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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
HCBS Waiver for Aged and Adults and Children with Disabilities

C. Waiver Number:NE.0187
Original Base Waiver Number: NE.0187.

D. Amendment Number:

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

10/01/20

Approved Effective Date of Waiver being Amended: 08/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to comply with CMS's corrective action plan.
1. Remove Nutrition as a service: The HCBS Waiver for Aged and Adults and Children with Disabilities currently provides Nutrition service. This service is now available under the Medicaid State Plan and will be removed from the waiver.
2. Re-locate and update QI Performance Measures related to non-licensed/certified providers: Through technical assistance with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) it was determined that the providers that were currently being counted as non-licensed/certified providers should be counted as non-licensed/non-certified. This update is comprised of moving three performances measures currently located under Sub-Assurance a.: 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 to Sub Assurance b.: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
3. Add the Medicaid expansion group as individuals who can be eligible for the waiver: The new Medicaid eligibility group covered by Medicaid expansion, referred to as Heritage Health Adult, will be listed as a group that will qualify for the waiver provided they meet all other eligibility criteria for the waiver. The go live date for Medicaid expansion is set for 10/1/2020.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following

component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	B-3
☒ **Appendix C Participant Services**	C-1/C-3;C-2 a&b
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I Financial Accountability**	
☐ **Appendix J Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☒ **Modify Medicaid eligibility**

☒ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Appendix B – Include the Medicaid eligibility group covered by Medicaid expansion described in 42 CFR 435.119
Appendix C – Remove Nutrition as a service, now available under the State Plan
Appendix C – Update non-licensed/Certified providers to non-licensed/non-certified in sub assurances a & b.

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*):

HCBS Waiver for Aged and Adults and Children with Disabilities

C. Type of Request: amendment

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.0187
Draft ID: NE.018.06.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 08/01/16
Approved Effective Date of Waiver being Amended: 08/01/16

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:

N/A

○ **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:

- [x] **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.

The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long Term Care, operates the Home and Community-Based Services Waiver for Aged and Adults and Children with Disabilities. The Administrator of the HCBS unit reports to the Director of the Division of Medicaid and Long Term Care.

The Division of Medicaid and Long Term Care contracts with community partners to provide services coordination (case management). These activities include conducting waiver Level of Care evaluation, developing the Plan of Services and Supports, completing service authorization, approving claims, and monitoring services delivery.

DHHS contracts for provision of services coordination with 1) Area Agencies on Aging for the aged population; 2)Independent Living Centers for adults with disabilities; and 3) Early Development Network agencies for infants and toddlers. DHHS local office staff provide services coordination for children with disabilities age 3 to 17 years.

The Aged and Disabled (A&D) Waiver was established to provide aged persons and adults and children with disabilities options related to needed services and community supports. The A&D Waiver is based on a family-centered, client-directed philosophy with an emphasis on the use of informal and natural supports in the community. The majority of services are provided by independent contractors in order to allow services delivery in the rural and frontier areas of our state. State requirements are developed for every waiver service and local resource development staff certify that providers meet waiver requirements on an annual basis. Resource development staff and services coordination staff monitor services delivery.

The goal of this waiver is to rebalance the long-term care system, and thus Medicaid costs, in the State of Nebraska by offering a community alternative to institutional services for persons who meet the nursing facility level of care. This will allow clients to remain at home and prevent institutionalization. By the last year of the waiver period, Nebraska plans to meet its objective of serving up to 6500 Nebraskans who are aged or have physical disabilities with community based services, rather than nursing facility services.

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:

Amendment effective 10/1/2020: The Waiver Amendment was sent for Tribal Notice on April 6, 2020. Notice of the public comment period was shared published electronically on Nebraska’s DHHS website May 8, 2020 and posted in the Omaha World Herald May 12, 2020. The public comment period was from May 12, 2020 to June 11, 2020 including two Webinar meetings with a toll free number to call in.

Summary of public comments will follow public comment period.
Public comments can be found on the following website: http://dhhs.ne.gov/Pages/Medicaid-HCBS-Public-Comments.aspx

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: Brunssen

First Name: Jeremy

Title: Interim Director

Agency: DHHS Medicaid and Long - Term Care

Address: P.O. Box 95026

Address 2:

City: Lincoln

State: **Nebraska**

Zip: 68509

Phone: (402) 471-4535 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: DHHS.MedicaidSPA@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: N/A

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nebraska**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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 amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

To ensure adequate character space for performance measures, the symbol "#" will be used for the word "number" and the symbol "%" will be used for the word "percentage" for those performance measures that exceed character limits.

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:

Division of Medicaid and Long Term Care

(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.

(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:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the

State Medicaid agency. Thus this section does not need to be completed.

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.:*

Area Agencies on Aging, Independent Living Centers, and Early Development Network agencies perform all of the following operational and administrative functions, except where noted:
Disseminate information concerning the waiver to potential enrollees
Assist individuals in waiver enrollment
Conduct level of care evaluation activities
Develop Plan of Services and Supports
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 (Early Development Network does not complete this function. Area Agencies on Aging, Independent Living Centers complete provider service referrals in the provider enrollment brokerage system.)
Conduct training and technical assistance concerning waiver requirements
Perform supervisory oversight and training of local waiver staff
Monitor and approve claims (Early Development Network is in the process of assuming this function)
Monitor service provision
Conduct on-going case management
Assess and re-assess clients needs, strengths, and priorities
Complete quality assurance reviews
Investigate, resolve and report incidents and complaints

Provider Enrollment Broker:
Execute the Medicaid Provider Agreement including all tasks related to execution of the agreement. The provider enrollment broker does not complete wage negotiation with the provider.

Early Development Network(EDN)agencies do not execute the Medicaid Provider Agreement, as this function is completed by staff who are employees of the Department of Health and Human Services (DHHS). DHHS staff conduct this function for providers, rather than it being done by EDN staff.

Assigned EDN agencies monitor and approve claims. In some locations DHHS staff conduct this activity to assure appropriate claims payment occurs.

○ **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 Medicaid and Long Term Care is responsible 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 clients to identify risks, trends, and needed actions.
4) Conduct participant/family experience surveys or applicable surveys for satisfaction and outcome needs every 3 years or increased at the discretion of the department. The State has begun the process to implement the use of National Core Indicators (NCI). Use of the participant/family experience surveys will be discontinued upon implementation of the NCI. It is the State's intent to implement the NCI to collect data for the year June 1, 2017 through May 31, 2018, making its first report available in October of 2018. Currently the State is operating under administrative expenditure restraints and implementation is dependent upon budget availability.
5) Continuous and on-going monitoring of service expenditures and utilization.
6) Continuous and on-going monitoring of participant enrollment.
7) Continuous and on-going local level supervisory and HCBS unit reviews of client and provider files, remediation and analysis.
8) Continuous and on-going local level supervisory and HCBS unit review of level of care, plan of services and supports, health and welfare, choice, financial oversight, qualified providers; remediation and data analysis.
9) Annually present program data aggregation and analysis to the HCBS Waivers Quality Council 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 assigned quality assurance reviews completed quarterly by the contracted agencies. Numerator = number of quarterly quality assurance reviews completed by contracted agencies; Denominator = number of quarterly quality assurance reviews assigned to contracted agencies.

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

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 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**
	☐ **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.

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

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 contracted Local Level Services Coordination Agencies are responsible to remediate all identified individual problems identified through its discovery processes in an appropriate and timely manner (45 days). Local Level discovery processes include: inputting data entry; conducting Local Level supervisory file reviews; reporting Local Level incidents; reporting Local Level complaints; and reporting death reviews.

As part of their discovery processes, all HCBS Waivers' supervisors are required to conduct a review of services coordination/resource development files on an on-going basis as assigned by the HCBS Waiver Unit Staff. These reviews ensure that all delegated waiver activities are being applied correctly. The review responses are documented in an electronic data system. Indicators that do not meet standards require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from date of review and be recorded in the "Remediation/Supervisory Action" Section of the electronic data system. The HCBS Waiver Unit monitors statewide reviews to ensure reviews and remediation activities are completed as assigned.

HCBS Waiver Unit 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 created jointly between the Local Level Supervisor and HCBS Waiver Services Unit staff detailing corrections which must be made. Local level supervisors are responsible for reporting remediation activities to the assigned HCBS Waiver Services Unit staff. Assigned HCBS Waiver Unit staff are responsible for documenting corrections in an electronic data system.

Shared Resolution is a formally-defined process, based on proactive partnership, to work with local 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 client 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 local level supervisors and documented by HCBS Waiver Unit staff. The plan details how resolution and results will be monitored and measured. HCBS Waiver Unit staff are responsible for verifying corrections have been made.

The Quality Improvement Plan 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 client health and safety. 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 local level supervisory staff using the DHHS Quality Improvement Plan template detailing specific, measureable steps, persons responsible, and start and ending dates. The Quality Improvement Plan also details supportive documentation on final follow up. HCBS Waiver Unit staff approves this plan before it is implemented and monitors its progress through completion.

Agencies that do not successfully complete their Quality Improvement Plan process or fail to provide delegated functions, may be referred to the HCBS Waiver Unit contract manager for contract review and possible payment reimbursement.

In addition to individual remediation, practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level 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**	65		☒
	☒	**Disabled (Physical)**	0	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

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:

N/A

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:

This waiver does not actually have a maximum age limitation, but the subgroup of "aged" begins at age 65. Because of the web based system (CONNECT), the physical disabled subgroup has a maximum age of 64 years. Staff in the Local Level Services Coordination offices that serve adults utilize the CONNECT system to run data reports that indicate which clients are close to reaching age 65 so they can monitor and ensure cases are being transferred in a timely manner. When such an individual reaches age 65, the individual continues on this waiver under the "aged" subgroup.

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	6100
Year 2	6200
Year 3	7200
Year 4	7500
Year 5	7700

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:

The waiver provides for the entrance of all eligible persons.

Nebraska has not had a waiting list for the Aged and Disabled 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 5 outline the priority criteria.

Priority criteria for children include the following:
(1) Needs in NF domains are so severe that the health and welfare of the child are jeopardized, but the needs could safely be met with immediate waiver services;
(2) Family is 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 child to return home (e.g., a Medicaid-eligible child is ready to be discharged from a hospital);
(7) Family of a child with an identified waiver service need lacks access to resources to meet the child's needs in NF domains AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
(8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications whose family lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Priority criteria for aged persons and adults with disabilities include the following:
(1) Needs in domains which define NF level of care are so severe that the health and welfare of the client 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 client to return home (e.g., a Medicaid-eligible recipient is ready to be discharged from a hospital);
(7) A client with an identified waiver service need lacks access to resources to meet needs in domains which define NF level of care AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
(8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modifications 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:

PCR (435.110)
MAGI Child (435.118)
Deemed Newborns (435.117)
IV-E (435.145)
M-CHIP (435.229)
FFC (1902(a)(10)(A)(i)(IX))
TMA (1925)
BCC/Women's Cancer (1902(a)(10)(A)(ii)(XVIII))
Reasonable Classification (435.222)
Medicaid expansion (42 C.F.R. 435.119)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and*

community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage: ☐

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

Specify dollar amount: ☐

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

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

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

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

Select one:

◉ **100% of FPL**

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

Specify percentage amount: ☐

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

Specify:

* Recipients 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 needs 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 clients receiving Assisted Living Services: The State protects the SSI standard.

  (2) For clients 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 clients receiving Assisted Living Services: The State protects the SSI standard.
  (2) For clients 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:

This responsibility is performed directly by staff of the Medicaid agency and staff of contracted entities of the Medicaid agency. Level of care evaluations and reevaluations are performed by services coordination staff in the local waiver agencies. For children with disabilities, additional oversight and certification is performed within the Medicaid division.

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:

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

Education

(a) Baccalaureate or graduate degree in the following fields: human services, education or health/medical;

(b) Registered Nurse, currently licensed in Nebraska; or

(c) DHHS Social Services Worker who has received case management and waiver training to implement and operate the waiver program for at least five (5) years, AND

Experience

(a) At least two (2) years professional experience in one of the following fields: long term care, gerontology, rehabilitation, health/disability case management, children with special health care needs, or health/medical.

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.

The Services Coordinator gathers information using functional Level of Care criteria or the Child/Client's Level of Care to determine whether the client initially meets or continues to meet the nursing facility level of care required for eligibility.

Nebraska uses the same criteria for Level of Care eligibility in nursing facilities and in this waiver program. Information gathered with the above documents is entered on the automated Level of Care instrument found on the CONNECT system. (CONNECT is the acronym for Coordinating Options in Nebraska's Network through Effective Communications and Technology. It is the division's automated system for waiver client tracking and other management functions.)

Regulations found in Nebraska Administrative Code Title 471 Chapter 12 and/or 480 Chapter 5 define client eligibility criteria.

Adults and aged clients 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.
*Medical conditions and interventions - a medical condition is present which requires a specific intervention to prevent a decline in health status.
*Cognitive Function - memory, orientation, and judgment.

Adult and aged clients meet the nursing facility level of care by meeting at least one of the following:
1) a limitation in at least three Activities of Daily Living and at least one risk factor;
2) a limitation in at least three Activities of Daily Living and at least one medical condition and intervention;
3) a limitation in at least three Activities of Daily Living and at least one area of cognitive limitation; or
4) a limitation in at least one Activity of Daily Living and at least one risk factor and at least one area of cognitive limitation.

Children are evaluated based on the following assessment categories:
*Medical treatment/therapies - a medical or health condition is present which requires a specific intervention to prevent a decline in health status and impacts the child's ability to function independently;
*Activities of Daily Living - the ability to self-perform dressing, grooming, bathing, feeding/eating, transferring, mobility, and toileting;
*Other considerations - behavior, communication, hearing and vision.

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.

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 is the same and is outlined in the 480 NAC regulations for the Waiver. The Services Coordinator must meet in person with the potential client and legal guardian, if any, initially within 14 days of referral to evaluate Nursing Facility level of care. This visit must be conducted, if possible, at the client's residence to allow observations of the home situation. The meetings must be held at a date and time convenient to the client/guardian. Level of Care reevaluations must be completed every 12 months or sooner if client care needs change.

The assessment evaluates the client'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 and assistive technology usage and needs, nutritional status, and medication usage.

Information is gathered in the following assessment categories: Activities of Daily Living (ADL's), Risk Factors, Medical Conditions and Interventions, and Cognitive Function. The Services Coordinator must determine the clients needs and abilities in each of these areas.
Other areas assessed include formal and informal supports, housing, equipment and assistive technology usage and needs, nutritional status, and medication usage.

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 480 NAC 5 specify the procedures which ensure timely reevaluations for level of care.
The Services Coordinator must annually review each client's situation to assure both continued eligibility and that the well-being of the client is safeguarded. Reassessment must take place every 12 months completed prior to the end date of previous eligibility period and be documented. Reassessment must be face to face and preferably take place in the clients home at least every 12 months.

The Division's electronic client tracking system, CONNECT, contains reports on the client's Level of Care and due dates. These reports allow the Services Coordinator and Local Level 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 contained in the client files in the local services coordination offices/agencies and on the automated client tracking system, CONNECT.

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 reviewed for whom nursing facility Level of Care (LOC) was determined prior to the receipt of services. Numerator = number of new waiver eligible applicants reviewed for whom nursing facility LOC was determined prior to receipt of services; Denominator = number of new waiver eligible applicants reviewed.

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

Record reviews, combined on and off site.

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 interval 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:

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 reviewed in which LOC criteria were accurately applied. Numerator = number of initial and annual LOC determinations reviewed in which LOC criteria were accurately applied; Denominator = number of initial and annual LOC determinations reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 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 reviewed for whom LOC is determined.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic client 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.

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

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 local level services coordinator uses an automated Level of Care Review tool to record the clients initial level of care determination and to document review of the clients annual level of care redetermination.

A number of activities and processes at both the local and state levels 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.The Local Level Services Coordination Agencies are responsible to remediate all identified level of care individual problems identified through its discovery processes in an appropriate and timely manner (45 days). The Quality Management Strategies for reviewing Level of Care are:

1. Local Level Supervisory Reviews
Level of Care reviews, as assigned by the HCBS Waiver Unit, are completed by supervisors on an automated system by each local agency providing services coordination.
Remediation must be completed for those indicators that didnt meet standard and must occur within 45 days from date of review.
If a level of care has not been assessed and determined correctly, the supervisor provides the services coordinator with information concerning corrections needed. Required corrections are documented by the services coordinator on the Level of Care Review tool.
If a client does not continue to meet level of care, the case is closed, a notice of action is sent to the client, and the client is referred to other possible services.
Follow-up action must be recorded in the Remediation/Supervisory Action Section of the quality assurance review tool.

2. The HCBS Waiver Unit File Review and Electronic Reports
LOC quality improvement reviews are completed by the HCBS Waiver Unit on an automated system for each local agency providing services coordination.
If a level of care assessment has not been adequately determined, the HCBS Waiver Unit staff provides the local level supervisor with information concerning corrections needed.
Reassessment occurs and the required corrections are documented by the services coordinator on the automated Level of Care Review tool.
If the client is found to be eligible, he/she continues to receive services.
If the client is found to be ineligible, the case is closed, a notice of action is sent to the client, and the client is referred to other possible services.
Local level supervisors report remediation activities to the HCBS Unit quality staff. The HCBS Waiver Unit quality staff documents corrections in an electronic data 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 client that didnt meet LOC, a referral is made to Program Integrity for claims recovery.
If there is a concern that the agency didnt 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.
Level of care reports are also conducted to assure local level reviews and remediation activities are completed as assigned.

Practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level 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 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 client or his/her guardian are offered the option of accepting Nursing Facility or waiver services as described in the Plan of Services and Supports. If the client 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 only and remains valid as long as the waiver case is open. If guardianship or legal status changes, the Services Coordinator must obtain a new, signed consent (for example, a child whose parent had previously consented becomes an adult or an adults 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 (waiver consent) forms are contained in the client files in the local services coordination offices/agencies.

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:
1) AT&T language line is used statewide
2) All contracted Services Coordination Agencies are required to provide interpreters

In addition, notices are issued in English and Spanish. The Medicaid application contains information, including a toll free telephone number, about how to request information in a different language.

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	**Adult Day Health Services**		
Statutory Service	**Chore Services**		
Statutory Service	**Respite Services**		
Other Service	**Assisted Living Service**		
Other Service	**Assistive Technology Supports and Home Modifications**		
Other Service	**Extra Care for Children with Disabilities**		
Other Service	**Home Again Services**		
Other Service	**Home Delivered Meals**		
Other Service	**Independent Skills Building**		
Other Service	**Nutrition Services**		
Other Service	**Personal Emergency Response System (PERS)**		
Other Service	**Transportation Services**		

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):

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:**

Service Definition *(Scope):*

Adult Day Health Services are structured social, habilitation, and health activities provided outside of the clients home in a community-based setting. Transportation is not a component of adult day health, and is charged under the transportation service. Physical, occupational and speech/language therapies are not included as components of 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 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:

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 Plan of Services and Supports. Adult Day Health Services may be occasionally provided to a client for less than four hours in a day when the client must leave the adult day program due to an emergency.

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: 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):*

The facility must:
Provide a telephone with assistive devices
Observe and report significant changes and incidents to the Services Coordinator
* Employ or contract with a licensed nurse

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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):

Chore Services

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope)*:

Category 4:

Sub-Category 4:

A range of assistance to enable clients to accomplish tasks that they would normally do for themselves if they did not have a disability. This includes the performance of general household tasks to maintain the home in a clean, sanitary and safe environment. The assistance may take the form of supervision or actually performing the task for the client. Personal care may be provided on an episodic or on a continuing basis. For individuals who are 0-21 served by this waiver, personal care is available under EPSDT through the State Plan. Health related services that are provided may include medication administration to the extent permitted by Nebraska State law. Types of assistance furnished may include assistance with Activities of Daily Living; bill paying; essential shopping; food preparation; housekeeping activities; ice/snow removal; laundry services; and supervision.
Chore under the waiver differs in scope and nature from the personal care offered under the State Plan as supervision may be provided.

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 clients home when they are responsible for the home.

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 chore provider
Agency	Agency chore provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:

Independent chore provider

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
* Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the client
Have qualifications, experience, and abilities necessary in carrying out chore services comparable to those that will be authorized
Use universal precautions

Verification of Provider Qualifications
Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Chore Services

Provider Category:
Agency
Provider Type:

Agency chore provider

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
* Employ staff who have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the client
* Employ staff based on qualifications, experience, and abilities in carrying out chore services comparable to those that will be authorized
* Require staff use of universal precautions
Provide DHHS with training plans upon request
Ensure availability of services

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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):

Respite Services

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

Respite services are provided to clients unable to care for themselves that are furnished on a short-term basis because of the absence of or need for relief of those persons who normally provide care for the client.
Respite may be provided in or out of the clients home. Out of home respite may be provided in the following locations: private residence of a respite service provider, Medicaid certified nursing facility, Licensed Assisted Living Facility, Licensed Respite Facility, Licensed or approved child care home or center, or other community settings.
FFP may not be claimed for room and board when respite is provided in the clients home or place of residence.

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

Respite services may not be used to allow the caregiver to accept or maintain employment. When the need for respite 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 then 360 hours annually 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 Respite Provider
Agency	Agency Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:
Individual

Provider Type:

Independent Respite Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Never leave the client alone while providing respite
Prepare meals or snacks to comply with clients dietary needs
Use universal precautions
* Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the client
Out of home providers must assure their home is accessible and safe

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Agency Respite Provider

Provider Qualifications

License *(specify):*

Respite Care Service when mandated per 175 NAC 15

Certificate *(specify):*

N/A

Other Standard *(specify):*

Direct care staff of the respite provider agency must:
Never leave the client alone while providing respite
Prepare meals or snacks to comply with clients dietary needs
Use universal precautions
* Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the client
Out of home agency providers must assure their setting is accessible and safe
Provide training to staff and provide DHHS with training plans upon request
Ensure availability of services

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:

Assisted Living Service

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:**

Service Definition *(Scope):*

Assisted Living Services are provided in a homelike, non-institutional setting and include personal care and supportive services. This includes 24-hour response capability to meet scheduled or unpredictable client needs and to provide supervision, safety, and security.
Depending on the needs of the client, Assisted Living Services may include medication administration, transportation, escort services, activities, essential shopping, housekeeping services, laundry services, dining services, and personal care services. When provided to the client, the above services are included in the comprehensive rate paid to the assisted living provider, and are not billed separately.
Provider qualifications for persons administering medications in an assisted living facility are referenced in the Assisted Living Facility licensing regulations (175 NAC 4).
Escort services are accompanying or physically assisting a client who resides in an assisted living facility who is unable to travel or wait alone to medical appointments.
Activities are social and recreational programming.
Nursing and skilled therapy services are incidental rather than integral to the provision of this service. Payment is not made for 24-hour skilled care. FFP is not available for room and board, items of comfort or convenience, or costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from the payments for assisted living services is described in Appendix I-5.
No therapies are included in the assisted living service.
Assisted 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 client's residence is noted as Assisted Living, then any claims for personal care are denied.
Relatives/guardians who provide assisted 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 Assisted Living Services rate includes the provision of five roundtrip medical transportation trips. If the client's service plan reflects the need for more medical transportation, it may be authorized outside of the assisted living service payment, as a state plan Medicaid service. The Assisted Living Service does not include medical transportation in excess of 50 miles roundtrip. This also is authorized as a state plan Medicaid 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	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Service

Provider Category:
Agency
Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Assisted Living Facility

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Provide a private living unit with bath consisting of a toilet and sink
Supply normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products
Provide essential furniture

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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 Supports and 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:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Assistive Technology Supports are specialized equipment and supplies that enable a client to increase, maintain, or improve his/her functional capabilities. It includes the evaluation and purchasing (not leasing) of the assistive technology. It includes selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the assistive technology device, and any training or technical assistance for the client and family members, guardians, etc.

Home Modifications are the physical adaptations to the primary residence of the client or clients family that are necessary to ensure the health, welfare and safety of the client or that enable the client to function with greater independence in the home.

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 two components of Assistive Technology Supports and Home Modifications. This allows flexibility for the client's needs to be met if a modification is necessary to remain or return home.

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, 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 client's need. Environmental adaptations shall exclude costs for improvements exclusively required to meet local building codes. Assistive technology supports also must be of direct medical of physical benefit to the client. 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). Home modifications are not available to adapt an assisted living apartment.

The State receives reports on services received by clients which include details on the exact technology or modification received and the cost involved. Service and claims information is also stored in the client 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: Assistive Technology Supports and Home Modifications

Provider Category:
Agency
Provider Type:

Specialized equipment, supplies, home repair companies.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

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:

Extra Care for Children with Disabilities

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04080 medical day care for children
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The purpose of Extra Care for Children with Disabilities (ECCD) is to provide the medically necessary portion of assistance related to the physical, medical or personal care needs required by the client while his/her parent or guardian works, seeks employment, or attends school. Clients must require this additional assistance which is beyond the routine care and supervision given to clients without disabilities or special health conditions who are in a child care setting.

This service does not include the cost of routine child care for the care and supervision of the client, normally provided by parents/guardians in their own home. This service encompasses extraordinary care needs due to disability or special health condition of the child. Some examples of this include, but are not limited to, preparing and administering a tube feeding for nutrition; suctioning a childs airway every hour to remove secretions the child is unable to cough out or swallow; providing physical assistance needed to transfer a child in and out of a wheelchair; or changing an ileostomy or colostomy appliance and completing skin care necessary to maintain an infection-free stoma and surrounding area.

In a two parent/guardian household, this service may be prior authorized when both parents/guardians are working/attending school at the same time. School attendance by the parent(s)/guardian(s) is defined as enrolling in and regularly attending vocational or educational training to attain a high school or equivalent diploma or an initial undergraduate degree or certificate.

Personal care assistance provided under this service does not overlap with personal care assistance provided under the chore service of this waiver. A client cannot be authorized to receive both services at the same time.

This service of the Aged & Disabled waiver only covers those medically necessary services associated with the childs physical, medical or personal care needs. These more specialized needs/services are not included in routine child care, as that (routine child care) is expected to cover the care and supervision provided to children whose parents/guardians have elected to work or attend school and must arrange for someone else to take on those responsibilities in absentia. All of the cost related to the extraordinary care related to the physical, medical or personal care needs required by the client will be included in the waiver payment for the waiver service. This cost is currently included in the payment for the waiver service. Routine child care and its cost, paid by parents/guardians, do not cover the medically necessary services needed to address disability and special health care conditions of the client. Cost sharing is payment made for a covered service and is usually in the form of a co-insurance, co-payment, or deductible. Routine child care is not a covered service of this waiver.

The cost of routine child care is being separated from the cost of the extraordinary care needs due to the childs disability or special health condition. This is done by determining the cost of routine child care, cost for similar childcare needs in the area and access to service is considered to establish a rate that covers the extraordinary care related to the physical, medical or personal care needs required by the client.

Care is provided in a childs home by an approved provider or in a setting approved or licensed by the Department of Health and Human Services.

In Nebraska, because of the Nurse Practice Act and the Tim Kolb Amendment, parents/guardians must train the provider on the delivery of medical treatment and therapies. Because of this medical component, providers receive a higher rate based on the childs medical needs which affect staffing requirements.

The Department has the authority to establish ECCD rates.

Extra care for children with disabilities is designed to provide medically necessary care needs from ages 0-17 years of age.

Routine cost of care is established by the childcare subsidy rate chart established by the childcare subsidy division.

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

Extra Care for Children with Disabilities may be provided to clients whose parent/guardian is working, attending school, or seeking employment. In a two parent/guardian household, this service may be prior authorized when both parents/guardians are working/attending school at the same time. School attendance by the parent(s)/guardian(s) is defined as enrolling in and regularly attending vocational or educational training to attain a high school or equivalent diploma or an initial undergraduate degree or certificate. This service will not be authorized for attendance of the parent(s)/guardian(s) for additional undergraduate degrees, certificates and graduate education or higher. Clients whose parent(s)/guardian(s) are seeking employment may be authorized up to 12 hours per week of this service for two consecutive months.

The duration of the service averages less than 12 hours per day. It may be authorized in a household with two parents/caregivers when both are absent at the same time. Service expenditures must be cost effective in comparison to employment income.

Services available through public education programs are excluded from coverage under this service.
The costs of child care unrelated to the child's disability are excluded.

Transportation is not provided under this 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
Individual	Licensed Family Child Care Home I or II
Agency	Licensed Child Care Center
Individual	License-exempt family child care home
Individual	In-Home Child Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extra Care for Children with Disabilities

Provider Category:
Individual
Provider Type:

Licensed Family Child Care Home I or II

Provider Qualifications
License *(specify):*

Family Child Care Home I or II licenses as found in 391 NAC

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child
* Have at least one CPR trained person on duty
* Assure the home is compatible with medical and safety considerations of the child
* Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs
* Family Child Care Home I have a maximum capacity of 8 children of mixed ages and 2 additional school age children during non-school hours.
* Family Child Care Home I can provide care for no more than 3 infants (under 18 months) per adult as long as no more than 2 infants per adult are under 12 months of age.
* Family Child Care Home I serving mixed ages of children can provide care for no more than 2 additional school-age children during non-school hours as long as no more than 2 children are under 18 months of age.

* Family Child Care Home II have a maximum capacity of 12 children with two providers present.
* Family Child Care Home II can provide care for no more than 3 infants (under 18 months) per adult as long as no more than 2 infants per adult are under 12 months of age.
* Family Child Care Home II serving mixed ages of children can provide care for no more than 2 additional school-age children during non-school hours as long as no more than 2 children are under 18 months of age.
* Family Child Care Home II may care for up to 12 school age children, however if the provider has their own children who are under 8 years old, these children are included in the child/staff ratio.

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extra Care for Children with Disabilities

Provider Category:

Agency

Provider Type:

Licensed Child Care Center

Provider Qualifications

License *(specify):*

Child Care Center license as found in 391 NAC

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child
* Have at least 1 CPR trained person on duty
* Assure the home is compatible with medical and safety considerations of the child
* Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extra Care for Children with Disabilities

Provider Category:

Individual

Provider Type:

License-exempt family child care home

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child
* Assure the home is compatible with medical and safety considerations of the child
* Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs

License-Exempt providers are not required to hold CPR training because they are not licensed by the DHHS Division of Public Health (which has licensing duties for other child care provider types). This group of individual providers, however, must be able to meet the needs of the child and be trained in areas as specified by the parent/guardian of the child. It will include CPR training as specified by the parent/guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extra Care for Children with Disabilities

Provider Category:

Individual

Provider Type:

In-Home Child Care Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child
* Assure the home is compatible with medical and safety considerations of the child
* Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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 Again Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Home Again Services are non-recurring set-up expenses for clients transitioning from a nursing facility to a living arrangement in a private residence where the client is directly responsible for his/her own living expenses. Allowable expenses are those necessary to enable a client to establish a basic household and may include furniture, furnishings, televisions, household supplies, security deposits, utility installation fees or deposits, moving expenses, and assistance from a Home Again provider in obtaining the above items. Rent is not included. Televisions are not considered an item for recreational/diversion purposes because clients rely on broadcasted information for weather conditions. Clients in their own homes must be able to obtain accurate weather reports to assure their safety and be prepared in situations of tornadoes, floods, snow/ice, and dangerous heat indexes.

Home Again services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Home Again services do not include mortgage expense, food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Home Again services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provisions of these items and services are inherent to the service they are already providing.

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

Home Again Services is limited to once during a twelve-month period.

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 Again Service Provider
Individual	Independent Home Again Service Provider Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Again Services

Provider Category:

Agency

Provider Type:

Agency Home Again Service Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Employ staff who have qualifications, experience, and abilities necessary in carrying out services comparable to those that will be authorized

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Again Services

Provider Category:

Individual

Provider Type:

Independent Home Again Service Provider Contractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
Have qualifications, experience, and abilities necessary in carrying out services comparable to those that will be authorized

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:**

Service Definition *(Scope):*

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

Home-Delivered Meals is a service for adults which provides a meal prepared outside the clients 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
Individual	Independently operated home delivered meal provider
Agency	Agency 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:

Individual

Provider Type:

Independently operated home delivered meal provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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
* Conform to applicable laws and regulations in Nebraska Food Code (Neb.Rev. Stat. 81-2,257.01)

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:

Agency

Provider Type:

Agency home delivered meal provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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
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:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:

Independent Skills Building

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Independence Skills Building (ISB)is training for aged persons and adults and children with disabilities in activities of daily living, instrumental activities of daily living, and home management to increase independence. It may be provided to the client and/or to a primary caregiver to promote independence of the client. Training may occur in the clients home or in the community, and may be provided individually or in a group setting. This service differs from chore because it involves training the client or caregiver, not the actual provision of completing the ADL or IADL.

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

ISB services are authorized as long as there is measureable progress. ISB is not authorized when the public school system or rehabilitation services are responsible for providing training for independent living; if the client receives Adult Day Health Services and the components of Independence Skills Building would be duplicated by Adult Day Health Services; when the training is for the client to acquire general educational background, knowledge, and skills to prepare for vocational training or for actual vocational training; when the training can only be performed by licensed audiologists, hearing aid dealers, occupational therapists, optometrists, physical therapists, speech pathologists, and other related health care professionals.

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 ISB Provider
Individual	Independent ISB Provider Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Skills Building

Provider Category:

Agency

Provider Type:

Agency ISB Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Provider must:
Employ staff based on qualifications, experience, and abilities in carrying out services comparable to those that will be authorized

Meet facility standards outlined in 480 NAC 5

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Skills Building

Provider Category:

Individual

Provider Type:

Independent ISB Provider Contractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Provider must:
Have qualifications, experience, and abilities in carrying out services comparable to those that will be authorized

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:

Nutrition Services

HCBS Taxonomy:

Category 1: 11 Other Health and Therapeutic Services

Sub-Category 1: 11040 nutrition consultation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

This service will be removed from the waiver as it is now available through the State Plan Nutrition Services identifies the presence, nature, extent of impaired nutritional status of any type, in order to obtain the information needed for intervention, planning, and improvement of nutritional care. The service includes assessment and intervention, including education/counseling and follow-up. Providers address diet modification needs and specialized nutrition support, such as if the client needs enteral and parenteral nutrition. Impaired nutritional status includes obesity, malnutrition,dehydration, and imbalances of nutrient needs. Persons 0-21 years old will receive this service via EPSDT requirement.

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

Nutrition services are authorized for an initial three-month period. If it is determined, based on reivew of progress reports from the provider, that the client will benefit from additional services, an additional service period of nutrition services 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 Nutrition Service Provider Contractor
Agency	Agency Nutrition Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition Services

Provider Category:
Individual
Provider Type:

Independent Nutrition Service Provider Contractor

Provider Qualifications
License *(specify):*

Licensed Medical Nutrition Therapist

Certificate *(specify):*

N/A

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition Services

Provider Category:
Agency
Provider Type:

Agency Nutrition Services Provider

Provider Qualifications
License *(specify):*

Employ Licensed Medical Nutrition Therapists

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:**

Service Definition *(Scope):*

PERS is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable help button to allow for mobility. The system is connected to the clients phone and programmed to signal a response center once a help button is activated. Trained professionals staff the response center. 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 client must live alone or be left alone a significant portion of the day and must be able to cognitively understand when and how to use the PERS 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	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):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

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:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation 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:

Transportation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation Services are provided to enable clients to gain access to waiver and other community services and resources as outlined in the Plan of Services and Supports. This service may include accompanying a client unable to travel and wait alone.
All transportation service provided under the waiver is non-medical transportation. Waiver transportation services may not be substituted for the transportation services Nebraska is obligated to furnish under the requirements of 42 CFR 440.170.

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

Clients may be authorized for non-medical transportation if they do not have access to a working licensed vehicle or a valid drivers 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
Agency	Public Service Commission Exempt Transportation Provider
Agency	Certified Commercial Carrier/Common Carrier
Individual	Individual Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Services

Provider Category:

Agency

Provider Type:

Public Service Commission Exempt Transportation Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Certified to operate as a public transit authority issued by the Nebraska Department of Roads

Other Standard *(specify):*

Providers must:
Ensure drivers possess a current and valid driver's license with no more than three points assessed against his/her Nebraska driver's license within the past two years or meet a comparable standard in the state in which s/he is licensed to drive
* Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Services

Provider Category:
Agency
Provider Type:

Certified Commercial Carrier/Common Carrier

Provider Qualifications
License *(specify):*

N/A

Certificate *(specify):*

Certificate of Authority issued by the Nebraska Public Service Commission

Other Standard *(specify):*

Providers must:
* Ensure drivers possess a current and valid driver's license with no more than three points assessed against his/her Nebraska driver's license within the past two years or meet a comparable standard in the state in which s/he is licensed to drive
* Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years

Verification of Provider Qualifications
Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Services

Provider Category:
Individual
Provider Type:

Individual Transportation Provider

Provider Qualifications
License *(specify):*

Provider must have a valid driver's license and have no more than three points assessed against his/her Nebraska driver's license within the past two years, or meet a comparable standard in the state in which s/he is licensed to drive.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Providers must:
use their own personally registered vehicle to transport the client
*the provider must maintain the minimum vehicle insurance coverage as required by state law

Verification of Provider Qualifications

Entity Responsible for Verification:

This will be completed by designated Resource Development personnel and background verification is done in combination with designated provider enrollment broker.

Frequency of Verification:

Background checks are completed annually and revalidation is completed every 5 years.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Area Agencies on Aging, Independent Living Centers, DHHS local staff, Early Development Network, and Assistive Technology Partnership 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) Independent contractors
(c) Persons employed by contracting provider agencies. Waiver Resource Development staff are responsible for completing criminal history checks for Independent Contractors 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 assure criminal history compliance. Individual 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 his/her 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 agencys practice in assuring that safeguards are in place to protect the well-being of waiver clients.
For agency providers, Resource Development staff review the policy of the agency to determine that safeguards are in place to protect the well-being of waiver clients. 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, crimes involving the illegal use of a controlled substance, 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 client.
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 clients safety is in jeopardy. Completion of the criminal history background checks are documented in the file and reviewed during the Quality Assurance File Review. Quality assurance files reviews are completed annually by the HCBS Waiver Unit staff and quarterly by the local level agency supervisors.

Beginning 12/1/15 information related to criminal history/background investigations related to a provider agreement is stored electronically through our Provider Screening and Enrollment vendor’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 service providers must be screened against the child and adult abuse registries. DHHS staff conducts the screenings against the registries. Agency providers must have a policy that governs central registry checks for direct service staff. Per (NAC)480, 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 assure that no staff person identified through this process poses a danger to the health and safety of any waiver client. DHHS designated staff determines whether the agency's policy safeguards waiver clients. Agency must adhere to Title 471 NAC Provider Participation. For individual providers, staff must clear the name of each potential individual provider against the DHHS Adult Protective Services Central Registry, the DHHS Child Central Register of Abuse and Neglect, the Nebraska Sex Offenders Website, and the License Information System. If the Resource Developer learns that a protective services investigation is in progress, s/he must review the situation to determine if the clients safety is in jeopardy. The RD may terminate an existing service provider approval immediately.
(c) The HCBS division reviews the process for Services Coordination agencies. Resource Development staff 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)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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.

There are no limits on the types of non-legally responsible relatives/legal guardians who may furnish services. 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 clients needs and by reviewing billing documentation submitted by the relative/legal guardian signed by the client. The Services Coordinator monitors on a monthly basis that services are furnished and paid for as specified on the Plan of Services and Supports.

○ **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:

Waiver 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 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 assures 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:
***To be edited and moved to sub assurance B* Number and percent of enrolled non-licensed, certified providers reviewed that met provider standards at annual review. Numerator = number of enrolled non-licensed, certified providers reviewed that met provider standards at annual review; Denominator = number of enrolled non-licensed, certified providers reviewed that have had an annual review.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, combine on and off site.

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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 interval 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 enrolled licensed, certified providers reviewed that initially met provider standards prior to furnishing waiver services. Numerator = number of enrolled licensed, certified providers reviewed that initially met provider standards; Denominator = number of initial enrolled licensed, certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 enrolled licensed, certified providers reviewed that met provider standards at annual review. Numerator = number of enrolled licensed, certified providers reviewed that met provider standards at annual review; Denominator = number of enrolled licensed, certified providers reviewed that have had an annual review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, combined on and off site.

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 interval 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:
***To be edited and moved to sub assurance B* Number and percent of enrolled non-licensed, certified providers reviewed that initially met provider standards prior to furnishing waiver services. Numerator = number of enrolled non-licensed, certified providers reviewed that initially met provider standards; Denominator = number of initial enrolled non-licensed, certified providers reviewed.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:
***To be edited and moved to sub assurance B* Number and percent of enrolled non-licensed, certified providers reviewed that have had an annual review. Numerator = number of enrolled non-licensed, certified providers reviewed that have had annual review; Denominator = number of enrolled non-licensed, certified providers reviewed.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records review, on and off site.

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 interval 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**	☒ **Annually**

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, on and off site combined.

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 interval 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 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:
***Edited and moved from sub assurance A* Number and percent of enrolled non-licensed, non-certified providers reviewed that met provider standards at annual review. Numerator = number of enrolled non-licensed, non-certified providers reviewed that met provider standards at annual review; Denominator = number of enrolled non-licensed, non-certified providers reviewed that have had an annual review.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, combine on and off site.

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
☐ **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:
***Edited and moved from sub assurance A* Number and percent of enrolled non-licensed, non-certified providers reviewed that initially met provider standards prior to furnishing waiver services. Numerator = number of enrolled non-licensed, non-certified providers reviewed that initially met provider standards; Denominator = number of initial enrolled non-licensed, non-certified providers reviewed.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, combine on and off site.

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

☐ **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:
***Edited and moved from sub assurance A* Number and percent of enrolled non-licensed, non-certified providers reviewed that have had an annual review. Numerator = number of enrolled non-licensed, non-certified providers reviewed that have had annual review; Denominator = number of enrolled non-licensed, non-certified providers reviewed.**

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, combine on and off site.

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
☐ **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:

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 all newly hired Service Coordination (SC) and Resource Development (RD) staff enrolled in web-based training who successfully completed the training. Numerator = number of newly hired SC and RD staff enrolled in web-based training who successfully completed the training; Denominator = number of newly hired SC and RD staff enrolled in web-based training.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The state does not enroll any non-certified/non licensed providers.

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

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

A number of activities and processes at both the local and state levels have been developed to discover whether the 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 Local Level Services Coordination Agencies are responsible to remediate all (100%)identified provider problems identified through its discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing qualified providers are:

1. Local Level Supervisory Reviews
Qualified provider reviews, as assigned by the HCBS Waiver unit, are completed by supervisors on an automated system by each local agency enrolling providers. These reviews ensure that enrolled licensed and non-licensed certified providers meet Medicaid provider standards before furnishing waiver services and continue to meet Medicaid standards at annual review.
For those indicators that didnt meet standards, supervisory remediation follow-up must occur with the resource developer within 45 calendar days from date of review.
If after further review the provider does not continue to meet qualifications, the provider agreement is terminated.

The local agency notifies the HCBS Waiver unit for referral to Program Integrity for possible claim recovery.
Follow-up action must be recorded in the Remediation/Supervisory Action Section of the quality assurance review tool.

2. The HCBS Waiver Unit File Review and Electronic Reports
Qualified providers quality improvement reviews are completed by the HCBS Waiver Unit on an automated system for each local agency providing resource development.
If a provider agreement has not been adequately determined, the HCBS Waiver Unit staff provides the local level supervisor with information concerning corrections needed.
Reassessment occurs and the required corrections are completed.
If the provider is found to be qualified, he/she continues to provide services.
If the provider is found to be ineligible, the provider agreement is terminated.
Local level supervisors report remediation activities to the HCBS Unit quality staff. The HCBS Waiver Unit quality staff documents corrections in an electronic data system. The review documentation must include information that all negative qualified provider issues have been resolved correctly.
If services have been provided, a referral is made to Program Integrity for claims recovery.
If there is a concern that the agency didnt 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 HCBS Waiver 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.
3. Training for Case Management Agencies: All Services Coordinators/Resource Developers/Supervisors must complete training on the Aged and Disabled Waiver Program upon initial hire. To assure all waiver staff is qualified; each trainee will be evaluated for competency by completing a final test. If the required test score of 80% is not achieved, the trainee will need to retake the course and final test.

The web-based training oversight is provided by the HCBS Waiver Staff. They monitor completion of the course and work with the local level supervisor to assure remediation of individual issues. If the trainee does not complete the course successfully, the waiver agency billing for that services coordination/resource development function is not approved.

Practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level

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 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.

Refer to Attachment 2 of this Waiver renewal.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Services and Supports

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):*

- [x] **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)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- [ ] **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.

a) The Services Coordinator must, together with the potential client, develop a Plan of Services and Supports based upon assessment results. This is accomplished by identifying desired client outcomes related to one or more of the areas of client functional criteria and assessment. Upon initial contact with clients for scheduling assessment and care planning, the services coordinator informs clients that anyone they choose may participate in the planning process. The Services Coordinator must indicate in the Plan of Services and Supports any outside (that is non-DHHS office or contractor agency) person or agency the client wishes to receive a copy of the Plan. If this type of step is included, the client/guardian must sign the Plan.

b) The client has the right and responsibility to participate in decision-making in all aspects of supports and services, including determining who is included in the service plan development 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) The Area Agencies on Aging, Independent Living Centers, Early Development Network and Health and Human services local waiver staff provide waiver case management and are responsible for developing the client-centered Plan of Services and Supports. The plan is developed once the initial assessment is completed and reflects the client's needs, goals, and preferences. During the assessment process, the waiver services coordinator discusses and documents information about current health status, physicians, medications, and medical equipment. The initial Plan of Services and Supports is developed jointly by the waiver case manager (Services Coordinator) and the client and legal guardian (including parents of a minor child). Family members or others may participate at the invitation of the client. At the initial assessment visit and annual review, discussions include medical appointments scheduled or needed; any recent illnesses and recovery; condition or therapeutic changes; and summary reporting of ongoing monitoring. The Plan of Services and Supports must be in place prior to the authorization of waiver services. Meetings to develop the Plan of Services and Supports must be held at times and locations convenient to the client and legal guardian. Services Coordinators ask when and where meetings should be held. The majority for planning meetings occur in the clients home. Occasionally, and usually only in the case of clients receiving school services, meetings are held at the school to accommodate parents already attending another meeting/function at their child's school. Services Coordinators will accommodate clients and guardians.

b) Standard tools in use for the waiver for level of care (LOC) include a tool for adults (MILTC-14AD "Functional Criteria for Aged/Adults") and a tool for children ("HCBS Waiver Child's Level of Care"). Standard tools in use for assessing additional service needs when developing the plan of services and supports include a tool for adults (MILTC-2AD "Aged and Disabled Waiver Adult Assessment"), a tool for youth ages 3-17 (MILTC-7AD "Child's Functional Assessment and Family Support Survey"), and a tool for youth ages birth-3 (EI-1 Nebraska Early Intervention Program IFSP).

At the initial assessment visit and annual review, discussions include medical appointments scheduled or needed; any recent illnesses and recovery; condition or therapeutic changes; and summary reporting of ongoing monitoring. The in-person assessment includes determining the client's functional abilities and needs related to Activities of Daily Living and Instrumental Activities of Daily Living. The client's needs, goals, preferences, formal and informal resources/supports; medical and nutritional information; communication; housing; and risk factors are assessed and documented. During the assessment process, the waiver services coordinator discusses and documents information about current health status, physicians, medications, and medical equipment. This supplements medical information gathered in determining level of care eligibility. Additional assessments may be administered as appropriate to further identify memory, orientation and judgment limitations. Information from other sources, such as medical records/reports and special education plans may be reviewed. This information guides the development of the Plan of Services and Supports.

c) The Services Coordinator has primary responsibility to inform the client and legal guardian of available services under this waiver. Information about available services is shared with the client and/or legal guardian from the point of referral through the development of the Plan of Services and Supports (POSS). Timelines can vary based on individual needs and preferences, although the assessment upon which the POSS is based must occur within 14 days of the date waiver services were requested. The Medicaid Home and Community-Based Waiver Consent Form is not signed until the client has participated in the development of the POSS and has reviewed the POSS to ensure all service needs have been addressed. Services coordinators continue to provide information about services through monthly monitoring contacts as clients' needs and preferences change. The DHHS website also provides further information on waiver services and other resources.

d) The Services Coordinator must, together with the client/legal guardian, develop the plan based upon assessment results. This is accomplished by identifying the needs, goals and preferences related to one or more of the areas in which information is obtained in the assessment. Plan development builds on client/family strengths and is intended to support informal and formal services already in place to meet the needs of the client/family and is not intended to replace them. The client-centered philosophy holds that each client has the right and responsibility to participate to the greatest extent possible in the development and implementation of his/her service plan.

e) All services the client receives, including waiver and other services (i.e. State Plan services and services furnished through other state and Federal programs), must be documented on the Plan of Services and Supports. The role of the Services Coordinator, together with the client and guardian if applicable is to coordinate waiver and other services, to confirm the client's service provision with providers of service and to ensure that client needs and desired outcomes are met.

f) The Plan of Services and Supports is the document that outlines the objectives that reflect the client's needs, goals and preferences. The Plan of Services and Supports identifies the services to be provided, the amount and frequency of service provision, and the individuals responsible for the delivery of the services required (i.e. the type of provider). Individuals responsible may include the client, family members, waiver providers, other providers, informal supports, and the Services Coordinator. The Services Coordinator is responsible for monitoring the plan, and this is accomplished through at least monthly contact with the client/guardian.

g) Regulations found at Title 480 NAC 5 require the Plan of Services and Supports is modified as the client's needs change and annually. The plan modification or annual review is also a joint Services Coordinator-client/family planning process.

The Plan of Services and Supports must be in place prior to the authorization of waiver services. The State does not use interim service plans.

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 functional criteria, level of care, and assessment processes.
The Services Coordinator must determine the presence and effect of risk factors. Risk factors are concerns which cause significant impact to the persons 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 are:

1. Documented Abuse/Neglect.
2. Socially inappropriate behavior: The client exhibits a recurring behavior that is 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 that is not related to a severe and persistent mental illness
3. Communication: The client is unable to communicate information in a manner that is understandable. Information may be conveyed by any means (for example, verbally, in writing, sign language, message board). This does not include speaking a language other than English.
4. Continence: The client is incontinent (that is, unable to control his/her body to empty the bladder and/or bowel) and is unable to self-manage related needs.
5. Falls: The client has fallen at least twice in 6 months 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 clients life. At renewal, the client would be at risk of these factors recurring in the absence of waiver services.
7. Nutrition or Hydration Concerns: The client has a history/present diagnosis of dehydration or malnutrition. In absence of diagnosis, the client does not demonstrate interest/motivation to eat.
8. Lack of informal support: The client 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 are incorporated into the Plan of Services and Supports, subject to participant needs and 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 client 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 client's Plan of Services and Supports. The LOC tool addresses health and safety risk factors. Each client’s POSS is required to have outcomes and action steps which address all needs identified on the LOC tool, including risk factors. The POSS also is required to address the supports and interventions that are related to the identified health and safety risks that are needed to prevent harm to the individual. In addition, all POSS’ 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 clients are to be involved in writing the POSS and receive a copy of the POSS.

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.

Clients have ready access to accessible information about the qualified waiver providers that are available to furnish the services included in the plan. All provider information is captured electronically on the departments computerized system. Services Coordinators access that information based on client needs regarding geographic, hours of operation when services are needed, travel requirements, and past history of service provision. Clients are also given the option of recommending a potential provider who is then subject to the provider approval process. Clients may receive a list of providers upon request from their Services Coordinator. Because new providers are enrolled on an on-going basis, a list is not kept/printed, because it would be outdated as soon as it was printed. Rather, when the client needs information on qualified providers, a report may be run to capture all qualified providers for the service they are authorized to receive.

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):

Plans of Services and Supports are subject to approval by the Medicaid agency and oversight is exercised on a routine and periodic basis.

The Medicaid agency reviews a sample of service plans retrospectively through its quality assurance process. The reviews are completed on a continuous and on-going basis by HCBS waiver unit staff who have completed training and have in-depth knowledge of waiver regulations, policies, procedures, philosophy, and documentation requirements. The sample size is based on a representative sample with a 95% confidence interval.

The Medicaid agency conducts 100% review of all service plans for clients who have died during their waiver eligibility.

An electronic file review format is utilized in CONNECT for review of the POSS. Since the LOC tool is done in the CONNECT system, the file review format has been programed so that any needs identified on the LOC are automatically transferred to the file review question which addresses whether or not needs have been addressed in the POSS. The needs assessment is done manually, but all sections of the assessment tool have been programmed into the file review so that the reviewer scores a “yes” or “no” in the file review to indicate whether or not the specific section has been filled out correctly. The reviewer also scores whether or not a need has been identified in the particular area. The CONNECT system then transfers any need identified to the file review question which addresses whether or not needs have been addressed in the POSS. As a result, when the reviewer reviews the POSS, a list of all identified needs shows up on the file review form and the reviewer scores “yes” or “no” to indicate whether or not there was both an outcome and action step which addresses the specific need. In addition, the file review format also addresses the parties needed to address the client’s outcomes/action steps as well as POSS updates that are needed due to changing needs.

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 are responsible for monitoring the implementation of the Plan of Services and Supports and updating the Plan as needed when it has been identified the client's Level of Care and/or assessed needs have changed.
Services Coordinators are also responsible for monitoring client's health and welfare.
Services Coordinators along with the client develop a backup plan to ensure the client's needs are met when the regular provider is not available.
Services Coordinators make referrals, as appropriate, to assure client safety (i.e., additional programs, providers, Adult Protective Services, law enforcement and Licensure). Services Coordinators and clients have access to the Nebraska Resource and Referral System which identifies all resources in the State related to health and human services.
The Services Coordinator is responsible for monitoring the client's satisfaction of services.
b.) The following describes the monitoring process;
Services Coordinators monitor the Plan of Services and Supports by
interviewing and observing the client and their surroundings and interviewing the client's family members, client representatives and providers regarding the provision of waiver and non-waiver services including health services. The services coordinator then determines with input from those mentioned previously whether or not the services continue to meet the client's needs. When there is a change in client needs the Plan of Services and Supports is updated to include a new statement to cover the newly identified client need.
These same methods are used to determine if the client is choosing the providers they want to provide the needed services and to also monitor the effectiveness of the backup plan when the regular providers are not available.
The Services Coordinator also encourages the client's family to monitor service provision. Services Coordinators monitor service provision by doing unannounced in-person visits to clients. The Services Coordinator also monitors the usage of services and the cost of services by reviewing provider billing documentation when submitted by the provider for payment and by using DHHS systems which contain this information on a regular basis.
Services Coordinators maintain 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 Plan of Services and Supports monitoring process, if an incident or a complaint is reported to the Services Coordinator, the Services Coordinator follows up on what was reported prior to the next monthly contact with the client. If the issue is more complex or is ongoing an action step will be added to the Plan of Services and Supports and will be addressed accordingly.
The Services Coordinator maintains a working relationship with the Nebraska Medicaid eligibility worker, monitors Medicaid eligibility and client share of cost obligations using the DHHS systems containing this information. The Services Coordinator also monitors the share of cost obligation being obligated to Medicaid services, including waiver services in order for the client to maintain Medicaid eligibility.
c.) The following describe the frequency of monitoring;
The Services Coordinator must contact the client, their representative or guardian at least monthly and more often depending on the client's level of need at any particular time.
The Services Coordinator must have a face-to-face meeting with the client, their representative or guardian at least quarterly and more often depending on the client's level of need at the time.
The Services Coordinator must monitor Medicaid eligibility monthly.

Any issue which requires follow up is documented by the services coordinator following the monthly monitoring visit or following other contact with the client, provider, or other interested person. Depending upon the identified problem, it is addressed immediately and prior to the next monthly contact. If the problem is more complex or is ongoing, it is added as an outcome or action step on the Plan of Services and Supports and addressed accordingly. Follow-up and remediation of complaints and incidences occurs as detailed in the waiver's Quality Improvement System. This includes issue resolution within 30 days with results reported to the Division of Medicaid and Long-Term Care for review within 15 days after resolution. Division staff review these reports and accept them or provide consultation and direction for additional activity.
Services Coordinators review each client's satisfaction with the services provided, review each client's overall health status, and verify that the provider(s) is complying with the requirements of service provision. Complaints and incidents identified through service plan monitoring are documented in the Complaint and Incident data system. Incidents must be acted upon immediately by reporting the situation to Adult Protective Services, law enforcement or the Licensure Unit in the DHHS Division of Public Health. Client complaints about the provider are addressed by Services Coordinators as they arise.
Back up plan effectiveness is monitored through file reviews and through the Services Coordinators' monthly contacts

with clients.

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 reviewed for whom all assessed personal goals have been addressed in the Plan of Services and Supports (POSS). Numerator = number of participants reviewed for whom all assessed personal goals have been addressed in the POSS; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 reviewed for whom all assessed needs (including health and safety risk factors) have been addressed in the Plan of Services and Supports (POSS). Numerator = number of participants reviewed for whom all assessed needs have been addressed in the POSS; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed whose Plans of Services and Supports (POSS) were revised, as needed, to address changing needs. Numerator = number of participants reviewed whose POSS were revised, as needed, to address changing needs; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 reviewed whose Plans of Services and Supports (POSS) were reviewed and revised on or before the annual review date. Numerator = number of participants reviewed whose POSS were reviewed and revised on or before the annual review date. Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 participants reviewed for whom there is monthly monitoring narrative evidence that waiver services were delivered in accordance with the Plan of Services and Supports (POSS). Numerator: # of participants reviewed for whom there is monthly monitoring narrative evidence that waiver services were delivered in accordance with the POSS. Denominator: # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 reviewed whose file indicated participants chose among providers. Numerator = number of participants reviewed whose files indicated participants chose among providers; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:
 # and % of participants reviewed who have been informed about provision of services and provision of Services Coordination (SC) when served by SC Agencies that also provide waiver services. Numerator=# of participants reviewed who have been informed about provision of services and provision of SC when served by SC Agencies that also provide waiver services. Denominator= # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 reviewed whose file is free of evidence of conflict of interest between the provision of services and the provision of Services Coordination. Numerator = Number of participants reviewed whose file is free of evidence of conflict of interest between the provision of services and the provision of Services Coordination. Denominator = Number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:

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

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

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.

1. Local Level Supervisory Reviews
Plan of Services and Supports (POSS) reviews, as assigned by the HCBS Waiver Unit, are completed by supervisors on an automated system by each local agency providing services coordination. These reviews ensure that POSSs are completed accurately, consistent with assessed need and services are delivered in accordance with the participant's POSS.
Remediation must be completed for those indicators that didnt meet standard and must occur within 45 calendar days from date of review. If a POSS needs to be revised, the supervisor provides the services coordinator with information concerning corrections needed. Required corrections are documented by the services coordinator on the POSS form.
Indications of abuse, neglect, exploitation, and client safety risks with no documentation that a referral, investigation and/or action occurred to address the problem must be followed up on immediately with the services coordinator.
If the client's Plan of Services and Supports cant assure the client's safety, the case is closed, a notice of action is sent to the client, and the client is referred to other possible services.
Follow-up action is recorded in the Remediation/Supervisory Action Section of the quality assurance review tool and finalized.

2. The HCBS Waiver Unit File Review and Electronic Reports
POSS quality improvement reviews are completed by the HCBS Waiver Unit on an automated system for each local agency providing services coordination.
If a POSS identifies individual problems, the HCBS Waiver Unit staff provides the local level supervisor with information concerning corrections needed.
Reassessment occurs and the required corrections are documented by the services coordinator on the POSS.
Indications of abuse, neglect, exploitation, and client safety risks with no documentation that a referral, investigation and/or action occurred to address the problem must be followed up on immediately with the local level supervisor.
If the client's Plan of Services and Supports can’t assure the client's safety, the case is closed, a notice of action is sent to the client, and the client is referred to other possible services.
Local level supervisors report remediation activities to the HCBS Unit quality staff. The HCBS Waiver Unit quality staff documents corrections in an electronic data system. The review documentation must include information that all assessed needs have been resolved correctly.
If there is a concern that the agency didnt 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
POSS reports are also conducted to assure local level reviews and remediation activities are completed as assigned.

Practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level 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**

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

Persons who apply for or receive services may appeal any adverse action or inaction. These may include, but are not limited to a potential waiver client being denied services, a waiver client's services being reduced, or a waiver client being determined ineligible for continued waiver eligibility. A consent form explained and signed at the initiation of services states “To file an appeal, you may contact your local waiver agency office or the Nebraska Department of Health and Human Services. DHHS will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing.” Services Coordinators are expected to help with this process. Clients are given notice in situations when choice of HCBS vs. institutional services is denied and when the choice of provider or service is denied. Clients are informed of their right to a fair hearing in writing on a uniform form at the time waiver eligibility is determined and at any time when waiver services are reduced or terminated. This form states that services will continue during the period when their appeal is under consideration. The Services Coordinator must send written notice of denial, reduction, or termination of services to the client/guardian. The form used is a Notice of Action. This notice of adverse action and opportunity to request a fair hearing is maintained in the client file. Notice to clients/guardians contains:

1. A clear statement of the action to be taken;
2. A clear statement of the reason for the action;
3. A specific regulation citation which supports the action;
4. A complete statement of the client/guardian's right to appeal; and
5. A clear statement that if an appeal hearing is requested within ten days following the date the notice of finding is mailed, the adverse action will not be carried out until a fair hearing decision is rendered.

There is a statement on the Medicaid application form which informs individuals that if they need help or documents in a language other than English, a toll-free number may be called. Fair Hearing rights are included and explained with the consent form information. Interpreters are engaged to inform individuals are informed of Fair Hearing rights in languages other than English as needed at that time. All notices are system-generated and are sent in English or Spanish, based upon individuals’ preferences, as indicated at the time of application for Medicaid. Once the individual indicates a language preference, the language is coded in the system and all notices are sent accordingly. Notices of fair hearing rights are issued in Spanish and recipients do not need to request translation.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. However, if the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility. Notices are issued in English and Spanish. The Medicaid application contains information, including a toll free telephone number about how to request information in a different language.

If the adverse action is to deny acceptance of a waiver referral, the Services Coordinator must send the notice to the applicant/guardian as soon as the decision is made.

This is outlined in Title 480 NAC 5.

The DHHS Legal Services Administrative Hearing Team tracks all fair hearing requests and findings of order. The HCBS Waiver & Community Supports unit of the Medicaid & Long-Term Care Division also maintains a tracking log of appeal hearings and findings of order to identify issues and training needs.

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 HCBS Waiver Unit of Medicaid & Long-Term Care Division 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).

a) The Local Level Consumer Complaint Process records problems and issues clients have with services they receive and/or accessing services they have been authorized to receive that are likely to result in actions against providers such as corrective action or termination. Clients or their representatives may report complaints.

b and c) The process and mechanisms are as follows:

Each Local Level Agency/office providing Services Coordination and Resource Development for HCB Waiver services will investigate and track complaints that are likely to result in actions against providers using the following process:

1. Local Level Agency/office staff receives a complaint about the provision of services from a client or clients representative. The report may be given either verbally or in writing. Staff must begin completing the automated Local Level Complaint Form once the report is received.

Note: Local Level Agency staff may clarify with the client that the person filing the complaint is indeed representing him/her.

2. Local Level Agency/office staff must begin the investigation and respond to the complainant either verbally or in writing within 7 working days.

3. Local Level Agency/office staff must complete the investigation and take action to resolve the complaint within 30 working days. If the investigation cannot be completed within 30 working days, the agency/office must document the reason for the delay. This must be documented in the Description of the Complaint Field on the Local Level Complaint Form.

4. Local Level Agency staff must document the provider action taken to resolve the complaint on the automated Local Level Complaint Form.

5. Upon resolution of the complaint, Local Level Agency staff will finalize the Local Level Complaint Form. Local Level Agency staff will email the complaint to the HCBS Waiver Unit staff to inform the HCBS Waiver Unit staff that a complaint has been completed. This must be completed within 15 working days of the complaint being resolved.

HCBS Waiver Unit staff review the content of each complaint and follow up as necessary with Local Level Agency staff. A complaint alleging a violation by the State in general may also be filed.

The statewide results are analyzed and presented to the HCBS Waivers Quality Council.

The Complaint Process does not take away a clients right to a fair hearing or right to refer to Central Office. Clients are informed of this when they make a complaint to the Services Coordinator. The MLTC HCBS Unit complaint process addresses complaints about the provision of services or services coordination. A complaint alleging a violation by the State in general may also be filed. The notification will include an explanation of the complainant's right to request the DHHS Chief Executive Officer to review the final decision. If, as a result of extenuating circumstances, MLTC HCBS Unit Staff cannot complete the investigation within 30 calendar days, an extension will be implemented. The MLTC HCBS Waiver Unit Staff will notify the person or organization filing the complaint and the local agency of the extension. These processes are part of the HCBS Waivers' Quality Improvement System, but are not part of an overall grievance process.

Filing a grievance or making a complaint is not a prerequisite or a substitution for requesting a Fair Hearing.

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 Incident Process records critical events or incidents that bring harm, or risk of harm to clients, including abuse, neglect, exploitation, or licensing violations. An incident report may be received from any source and must be reported to appropriate authorities to conduct follow-up action. Appropriate authorities include Adult or Child Protective Services, law enforcement, and DHHS Division of Public Health Licensure Unit for licensed providers.

Local Level Agency (Area Agencies on Aging, Independent Living Centers, local DHHS, and Early Development Network) staff receive and track incidents using the following processes:

1. Local Level agency/office staff receives the report of the incident. The report may be from any source. The report may be given either verbally or in writing. Staff begin completing the automated Local Level Incident Form.

2. Local Level agency/office staff must take appropriate action and document that action, including reporting to appropriate authorities and the Waiver resolution activities.

3. Local Level agency/office staff must complete the automated Local Level Incident Form and notify the HCBS Waiver Unit via email (using the link in automated system) within 15 working days of completion of the waiver resolution activities.

4. HCBS Waiver Unit staff review the reports within 30 days. In order to determine if appropriate Waiver actions have been taken, more information may be requested. Local agency/office staff has up to 15 working days to provide the information requested. HCBS Waivers and Community Supports staff then complete and finalize the review within 15 working days.

5. HCBS Waiver Unit staff inform the Local agency/office staff that the Incident has been finalized.

For incidents representing imminent (serious or life threatening) danger, the local agency/office supervisor or designee must notify HCBS Waiver Unit staff by the next working day that a situation of imminent danger has occurred. This notification may occur by either telephone or email. By the end of the following working day, HCBS Waiver Unit staff will review the incident with the supervisor to determine if appropriate action is being taken.

The statewide results are analyzed and findings are presented to the HCBS Waivers Quality Council.

Individuals and entities required to report: All suspected incidents or critical events are required to be reported to Protective Services or Law Enforcement per Nebraska statute. Waiver staff are mandatory reporters of such events. Timelines for reporting are immediately. As outlined in 480 NAC 5, Services Coordinators must report to Adult Protective Services/law enforcement/licensure when client safety is at risk. The types of critical incidents include Emotional Abuse, Physical Abuse, Sexual Abuse, Environmental Event (e.g. fire, weather, flood), Financial exploitation, Imminent danger, Licensing compliance, Medication mismanagement, Neglect, Theft (non-medication), Theft of medication, Unsafe environment, and Other. The use of restraints, seclusion or other restrictive interventions would be reportable as emotional and physical abuse as well as licensing compliance.

Adult Protective Services regulations can be found at 463 NAC 1 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 located 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 located 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.

The definition of child abuse or neglect is located in Nebraska Revised Statutes 28-710. Child abuse or neglect means knowingly, intentionally, or negligently causing or permitting a minor child to be: placed in a situation that endangers his

or her life or physical or mental health; cruelly confined or cruelly punished; deprived of necessary food, clothing, shelter, or care; left unattended in a motor vehicle if such minor child is six years of age or younger; sexually abused; or sexually exploited by allowing, encouraging, or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films, or depictions.

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 clients and 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 client upon waiver eligibility and discussed during monitoring visits. Client health and welfare is monitored during visits with clients, and Services Coordinators address protection and safety issues as the need arises when working with their clients.

All Services Coordinators are mandatory reporters, so any instance of abuse, neglect or exploitation related by the client to the Services Coordinator during monitoring would be reported to Protection and Safety. Services Coordinators do in-home visits, giving the participant the opportunity to file a report in person. If at times other than when the Services Coordinator is doing visits, participants may report to any mandatory reporter, including but not limited to medical professionals, law enforcement, caregiver, employee of any facility licensed by the Department, or human services professional.

Local Level Agency staff receive training on how to recognize abuse/neglect and also their role as a mandatory reporter to proper authorities.

Additional information on abuse/neglect is available on the Answers4Families.org website and the Nebraska Department of Health and Human Services website (dhhs.nebraska.gov). Clients/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.

Services Coordinators' responsibility in the review and response to critical incidents is to recognize and report to appropriate authorities. Investigations 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.

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 Title 463 NAC. APS/CPS and law enforcement have the primary responsibility of critical event and incident investigation. Data is obtained on an annual basis from the computerized Protective Services system which categorizes reporter types. The HCBS Waivers and Community Supports unit has a field in the waivers electronic client information system which identifies reports made to protective services on an individual client basis.

HCBS Waivers Quality Council identifies methods to analyze this data and identify trends.

As outlined in 480 NAC 5 , Services Coordinators must report to Adult Protective Services/Child Protective Services/law enforcement/licensure when client safety is at risk.

As outlined in 480 NAC 5, 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 substantiated. If the Resource Developer learns that a Protective Services investigation is in progress, s/he must review the situation to determine if the clients 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 it 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 was 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 with the victim within 10 calendar days of the date of the report was accepted for investigation.
Contact exceptions (i.e. exception for contacting the victim within the 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.

Child Protective Services (CPS) timelines for investigations are similar to APS timelines with a couple of exceptions. For Priority 1 allegations, the practice is that CPS staff immediately begin the investigation unless law enforcement is there. Documentation must be done within 24 hours. The other major difference is that CPS investigations must be completed within 30 days. Additional information about the Child Protection and Family Safety Act may be found in Nebraska Revised Statute Sections 28-701 to 28-727.

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.

Protection and Safety 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. Protection and Safety staff are responsible for the oversight of the critical incident management system.

On at least an annual basis, both adult and child Protection and Safety provide to the HCBS Waivers & Community Supports unit information about critical incidents that involved waiver clients. Data is obtained and analyzed on waiver clients involved in Protection and Safety reports. The data includes demographical information, types of abuse/neglect reported, and the findings of investigations.

Staff from the Protection and Safety and HCBS Waiver unit work together to identify strategies to reduce the occurence of critical incidents and to coordinate better on both a system wide and individual client 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 automated Critical Incidents process 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.

Both the Medicaid agency and Quality Council oversee the results of critical incidents and events on an annual basis, as the data from Protection and Safety is reported to the waiver unit at least once per year. Data from this process is part of Nebraskas 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 chore, respite, escort during transportation, and child care for children with disabilities/extra care include supervision components which assure that waiver clients receive individualized oversight from qualified providers to maintain client 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 Assisted Living, Respite, and Adult Day services. Regulations in Nebraska Administrative Code Title 175 for these licensed providers state that clients 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.

Local level waiver staff in services coordination offices and agencies are responsible for client monitoring which includes satisfaction interviewing and observation of service delivery. 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 State Medicaid 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 chore, respite, escort during transportation, and child care for children with disabilities/extra care include supervision components which assure that waiver clients receive individualized oversight from qualified providers to maintain client 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 Assisted Living, Respite, and Adult Day services. Regulations in Nebraska Administrative Title 175 address client 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 HCBS Waiver Services unit which are then forwarded to the local waiver staff for follow up action.

Local level waiver staff in services coordination offices and agencies are responsible for client monitoring which includes satisfaction interviewing 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 State Medicaid 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 chore, respite, escort during transportation, and child care for children with disabilities/extra care include supervision components which assure that waiver clients receive individualized oversight from qualified providers to maintain client 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 Assisted Living, Respite, and Adult Day services. Regulations in Nebraska Administrative Code Title 175 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 HCBS Waiver Services unit which are then forwarded to the local waiver staff for follow up action.

Local level waiver staff in services coordination offices and agencies are responsible for client monitoring which includes satisfaction interviewing 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 State Medicaid 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.

One service of the Aged and Disabled waiver is the assisted living service. These facilities are licensed by the DHHS Division of Public Health, Licensure Unit. The Licensure Unit has ongoing responsibility for monitoring client medication regimens, the methods for conducting monitoring, and the 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 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 being 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 HCBS Waiver Services & Community Supports unit and Services Coordinators 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 client 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 client. 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 client'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 the HCBS Waiver Services Unit and Services Coordinators 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 the HCBS Waiver Services Unit and Services Coordinators for review. Such reports are available to the HCBS Waiver Services Unit on the DHHS website, and also accessible on the website to Services Coordination 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 assisted living service includes medication administration as one of the components. Waiver regulations reference that assisted living providers must be licensed and abide by the assisted living facility licensure regulations found at 175 NAC 4 and described below.

As outlined in 175 NAC 4, a client 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 provider 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 client or guardian, if applicable, 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 that 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.

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 recipients 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 recipients 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 71-1132.01 to 71-1132.53, 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.

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:

Assisted living providers 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 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 resident 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.

One of the Aged and Disabled Waiver's services is assisted living and the DHHS Division of Public Health, Licensure Unit has ongoing responsibility for monitoring licensed assisted living facilities in the administration of medications to all clients, 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 Services 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 and assisted living waiver providers related to improving the quality of the assisted living services. 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 client 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:
Number and percent of participants reviewed who received information/education about how to report abuse, neglect exploitation and other critical incidents as specified in the approved waiver. Numerator = number of participants reviewed who received information/education; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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 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 HCBS Waiver Incident reports completed with appropriate waiver resolution activity. Numerator = number of HCBS Waiver Incident reports completed with appropriate waiver resolution activity; Denominator = number of HCBS Waiver Incident reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic client 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**	☐ **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 incident reports submitted by Service Coordination Agencies for substantiated Adult and Child Protective Services (APS/CPS) intakes. Numerator = Number of incident reports submitted by the Service Coordination agencies for substantiated APS/CPS intakes. Denominator = Number of substantiated APS/CPS intakes.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Electronic client 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**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **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 reviewed for whom the file contains no evidence of the use of restrictive measures, including restraints and seclusion. Numerator = Number of participants reviewed 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):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:

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

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

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

A number of activities and processes at both the local and state levels have been developed to discover whether the federal Participant Safeguards 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 Local Level Services Coordination Agencies are responsible to remediate all identified Health and Welfare individual problems identified through its discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing health and welfare are:
1. Incident process; The local level services coordinator uses an automated Local Level Incident form to record critical incidents.
Once the incident report has been completed, it is submitted to the HCBS Waiver Unit.
The incident is reviewed by the HCBS Waiver unit and determined if the waiver resolution activities were complete. If further remediation is necessary, the HCBS Waiver staff reviews the incident with the supervisor to determine appropriate actions. Remediation is documented by the HCBS Waiver staff on the incident report form.

After remediation is completed, the HCBS Waiver staff complete the state oversight review section and finalizes the review.

2. Local Level Supervisory Reviews;
As part of their discovery processes, all HCBS Waivers' Supervisors are required to complete a review of Services Coordination files on an on-going basis as assigned by the HCBS Waiver Staff. These reviews ensure that any identified individual issues of abuse, neglect and exploitation are addressed.
These review activities are documented in an automated quality assurance review system. Indicators that did not meet standards require remediation/supervisory follow-up. Indications of abuse, neglect, exploitation, and client safety risks with no documentation that a referral, investigation and/or action occurred to address the problem must be followed up on immediately with the services coordinator.
After clients reassessment to determine if waiver services and supports are sufficient to ensure the clients health and welfare, the client may continue on waiver. If waiver services and supports are insufficient to ensure the client's health and welfare, the case is closed, a notice of action is sent to the client, and the client is referred to other possible services.
Follow up action must be recorded in the "Remediation/Supervisory Action" Section.

3. The HCBS Waiver Unit File Review and Electronic Reports;
Quality improvement reviews are completed by the HCBS Waiver Unit on an automated system for each local agency providing services coordination.
Indicators that did not meet standards require remediation/supervisory follow-up. Indications of abuse, neglect, exploitation, and client safety risks with no documentation that a referral, investigation and/or action occurred to address the problem are followed up on immediately by the HCBS Waiver unit with the Local Level supervisor. Local level supervisors report remediation activities to the HCBS Unit quality staff. The HCBS Waiver Unit quality staff documents corrections in an electronic data system. The review documentation must include information that all health and welfare issues have been resolved correctly.
The HCBS Waiver Unit 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 HCBS Waiver Unit contract manager for contract review and possible payment reimbursement.

Practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level 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 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 clients through continuous client-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 states process for monitoring the safeguards and standards under the waiver. A set of key principles guide the QIS and are contained in the Nebraskas HCBS Quality Improvement System document. Nebraskas 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.

A Quality Council is in place to advise DHHS on strategies to improve all aspects of waiver quality management. Data is presented to the Quality Council for review and analysis. The Quality Council considers these findings in their overall quality analysis and advisory role.

Nebraska's HCBS Waiver quality oversight involves Program Management and Quality Management staff in the HCBS Waiver Unit of the Medicaid and Long-Term Care Division, Department of Health and Human Services (DHHS). (This is the single state Medicaid agency.) A HCBS Waiver Unit Quality Improvement Subcommittee is composed of staff from both the program and quality areas, as well as representation from Local Level Services Coordination Agencies and the Quality Council. This subcommittee meets at least quarterly (or four times per year) to review aggregate data for Waiver performance measures and any other identified issues. The subcommittee 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 will be provided to QI Subcommittee members and Quality Council members, as well as other identified stakeholders, and posted on the DHHS website at least quarterly. Issues or concerns about the reports will be communicated to the Department and referred back to the QI Subcommittee and/or Quality Council.

Program Management staff design and monitor services, including specific performance related to service and remediation. Discovery methods under Program Management are: expenditure and utilization monitoring; technical assistance; professional research, observation, and insight; contract management and monitoring; and analysis of data sources.

The Quality Assurance/Improvement staff provides systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under Quality Assurance include reviewing electronic client data, conducting file reviews; implementing participant experience surveys; and oversight of the various local level supervisory efforts. (It is the State’s intent to implement the NCI to collect data for the year June 1, 2017 through May 31, 2018, making its first report available in October of 2018. Currently the State is operating under administrative expenditure restraints and implementation is dependent upon budget availability. Use of participant/family experience surveys will be discontinued upon implementation of the NCI.)

Both Program Management and Quality Assurance/Improvement staff are involved in discovery related to death review; complaints; incident reports; and data collection and analysis.

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/children protective service data, electronic client data system reports, service expenditure data, and service authorization data. Of these reports, the following are compiled by HCBS Waiver Unit staff and analyzed by the HCBS Waiver Unit staff and the Quality Council annually or as needed: death review, appeals, supervisory file review, local level and central office complaints, incidents, adult protective services, electronic client data system reports, service expenditures, and service authorizations. These reports are shared with the SC agency continuously and on-going.

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

The State's waiver service delivery design incorporates two local level functions, Services Coordination and Resource Development. These two roles provide check's and balance's as each focuses on a key area. Services

Coordination staff work with clients 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 Quality Council. Lines of communication are fluid to allow information to flow to and from program and quality staff. Information also flows freely to and from the Quality Council and to and from 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 mandated 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.
3. Informational materials including written guidance for staff or brochures directed toward clients or the public.
4. Best practices. This includes the identification, dissemination, and implementation of best practice concepts on a statewide basis.
5. Remediation of individual problems. This is the responsibility of the local level agencies with the HCBS Waiver Unit providing the oversight to ensure completion. Technical assistance is also provided to local service delivery staff on a continuous ongoing basis to aid understanding of policies and procedures and to address individual situations.
6. Shared resolution. This is a formally-defined process, based on proactive partnership, to work with local 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 client safety concern; or (3) are identified through formal discovery and determined not egregious as defined in the Quality Improvement Plan process.
7. 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 client 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 HCBS Waiver Unit of the Nebraska Department of Health and Human Services' Medicaid and Long Term Care Division 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 HCBS Unit Manager, along with the Program Staff, is responsible for coordinating the development, implementation and monitoring of any system design changes. The HCBS Unit Manager works closely with the HCBS Quality Improvement Subcommittee and the Quality Council to assure the appropriate identified priority system issues are developed, implemented and monitored to assure system change occurs. Annual data is aggregated and compared to the previous baseline evidence to determine if the identified system change is effective.

HCBS Waiver Unit 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 in place a Quality Improvement System 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.

State staff in the HCBS Waiver Unit fulfill the lead role in guiding this improvement along with input from local services coordination agencies/offices and the Quality Council.

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

Quality management staff, program management staff, and administrative staff of the HCBS Waiver Services Unit located in the Medicaid and Long-Term Care Division evaluate the effectiveness of the waiver Quality Improvement System on a continuous, ongoing basis. Nebraska QIS strategies stratify information for the Aged and Disabled Waiver (NE.0187) and the Traumatic Brain Injury Waiver (NE.40199). Data for the AD waiver and TBI waiver is aggregated and analyzed separately. The HCBS Unit is located in the Division of Medicaid and Long-Term Care so 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 Quality Council provides an additional review 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 automated DHHS Nebraska Family Online Client User System (N-FOCUS). Assisted 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 N-FOCUS or MMIS. N-FOCUS contains all Medicaid eligibility information. All claims are edited against Medicaid eligibility, prior authorization, and provider approval before warrants are issued.

Financial Services within the DHHS Operations division tracks audit reports, prepares and monitors budget projections for the Division of Medicaid and Long-Term Care, prepares federal and state reports as required, and prepares the CMS-64 and 372 reports.

a) The N-FOCUS and MMIS systems establish the audit trail necessary for the state auditors office to conduct the single state audit on an annual basis. Auditors conduct audits based on federal audit guides where priorities are identified. Cases are pulled from random samples and auditors request all documentation contained in case files to substantiate the states 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.

b) The HCBS Waiver unit tests a sample of provider billings in its file review process as part of the ongoing Quality Management system. One or more providers of the clients case under review are selected for the audit. Paid claims are reviewed against the prior authorization, documentation of service provision, and provider certification process, to ensure approriate payment was made to the provider.

c) The State Auditor and DHHS are responsible for conducting these financial audits. The Nebraska Auditor of Public Accounts is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. Audits by the State auditor occur annually.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State*

financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver. Numerator: Number of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Number of paid claims reviewed.

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

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 interval 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 reviewed which were in accordance with the reimbursement methodology specified in the approved waiver. Numerator = Number of paid claims reviewed which were in accordance with the reimbursement methodology specified in the approved waiver. Denominator = Number of paid claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval 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:*

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 reviewed for whom rate changes were consistent with the approved rate methodology. Numerator = Number and percent of providers reviewed for whom rate changes were consistent with the approved rate methodology. Denominator = Number of providers reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews, combined on and off site.

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 interval with a +/- 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.*

Quarterly on-site file reviews are conducted by Local Level supervisors. Additionally, HCBS Waiver Unit quality staff annually conduct off-site file reviews to verify the work of the Local Level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver QIS off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The Raosoft calculator at http://www.raosoft.com/samplesize.html will be used annually to validate the sample size.

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 Local Level Services Coordination Agencies are responsible to remediate all identified claim problems identified through its discovery processes in an appropriate and timely manner (45 days). As part of their discovery processes, all HCBS Waivers' Supervisors are required to complete an on-site review of services coordination/resource development files on an on-going basis as assigned by the HCBS Waiver Staff. These reviews ensure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. These responses are documented in an electronic data system. File review indicators that are answered "No" will be highlighted and will require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from date of review and be recorded in the "Remediation/Supervisory Action" Section. Once all errors have been corrected and the remediation/supervisory actions are documented, the review is finalized and no other edits are allowed for the review. Payment errors could be referred to Program Integrity for claim recovery processing.

The HCBS Waiver Unit monitors statewide reviews to ensure review and remediation activities are completed as assigned. Review documentation must include information that all claims are coded and billed correctly have been resolved correctly.

The HCBS Waiver Staff also conducts off-site file reviews and reviews claim data reports to ensure local level 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.

Practices are in place to assist Local Level Services Coordination Agencies in evaluating whether problems are systemic to their Agency. Local Level supervisors use the CONNECT system to run reports of file review and other data to evaluate the performance of their Agency. Local Level supervisors may also use CONNECT to perform additional Agency specific file reviews. The CONNECT system enables the Local Level Agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with Local Level 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***

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

This waiver employs a fixed rate method of rate determination for the following services: Assisted Living Services, Adult Day Health Services, Extra Care for Children with Disabilities, Home Again, Nutrition Services, Respite Services, and Non-Medical Transportation. These fee-for-service rates are established by the Division of Medicaid and Long-Term Care. Rates were initially 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 rate determination methods 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.

Initial rates for the Assisted 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 HCBS Waivers staff information they have directly received from providers on adequacy of rates and rate setting methods.

For the Assisted 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 once per year to reflect a legislative increase.

Title 402 of the Nebraska Administrative Code sets forth the Nebraska Health Care Funding Act, which provided state funded grants for conversion of units in a nursing facility to assisted living units. The state funding was for one-time capital or expenditure costs for each facility, and is not on-going payment for assisted living services the facility provides as a waiver service. Grant fund monies were distributed to nursing facilities from June 1999 through December 2004. No funds have been distributed to nursing facilities for conversion purposes since December 2004. Nursing facilities which received the state grant funding were required to demonstrated that their facilitys conversion to assisted living would be an economical option to persons needing long-term care services; be available for Medicaid eligible individuals; not cause hardship on persons needing nursing facility services by reducing the availability of such services; and result in lower Medicaid reimbursement rates.

Health Care Trust Fund rates are set at 95% of the Standard Rates. Both the Standard Rates and the Health Care Trust Fund rates are further broken down into rural and urban rates. Rates differentiate between the single occupancy of an assisted living unit, and the multiple occupancy of one unit. Each rate consists of three parts: 1) The amount the facility must collect for room and board from the client; 2) the Medicaid responsibility; and 3) the clients share of cost (SOC) that must be obligated before HHSS will assume financial responsibility for the service component. The room and board, Medicaid responsibility and clients share of cost together equal the total monthly rate.

Rates for other waiver services 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. Providers also may request renegotiation if a client's care needs have increased. The provider may not attempt to charge the State more than private pay individuals are charged. The Medicaid Division has authority to establish rates for these services, which include: Chore, Independence Skills Building Services, and Personal Emergency Response System. Rate negotiating takes into account the level of client 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. A Provider Bulletin with new rate chart is posted on the DHHS public website.

Home-delivered meal rates are a combination of fixed and negotiated rates, depending on provider type. Assistive

Technology Supports and Home Modifications are based on the individual client needs. The State does not have an annual maximum for each of the two service components for Assistive Technology Supports and Home Modifications. This allows flexibility for the client's needs to be met if a modification is necessary to remain or return home.

Many providers in this waiver are independent contractors so DHHS abides by minimum wage standards & FICA requirements.

Payment rates are discussed with clients at the time the service plan is being developed so they can make decisions on service utilization.

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:*

For all waiver services, except assisted living and assistive technology supports and home modifications, billings flow directly from providers to NFOCUS, the State's electronic claims payment system. Preprinted billing documents, generated by NFOCUS, 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 client 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 nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the states accounting system, the Nebraska Information System (NIS). NIS 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 Nebraska Information System (NIS). N-FOCUS 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.

Assistive technology supports and home modifications claims are processed directly through NIS.

Assisted living claims are processed through MMIS.

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 N-FOCUS. Assisted Living payments are processed through MMIS. Both of those systems require that eligible clients 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 client, the provider, the authorizations time frame, frequency, rate, code, etc. In addition, MMIS matches N-FOCUS for client eligibility and share of cost. Only if all elements (client, 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 participants approved service plan, and 3) The services were provided.

Each claim is compared to a service authorization and reviewed for client name, client ID, authorization number, service code, service from date, service through date, frequency, total number of units, rate, customer obligation and provider ID. Both the client 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 post-payment review is completed as part of the Nebraska HCBS Waivers Quality Improvement System (QIS) off-site and on-site review processes. The DHHS Division of Medicaid and Long-Term Care (MLTC) HCBS Unit staff complete off-site reviews, and supervisory staff at local level agencies contracted to provide services coordination complete on-site reviews. The review form is the same for both the off-site and on-site reviews.

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 finance unit to take the necessary corrective action.

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

Assistive Technology and Home Modification claims are processed through the Nebraska Information System (NIS) by DHHS Finance staff. Claims are coded by DHHS based on billings submitted by Assistive Technology Partnership contracted staff for eligible clients. 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 participants approved service plan, and 3) The services were provided.

b) Service authorizations are created and entered by local Services Coordinators based upon each individual client'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, 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, 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.

Clients are provided the choice of providers and have employer authority with hire and fire rights. The POSS has a provider choice section signed by the client during development of the POSS, indicating the client has freely chosen providers for the time period of the POSS. Services Coordinators are to make monthly contact with clients to evaluate the effectiveness of the POSS and the quality of the services provided, and ascertain if both the formal and informal supports being provided continue to meet the client's needs, and the client'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 Medicaid agency.

(a-d) Services which are not paid through an approved MMIS system are Adult Day Health Care, Assistive Technology Supports and Home Modifications, Extra Care for Children with Disabilities, Chore, Home Again, Home-Delivered Meals, Independence Skills Building, Nutrition, Personal Emergency Response System, Respite, and Non-Medical Transportation.

The Department has an automated eligibility system, N-FOCUS, which is an integrated computer system designed to provide comprehensive information about clients served. It includes client, provider, and service authorization databases in addition to payment history and billing status information. The N-FOCUS system keeps track of all providers who have, or have had, provider agreements with the Department to deliver services to eligible clients. This information includes rates and the specific time periods the rates were applicable. The Services Coordinator enters individual client services authorizations which specifies the service code and rate the provider is authorized. Provider claims are reviewed at the local level and signed/approved before submission to DHHS for processing. N-FOCUS 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.
Payments for waiver services are made through a system called N-FOCUS, which is not an approved MMIS. The following functions are incorporated into the N-FOCUS application with the exception of the actual issuance of payment which is via the NIS application and is explained below.

After a client is determined to be eligible for Medicaid on N-FOCUS, 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 N-FOCUS. The client, 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 client and the provider) specifies the individual client 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 client 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 N-FOCUS, 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 nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher which is then sent to the states accounting system, the Nebraska Information System (NIS).

All payments are processed as described above by the Nebraska Department of Health and Human Services System through its N-FOCUS 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 client basis to the provider. Each service is prior authorized and the prior authorization number which links the provider to the client 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). N-FOCUS 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, chore, transportation, and/or personal emergency response system. 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. Clients 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 client and assisted living provider of the Room and Board and any share of cost the client is responsible to pay.

The billing document used by assisted living facilities captures the share of cost amount to be paid by the client 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 client'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	12471.03	7626.00	20097.03	35431.00	3506.00	38937.00	18839.97
2	12715.29	7778.00	20493.29	36140.00	3576.00	39716.00	19222.71
3	11345.00	7934.00	19279.00	36863.00	3648.00	40511.00	21232.00
4	11281.05	8093.00	19374.05	37600.00	3721.00	41321.00	21946.95
5	11379.60	8254.00	19633.60	38352.00	3795.00	42147.00	22513.40

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	6100	6100
Year 2	6200	6200
Year 3	7200	7200
Year 4	7500	7500
Year 5	7700	7700

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.*

Average length of stay is calculated as an average between waiver days for NFOCUS waiver services (calculated by the count of days of service for all claims by person) and averaged with the average number of days of assisted living. These were based on waiver year 2015 actuals. The ALOS is expected to remain constant because the new participants added are expected to have similar care needs to those already on the waiver. It is not expected that the new participants would need to receive services longer than the current population.

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:*

The estimates are based on waiver year 2015 actuals for these services and inflated each year of the renewal by a population growth factor and a price growth factor.
This waiver does not cover the cost of prescribed drugs and therefore Factor D does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates are based on waiver year 2015 actuals for acute services for the waiver population and inflated each year of the renewal by a growth factor of two percent.

The two percent growth factor is based on the estimated rate increase that has been historically approved by Nebraska' s Legislature. An increase in waiver and/or nursing facility clients is not expected to change the average cost of services, except for rate increases.

This waiver does not cover the cost of prescribed drugs and therefore Factor D does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

iii. **Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Based on waiver year 2015 actuals of nursing facility expenditures and inflated each year of the renewal by a growth factor of two percent.

The two percent growth factor is based on the estimated rate increase that has been historically approved by Nebraska' s Legislature. An increase in waiver and/or nursing facility clients is not expected to change the average cost of services, except for rate increases.

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:*

The estimates are based on waiver year 2015 actuals for acute services for the nursing facility population and inflated each year of the renewal by a growth factor of two percent.

The two percent growth factor is based on the estimated rate increase that has been historically approved by Nebraska' s Legislature. An increase in waiver and/or nursing facility clients is not expected to change the average cost of services, except for rate increases.

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	
Adult Day Health Services	
Chore Services	
Respite Services	
Assisted Living Service	
Assistive Technology Supports and Home Modifications	
Extra Care for Children with Disabilities	
Home Again Services	
Home Delivered Meals	
Independent Skills Building	
Nutrition Services	
Personal Emergency Response System (PERS)	
Transportation Services	

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
Adult Day Health Services Total:						514323.10
Adult Day Health Services	Day	85	97.00	62.38	514323.10	
Chore Services Total:						28589284.08
Chore Services Day	Day	782	186.00	62.04	9023842.08	
Chore Services Hourly	Hourly	2600	593.00	12.69	19565442.00	
Respite Services Total:						1144803.55
Respite Care Day	Day	565	11.00	67.22	417772.30	
Respite Care Hourly	Hourly	825	75.00	11.75	727031.25	
Assisted Living Service Total:						37225541.84
Assisted Living Rural / Single	Monthly	1269	8.00	1675.04	17005006.08	
Assisted Living Rural / Multiple	Monthly	63	8.00	1218.31	614028.24	
Assisted Living Urban / Single	Monthly	1199	8.00	1974.68	18941130.56	
Assisted Living Urban / Multiple	Monthly	57	8.00	1459.16	665376.96	
Assistive Technology Supports and Home Modifications Total:						1987777.68
Assistive Technology Supports	Project	148	1.00	2351.62	348039.76	
Home Modifications	Project	538	1.00	3047.84	1639737.92	
Extra Care for Children with Disabilities Total:						5304441.00
Child / Youth Care Day	Day	230	111.00	72.65	1854754.50	
Child / Youth Care Hourly	Hourly	541	585.00	10.90	3449686.50	
				GRAND TOTAL:		76073309.17
				Total Estimated Unduplicated Participants:		6100
				Factor D (Divide total by number of participants):		12471.03
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Again Services Total:						22500.00
Home Again Services	Occurrence	15	1.00	1500.00	22500.00	
Home Delivered Meals Total:						591362.20
Home Delivered Meals	Day	667	155.00	5.72	591362.20	
Independent Skills Building Total:						50323.00
Independent Skills Building	Hourly	10	553.00	9.10	50323.00	
Nutrition Services Total:						23529.00
Nutrition Services	Day	50	3.00	156.86	23529.00	
Personal Emergency Response System (PERS) Total:						475902.72
Personal Emergency Response System (PERS)	Unit	1516	9.00	34.88	475902.72	
Transportation Services Total:						143521.00
Non-Medical Transportation By One Way Trip	One Way Trip	216	35.00	7.59	57380.40	
Non-Medical Transportation By Mile	Miles	169	430.00	0.58	42148.60	
Non-Medical Transportation By Hour	Hourly	94	45.00	10.40	43992.00	
				GRAND TOTAL:		76073309.17
				Total Estimated Unduplicated Participants:		6100
				Factor D (Divide total by number of participants):		12471.03
				Average Length of Stay on the Waiver:		283

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
Adult Day Health Services Total:						530801.46
Adult Day Health Services	Day	86	97.00	63.63	530801.46	
Chore Services Total:						29630389.24
Chore Services Day	Day	795	186.00	63.28	9357213.60	
Chore Services Hourly	Hourly	2642	593.00	12.94	20273175.64	
Respite Services Total:						1186459.34
Respite Care Day	Day	574	11.00	68.56	432887.84	
Respite Care Hourly	Hourly	838	75.00	11.99	753571.50	
Assisted Living Service Total:						38571378.88
Assisted Living Rural / Single	Monthly	1289	8.00	1708.54	17618464.48	
Assisted Living Rural / Multiple	Monthly	64	8.00	1242.68	636252.16	
Assisted Living Urban / Single	Monthly	1218	8.00	2014.17	19626072.48	
Assisted Living Urban / Multiple	Monthly	58	8.00	1488.34	690589.76	
Assistive Technology Supports and Home Modifications Total:						2060311.10
Assistive Technology Supports	Project	150	1.00	2398.65	359797.50	
Home Modifications	Project	547	1.00	3108.80	1700513.60	
Extra Care for Children with Disabilities Total:						5502533.40
Child / Youth Care Day	Day	234	111.00	74.10	1924673.40	
Child / Youth Care Hourly	Hourly	550	585.00	11.12	3577860.00	
Home Again Services Total:						22500.00
Home Again Services	Occurrence	15	1.00	1500.00	22500.00	
Home Delivered Meals Total:						612674.70
Home Delivered Meals	Day	678	155.00	5.83	612674.70	

GRAND TOTAL:	78834784.02
Total Estimated Unduplicated Participants:	6200
Factor D (Divide total by number of participants):	12715.29
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Skills Building Total:						**51318.40**
Independent Skills Building	Hourly	10	553.00	9.28	**51318.40**	
Nutrition Services Total:						**24480.00**
Nutrition Services	Day	51	3.00	160.00	**24480.00**	
Personal Emergency Response System (PERS) Total:						**493138.80**
Personal Emergency Response System (PERS)	Unit	1540	9.00	35.58	**493138.80**	
Transportation Services Total:						**148798.70**
Non-Medical Transportation By One Way Trip	One Way Trip	219	35.00	7.74	**59327.10**	
Non-Medical Transportation By Mile	Miles	172	430.00	0.59	**43636.40**	
Non-Medical Transportation By Hour	Hourly	96	45.00	10.61	**45835.20**	
				GRAND TOTAL:		**78834784.02**
				Total Estimated Unduplicated Participants:		**6200**
				Factor D (Divide total by number of participants):		**12715.29**
				Average Length of Stay on the Waiver:		283

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
Adult Day Health Services Total:						**547691.10**
Adult Day Health Services	Day	87	97.00	64.90	**547691.10**	
Chore Services Total:						**30710368.80**
Chore Services Day	Day	808	186.00	64.55	**9701090.40**	
				GRAND TOTAL:		**81683982.33**
				Total Estimated Unduplicated Participants:		**7200**
				Factor D (Divide total by number of participants):		**11345.00**
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Services Hourly	Hourly	2684	593.00	13.20	21009278.40	
Respite Services Total:						1229040.84
Respite Care Day	Day	583	11.00	69.93	448461.09	
Respite Care Hourly	Hourly	851	75.00	12.23	780579.75	
Assisted Living Service Total:						39956159.84
Assisted Living Rural / Single	Monthly	1309	8.00	1742.71	18249659.12	
Assisted Living Rural / Multiple	Monthly	65	8.00	1267.53	659115.60	
Assisted Living Urban / Single	Monthly	1237	8.00	2054.45	20330837.20	
Assisted Living Urban / Multiple	Monthly	59	8.00	1518.11	716547.92	
Assistive Technology Supports and Home Modifications Total:						2134951.12
Assistive Technology Supports	Project	152	1.00	2446.62	371886.24	
Home Modifications	Project	556	1.00	3170.98	1763064.88	
Extra Care for Children with Disabilities Total:						5705022.54
Child / Youth Care Day	Day	238	111.00	75.58	1996672.44	
Child / Youth Care Hourly	Hourly	559	585.00	11.34	3708350.10	
Home Again Services Total:						22500.00
Home Again Services	Occurrence	15	1.00	1500.00	22500.00	
Home Delivered Meals Total:						635430.25
Home Delivered Meals	Day	689	155.00	5.95	635430.25	
Independent Skills Building Total:						52369.10
Independent Skills Building	Hourly	10	553.00	9.47	52369.10	
Nutrition Services Total:						25459.20
Nutrition Services	Day	52	3.00	163.20	25459.20	

GRAND TOTAL:	81683982.33
Total Estimated Unduplicated Participants:	7200
Factor D (Divide total by number of participants):	11345.00
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS) Total:						**510818.04**
Personal Emergency Response System (PERS)	Unit	1564	9.00	36.29	**510818.04**	
Transportation Services Total:						**154171.50**
Non-Medical Transportation By One Way Trip	One Way Trip	222	35.00	7.89	**61305.30**	
Non-Medical Transportation By Mile	Miles	175	430.00	0.60	**45150.00**	
Non-Medical Transportation By Hour	Hourly	98	45.00	10.82	**47716.20**	
				GRAND TOTAL:		**81683982.33**
				Total Estimated Unduplicated Participants:		**7200**
				Factor D (Divide total by number of participants):		**11345.00**
				Average Length of Stay on the Waiver:		283

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
Adult Day Health Services Total:						**565083.20**
Adult Day Health Services	Day	88	97.00	66.20	**565083.20**	
Chore Services Total:						**31812495.32**
Chore Services Day	Day	821	186.00	65.84	**10054163.04**	
Chore Services Hourly	Hourly	2726	593.00	13.46	**21758332.28**	
Respite Services Total:						**1272556.96**
Respite Care Day	Day	592	11.00	71.33	**464500.96**	
Respite Care Hourly	Hourly				**808056.00**	
				GRAND TOTAL:		**84607902.37**
				Total Estimated Unduplicated Participants:		**7500**
				Factor D (Divide total by number of participants):		**11281.05**
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		864	75.00	12.47		
Assisted Living Service Total:						41380910.08
Assisted Living Rural / Single	Monthly	1329	8.00	1777.56	18899017.92	
Assisted Living Rural / Multiple	Monthly	66	8.00	1292.88	682640.64	
Assisted Living Urban / Single	Monthly	1256	8.00	2095.54	21055985.92	
Assisted Living Urban / Multiple	Monthly	60	8.00	1548.47	743265.60	
Assistive Technology Supports and Home Modifications Total:						2211750.70
Assistive Technology Supports	Project	154	1.00	2495.55	384314.70	
Home Modifications	Project	565	1.00	3234.40	1827436.00	
Extra Care for Children with Disabilities Total:						5915271.18
Child / Youth Care Day	Day	242	111.00	77.09	2070791.58	
Child / Youth Care Hourly	Hourly	568	585.00	11.57	3844479.60	
Home Again Services Total:						22500.00
Home Again Services	Occurrence	15	1.00	1500.00	22500.00	
Home Delivered Meals Total:						658595.00
Home Delivered Meals	Day	700	155.00	6.07	658595.00	
Independent Skills Building Total:						53419.80
Independent Skills Building	Hourly	10	553.00	9.66	53419.80	
Nutrition Services Total:						26467.14
Nutrition Services	Day	53	3.00	166.46	26467.14	
Personal Emergency Response System (PERS) Total:						529089.84
Personal Emergency Response System (PERS)	Unit	1588	9.00	37.02	529089.84	
Transportation						159763.15

GRAND TOTAL:	84607902.37
Total Estimated Unduplicated Participants:	7500
Factor D (Divide total by number of participants):	11281.05
Average Length of Stay on the Waiver:	283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Non-Medical Transportation By One Way Trip	One Way Trip	225	35.00	8.05	63393.75	
Non-Medical Transportation By Mile	Miles	178	430.00	0.61	46689.40	
Non-Medical Transportation By Hour	Hourly	100	45.00	11.04	49680.00	
				GRAND TOTAL:		84607902.37
				Total Estimated Unduplicated Participants:		7500
				Factor D (Divide total by number of participants):		11281.05
				Average Length of Stay on the Waiver:		283

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
Adult Day Health Services Total:						582900.16
Adult Day Health Services	Day	89	97.00	67.52	582900.16	
Chore Services Total:						32954879.36
Chore Services Day	Day	834	186.00	67.16	10418127.84	
Chore Services Hourly	Hourly	2768	593.00	13.73	22536751.52	
Respite Services Total:						1317674.36
Respite Care Day	Day	601	11.00	72.76	481016.36	
Respite Care Hourly	Hourly	877	75.00	12.72	836658.00	
Assisted Living Service Total:						42846684.48
Assisted Living Rural / Single	Monthly	1349	8.00	1813.11	19567083.12	
Assisted Living Rural / Multiple	Monthly	67	8.00	1318.74	706844.64	
				GRAND TOTAL:		87622930.87
				Total Estimated Unduplicated Participants:		7700
				Factor D (Divide total by number of participants):		11379.60
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Urban / Single	Monthly	1275	8.00	2137.45	21801990.00	
Assisted Living Urban / Multiple	Monthly	61	8.00	1579.44	770766.72	
Assistive Technology Supports and Home Modifications Total:						2290769.42
Assistive Technology Supports	Project	156	1.00	2545.46	397091.76	
Home Modifications	Project	574	1.00	3299.09	1893677.66	
Extra Care for Children with Disabilities Total:						6130101.78
Child / Youth Care Day	Day	246	111.00	78.63	2147070.78	
Child / Youth Care Hourly	Hourly	577	585.00	11.80	3983031.00	
Home Again Services Total:						22500.00
Home Again Services	Occurrence	15	1.00	1500.00	22500.00	
Home Delivered Meals Total:						682168.95
Home Delivered Meals	Day	711	155.00	6.19	682168.95	
Independent Skills Building Total:						54470.50
Independent Skills Building	Hourly	10	553.00	9.85	54470.50	
Nutrition Services Total:						27505.98
Nutrition Services	Day	54	3.00	169.79	27505.98	
Personal Emergency Response System (PERS) Total:						547822.08
Personal Emergency Response System (PERS)	Unit	1612	9.00	37.76	547822.08	
Transportation Services Total:						165453.80
Non-Medical Transportation By One Way Trip	One Way Trip	228	35.00	8.21	65515.80	
Non-Medical Transportation By Mile	Miles	181	430.00	0.62	48254.60	
Non-Medical Transportation By Hour	Hourly	102	45.00	11.26	51683.40	

GRAND TOTAL:	87622930.87
Total Estimated Unduplicated Participants:	7700
Factor D (Divide total by number of participants):	11379.60
Average Length of Stay on the Waiver:	283