Appendix B: Participant Access and Eligibility (4154 Amendment)

Appendix 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:
   Intellectual Disability or Developmental Disability, or Both

   Target sub-group included:
   Autism
   Developmental Disability
   Intellectual Disability

   Minimum Age: No
   Maximum Age Limit: No

b. **Additional Criteria.** The State further specifies its target group(s) as follows: No additional criteria

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

Appendix B-2: Individual Cost Limit

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.

b. **Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**
Appendix B-3: Number of Participants Served

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>4200</td>
</tr>
<tr>
<td>Year 2</td>
<td>4350</td>
</tr>
<tr>
<td>Year 3</td>
<td>4500</td>
</tr>
<tr>
<td>Year 4</td>
<td>4500</td>
</tr>
<tr>
<td>Year 5</td>
<td>4500</td>
</tr>
</tbody>
</table>

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.

Table B-3-b

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>4150</td>
</tr>
<tr>
<td>Year 2</td>
<td>4263</td>
</tr>
<tr>
<td>Year 3</td>
<td>4410</td>
</tr>
<tr>
<td>Year 4</td>
<td>4410</td>
</tr>
<tr>
<td>Year 5</td>
<td>4410</td>
</tr>
</tbody>
</table>
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 reserves capacity for the following Purpose(s):
1. Emergency
2. Transition from Child Welfare System
3. Transition of Persons from Institutions
4. Developmental Disability Court Custody Act
5. Transition of Participants from Other Waivers
6. Dependents of Military Families Assigned to Nebraska

1. **Purpose** Emergency

**Purpose:** Capacity is reserved for emergency purposes to support individuals in immediate crisis due to caregiver death, homelessness or other situations that threaten the life and safety of the individual.

**Describe how the amount of reserved capacity was determined:** Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>40</td>
</tr>
<tr>
<td>Year 2</td>
<td>40</td>
</tr>
<tr>
<td>Year 3</td>
<td>40</td>
</tr>
<tr>
<td>Year 4</td>
<td>40</td>
</tr>
<tr>
<td>Year 5</td>
<td>40</td>
</tr>
</tbody>
</table>

2. **Purpose** (provide a title or short description to use for lookup): Transition from Child Welfare System

**Purpose:** Capacity is reserved for individuals placed under the supervision of the Administrative Office of Probation by the Nebraska court system who are transitioning upon age nineteen into services provided by the Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DHHS-DD), and for individuals who are wards of the DHHS Division of Children and Family Services. The purpose is to ensure waiver capacity is available to support residential needs, employment and community integration.

**Describe how the amount of reserved capacity was determined:** Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.
The capacity that the State reserves in each waiver year is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>29</td>
</tr>
<tr>
<td>Year 2</td>
<td>45</td>
</tr>
<tr>
<td>Year 3</td>
<td>35</td>
</tr>
<tr>
<td>Year 4</td>
<td>35</td>
</tr>
<tr>
<td>Year 5</td>
<td>35</td>
</tr>
</tbody>
</table>

3. **Purpose** (provide a title or short description to use for lookup): Transition of Persons from Institutions

**Purpose:** Capacity is reserved for participants who have resided in an institutional setting for a period of at least one year, who are eligible for the waiver, and who are requesting community based services. This category applies to the following institutions: a private or public intermediate care facility for persons with an intellectual or developmental disability (ICF-IDD); a nursing facility (NF); or an institution for persons with mental disease (IMD). The state has set a one year requirement to prevent the use of loop holes to acquire funding by jumping ahead of those who are waiting for funding.

**Describe how the amount of reserved capacity was determined:** Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>25</td>
</tr>
<tr>
<td>Year 2</td>
<td>25</td>
</tr>
<tr>
<td>Year 3</td>
<td>25</td>
</tr>
<tr>
<td>Year 4</td>
<td>25</td>
</tr>
<tr>
<td>Year 5</td>
<td>25</td>
</tr>
</tbody>
</table>

4. **Purpose** (provide a title or short description to use for lookup): Developmental Disabilities Custody Act

**Purpose:** Capacity is reserved to provide community services to individuals identified through the Nebraska court system, pursuant to the Developmental Disabilities Custody Act, in order to provide immediate access to community based services to reduce recidivism and avoid incarceration. These individuals do not meet the definition of an inmate of a public institution as defined at 42 CFR. §435.1010 and further explained in CMS State Health Official Letter 16-007.
Describe how the amount of reserved capacity was determined: Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>10</td>
</tr>
<tr>
<td>Year 2</td>
<td>10</td>
</tr>
<tr>
<td>Year 3</td>
<td>10</td>
</tr>
<tr>
<td>Year 4</td>
<td>10</td>
</tr>
<tr>
<td>Year 5</td>
<td>10</td>
</tr>
</tbody>
</table>

5. **Purpose** (provide a title or short description to use for lookup): Transition of Participants from Other Waivers.

**Purpose:** Capacity is reserved to accommodate the transition of participants from other Medicaid HCBS 1915(c) waivers. The purpose is to ensure waiver capacity is available to support eligible participant’s health and safety needs, choice in waiver, and services that support their residential needs, employment, and community integration under the most appropriate HCBS waiver.

Describe how the amount of reserved capacity was determined: Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>10</td>
</tr>
<tr>
<td>Year 2</td>
<td>10</td>
</tr>
<tr>
<td>Year 3</td>
<td>10</td>
</tr>
<tr>
<td>Year 4</td>
<td>10</td>
</tr>
<tr>
<td>Year 5</td>
<td>10</td>
</tr>
</tbody>
</table>

6. **Purpose** (provide a title or short description to use for lookup): Dependents of Military Families Assigned to Nebraska.

**Purpose:** Capacity is reserved to support a military member’s assignment in Nebraska whose dependent meets ICF-DD level of care for this waiver. The purpose is to ensure waiver capacity is available to eligible dependents of a member of the armed forces of the United States who is a legal resident of this state, to support residential needs, employment, and community integration.
Describe how the amount of reserved capacity was determined: There is no historical data to determine the number of reserved slots. The State believes the number of slots reserved will meet the projected need.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Capacity Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>0</td>
</tr>
<tr>
<td>Year 2</td>
<td>10</td>
</tr>
<tr>
<td>Year 3</td>
<td>10</td>
</tr>
<tr>
<td>Year 4</td>
<td>10</td>
</tr>
<tr>
<td>Year 5</td>
<td>10</td>
</tr>
</tbody>
</table>

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 a phase-out schedule that is included in Attachment #1 to Appendix B-3.

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.

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

Persons who meet eligibility criteria as defined in Nebraska Revised Statute §83-1205 will be assessed for Medicaid HCBS Waiver level of care and placed on a waiting list. The date used to establish a person's placement on the waiting list is the date of application from which eligibility for developmental disabilities in Nebraska was originally established. Persons remain on the waiting list until a waiver slot has been assigned to them for use, the Legislature appropriates special funds to serve a specific class of people, they withdraw from the list, or they become ineligible for the waiver. Waiver dollars are not used for the assessments that are done prior to placing an individual on the waiting list.

Selection of individuals for entrance to the waiver is referred to priority funding and is defined in Nebr. Rev. Stat. §83-1216. The priorities for funding the Medicaid home and community-based services waivers are as follows:
1. Responding to an immediate crisis due to caregiver death, homelessness, or a threat to the life and safety of the person;
2. Responding to the needs of persons that have resided in an institutional setting for a period of at least twelve consecutive months and who are requesting community-based services;
3. Responding to the needs of wards of the department or persons placed under the supervision of the Office of Probation Administration by the Nebraska court system who are transitioning upon age nineteen with no other alternatives as determined by the department to support residential services necessary to pursue economic self-sufficiency;
4. Responding to the needs of persons transitioning from the education system upon attaining twenty-one years of age to maintain skills and receive the day services necessary to pursue economic self-sufficiency;
5. Responding to the needs of persons who are dependents of members of the armed forces of the United States who are legal residents of this state due to the service member's military assignment in Nebraska; and
6. Responding to the needs of all other persons by date of application.

If there is a change in a person's needs, they may contact DHHS-DD and request that an assessment of an immediate crisis be completed. Persons who are assessed to be in an immediate crisis and the crisis cannot be resolved in another way shall be prioritized highest on the waiting list. An immediate crisis due to caregiver death, homelessness or other situations that threaten the life and safety of the individual is defined by the following criteria:

1. Homelessness: the person does not have a place to live or is in imminent danger of losing their home and has no resources/money to secure housing.
2. Abusive or neglectful situation: the person is experiencing or is in imminent risk of physical, sexual or emotional abuse or neglect in the person’s present living situation.
3. Danger to self or others: the person's behavioral challenge is such that the person is seriously injuring/harming self or others in their home, or is in imminent danger of doing so.
4. Loss of primary relative caretaker due to caretaker death or the caretaker is in need of long term services and support themselves.

Once the maximum number of unduplicated participants is reached in each waiver year, no additional participants will be enrolled.

Appendix B-3: Number of Individuals Served – Attachment #1 Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification.
   ☐ §1634 State
   ☒ SSI Criteria State
   ☐ 209(b) State
2. Miller Trust State.
☐ No
☐ Yes

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

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

☐ Low income families with children as provided in §1931 of the Act
☒ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☒ Optional State supplement recipients
☒ Optional categorically needy aged and/or disabled individuals who have income at:
Select one:
☑ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL Specify percentage: ___%
☒ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☒ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐ Medically needy in 209(b) States (42 CFR §435.330)
☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)
Specify:
- Former Foster Care Children (435.150)
- Infants and Children Under Age 19 (435.118)
- Pregnant Women (435.116)
- Parent/Caretaker Relative (435.110)
- Reasonable Classification (435.222)
- Children Eligible under Title IV-E Foster Care and Adoption Agreements (435.145)
- Children under 19 with Non-IV-E Adoption Assistance (435.227)
- Optional Targeted Low Income Children (435.229)
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:
  ☐ 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 spenddown 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:
  ☐ 100% of FPL
  ☐% of FPL, which is lower than 100%. 

☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) Specify:
  • Recipients who are medically needy with spenddown: The State will use the actual maximum monthly allowable ICF/ID rate to reduce
an individual's income to an amount at or below the medically needy income limit (MNIL) for persons who are medically needy with a Share of Cost.

Appendix B-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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

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

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

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

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

☒ The following standard included under the State plan (select one):
  □ SSI Standard
  □ Optional State supplement standard
  □ Medically needy income standard
  □ The special income level for institutionalized persons (select one):
    □ 300% of the SSI Federal Benefit Rate (FBR)
    □ A percentage of the FBR, which is less than 300%. Specify the percentage: ______
    □ A dollar amount which is less than 300%. Specify dollar amount:
  □ A percentage of the Federal poverty level. Specify percentage:
☒ Other standard included under the State Plan. Specify:
  • Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL
  • Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

☐ The following dollar amount. Specify dollar amount: ____. If this amount changes, this item will be revised.

☐ The following formula is used to determine the needs allowance: Specify:

☐ Other

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

☒ Not Applicable

☐ The State provides an allowance for a spouse who dies 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
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

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-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-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(d) 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 amount for incurred expenses for medical or remedial care (as specified below).

i. **Allowance for the personal needs of the waiver participant: (select one):**
   - ☐ SSI Standard
   - ☐ Optional State supplement standard
   - ☐ Medically needy income standard
   - ☐ The special income level for institutionalized persons
   - ☐ A percentage of the Federal poverty level. Specify percentage:
   - ☐ The following dollar amount: Specify dollar amount: _____. If this Amount changes, this item will be revised.
   - ☒ The following formula is used to determine the needs allowance: Specify formula:
   - ☒ Other. Specify:
     - • Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL
     - • Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

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

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**
   a. Health insurance premiums, deductibles and co-insurance charges
   b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:
   - ☐ Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
   - ☒ The State does not establish reasonable limits.
   - ☐ The State used the same reasonable limits as are used for regular (non-spousal) post-eligibility.

**Appendix 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-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-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.**

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

**Appendix 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:
The minimum frequency for the provision of the waiver service is ninety days. A participant’s approved waiver slot will remain available to the participant when the participant is hospitalized, receiving rehabilitation services, receiving non-community based crisis services, or is incarcerated and cannot utilize a waiver service for ninety days. A request to keep the slot available beyond ninety days for a participant must be based on critical health or safety concerns and other relevant factors, and is subject to approval by the Department.

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):
   - Directly by the Medicaid agency

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:

   DHHS-DD staff perform the initial evaluation of level of care. Disability Services Specialists (DSSs) complete the initial evaluation and are required to have a Bachelor’s degree and professional experience in: education, psychology, social work, sociology, human services, or a related field and experience in services or programs for persons with intellectual or other developmental disabilities.

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

   Individuals who are deemed to require ICF-IDD level of care are enrolled in and maintained on (pursuant to reevaluation) this waiver. All waiver participants must meet the criteria for a developmental disability as defined under Neb. Rev. Stat. §83-1205.

   As defined by CMS, the process that is used to assess ICF-IDD level of care and determine whether new waiver entrants meet all waiver eligibility criteria is termed “evaluation.” The evaluation must find that there is a reasonable indication that the individual would need waiver services within the near future (two months or less). The periodic review to verify that the individual continues to meet all waiver eligibility criteria is termed “reevaluation.”

   The following waiver eligibility criteria is used to initially determine, or evaluate, whether an individual needs services through the waiver:
   a. Eligibility status as defined under Neb. Rev. Stat. §83-1205, which is verified at ages 9 and 18;
   b. Medicaid eligibility status;
c. Draft initial service plan (Individual Support Plan - ISP);
d. ICF-IDD Level of Care assessment (Developmental Index); and
e. Signed form for request/consent to community based services, which is the choice between home and community based waiver services and ICF-IDD services and choice of providers.

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

- [ ] The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
- [ ] A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

The Developmental Index ICF-LOC assessment tool for waiver evaluation and reevaluation is comparable to the ICF/DD Utilization Review assessment tool completed for institutional ICF placement. Both tools note skills, abilities, preferences, and needs, including health needs, means of communication, and behavioral concerns. The participant and his/her Service Coordinator (SC), provider staff, or others who are familiar with the participant complete the applicable tool.

The Developmental Index LOC assessment is completed on an annual basis. Although the tools are different, reliability and validity testing using a sampling methodology indicates that the outcome of the determinations yielded from the Developmental Index is similar to the outcome of determinations yielded from the assessment completed for ICF placement.

If a former waiver participant enters the State ICF for short-term intensive behavioral treatment, the LOC is determined using the ICF/DD Utilization Review assessment tool.

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:

DHHS-DD requires that an initial evaluation and an annual reevaluation of waiver eligibility are conducted by DHHS-DD staff to access waiver services. The DSSs perform
the initial waiver approval, as stated in Section B-6-d. A determination of initial waiver eligibility is made within 14 calendar days of the DSS receiving notification from the SC that a participant is ready for entrance to the waiver. The DSS provides notification of initial eligibility for waiver services to the participant and/or representative.

Assigned DHHS-DD staff complete the annual waiver reevaluation. The following criteria is used to annually reevaluate, or reevaluate, continued eligibility for Medicaid HCBS DD waiver services:

- Medicaid eligibility status;
- Annual service plan (Individual Support Plan - ISP); and
- ICF-IDD Level of Care assessment (Developmental Index).

The process for the annual waiver reevaluation includes a review of the Developmental Index ICF-Level of Care assessment; the service plan; and Medicaid eligibility status.

The Developmental Index ICF-Level of Care Assessment is completed by the participant, their service coordinator, provider staff, and other team members. This process allows all team members to have and provide input. Within ten calendar days, the annual reevaluation is completed and the participant’s annual budget is approved and authorized by Service Coordination in accordance with policy and state and federal regulations.

As a last step, the DHHS-DD staff provides notification of the annual waiver reevaluation to the participant and their service plan team. If eligible, the participant is maintained on the waiver. If the participant is not eligible because they are not Medicaid eligible or do not meet ICF-IDD Level of Care for waiver, these participants are removed from the waiver and their waiver case is closed.

Participants who are determined not eligible for waiver services receive written notification of their ineligibility via a Notice of Decision and are then eligible for a Fair Hearing under the state regulations if they believe that the eligibility determination was made in error or the ICF-Level of Care determination is not accurate.

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

- [ ] Every three months
- [ ] Every six months
- [ ] Every twelve months
- [ ] Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations. The qualifications are different. Specify the qualifications:

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

DHHS-DD staff that complete reevaluations utilize the web-based case management system and the processes within it that are components of case management to ensure timely reevaluations of waiver eligibility. DHHS-DD staff run electronic reports to determine if reevaluations are conducted timely and review findings at monthly supervision meetings.

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

The state assures that written and/or electronically retrievable documentation of all evaluations for initial waiver and reevaluations for annual waiver are maintained for a minimum period of 3 years as required in 45 CFR §92.42. DSSs who are responsible for the level of care evaluations, initial waiver evaluation and approval maintain an electronic record for each waiver participant. DHHS-DD staff who are responsible for performing the annual waiver reevaluation also keep an electronic record for each participant. The electronic records are maintained in a web-based case management system permanently.

**Quality Improvement: Level of Care**

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:**

A-1. Number and percent of new waiver eligible applicants for whom Intermediate Care Facility (ICF) Level of Care (LOC) was determined prior to the receipt of services. Numerator = number of new waiver eligible applicants for whom ICF LOC was determined prior to receipt of services; Denominator = number of new waiver eligible applicants.

Data Source:

- Record reviews, on site

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<thead>
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<th>Responsible Party of data collection/generation (check each that applies)</th>
<th>Frequency of data collection/generation (check each that applies)</th>
<th>Sampling Approach (check each that applies)</th>
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<td>□ Operating Agency</td>
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<td>□ Less than 100% Review</td>
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Data Aggregation and Analysis:

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

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

**Performance Measure:**

C.1. Number and percent of participants for whom annual Intermediate Care Facility (ICF) Level of Care (LOC) determinations were completed within 12 months of their initial LOC determination. Numerator = number and percent of participants for whom an annual LOC determinations completed within 12 mos. of initial LOC determination. Denominator = Number and percent of participants for whom annual Level of Care (LOC) determinations were completed.

**Data Source:**
- Record reviews, off site

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

Annual reevaluation of waiver eligibility is completed for all (100%) waiver participants. The Developmental Index LOC assessment is reviewed during the participant’s annual service plan meeting and documented in the service plan.

Additionally, the DHHS-DD quality team will conduct annual off-site file reviews to verify the dates that work was completed by the assigned DHHS-DD staff. The percentage of file reviews is included in the State's internal HCBS Waiver quality improvement processes. Those processes are reviewed at a minimum, 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 sample size for this review is determined by:
1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR
2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

b. Methods for Remediation/Fixing Individual Problems

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

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

Monthly quality assurance reports are electronically generated for access by DHHS-DD staff and are reviewed at both the field office and central office levels to ensure continued Medicaid and DD waiver eligibility for participants. DSSs, SCs, and SCSs review reports and take appropriate action as needed on individual cases. Examples of such action may be facilitating activities for recertification of Medicaid, correcting a service authorization to change or end DD waiver services, completing a LOC assessment, etc.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification):
Responsible Party for data aggregation and analysis (check each that apply)  | Frequency of data aggregation and analysis (check each that apply)
---|---
☒ State Medicaid Agency | ☐ Weekly
☐ Operating Agency | ☐ Monthly
☐ Sub-State Agency | ☐ 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**

**Appendix B-7: Freedom of Choice**

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

i. Informed of any feasible alternatives under the waiver; and

ii. Given the choice of either institutional or home and community-based services.

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

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

A signature for consent, documenting that waiver participant's choice is to receive community based waiver services over services in an institutional setting, is obtained upon initial termination of waiver eligibility and is kept in the participant's electronic waiver file. If guardianship or legal status changes, the SC must obtain a new, signed consent.
b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The waiver consent form is kept in the participant’s electronic file maintained by DHHS-DD staff. The records are maintained permanently in electronic files by DHHS-DD staff.

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

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

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

- Oral language assistance services such as interpreters;
- Spanish translation of written materials, such as applications, brochures, due process, and the Notice of Decision;
- Spanish language placards, posters, etc.;
- Second language hiring qualifications;
- Availability of translators, including sign language;
- AT&T statewide language line; and
- Spanish language web sites.

Based on a published table of Estimate of at Least Top 15 Languages Spoken by Individuals with Limited English Proficiency (LEP) for the 50 States, the District of Columbia, Puerto Rico and each U.S. Territory from the U.S. Department of Health and Human Services, Office for Civil Rights, August 2016, Spanish is the prevalent non-English language in Nebraska. When the primary language is not English or Spanish, the state provides timely and accurate language assistance services, such as oral interpretation, and written translation when written translation is a reasonable step to provide meaningful access to an individual with LEP.