is reported to the SC, the SC may follow up on what was reported prior to the next monthly contact with the participant depending on the situation. When the issue is more complex or is ongoing an action step will be added to the person-centered plan and will be addressed accordingly.

The SC monitors Medicaid eligibility and participant share of cost obligations using the DHHS systems containing this information. The SC also monitors the share of cost obligation being obligated to Medicaid waiver services in order for the participant to maintain Medicaid eligibility.

c.) The following describe the frequency of monitoring;

The SC must contact the participant, their legal representative or guardian at least monthly and more often depending on the participant's level of need at any particular time. The SC must have a face-to-face meeting with the participant at least quarterly and more often depending on the participant's level of need at the time. If the participant has a legal representative or guardian, they should be included in the meeting. If the representative or guardian is a paid provider, an individual with knowledge about the participant's care will also be contacted to provide monitoring information. The Services Coordinator must monitor Medicaid eligibility monthly.

Should immediate safety concerns be evident, the concern will be expressed verbally to appropriate personnel. When it is necessary for the SC to intervene to ensure the health and/or safety of the participant, such incidents will be documented. Suspected abuse or neglect will be reported to DHHS Adult Protective Services/Child Protective Services as appropriate. Any issue which requires follow up is documented by the Service Coordinator following the monthly monitoring visit or following other contact with the participant, provider, or other interested person (when appropriate). Depending upon the identified problem, it is addressed immediately and prior to the next monthly contact. When the problem is more complex or is ongoing, it is added as an outcome or action step on the person-centered plan and addressed accordingly. The SC will document health and safety concerns and complete an incident report as necessary. Refer to Appendix G for a detailed description of the critical incident process. The SC will review each participant's satisfaction with the services provided, review each participant's overall health status, and verify the provider(s) is complying with the requirements of

service provision. Participant complaints about the provider are addressed by SC as they arise. Back-up plan effectiveness is monitored through file reviews and through the SCs' monthly contacts with participant.

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 participants for whom assessed needs (including health and safety risk factors) have been addressed in the service plan. Numerator = number of participants for whom assessed needs have been addressed in the service plan; Denominator = number of participants 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** 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**

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** Specify:

Performance Measure:
Number and percent of participants for whom assessed personal goals have been addressed in the service plan. Numerator = number of participants for whom assessed personal goals have been addressed in the service plan; 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** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	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 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 whose service plans were reviewed and/or revised on or before the annual review date. Numerator = number of participants whose service plans were reviewed and/or 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** 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:

Performance Measure:
Number and percent of participants whose service plans were revised, as needed, to address changing needs. Numerator = Number of participants whose service plans were revised, as needed, to address changing needs; Denominator = number of participants whose service plans required revision to address 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** 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**

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** 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 participant files with monthly narratives reflecting waiver services were delivered in accordance with the type, scope, amount, duration, and frequency in the PCP. Numerator: # of participant files with monthly narratives reflecting waiver services were delivered in accordance with the type, scope, amount, duration, and frequency in the PCP. Denominator: # 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** 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:

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 whose file indicated participants chose among types of services. Numerator = number of participants whose files indicated participants chose among types of services; Denominator = number of participants 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** 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:

Performance Measure:
Number and percent of participants whose file indicated participants chose among providers. Numerator = number of participants whose files indicated participants chose among providers; Denominator = number of participants 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** 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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.

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 Quality team file reviews:
•Service plan quality improvement reviews are completed by DDD Quality staff on an electronic system.
•If a service plan review identifies individual problems, the DDD quality staff staff provides the services coordination supervisor with information concerning corrections needed.
•The required corrections are made by the services coordinator on the service plan.
•Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation and/or action occurred to address the problem are followed up on immediately with the local level supervisor.
•If the participant's service plan can't assure the participant's safety, the case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
•Services coordination supervisors report remediation activities to the DDD quality staff by documenting corrections in the electronic data system. The review documentation must include information that all assessed needs have been resolved correctly.
•If there is a concern the agency didn't meet performance compliance, they are responsible for a Shared Resolution or Quality Improvement Plan that will demonstrate how the agency will remediate and then determine system improvement.
•Service plan review reports are also reviewed to assure reviews and remediation activities by the agency are completed as assigned.

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. The electronic data system can be used to run reports of file review and other data to evaluate their agency's performance. Services coordination supervisors may also use the electronic system to perform additional agency specific file reviews.

Performance measure related data reports developed by the Performance Measure Subcommittee will be shared with services coordination agencies quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

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 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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

Participants and/or their legal representative are advised of their appeal rights at the time of initial eligibility by DHHS-DDD staff who determine initial eligibility and thereafter by their Services Coordinator (SC) at the time of the initial and annual service plan meeting, facilitated by their SC. At the annual service plan meeting, the participant is given a Notice of Rights and Responsibilities. Hearing rights are also provided with the Notice of Decision.

Participants will receive and have the opportunity to dispute a Notice of Decision in any of the following circumstances:
1. The applicant is determined ineligible for Medicaid HCBS waiver services;
2. The applicant is not given the choice of Medicaid HCBS waiver services as an alternative to institutional care;
3. The participant's choice of providers is denied; or
4. Services to the participant are denied, suspended, reduced, or terminated.

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; or
7. They thinks 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 when they begin receiving services and annually thereafter. This information is also posted on the public website at www.dhhs.ne.gov/developmental_disabilities.

Designated Department of Health and Human Services Division of Developmental Disabilities (DHHS-DDD) staff complete and retain the Notice of Decision in Nebraska's electronic 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 final outcome of the fair hearing if 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-DD. Fair hearing rights are provided in English and Spanish according to the language spoken at home on file 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 DHHS-DDD. The petition may be made on a form provided by DHHS-DDD for such purpose, or in another writing that 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 that 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:

The Division of Developmental Disabilities is responsible for the operation of the complaint system.

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).

Each Service Coordination/Resource Development agency is required to have an internal complaint process and keep documentation of all complaints and the resolutions to those complaints. This information is provided to DDD as requested.

Filing a complaint with the Service Coordination/Resource Development agency does not take away a participant's right to a fair hearing or right to refer the complaint to DDD. Participants are informed of this when they make a complaint to the Services Coordinator.

Complaints are also received by DDD Central Office. Any complaint related to the TBI waiver may be submitted via phone call, website form, mail, in office visit or email. A complaint form and email link are listed on the DDD web page. Complaints are assigned to appropriate DDD staff who will resolve and track the complaint.

Filing a grievance or making a complaint is not a prerequisite or a substitution for requesting a Fair Hearing. A Request for Fair Hearing form and email link are listed on the DDD web page.

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).

The Critical Incident Management Process is used to document, track, and analyze critical events/incidents. Reports of incidents may be received from any source, including sources other than the participant or participant representative.

Critical events/incidents are those events that bring harm or risk of harm to participants which could potentially result in abuse, neglect, or exploitation. This includes licensing violations for licensed providers/facilities that have the potential to result in abuse, neglect, or exploitation. These events must be reported to appropriate authorities to conduct follow-up action. Appropriate authorities include DHHS, Division of Child and Family Services (Adult Protective Services/Child Protective Services), Law Enforcement, and DHHS, Division of Public Health (for licensed providers/facilities).

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.

Adult Protective Services regulations can be found at Title 463 NAC and the definition of abuse is located in Nebraska Revised Statutes 28-351. Abuse means any knowing or intentional act on the part of a caregiver or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, or sexual exploitation of a vulnerable adult. The definition of neglect is in Nebraska Revised Statutes 28-361.01 Neglect means any knowing or intentional act or omission on the part of a caregiver to provide essential services or the failure of a vulnerable adult, due to physical or mental impairments, to perform self-care or obtain essential services to such an extent that there is actual physical injury to a vulnerable adult or imminent danger of the vulnerable adult suffering physical injury or death. The definition of exploitation is in Nebraska Revised Statutes 28-358. Exploitation means the wrongful or unauthorized taking, withholding, appropriation, conversion, control, or use of money, funds, securities, assets, or any other property of a vulnerable adult or senior adult by any person by means of undue influence, breach of a fiduciary relationship, deception, extortion, intimidation, force or threat of force, isolation, or any unlawful means or by the breach of a fiduciary duty by the guardian, conservator, agent under a power of attorney, trustee, or any other fiduciary of a vulnerable adult or senior adult.

Incident reports will be recorded and analyzed for any type of event in which abuse, neglect or exploitation is either suspected or substantiated. This includes incidents that aren't initially considered to be critical, but after review or investigation, are found to have resulted in abuse, neglect, or exploitation.

Incident reports are also completed for events that aren't required to be reported to appropriate authorities but appear to have a potential for risk to a participant's health or safety. Examples include, but aren't limited to, accidents, hospitalizations, illnesses, injuries, falls, and medication errors.

All incidents, both those considered to be critical events that need to be reported to authorities and those that don't need to be reported to authorities, are reported to DDD.

Incident forms are recorded in DDD's electronic incident management system.

Services Coordinators and providers record and track incidents using the following processes:

When critical events/incidents that are required to be reported to appropriate authorities (i.e., abuse, neglect, exploitation, licensing violations) become known to Services Coordinators or providers, Services Coordinators and providers must report the incident to the appropriate authorities if this has not already been done. Appropriate authorities include Adult Protective Services/Child Protective Services and Law Enforcement as appropriate, and DHHS, Division of Public Health for incidents involving licensed providers/facilities. Depending on the situation, it may be appropriate to contact more than one type of authority. Notifications to appropriate authorities will be documented on the electronic incident form.

After reporting to appropriate authorities has been done, the Services Coordinator or provider will record the incident in the electronic incident management system.

Services Coordinators and providers will also record incidents in the electronic incident management system when these incidents appear to have a potential for risk to a participant's health or safety, but do not rise to the criteria for reporting to authorities.

Providers will only be responsible for incidents that occur while the provider is providing waiver services. Providers will report these incidents to the participant's Services Coordinator as soon as possible. Services Coordinators will enter the

incident in the electronic incident management system within 24 hours of the verbal report to the Services Coordinator.

Services Coordinators receive electronic alerts when a waiver participant is involved in an APS or CPS abuse, neglect, or exploitation intake. If the Services Coordinator is unaware of the situation related to the APS/CPS intake, the Services Coordinator is responsible for contacting applicable APS/CPS or DDD staff to determine if a critical event has occurred to help determine what type of action, if any, needs to be taken to ensure the safety and health of the participant without impeding an APS/CPS investigation. The Services Coordinator will be responsible for entering the related incident into the electronic incident management system.

For incidents representing imminent (serious or life threatening) danger or environmental events (e.g., fire, weather, flooding), designated Service Coordination Agency staff must notify QIO-like entity staff or designated DDD staff by the next business day to ensure appropriate resolution activities are occurring to mitigate the incident and ensure the health and safety of the participant.

Supervisors of the Services Coordinators entering the incidents will be responsible for reviewing incidents within one business day to ensure the incident was entered correctly and without missing information and have appropriate assigned follow-up activities/actions.

Quality Improvement Organization (QIO)-like entity staff will review 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 electronic incident management system is also used to record all participant deaths. Designated Service Coordination Agency staff notify QIO-like entity staff or designated DDD staff of all deaths by the next business day. Services Coordinators enter the incident in the electronic incident management system within 24 hours of notification of the death. Within 10 working days of the notification of the death, the Services Coordinator also provides additional detailed information related to the death. This information is electronically submitted to QIO-like entity staff who will complete a mortality review.

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 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.

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.

Services Coordinators provide new participants and their legal representatives with written information on their right to be free from abuse, neglect, and exploitation. This includes information on how to notify appropriate authorities of abuse, neglect, or exploitation by calling the toll-free Nebraska Abuse/Neglect Hotline. This information is given to the participant and their legal representative at initial and annual person-centered planning meetings and is discussed during monitoring visits. Participant health and welfare is monitored during visits, and Services Coordinators address protection and safety issues as the need arises.

All Services Coordinators are mandatory reporters, so any instance of abuse, neglect or exploitation related by the participant to the Services Coordinator during monitoring would be reported to Adult Protective Services/Child Protective Services.

Services Coordinators do in-home visits, giving the participant the opportunity to report an instance of abuse, neglect or exploitation in person, but this information can also be related to the Services Coordinator in a phone call if monitoring is occurring via a telephone call. Participants may also report instances of abuse, neglect or exploitation to any mandatory reporter, including but not limited to waiver provider staff, medical professionals, law enforcement, caregiver, employee of any facility licensed by the Department, or human services professional.

Services Coordination agency staff receive training on how to recognize abuse, neglect, or exploitation and their role as a mandatory reporter to proper authorities.

Additional information on abuse/neglect is available on the Nebraska Department of Health and Human Services website (dhhs.nebraska.gov). Participants/guardians and family members may be directed to those websites for resource information.

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.

The Services Coordinator's responsibility in the review and response to critical incidents is to recognize and report to appropriate authorities. An investigation of the incident is then conducted by law enforcement, Nebraska Department of Health and Human Services Protection and Safety staff, or the Nebraska Department of Health and Human Services Licensure Unit.

Adult Protective Services staff receive reports of the critical events or incidents specified in item G-1-a and determine response based on current policies and practices in compliance with the regulations stated in regulations Title 463 NAC. Data is obtained on an annual basis from the computerized Adult Protective Services system which categorizes reporter types. The DDD has a field in the waiver's electronic information system which identifies reports made to protective services on an individual participant basis.

The DDD Incident Management Committee assists in identifying methods to analyze this data and identify trends. This committee also makes recommendations to the DDD QI Committee.

Services Coordinators must report to Adult Protective Services/Child Protective Services/law enforcement/licensure when participant safety is at risk.

As outlined in Title 480 NAC, no provider approval will be issued or remain in effect if a registry/website report on the provider (or household member, if applicable) as perpetrator is shown as inconclusive or substantiated. If the Resource Developer learns that an Adult Protective Services investigation is in progress, they must review the situation to determine if the participant's safety is in jeopardy.

Allegations of abuse, neglect and exploitation are reported and investigated per statute and policy.

Adult Protective Services (APS) staff conduct screenings of abuse and/or neglect and/or exploitation and if the report is accepted for investigation, the reports are prioritized as follows:

A Priority 1 report of an allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult participant, including death or other vulnerable participants still at risk has a 60-day time frame in which to complete an investigation. Face-to-face contact must be made with the victim as quickly as possible, but no later than within 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they make the initial contact and send a written summary of their investigation to the Children and Family Services Specialist (CFSS). APS staff may work simultaneously with law enforcement if requested.

A Priority 2 report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult participant has 60 days in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 5 calendar days of the date of the report being accepted for investigation.

A Priority 3 report alleges harm to a vulnerable adult participant which is serious, but not serious enough to be considered Priority 1 or 2 and has 60 days in which to complete an investigation. Face-to-face contact by APS staff or law enforcement must be made to the victim within 10 calendar days on the date of the report being accepted for investigation.

Contact exceptions (i.e. exception for contacting the victim within 8 hr., 5 day, or 10 day timeframes listed above) can be granted in the following circumstances: unable to locate the victim; unable to identify the victim; refusal of the victim; death of the victim; law enforcement request for no contact during ongoing investigation, or other circumstances beyond the control of the worker.

Investigations are to be completed within 60 days from the intake acceptance date. An extension of 15 days (beyond the 60) can be granted for just cause as determined by the supervisor. If a case stays open beyond the extension, the worker has to make contact with the victim monthly to justify why the case is still open.

Victims and perpetrators are notified via mail within 10 working days of completion of the assessment. If the investigation involved an Organization such as an Assisted Living facility, the administrator of the facility is also sent a letter within 10 business days of completion.

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.

Adult Protective Services/Child Protective Services staff are contained within the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services. DHHS is the single-state Medicaid Agency. Adult Protective Service staff are responsible for the oversight of the critical incident management system which contains intakes of abuse, neglect, or exploitation.

On at least an annual basis, Adult Protective Services/Child Protective Services provide to DDD staff information about critical incidents that involved waiver participants. Data is obtained and analyzed on participants involved in Protection and Safety reports. The data includes demographical information, types of abuse/neglect reported, and the findings of investigations.

Adult Protective Services/Child Protective Services staff and DDD staff work together to identify strategies to reduce the occurrence of critical incidents and to coordinate better on both a system wide and individual participant basis. Examples include training of staff from Protection and Safety about this waiver, and cross training to waiver services coordination agencies about Protection and Safety.

The electronic incident management system described above in G-1-b allows data to be collected and analyzed by the action taken.

The Assisted Living Facility Licensure Compliance Log documents all complaints against waiver certified assisted living facilities. Data includes type of complaint and the result of the DHHS Licensure Unit's investigation.

The Incident Management Committee and the DDD QI Committee oversee the results of critical incidents and events on an annual basis, as the data from Protection and Safety is reported to DDD at least once per year. Data from this process is part of Nebraska’s quality management process.

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 TBI Personal Care and TBI Respite include supervision components which assure that waiver participants receive individualized oversight from qualified providers to maintain participant safety and dignity.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing health care facilities and services. These include licensed waiver providers of TBI Supported Residential Living, Respite, and Adult Day services. Regulations in NAC Title 175 for these licensed providers state that participants must be free of chemical and physical restraints. In addition, the use of mechanical restraints is not allowed. Surveyors from the Public Health Division may conduct on site compliance inspections on a random basis of state licensed health care facilities and services. In addition, the Public Health Division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act.

The DHHS Division of Public Health provides compliance survey inspection findings of Assisted Living Facilities to the HCBS Waiver Services unit which are then forwarded to the local waiver staff for follow up action.

Services Coordination Agency staff are responsible for participant monitoring which includes interviewing the participant regarding the satisfaction of their care, observation of service delivery, and documenting the monitoring. They are positioned to identify potential use of prohibited restraints and would report such a finding 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 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:

The State does not permit the use of restrictive interventions by any provider of any waiver service. Services such as TBI Personal Care and TBI Respite include supervision components which assure that waiver participant receive individualized oversight from qualified providers to maintain participant safety and dignity.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing health care facilities and services. These include licensed waiver providers of TBI Supported Residential Living, Respite, and Adult Day services. Regulations in NAC Title 175 address participant rights and surveyors from the Public Health Division conduct on site compliance inspections on a random basis. In addition, the Public Health Division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act.

The DHHS Division of Public Health provides compliance survey inspection findings of Assisted Living Facilities to the DDD staff which are then forwarded to the Services Coordination Agency staff for follow up action.

Services Coordination Agency staff are responsible for participant monitoring which includes interviewing the participant regarding the satisfaction of their care and observation of service delivery. They are positioned to identify potential use of restrictive interventions and would report such a finding 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 restrictive interventions.

○ **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:

The State does not permit the use of seclusion by any provider of any waiver service. Services such as TBI Personal Care and TBI Respite include supervision components which assure that waiver participant receive individualized oversight from qualified providers to maintain participant safety and dignity.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing health care facilities and services. These include licensed waiver providers of TBI Supported Residential Living, Respite, and Adult Day services. Regulations in Title 175 NAC for these licensed providers state that seclusion is not allowed. Surveyors from the Public Health Division may conduct on site compliance inspections on a random basis of state licensed health care facilities and services. In addition, the Public Health Division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act.

The DHHS Division of Public Health provides compliance survey inspection findings of Assisted Living Facilities to the DDD staff which are then forwarded to the Services Coordination Agency staff for follow up action.

Services Coordination Agency Staff are responsible for participant monitoring which includes interviewing the participant regarding the satisfaction of their care and observation of service delivery. They are positioned to identify potential use of seclusion and would report such a finding 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 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.

The TBI Supported Residential Living service is delivered in an assisted living facility setting which is licensed by the DHHS Division of Public Health, Licensure Unit. As a result, medication management, oversight, and follow-up are subject to review by the Licensure Unit. The Licensure Unit has the ongoing responsibility for monitoring participant medication regimens, the method for conducting monitoring, and frequency of monitoring.

The second line monitoring method utilized by the Licensure Unit is an on site inspection and record review at the assisted living facility. These methods include monitoring of all medication types, including behavior modifying medications.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Each year a random sample of 25% of all licensed assisted living facilities is selected for a compliance inspection, including medication management oversight. Focused inspections are conducted on facilities any time the Licensure Unit deems one necessary. These also include medication management oversight.

DHHS Division of Public Health survey staff conduct second line medication monitoring to detect potentially harmful practices by record reviews and actually observing all types of medication administration, including behavior modifying medications. This is to detect if assisted living staff (Medication Aides and licensed nurses) are following facility procedures, state regulations for medication administration by non-licensed personnel (Medication Aides are non-licensed in Nebraska), and the Nurse Practice Act for licensed nurses. The survey staff are monitoring to determine if the "five rights" of medication administration are begin followed. The "five rights" are the right medication to the right patient at the right time by the right dosage by the right route. The survey staff also review if PRN medications are administered pursuant to specific physician's orders which detail the symptoms and the frequency for usage. When survey staff note medication administration errors, they follow up by issuing a deficiency report to the assisted living facility. The facility must develop a plan of correction and provide evidence back to the DHHS Division of Public Health that deficiencies have been corrected and what plans are in place to prevent future errors.

All compliance inspection reports and assisted living facility statements of compliance are provided to the DDD and Services Coordination Agency for review.

Each assisted living facility must provide for a Registered Nurse to review medication administration policies and procedures annually and to provide or oversee the training of medication aides at such facility. Training of medication aides must include, but is not limited to:
1. Facility procedures for storing, handling, and providing medications;
2. Facility procedures for documentation of medications;
3. Facility procedures for documentation and reporting medication errors and adverse reactions;
4. Identification of person(s) responsible for direction and monitoring of medication aides; and
5. Other resident-specific training on providing medications in accordance with the limits and conditions of the Medication Aide Act.

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.

During any compliance inspection, the method used to ensure that participant medications are managed appropriately is the DHHS Division of Public Health Licensure Unit's surveyor observation of 20 medication opportunities. An opportunity is defined as any medication that is or should have been given to the participant. If there is one error observed, an additional 20 medication opportunities are observed to determine presence of a system failure. The error rate is calculated by dividing the number of errors by the number of opportunities and multiplying by 100. Errors are considered missing any one of the five rights (right resident, right dose, right drug, right time, and right route), as well as not administering a medication that is physician ordered.

A citation from the Licensure Unit is issued to the assisted living facility for a medication error rate of 5% or greater. When an error is considered significant enough to have a potential or actual adverse effect on the participant's health or well-being (i.e. missed insulin dose), a citation is issued regardless of the percentage of medication error rate.

The DHHS Division of Public Health Licensure Unit is responsible for follow up and oversight on medication management. All compliance inspection reports and assisted living facility statements of compliance are communicated to DDD staff and Services Coordination Agency staff for review.

When the assisted living facility submits and implements a statement of compliance that indicates a good faith effort to correct the violations, the DHHS Division of Public Health Licensure Unit does not take any further disciplinary action against the facility's license. When the facility fails to submit and implement a statement of compliance, the DHHS Division of Public Health Licensure Unit initiates disciplinary action against the assisted living facility's license. There may be additional action taken depending on the gravity and the frequency of the violation.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Each year a random sample of 25% of all licensed assisted living facilities is selected for a compliance inspection, including medication management oversight. Focused inspections are conducted on facilities any time the Licensure Unit deems one necessary. These also include medication management oversight. All compliance inspection reports and assisted living facility statements of compliance are communicated to DDD staff and Services Coordinators for review. Such reports are available to DDD staff on the DHHS website, and also accessible on the website to Services Coordination Agency staff. This information is provided to Services Coordination agencies which are responsible for the waiver certification process for assisted living facilities. Assisted Living Facility statements of compliance are reviewed by staff who complete the waiver certification process and paperwork to determine if outstanding issues are present which may prevent the facility from becoming waiver certified or retaining the waiver certification, and thus being a qualified waiver provider. Common issues may be identified when reviewing a grouping of statements of compliance (as opposed to isolated reviews of the documents). This information is then analyzed against quality assurances and to develop quality training.

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).

The TBI Supported Residential Living service is delivered in an assisted living facility setting which is licensed by the DHHS Division of Public Health, Licensure Unit. As a result, medication administration is subject to the assisted living facility licensure regulations found at 175 NAC 4 and described below.

As outlined in 175 NAC 4, a participant in an assisted living facility may self-administer medications under the following conditions:
1. Be at least 19 years of age;
2. Have cognitive capacity to make informed decisions about taking medication;
3. Be physically able to take or apply a dose of medication;
4. Have capability and capacity to take and apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for non-prescription medication; and
5. Have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The assisted living facility must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

Provision of medications may be provided by the assisted living facility as requested by the participant and in accordance with licensed health care professional statutes and the statutes governing medication provision by unlicensed personnel.

Medication Aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of: 1) a licensed health care professional whose scope of practice allows medication administration; 2) a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration); or 3) a caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for an individual.

A Medication Aide is listed on the Medication Aide registry operated by the Licensure Unit of DHHS, Division of Public Health. Medication Aides are allowed to perform Medication Provision which is a component of Medication Administration that includes giving or applying a dose of medication to an individual and includes helping an individual in giving or applying medication to him/herself. Each Assisted Living Facility must establish and implement policies and procedures that ensure medication aides who provide medications are trained through a Medication Aide Course and have demonstrated minimum competency standards in accordance with the Regulations governing the Provision of Medication Aides and other Unlicensed Persons and the Regulations governing the Medication Aide Registry. Direction and Monitoring means, for the purpose of medication administration by unlicensed persons, the acceptance of responsibility for observing and taking appropriate actions regarding any desired effects, side effects, interactions, and contraindications associated with the medications. Direction and Monitoring may be done by a competent individual for him/herself, a Licensed Health Care Professional, or a caretaker (a person who is directly and personally involved in providing care for a minor child or incompetent adult and/or is the parent, foster parent, family member, friend or legal guardian of such minor child or incompetent adult as referenced in the Nebraska Nurse Practice Act). A licensed health care professional is not mandated to be present during the provision of medication by an unlicensed person. Participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the Services Coordinator performs monitoring of a participant’s person-centered plan with the participant, including a review of the use or non-use of waiver services as well as reporting, reviewing, and remediating any critical incidents, including medication errors. When appropriate, critical incidents may also be referred to Adult Protective Services or Child Protective Services.

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

The training requirements for medication aides are outlined in 172 NAC 96-004.02. Medication aides providing services in an assisted-living facility must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient’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 person, 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 application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

Upon successful completion of the Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry.

State Statute 38-2201 to 38-2238, the Nurse Practice Act also applies and allows for the Medication Aide Act described above. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act. Specifically, State Statute 38-2219 states the Nursing Practice Act does not prohibit performance of health maintenance activities by a designated care aid for a competent adult at the direction of such adult or at the direction of a caretaker for a minor child or incompetent adult. Health maintenance activities are those activities which enable the minor child or adult to live in his or her home and community.

Participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the Services Coordinator performs monitoring of a participant's person-centered plan with the participant, including a review of the use or non-use of waiver services as well as reporting, reviewing, and remediating any critical incidents, including medication errors. When appropriate, critical incidents may also be referred to Adult Protective Services or Child Protective Services.

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:

TBI Supported Residential Living services providers providing services in an assisted living facility are required to record medication administration errors which are considered missing any one of the five rights (right resident, right dose, right drug, right time, and right route), as well as not administering a medication that is physician ordered. In addition, any adverse reaction to a medication must be recorded by the assisted living facility provider.

Per Title 175 NAC 4, each Assisted Living facility must establish and implement policies and procedures that specify how medication errors made by medication aides and adverse reactions to medications will be reported. The reporting must be: made to the identified person responsible for direction and monitoring; made immediately upon discovery; and documented in participant medical records.

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.

The TBI Supported Residential Living service is delivered in an assisted living facility setting which is licensed by the DHHS Division of Public Health, Licensure Unit. DHHS Division of Public Health, Licensure Unit has ongoing responsibility for monitoring licensed assisted living facilities in the administration of medications to all participants, including those who are on this Waiver. The Department of Health and Human Services is the State Medicaid agency and includes both the Division of Public Health and the Division of Medicaid and Long-Term Care. The Licensure Unit is under the Division of Public Health; therefore it is part of the State Medicaid agency. Medication errors made by assisted living facilities are reported to the Department of Health & Human Services.

Second line monitoring method utilized by the Licensure Unit is an on site inspection and record review at the assisted living facility.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Each year a random sample of 25% of all licensed assisted living facilities is selected for a compliance inspection, including medication management oversight. Focused inspections are conducted on facilities any time the Licensure Unit deems one necessary. These also include medication management oversight.

Licensure regulations require that an assisted living facility is cited for a medication error rate of 5% or greater. To determine the error rate, 20 medication opportunities are observed by Licensure surveyors. An opportunity is defined as any medication that is or should have been given. As many multiple routes, residents and administrators as possible are observed. If there are any errors, an additional 20 opportunities are observed for a system failure. The error rate is computed by dividing the number of errors by the number of opportunities and multiplying by 100. Errors are considered missing any one of the 5 rights (wrong resident, wrong dose, wrong drug, wrong time, wrong route) as well as not giving a medication that is ordered. A medication error is cited for anything below 5%. A second medication error is cited when the error is considered significant enough to have a potential (or actual) adverse effect on the resident's health or well being - i.e. missed insulin doses. An assisted living facility must submit a Statement of Compliance with a plan of correction to the Licensure Unit of the Nebraska Department of Health and Human Services, Division of Public Health for all identified citations. The Division of Public Health is responsible for reviewing and approving the Statement of Compliance and plan of correction.

All compliance inspection reports and assisted living facility statements of compliance are provided to the HCBS Waiver Unit and services coordinators for review. Monitoring reports provide information on service providers, and may be used and reviewed in the provider application and provider renewal process to determine if the provider meets criteria to be approved as a waiver provider. Trends identified in the review of the monitoring reports are used to set training priorities, as well as give technical assistance to waiver staff providing the TBI Supported Residential Living service in an assisted living facility setting related to improving the quality of the services provided in the assisted living facility setting. Data is acquired from DHHS Licensure inspection reports and statements of compliance that are completed by the facility. The reports are reviewed and analyzed in order to identify trends related to medication management issues and concerns.

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:
Number and percent of participants' death reviews conducted which did not require additional follow up/remediation. Numerator = number of participants' death reviews conducted which did not require additional follow up/remediation; Denominator = number of participants' death reviews conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant system data reports

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:

Performance Measure:
 # and % of participants who received information/education about reporting abuse, neglect exploitation and other critical incidents as specified in the approved waiver.
Numerator = # of participants who received information/education about reporting

abuse, neglect, exploitation, and other critical incidents as specified in the approved waiver; 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** 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:

Performance Measure:
 # and % of incident reports where additional actions or resolution activities requested by QIO/DDD staff were completed. Numerator = # of incident reports where additional actions or resolution activities requested by QIO/DDD staff were completed. Denominator = Number of incident reports where additional actions or waiver resolution activities were requested by QIO/DDD staff that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant data system reports

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** 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:

Performance Measure:

 # and % of substantiated abuse, neglect, exploitation, and unexplained death incidents that were referred to appropriate investigative entities. Numerator = # of substantiated abuse, neglect, exploitation, and unexplained death incidents that were referred to appropriate investigative entities; Denominator = # of substantiated abuse, neglect, exploitation, and unexplained death incidents.

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 =
☐ **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 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 incident reports submitted for substantiated Adult Protective Services (APS) intakes. Numerator = Number of incident reports submitted for substantiated APS intakes. Denominator = Number of substantiated APS intakes.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant system data reports

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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of critical incident reports completed with appropriate waiver resolution activity. Numerator = Number of critical incident reports completed with appropriate waiver resolution activity; Denominator = number of critical incident reports reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic participant data system reports

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** 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:

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** 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:

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:
Number and percent of participants for whom the file contains no evidence of the use of restrictive measures, including restraints and seclusion. Numerator = Number of participants for whom the file contains no evidence of the use of restrictive measures, including restraints and seclusion. Denominator = Number of participants 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** 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:

Performance Measure:
Number and percent of providers who have completed required training on rights, prohibition of restriction, restraint and seclusion, and alternative measures.
Numerator = Number of providers who have completed required training on rights, prohibition of restriction, restraint and seclusion, and alternative measures.
Denominator = Number of providers 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** 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**

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** 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 participants whose health care status was assessed at the initial review or annual assessment. Numerator = Number of participants whose health care status was assessed at the initial review or annual assessment. Denominator = Number of participants 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** 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.

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 service coordination agency and state levels have been developed to discover whether the Participant safeguards waiver assurances are 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 services coordination agencies are responsible to remediate all (100%) identified Health and Welfare individual problems identified through discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing health and welfare are:

1. Incident Process

- Incidents are reported in the electronic case management system.
- Once the incident report has been completed, it is submitted to DDD.
- The incident is reviewed by the QIO or DDD staff and a determination is made as to whether the appropriate resolution activities were completed. If further remediation is necessary, the QIO or DDD staff reviews the incident with the SC supervisor to determine appropriate actions. Remediation is documented by the DDD or QIO staff.
- After remediation is completed, the QIO or DDD staff finalize the review.

2. The DDD File Review and Electronic Reports

- Quality improvement reviews are completed by the DDD quality team in the electronic quality system.
- Indicators that did not meet standards require remediation/supervisory follow-up. Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation and/or action occurred to address the problem are followed up on immediately by the DDD quality staff with their supervisor.
- Services coordination supervisors report remediation activities to the DDD quality staff and document corrections in the electronic data system. The review documentation must include information that all health and welfare issues have been resolved appropriately .
- The DDD quality team monitors statewide reviews to ensure review and remediation activities are completed as assigned.
- Besides remediation being accomplished by follow up of individual or systemic issues, the agency could be responsible for a shared resolution or quality improvement plan. Agencies that do not successfully complete their Quality Improvement Plan process or fail to provide some of the delegated functions, may be referred to the DDD contract manager for contract review and possible withholding of payment reimbursement.

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. The QI data electronic system can be used to run reports of file review and other data to evaluate their agency's performance. Services coordination supervisors may also use the electronic system to perform additional agency specific file reviews.

Performance measure related data reports developed by the Performance Measure Subcommittee will be shared with services coordination agencies quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

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**
	☐ **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 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 HCBS Waivers Quality Improvement System is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a quality management system.

The Home and Community-Based Services (HCBS) Waiver Framework provides guidance as to the state's process for monitoring the safeguards and standards under the waiver. A set of key principles guide the QIS and are contained in the Nebraska's HCBS Quality Improvement System document. Nebraska's QIS 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.

Nebraska's HCBS Waiver quality oversight involves quality, service coordination/resource development, policy, and other staff in the Developmental Disabilities Division of the, Department of Health and Human Services (DHHS). (This is the single state Medicaid agency.)

Policy and service coordination/resource development staff design and monitor services, monitor expenditures and utilization, provide technical assistance; professional research, observation, and insight; contract management and monitoring; and analysis of data sources.

The quality staff provides systemic review of program outcomes and standards compliance to establish continuous improvement, which includes reviewing electronic participant data, conducting file reviews; and oversight of the various services coordination supervisory efforts. The National Core Indicators – Aging and Disabilities (NCI-AD) is used to assess the outcome of services provided to individuals.

Quality and service coordination staff are involved in discovery related to death review; complaints; incident reports; and data collection and analysis.

A DDD Quality Improvement Committee is composed of staff from service coordination, policy, and quality, as well as representation from services coordination agencies and DDD leadership. This committee meets at least quarterly to review recommendations from several subcommittees, create action plans in relation to these recommendations, and guide the division's quality management strategy and QI initiatives. The quality subcommittees include the Incident Management Committee, the Mortality Review Committee, and the Performance Measure Review Committee. The Performance Measures Review Committee reviews aggregate data for the TBI Waiver performance measures and makes recommendations for changes that may lead to systemic improvement in the quality of services, as well as recommendations related to remediation efforts. Relevant reports are provided to QI Committee members and division leadership, as well as other identified stakeholders.

Quality reports, which may or may not be related to performance measures, include: death review data, appeals data, supervisory file review data, central office file review data, local level complaint data, central office complaint data, incident data, adult protective service data, electronic participant data system reports, service expenditure data, and service authorization data. Of these reports, the following are compiled and analyzed by quality staff and shared with the QI Committee or one or more of the subcommittees quarterly or as needed: death review, file review, complaints to service coordination or DDD, critical incidents, adult/child protective services intakes, and electronic participant data system reports. These reports are shared with the services coordination agency continuously and on an on-going basis.

For those service coordination agencies who do not meet standards, a continuous improvement plan is required, with the DDD Waiver staff monitoring the plans to assure completion.

The State's waiver service delivery design incorporates two functions, services coordination and resource development. Services coordination staff assist the participant to determine their individual choices and needs, eligibility, and service planning. Resource development staff concentrate on issues of qualified providers, including their compliance with standards. Communications between the two functions is key and both provide continuous monitoring of service delivery.

Following discovery of needed improvement in any area, staff confer, plan, and involve the QI Committee and

division leadership. Lines of communication are fluid to allow information to flow between quality, service coordination, policy and other division staff to and from program and quality staff. Information also flows freely between the QI Committee and services coordination agencies and other contracted providers. Continuous Quality Improvement, that is statewide systemic program enhancement, occurs through any combination of the following remediation activities:

1. Training and meetings: These are offered or required for supervisors, services coordinators, and resource developers, as appropriate.
2. Policy or procedure development or implementation to add, revise, or clarify program expectations determined necessary for program improvement. This includes the identification, dissemination, and implementation of best practice concepts on a statewide basis
3. Informational materials including written guidance for staff or brochures directed toward participants or the public.
4. Remediation of individual problems: This is the responsibility of the services coordination/resource development agencies with DDD providing the oversight to ensure completion. Technical assistance is also provided to service delivery staff on a continuous ongoing basis to aid understanding of policies and procedures and to address individual situations.
5. Shared resolution: This is a formally-defined process, based on proactive partnership, to work with service delivery staff and agencies to resolve and improve instances which (1) reflect performance below expectations that cannot be remediated through technical assistance; (2) indicate a pattern of policy or procedure non-compliance which does not include a participant safety concern; or (3) are identified through formal discovery and determined not egregious as defined in the Quality Improvement Plan process.
6. Quality Improvement Plan: This is a formally-defined process, based on a performance oversight model, to resolve and improve performance when a discovery method has identified an apparent contract violation or immediate risk to participant health and safety. This remediation is appropriate for these egregious issues as well as when other remediation has been unsuccessful or determined ineffective.

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** Specify:	☐ **Other** Specify:

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.

The Division of Developmental Disabilities of the Nebraska Department of Health and Human Services 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 staff are responsible for coordinating the development, implementation and monitoring of any system design changes. The Quality Improvement Committee identifies the division's priorities for QI initiatives and provides oversight for the development, implementation, and monitoring of system changes. Data is aggregated and analyzed on an ongoing basis to determine if the identified system change is effective.

DDD staff review the QIS on an ongoing basis to adjust program outcomes, determine the need to modify data sources and to develop other methods to evaluate progress and services.

As described above in a.i. (System Improvements), the State has a Quality Improvement System in place that includes discovery leading to remediation. In turn, that leads to system improvement. This is an ongoing, circular system with components of discovery, remediation, improvement, design, and operations. DDD staff have a lead role in guiding this improvement along with input from services coordination agencies/offices and the QI Committee.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDD staff evaluate the effectiveness of the waiver Quality Improvement System on a continuous, ongoing basis. Nebraska QIS strategies stratify information for the Traumatic Brain Injury Waiver (NE.40199). Data for the TBI waiver is aggregated and analyzed separately from other Nebraska waivers. Identified state plan system issues would be relayed to staff responsible for services under the Medicaid State Plan.

The evaluation of the QIS involves assessing the effectiveness of the system in improving the quality of services as well as comparing the system to best practices. If efforts to improve the quality of services are not effective, additional analyses are conducted to identify weaknesses in the current QIS. These analyses aid in identifying potential changes to improve the efficacy of the overall system. In addition, the QI Committee provides an oversight of the effectiveness of the QIS and makes recommendations for improvement.

Just as the assumption is that services can always be improved, the same concept also holds with the QIS system. Efforts are continually being 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 quality improvement issues.

System improvements within the scope of current regulations can be implemented within six to nine months. System improvements dependent upon regulatory change are subject to the State timeline for regulation promulgation.

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).*

The majority of waiver payments are made through the state-mandated web-based case management systems. TBI Supported Residential Living payments are made through the Medicaid Management Information System (MMIS). Prior authorization of services is required for all waiver services. The Services Coordinator enters the prior authorization on state-mandated web-based case management system or MMIS. The state-mandated web-based case management system contains all Medicaid eligibility information. All claims are edited against Medicaid eligibility, prior authorization, and provider approval before payments, called warrants, are issued.

Financial Services within the DHHS Operations department tracks audit reports, operates the cost allocation plan, prepares and monitors budget projections for Division of Developmental Disabilities (DDD), prepares federal and state reports as required including the CMS-64 report.

a) The state-mandated web-based case management and MMIS systems establish the audit trail necessary for the Nebraska Auditor of Public Accounts (APA) to conduct the single state audit on an annual basis. The APA conduct audits based on federal audit guides where priorities are identified. Cases are pulled from random samples which may or may not be statically valid representative samples with a 95% confidence level and +/- 5% margin of error. Auditors request all documentation contained in case files to substantiate the state's process for prior authorization, provider approval, provision of services and claims processing. Auditors prepare a report of the findings identifying areas where corrective action is needed. DHHS prepares and follows corrective action plans.

All providers are required to retain financial and statistical records to support and document all claims. All financial records and documents relating to work performed or monies received are subject to audit by the State of Nebraska. Waiver providers are not required to secure an independent audit of their financial statements.

b) DDD quality staff review a representative sample of provider billings as part of the ongoing Quality Management system. Paid claims are reviewed against the prior authorization, documentation of service provision, and provider certification process, to ensure appropriate payment was made to the provider. Reviews may differ by service type. Tested claims are selected to create a statistically valid representative sample within each waiver year with a 95% confidence level and +/-5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html is used annually to validate the sample size.

c) The 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. Audits by the APA occur annually. The APA generally does not conduct audits for this program outside of those conducted under the provisions of the Single Audit Act.

d) The state implemented an Electronic Visit Verification System in January 2021. The following services are subject to EVV:
- TBI Personal Care
- TBI Respite Care
- TBI Companion
- Community Connections

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 that were coded in accordance with the reimbursement methodology specified in the approved waiver. Numerator: Number of paid claims that were coded in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Number of paid claims 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*** *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:*

Performance Measure:
Number and percent of paid claims which were paid in accordance with the reimbursement methodology specified in the approved waiver. Numerator = Number of

paid claims 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, 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*** *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***

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

Performance Measure:
Number and percent of paid claims that were coded and paid for rendered services.
Numerator = Number of paid claims that were coded and paid for rendered services;
Denominator = Number of paid claims 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*** *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 providers for whom rate changes were consistent with the approved rate methodology. Numerator = Number and percent of providers for whom rate changes were consistent with the approved rate methodology. Denominator = Number of providers 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*** *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.*

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 DDD quality Staff complete reviews of claim data to ensure continuous improvement. Besides remediation being accomplished by follow up of individual or systemic issues, the agency could be responsible for a shared resolution or quality improvement plan. Payment errors could be referred to Program Integrity for claim recovery processing.

Performance measure related data reports developed by the Performance Measure Subcommittee will be shared with services coordination agencies quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

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***	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
Specify:	
	☐ ***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 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).*

Effective October 1, 2023, the following services are being added to this waiver: Supported Employment-Individual, TBI Adult Day Health, TBI Personal Care, TBI Respite Care, Assistive Technology, Caregiver Training, Chore, Community Connections, Home Delivered Meals, Home Modifications, Non-Medical Transportation, Personal Emergency Response System (PERS), Supported Employment-Follow Along, TBI Companion, and Vehicle Modification.

This waiver employs a fixed rate method of rate determination for the following services: TBI Supported Residential Living Services, TBI Adult Day Health Services, TBI Respite Services, TBI Non-Medical Transportation and Care Giver Training. These fee-for-service rates are established by the state Medicaid agency. The Division of Medicaid and Long Term Care (MLTC) publishes the TBI Assisted Living (TBI Supported Residential Living service) and TBI Non-Medical Transportation fee schedules on an annual basis. These fee schedules can be found at https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx.

The reimbursement for Supported Employment Individual and Follow Along and Community Connections are based on Fee-For-Service model. In December 2016, DDD contracted with Optumas Consulting to develop a rate methodology process for fee-for-service rates for DDD's HCBS waivers and implemented in 2018. DDD built the proposed rates by estimating the total costs incurred by providers to deliver DD services. The models begin with an estimate of the cost of direct labor required to provide the specific service. The rate which accounts for the total cost of the service is determined by applying factors to this direct labor cost. All costs were categorized into the rate factors and care was taken to identify unallowable expenses, including room and board and fundraising expenses, and exclude these from consideration in the rate factors. The service rates do not differ geographically. Rates established in accordance with this methodology may be adjusted at the direction of the Nebraska State Legislature.

Initial rates for the TBI Supported Residential Living Services were determined through a public stakeholder process. Numerous meetings were held with provider association groups to determine the current formula which recognizes urban and rural variances. Resource development staff share with DDD staff information they have directly received from providers on adequacy of rates and rate setting methods.
For the TBI Supported Residential Living Service, variable rates are utilized to account for differences in costs for rural/urban and single/multiple occupancy. Standard Rates are for licensed and waiver certified facilities that did not receive a grant through the Nursing Facility Conversion Cash Fund. Health Care Trust Fund rates are for licensed and waiver certified assisted living facilities that did receive a Grant from the Nursing Facility Conversion Cash Fund. The Nursing Facility Conversion Cash Fund. Rates are adjusted when additional funding is appropriated by the Legislature.

Rates for Chore, Non-Medical Transportation, TBI Adult Day Health Services, TBI Supported Residential Living; TBI Companion, TBI Personal Care, and TBI Respite Care are based on a fee-for-service model in which provider rates are currently set on an individual provider basis through a negotiation process between the provider and the local resource developer. Rates are reviewed annually at the time the provider's annual agreement is scheduled to end. The provider may not charge the State more than private pay individuals are charged. Rate negotiating takes into account the level of participant service need, the skill level of the provider, and geographic location. Rates are established based on usual and customary rates that are not more than the provider would charge a private paying individual.

Providers in this waiver may be independent contractors so DHHS abides by minimum wage standards & FICA requirements.

Payment rates are discussed with participants at the time the service plan is being developed so they can make decisions on service utilization.
Home-delivered meal rates are a combination of fixed and negotiated rates, depending on provider type. Assistive Technology Supports and Home and Vehicle Modifications are based on the individual participant needs. The State does not have an annual maximum for these services. This allows flexibility for the participant's needs to be met if a modification is necessary to remain or return home.

Caregiver Training is paid on invoiced cost of provider training. The service is limited to $500 per waiver year based on a survey of similar services including those on MD.1466.R01.04 and PA.0354.R05.00 as well as stakeholder feedback.

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 that the cost neutrality requirement of the waiver is being met.

Rates are based on market analysis and input from the provider community. Rates are then increased, or decreased, at the direction of the Nebraska Legislature through the biennial budgeting 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 agency budget requests and the Governor's budget priorities. The budget recommendation comes as a bill which 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 state agencies and interested parties. Hearing notices are published in the Legislative Journal, listed by agency and bills referred to the committee. The notice of committee public hearing, when published in the legislative journal includes the date, time, location, and legislative bill number(s). Letters or written communication are accepted by committees during a bill's public hearing or persons wishing to send written information may send their correspondence to the office of the senator who chairs the committee. Agencies, interest groups and the general public are given the opportunity to comment regarding the preliminary recommendation of the committee, the agency request, the governor's recommendation. Comments are accepted about rates paid to Medicaid providers. Additional information regarding the public input process can be found in Main section 6-I.

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:*

The state currently has four different flow of billings for services provided on the Traumatic Brain Injury waiver:

1. Service claims processed through the state-mandated web-based case management system that are not subject to EVV:
The following services are processed by this flow of billings:
- Supported Employment – Individual
- TBI Adult Day Health Services
- Caregiver Training
- Home Delivered Meals
- Non-Medical Transportation
- Personal Emergency Response System (PERS)
- Supported Employment – Follow Along

Billings flow directly from providers to the state-mandated web-based case management system, the State's electronic claims payment system. Preprinted billing documents, generated by the state-mandated web-based case management system, are completed by the provider and submitted for claims processing following the delivery of services.

When a provider is approved, enrollment information is entered on the appropriate payment system. The provider information contains the rates the provider is approved to bill for and services they are approved to provide. The local Services Coordinator then enters individual participant services authorizations, which specifies the service code and rate for which the provider is authorized. Provider claims are reviewed at the local level and signed/approved before submission to data entry.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During 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 that is then sent to the state's accounting system, EnterpriseOne, then generates claims payment to the provider.

The program under which a claim is paid is stored on each individual 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 the EnterpriseOne, the state-mandated web-based case management 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 EnterpriseOne. Claims are processed on a daily basis.

2. Service claims processed through the state-mandated web-based case management system that are subject to EVV
The following services are processed by this flow of billings:
- TBI Personal Care
- TBI Respite Care
- Chore
- Community Connections
- TBI Companion

These services are billed electronically by providers in the state EVV system. EVV claims are processed by the state aggregator on a weekly basis. Claims approved by the EVV aggregator are sent to the state-mandated web-based case management system for payment processing.

3. Service claims processed through MMIS:
TBI Supported Residential Living Service claims are processed through the state MMIS.

4. Service claims processed directly through EnterpriseOne (formerly NIS):
Claims for Assistive Technology and Home and Vehicle Modifications are processed directly through EnterpriseOne. These services are authorized by the Nebraska Department of Education's Assistive Technology Partnership (ATP), in collaboration with DDD staff. Evaluation for these services and service authorizations are performed by ATP, with

monthly review by DDD staff. The authorizations and service delivery are documented in the ATP case management system. ATP sends monthly payment requests to Nebraska DHHS Finance for services rendered. Service providers are paid directly by DHHS through EnterpriseOne.

5. Claims processed through MMIS: Claims for the following services are processed through MMIS:
- Assisted Living (TBI Supported Residential Employment)

All providers, with the exception of those providing Assistive Technology and Home and Vehicle Modifications, are allowed to bill Medicaid directly. Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.

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) Most waiver service claims are processed through the state-mandated web-based case management system. The state-mandated web-based case management system is the state's claims payment system for the majority of services provided through this waiver. Services that are recorded through Electronic Visits Verification (EVV) are sent to the state-mandated web-based case management system for processing. TBI Supported Residential Living payments are processed through MMIS. Both of those systems require that eligible participants and qualified providers are loaded and specific service prior authorizations are entered prior to claims processing. When a claim is then received, the automated system matches it against the participant, the provider, the authorization's time frame, frequency, rate, code, etc. In addition, MMIS matches the state-mandated web-based case management system for participant eligibility and share of cost. Only if all elements (participant, provider, and authorization) are present will the claim be accepted for payment. Claims are paid when 1) the individual was eligible for Medicaid waiver payment on the date of service, 2) The service was included in the participant's approved service plan, and 3) The services were provided.

The following services are processed through the state-mandated web-based management system and are subject to EVV:
- TBI Personal Care
- TBI Respite Care
- Chore
- Community Connections
- TBI Companion

These services are billed electronically by providers in the state EVV system. EVV claims are processed by the state aggregator on a weekly basis. Claims approved by the EVV aggregator are sent to the state-mandated web-based case management system for payment processing.

Each claim is compared to a service authorization and reviewed for participant name, participant ID, authorization number, service code, service from date, service through date, frequency, total number of units, rate, customer obligation and provider ID. Both the participant and the provider must approve (sign) the billing before submitting the billing claim to the local agency/office to review and approve (sign) the claim.

A representative sample of post-payment claim reviews is completed by DDD quality staff as part of the file review process.

If an error is found in the pre-payment review process, the billing documents are returned to the provider to correct the errors.

If an error is found in a post-payment review, a finding is given and the claim must go through a remediation process. This process might include one or more of the following activities, depending on the error: provider training; claim adjustment; corrective action being taken against the provider; referral to program integrity unit; or services coordinator/resource developer training. When paid claims need to be adjusted in instances where a provider has been paid either too much, or not enough, a finance referral form detailing the error, and the corrective action needed, is submitted with all supporting documentation to DHHS Medicaid Financial Responsibility to take the necessary corrective action.

If fraud, waste or abuse are suspected a referral is made to the MLTC program integrity unit.

Assistive Technology and Home and Vehicle Modification claims are processed through the EnterpriseOne by DHHS Finance staff. Claims are coded by DHHS based on billings submitted by Assistive Technology Partnership contracted staff for eligible participants. Claims are paid when 1) the individual was eligible for Medicaid waiver payment on the date of service, 2) The service was included in the participant's approved service plan, and 3) The services were provided.

All inappropriate payments will be submitted with all supporting documentation to DHHS Medicaid Financial Responsibility to take the necessary corrective action and are removed from FFP.

b) Service authorizations are created and entered by local services coordinators based upon each individual participant's approved service plan.

c) All providers sign an agreement every five years stipulating that they maintain records and documentation in sufficient

detail to allow the State to verify units of service provided to individuals as certified on the state billing document. Each billing document must be signed by the provider or submitted through the Electronic Visit Verification (EVV), certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

When waiver services are delivered by an independent provider and are not subject to EVV, a service timesheet is submitted with each billing document and signed by the waiver participant or, if applicable, the family member/guardian. Both the timesheet and billing document are forwarded to local waiver staff who are responsible to review and verify the units of services billed by the provider. When these services are subject to EVV, the provider documents required billing data in the EVV system and sends this to Tellus, the state EVV data aggregator for processing.

Participants are provided the choice of providers and have employer authority with hire and fire rights. The participant makes their choice of providers through the person-centered plan process. Services Coordinators are to make monthly contact with participants to evaluate the effectiveness of the person-centered plan and the quality of the services provided, and ascertain if both the formal and informal supports being provided continue to meet the participant's needs, and the participant's satisfaction with the services.

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:

All providers are paid directly by the state Medicaid agency.

(a-d) Services which are not paid through an approved MMIS system are Supported Employment – Individual; TBI Adult Day Health Services; TBI Personal Care; TBI Respite Care; Assistive Technology; Caregiver Training; Chore; Community Connections; Home Delivered Meals; Home Modifications; Non-Medical Transportation Personal Emergency Response System (PERS); Supported Employment – Follow Along; TBI Companion; and Vehicle Modifications.

The Department has a state-mandated web-based case management system, which is an integrated computer system designed to provide comprehensive information about participants served. It includes participant, provider, and service authorization databases in addition to payment history and billing status information. The case management system keeps track of all providers who have, or have had, provider agreements with the Department to deliver services to eligible participants. This information includes rates and the specific time periods the rates were applicable. The Services Coordinator enters individual participant services authorizations which specifies the service code and rate the provider is authorized. Provider claims which are not required to use EVV are reviewed by the Services Coordinator office before submission to DHHS for processing. The state-mandated web-based case management system audits claims against services authorized and providers established rates. Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis after entered or received in the case management system. EVV claims are sent to the state-mandated web-based case management system on a weekly basis. Payments for waiver services are made through a the case management system, which is not an approved MMIS. The following functions are incorporated into the state-mandated web-based case management system with the exception of the actual issuance of payment which is via the NIS application and is explained below.

• After a participant is determined to be eligible for Medicaid on the state-mandated web-based case management system, a separate eligibility process is completed for eligibility for waiver services. Once waiver eligibility is established, the Services Coordinator notifies the local DHHS office to be entered into the case management system. The participant, the waiver program and the waiver services are then linked to a provider approved to provide the service for the program via a Service Authorization.

The Service Authorization (a copy of which is sent to both the participant and the provider) specifies the participant is authorized to receive the service, the provider authorized to provide the service, the program under which the service is to be provided, the specific service to be provided, the dates for which the authorization is valid, the rate, rate frequency and the maximum number of units for which the provider is authorized to bill. The completed Service Authorization forms the basis for future claims to be submitted.

A claim must include: The provider that provided the service, the participant who received the service, the Service Authorization identification number, the service type, the dates of service, the frequency and rate authorized for the service, the actual number of units provided for the stated time period and the total amount claimed. When a claim is submitted and entered into the case management system, the system validates all submitted information against the Service Authorization on file. Claims that fail to pass validation are suspended from processing for review by local staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. Claims that pass this validation are approved for payment.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During 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, the Nebraska Information System (NIS).
• All payments are processed as described above by the Nebraska DHHS through its state-mandated web-based case management system sub-system and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.
• The payment processes ensure a proper audit trail is maintained because the waiver service payment is linked on a per participant basis to the provider. Each service is prior authorized and the prior authorization number which links the provider to the participant and the service is present on the claim. If the prior authorization number is not on the claim, the claim will deny. As described above, the program under which a claim is paid is stored on each

individual 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 the Nebraska Information System (NIS). The case management 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 Nebraska Information System (NIS). Claims are processed on a daily basis.

○ ***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:

☐ ***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:

In Nebraska, public providers are regional Area Agencies on Aging, established by interlocal agreements. Some Area Agencies on Aging furnish home delivered meals, and/or personal emergency response systems. If the Area Agencies on Aging provides Services Coordination for that participant, they will not provide services to the participant to avoid a conflict of interest. Options are presented to the participant to either change Service Coordination Agency or chose a different services provider. Several assisted living facilities are public 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:*

The state utilizes the Federal SSI standard as the cost of room and board. The state deducts the SSI standard from the residential rate. Participants who reside in assisted living facilities pay their room and board directly to the provider. Room and board cost is excluded from the FFP. Room and board costs are payment for housing, food, utilities, or items of comfort or convenience, facility maintenance, upkeep or improvement. DHHS informs the participant and TBI Supported Residential Living provider of the Room and Board and any share of cost the participant is responsible to pay.

The billing document used by assisted living facilities captures the share of cost amount to be paid by the participant and this is deducted from the payment made to the provider. Share of Cost amounts are not included in Federal Financial Participation requests. The claims payment system has an edit for the share of cost so that it is deducted from payments made to providers, thus ensuring that the participant's share of cost is not included in expenditures reported to CMS.

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: Nursing Facility

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	33893.71	3255.79	37149.50	47378.69	1543.00	48921.69	11772.19
2	34567.60	3320.90	37888.50	48326.27	1573.86	49900.13	12011.63
3	35254.52	3387.32	38641.84	49292.79	1605.33	50898.12	12256.28
4	35953.19	3455.07	39408.26	50278.65	1637.44	51916.09	12507.83
5	36670.88	3524.17	40195.05	51284.22	1670.19	52954.41	12759.36

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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:
		Nursing Facility
Year 1	230	230
Year 2	230	230
Year 3	230	230
Year 4	230	230
Year 5	230	230

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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.*

Estimated average length of stay (ALOS) of 290 days on the waiver is based on the mean average number of days used over the past 3 years and noted on the 372 reports in waiver years 1-3. The date ranges for the calculation of the average length of stay are submitted 372 reports for NE.0187.R07.03 waiver year 3 (08/01/2018-07/31/2019), waiver year 4 (08/01/2019-07/31/2020), and waiver year 5 (08/01/2020-07/31/2021).

The average length of stay has been left to remain consistent over the 5 years. Once the state has data of the TBI population that consume the services, the ALOS for years 3-5 will be updated in a subsequent amendment if needed.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 estimates for new services are based actual paid claims from AD Waiver (NE.0187.R07.03) and DD Adult Day Waiver (NE.016.04.00) where applicable (Supported Employment, Supported Employment follow along, Community connections) for waiver year 4 (3/1/2020-2/28/2021) of DD Adult Day 372 report. The time frame used for AD waiver was waiver year 5 (08/01/2020-07/31/2021) of 372 report submitted. A 2% cost increase was factored in for increase of costs. The 2% has been the historical increase amount that the legislatures appropriates to keep up with the cost of living.

A 2% price increase is assumed for each year. The CPI between 2017 and 2020 averaged 2% according to the Bureau of Labor Statistics. Excluding American Rescue Plan Act funding, the Nebraska Legislature has appropriated an additional 2% in each budget from State Fiscal Year 2018 to State Fiscal Year 2023. 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.

The following are the added services with this renewal:
Assistive Technology - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Caregiver Training - Modelled after MD.1466.R01.04 Appendix J– Estimates were evaluated internally
Chore - Estimates based on NE.0187.R07.03 waiver year 1 (08/01/2021-07/31/2022)
Community Connections - Estimates based on NE.0394.R03.05 waiver year 4 (03/01/2020-02/28/2021)
Home Delivered Meals - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Home Modifications - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Non-Medical Transportation - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Personal Emergency Response System (PERS) on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Supported Employment - Follow Along - Estimates based on NE.0394.R03.05 waiver year 4 (03/01/2020-02/28/2021)
Supported Employment - Individual - Estimates based on NE.0394.R03.05 waiver year 4 (03/01/2020-02/28/2021)
TBI Adult Day Health Services - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
TBI Supported Residential Living - Estimates based on NE.40199.R04.10 waiver year 3 (10/01/2020-09/30/2021)
TBI Companion - Estimates based on NE.0187.R07.03 waiver year 1 (08/01/2021-07/31/2022)
TBI Personal Care - Estimates based on NE.0187.R07.03 waiver year 1 (08/01/2021-07/31/2022)
TBI Respite Care - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)
Vehicle Modifications - Estimates based on NE.0187.R07.03 waiver year 5 (08/01/2020-07/31/2021)

The 2% rate increase estimate is applied to the following services annually for WY 1-5: Chore; Community Connections; Home Delivered Meals; Non-Medical Transportation; Personal Emergency Response System (PERS); Supported Employment – Follow Along; Supported Employment – Individual; TBI Adult Day Health Services; TBI Supported Residential Living; TBI Companion; TBI Personal Care; and TBI Respite Care.

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 Medicaid expenditures for individuals on NE.40199.R04.10 waiver year 3 (10/01/2020-09/30/2021). The average cost for acute care for the reported year 3 was $3,068. Price increases of 2.0% were included for each waiver year.

A 2% price increase is assumed for each year. The CPI between 2017 and 2020 averaged 2% according to the Bureau of Labor Statistics. Excluding American Rescue Plan Act funding, the Nebraska Legislature has appropriated an additional 2% in each budget from State Fiscal Year 2018 to State Fiscal Year 2023.

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 nursing facility recipient was based on actual expenditures and inflated each year of the renewal by a growth factor of two percent. NE.40199.R04.10 waiver year 3 (10/01/2020-09/30/2021) $44,646 was used as the baseline and the subsequent years were adjusted by 2% increase.

A 2% price increase is assumed for each year. The CPI between 2017 and 2020 averaged 2% according to the Bureau of Labor Statistics. Excluding American Rescue Plan Act funding, the Nebraska Legislature has appropriated an additional 2% in each budget from State Fiscal Year 2018 to State Fiscal Year 2023.

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' was developed by using per-recipient acute care costs for Nursing Facility residents from NE.40199.R04.10 waiver year 3 (10/01/2020-09/30/2021) as our baseline. A 2% increase was added to the baseline number of $1,454 resulting in a WY 1 estimate of $1,543.

A 2% price increase is assumed for each year. The CPI between 2017 and 2020 averaged 2% according to the Bureau of Labor Statistics. Excluding American Rescue Plan Act funding, the Nebraska Legislature has appropriated an additional 2% in each budget from State Fiscal Year 2018 to State Fiscal Year 2023.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

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	
Supported Employment - Individual	
TBI Adult Day Health Services	
TBI Personal Care	
TBI Respite Care	
Assistive Technology	
Caregiver Training	
Chore	
Community Connections	
Home Delivered Meals	
Home Modifications	
Non-Medical Transportation	
Personal Emergency Response System (PERS)	
Supported Employment - Follow Along	
TBI Companion	
TBI Supported Residential Living	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

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*
Supported Employment - Individual Total:						***179256.00***
Supported Employment - Individual	*Hour*	*42*	*97.00*	*44.00*	***179256.00***	
TBI Adult Day Health Services Total:						***17430.00***
TBI Adult Day Health Services	*Day*	*3*	*83.00*	*70.00*	***17430.00***	
TBI Personal Care Total:						***3920478.00***
TBI Personal Care - Agency	*Hour*	*99*	*1223.00*	*28.00*	***3390156.00***	
TBI Personal Care - Independent	*Hour*	*26*	*1569.00*	*13.00*	***530322.00***	
TBI Respite Care Total:						***95272.00***
TBI Respite - Agency	*Hour*	*21*	*104.00*	*35.00*	***76440.00***	
TBI Respite Care - Independent	*Hour*	*16*	*107.00*	*11.00*	***18832.00***	
Assistive Technology Total:						***10000.00***
Assistive Technology	*Occurrence*	*4*	*1.00*	*2500.00*	***10000.00***	
Caregiver Training Total:						***12500.00***
Caregiver Training	*Occurrence*	*25*	*1.00*	*500.00*	***12500.00***	
Chore Total:						***1078297.50***
Chore - Agency	*Hour*	*75*	*472.00*	*25.00*	***885000.00***	
Chore - Independent	*Hour*	*25*	*639.00*	*12.10*	***193297.50***	
Community Connections Total:						***1318100.00***
Community Connections	*Hour*	*175*	*269.00*	*28.00*	***1318100.00***	
Home Delivered Meals Total:						***44946.00***
Home Delivered Meals	*Occurrence*	*33*	*227.00*	*6.00*	***44946.00***	
Home Modifications Total:						***13430.00***
Home Modifications	*Occurrence*	*2*	*1.00*	*6715.00*	***13430.00***	
Non-Medical						***2847.68***

GRAND TOTAL:	***7795554.16***
Total Estimated Unduplicated Participants:	***230***
Factor D (Divide total by number of participants):	***33893.71***
Average Length of Stay on the Waiver:	*290*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						
Non-Medical Transportation By Hour	Hour	1	39.00	16.34	**637.26**	
Non-Medical Transportation By Mile	Mile	1	1022.00	0.61	**623.42**	
Non-Medical Transportation By One Way Trip	One Way Trip	3	23.00	23.00	**1587.00**	
Personal Emergency Response System (PERS) Total:						**17661.98**
Personal Emergency Response System - Monthly	Month	41	12.00	32.47	**15975.24**	
Personal Emergency Response System - Installation - Occurrence	Occurrence	41	1.00	41.14	**1686.74**	
Supported Employment - Follow Along Total:						**750.00**
Supported Employment Follow Along - Agency	Hour	5	3.00	50.00	**750.00**	
TBI Companion Total:						**168376.00**
TBI Companion - Agency	Hour	28	131.00	26.00	**95368.00**	
TBI Companion - Independent	Hour	16	351.00	13.00	**73008.00**	
TBI Supported Residential Living Total:						**902887.00**
TBI Supported Residential Living	Day	25	346.00	104.38	**902887.00**	
Vehicle Modifications Total:						**13322.00**
Vehicle Modifications	Occurrence	2	1.00	6661.00	**13322.00**	

GRAND TOTAL:	**7795554.16**
Total Estimated Unduplicated Participants:	**230**
Factor D (Divide total by number of participants):	**33893.71**
Average Length of Stay on the Waiver:	290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

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
Supported Employment - Individual Total:						**182922.60**
Supported Employment - Individual	Hour	42	97.00	44.90	**182922.60**	
TBI Adult Day Health Services Total:						**17778.60**
TBI Adult Day Health Services	Day	3	83.00	71.40	**17778.60**	
TBI Personal Care Total:						**3998887.56**
TBI Personal Care - Agency	Hour	99	1223.00	28.56	**3457959.12**	
TBI Personal Care - Independent	Hour	26	1569.00	13.26	**540928.44**	
TBI Respite Care Total:						**97177.44**
TBI Respite - Agency	Hour	21	104.00	35.70	**77968.80**	
TBI Respite Care - Independent	Hour	16	107.00	11.22	**19208.64**	
Assistive Technology Total:						**10000.00**
Assistive Technology	Occurrence	4	1.00	2500.00	**10000.00**	
Caregiver Training Total:						**12500.00**
Caregiver Training	Occurrence	25	1.00	500.00	**12500.00**	
Chore Total:						**1099831.50**
Chore - Agency	Hour	75	472.00	25.50	**902700.00**	
Chore - Independent	Hour	25	639.00	12.34	**197131.50**	
Community Connections Total:						**1344462.00**
Community Connections	Hour	175	269.00	28.56	**1344462.00**	
Home Delivered Meals Total:						**45844.92**
Home Delivered Meals	Occurrence	33	227.00	6.12	**45844.92**	
Home Modifications Total:						**13430.00**
Home Modifications	Occurrence	2	1.00	6715.00	**13430.00**	
Non-Medical Transportation Total:						**2902.51**
Non-Medical					**650.13**	

GRAND TOTAL:	**7950548.55**
Total Estimated Unduplicated Participants:	**230**
Factor D (Divide total by number of participants):	**34567.60**
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation By Hour	Hour	1	39.00	16.67		
Non-Medical Transportation By Mile	Mile	1	1022.00	0.62	633.64	
Non-Medical Transportation By One Way Trip	One Way Trip	3	23.00	23.46	1618.74	
Personal Emergency Response System (PERS) Total:						18015.40
Personal Emergency Response System - Monthly	Month	41	12.00	33.12	16295.04	
Personal Emergency Response System - Installation - Occurrence	Occurrence	41	1.00	41.96	1720.36	
Supported Employment - Follow Along Total:						765.00
Supported Employment Follow Along - Agency	Hour	5	3.00	51.00	765.00	
TBI Companion Total:						171743.52
TBI Companion - Agency	Hour	28	131.00	26.52	97275.36	
TBI Companion - Independent	Hour	16	351.00	13.26	74468.16	
TBI Supported Residential Living Total:						920965.50
TBI Supported Residential Living	Day	25	346.00	106.47	920965.50	
Vehicle Modifications Total:						13322.00
Vehicle Modifications	Occurrence	2	1.00	6661.00	13322.00	

GRAND TOTAL:	7950548.55
Total Estimated Unduplicated Participants:	230
Factor D (Divide total by number of participants):	34567.60
Average Length of Stay on the Waiver:	290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

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
Supported Employment - Individual Total:						**186507.72**
Supported Employment - Individual	Hour	42	97.00	45.78	**186507.72**	
TBI Adult Day Health Services Total:						**18134.67**
TBI Adult Day Health Services	Day	3	83.00	72.83	**18134.67**	
TBI Personal Care Total:						**4078915.83**
TBI Personal Care - Agency	Hour	99	1223.00	29.13	**3526973.01**	
TBI Personal Care - Independent	Hour	26	1569.00	13.53	**551942.82**	
TBI Respite Care Total:						**99104.72**
TBI Respite - Agency	Hour	21	104.00	36.41	**79519.44**	
TBI Respite Care - Independent	Hour	16	107.00	11.44	**19585.28**	
Assistive Technology Total:						**10000.00**
Assistive Technology	Occurrence	4	1.00	2500.00	**10000.00**	
Caregiver Training Total:						**12500.00**
Caregiver Training	Occurrence	25	1.00	500.00	**12500.00**	
Chore Total:						**1121879.25**
Chore - Agency	Hour	75	472.00	26.01	**920754.00**	
Chore - Independent	Hour	25	639.00	12.59	**201125.25**	
Community Connections Total:						**1371294.75**
Community Connections	Hour	175	269.00	29.13	**1371294.75**	
Home Delivered Meals Total:						**46743.84**
Home Delivered Meals	Occurrence	33	227.00	6.24	**46743.84**	
Home Modifications Total:						**13430.00**
Home Modifications	Occurrence	2	1.00	6715.00	**13430.00**	
Non-Medical Transportation Total:						**2958.03**
Non-Medical					**663.00**	

GRAND TOTAL:	**8108539.55**
Total Estimated Unduplicated Participants:	**230**
Factor D (Divide total by number of participants):	**35254.52**
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation By Hour	Hour	1	39.00	17.00		
Non-Medical Transportation By Mile	Mile	1	1022.00	0.63	643.86	
Non-Medical Transportation By One Way Trip	One Way Trip	3	23.00	23.93	1651.17	
Personal Emergency Response System (PERS) Total:						18374.56
Personal Emergency Response System - Monthly	Month	41	12.00	33.78	16619.76	
Personal Emergency Response System - Installation - Occurrence	Occurrence	41	1.00	42.80	1754.80	
Supported Employment - Follow Along Total:						780.30
Supported Employment Follow Along - Agency	Hour	5	3.00	52.02	780.30	
TBI Companion Total:						175203.88
TBI Companion - Agency	Hour	28	131.00	27.05	99219.40	
TBI Companion - Independent	Hour	16	351.00	13.53	75984.48	
TBI Supported Residential Living Total:						939390.00
TBI Supported Residential Living	Day	25	346.00	108.60	939390.00	
Vehicle Modifications Total:						13322.00
Vehicle Modifications	Occurrence	2	1.00	6661.00	13322.00	

GRAND TOTAL:	8108539.55
Total Estimated Unduplicated Participants:	230
Factor D (Divide total by number of participants):	35254.52
Average Length of Stay on the Waiver:	290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

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 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual Total:						**190215.06**
Supported Employment - Individual	Hour	42	97.00	46.69	**190215.06**	
TBI Adult Day Health Services Total:						**18495.72**
TBI Adult Day Health Services	Day	3	83.00	74.28	**18495.72**	
TBI Personal Care Total:						**4160154.87**
TBI Personal Care - Agency	Hour	99	1223.00	29.71	**3597197.67**	
TBI Personal Care - Independent	Hour	26	1569.00	13.80	**562957.20**	
TBI Respite Care Total:						**101092.80**
TBI Respite - Agency	Hour	21	104.00	37.14	**81113.76**	
TBI Respite Care - Independent	Hour	16	107.00	11.67	**19979.04**	
Assistive Technology Total:						**10000.00**
Assistive Technology	Occurrence	4	1.00	2500.00	**10000.00**	
Caregiver Training Total:						**12500.00**
Caregiver Training	Occurrence	25	1.00	500.00	**12500.00**	
Chore Total:						**1144281.00**
Chore - Agency	Hour	75	472.00	26.53	**939162.00**	
Chore - Independent	Hour	25	639.00	12.84	**205119.00**	
Community Connections Total:						**1398598.25**
Community Connections	Hour	175	269.00	29.71	**1398598.25**	
Home Delivered Meals Total:						**47717.67**
Home Delivered Meals	Occurrence	33	227.00	6.37	**47717.67**	
Home Modifications Total:						**13430.00**
Home Modifications	Occurrence	2	1.00	6715.00	**13430.00**	
Non-Medical Transportation Total:						**3024.85**
Non-Medical					**676.26**	

GRAND TOTAL:	**8269233.92**
Total Estimated Unduplicated Participants:	**230**
Factor D (Divide total by number of participants):	**35953.19**
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation By Hour	Hour	1	39.00	17.34		
Non-Medical Transportation By Mile	Mile	1	1022.00	0.65	664.30	
Non-Medical Transportation By One Way Trip	One Way Trip	3	23.00	24.41	1684.29	
Personal Emergency Response System (PERS) Total:						18744.38
Personal Emergency Response System - Monthly	Month	41	12.00	34.46	16954.32	
Personal Emergency Response System - Installation - Occurrence	Occurrence	41	1.00	43.66	1790.06	
Supported Employment - Follow Along Total:						795.90
Supported Employment Follow Along - Agency	Hour	5	3.00	53.06	795.90	
TBI Companion Total:						178700.92
TBI Companion - Agency	Hour	28	131.00	27.59	101200.12	
TBI Companion - Independent	Hour	16	351.00	13.80	77500.80	
TBI Supported Residential Living Total:						958160.50
TBI Supported Residential Living	Day	25	346.00	110.77	958160.50	
Vehicle Modifications Total:						13322.00
Vehicle Modifications	Occurrence	2	1.00	6661.00	13322.00	

GRAND TOTAL:	8269233.92
Total Estimated Unduplicated Participants:	230
Factor D (Divide total by number of participants):	35953.19
Average Length of Stay on the Waiver:	290

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

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 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual Total:						**194044.62**
Supported Employment - Individual	Hour	42	97.00	47.63	**194044.62**	
TBI Adult Day Health Services Total:						**18866.73**
TBI Adult Day Health Services	Day	3	83.00	75.77	**18866.73**	
TBI Personal Care Total:						**4243815.45**
TBI Personal Care - Agency	Hour	99	1223.00	30.31	**3669843.87**	
TBI Personal Care - Independent	Hour	26	1569.00	14.07	**573971.58**	
TBI Respite Care Total:						**103141.68**
TBI Respite - Agency	Hour	21	104.00	37.89	**82751.76**	
TBI Respite Care - Independent	Hour	16	107.00	11.91	**20389.92**	
Assistive Technology Total:						**10000.00**
Assistive Technology	Occurrence	4	1.00	2500.00	**10000.00**	
Caregiver Training Total:						**12500.00**
Caregiver Training	Occurrence	25	1.00	500.00	**12500.00**	
Chore Total:						**1167196.50**
Chore - Agency	Hour	75	472.00	27.06	**957924.00**	
Chore - Independent	Hour	25	639.00	13.10	**209272.50**	
Community Connections Total:						**1426843.25**
Community Connections	Hour	175	269.00	30.31	**1426843.25**	
Home Delivered Meals Total:						**48616.59**
Home Delivered Meals	Occurrence	33	227.00	6.49	**48616.59**	
Home Modifications Total:						**13430.00**
Home Modifications	Occurrence	2	1.00	6715.00	**13430.00**	
Non-Medical Transportation Total:						**3082.53**
Non-Medical					**689.91**	

GRAND TOTAL:	**8434302.32**
Total Estimated Unduplicated Participants:	**230**
Factor D (Divide total by number of participants):	**36670.88**
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation By Hour	Hour	1	39.00	17.69		
Non-Medical Transportation By Mile	Mile	1	1022.00	0.66	674.52	
Non-Medical Transportation By One Way Trip	One Way Trip	3	23.00	24.90	1718.10	
Personal Emergency Response System (PERS) Total:						19119.53
Personal Emergency Response System - Monthly	Month	41	12.00	35.15	17293.80	
Personal Emergency Response System - Installation - Occurrence	Occurrence	41	1.00	44.53	1825.73	
Supported Employment - Follow Along Total:						811.80
Supported Employment Follow Along - Agency	Hour	5	3.00	54.12	811.80	
TBI Companion Total:						182234.64
TBI Companion - Agency	Hour	28	131.00	28.14	103217.52	
TBI Companion - Independent	Hour	16	351.00	14.07	79017.12	
TBI Supported Residential Living Total:						977277.00
TBI Supported Residential Living	Day	25	346.00	112.98	977277.00	
Vehicle Modifications Total:						13322.00
Vehicle Modifications	Occurrence	2	1.00	6661.00	13322.00	

GRAND TOTAL:	8434302.32
Total Estimated Unduplicated Participants:	230
Factor D (Divide total by number of participants):	36670.88
Average Length of Stay on the Waiver:	290