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 waiver's 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:**
Comprehensive DD waiver for adults
C. **Waiver Number:NE.0396**
Original Base Waiver Number: NE.0396.
D. **Amendment Number:NE.0396.R02.01**
E. **Proposed Effective Date:** *(mm/dd/yy)*
07/20/15
Approved Effective Date: 07/07/15
Approved Effective Date of Waiver being Amended: 01/01/11

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to update information related to rate determination methods, public input for the rate methodology study, service definitions impacted by the implementation of the new rate methodology, limitations to prospective individual budget amounts, flow of billings, and the billing validation process.

The following service definitions were revised to align with the rate methodology: Group home residential habilitation, Integrated Community Employment, Companion Home Residential Habilitation, Extended Family Home residential habilitation, In-home residential habilitation, Retirement services, Vocational Planning habilitation service, and Workstation habilitation. In an effort to have consistency among waivers, Prevocational Workshop Habilitation and Community Inclusion Day Habilitation were terminated and the definitions were incorporated into a new service, Day Habilitation. Waiver participants that were authorized for Prevocational Workshop habilitation or Community Inclusion day habilitation were authorized for Day Habilitation with no service disruption.

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	Main 6-I, Attachmen
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	C-3, C-4, and C-5
☐ 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	I-2 a., I-2 b.
☑ Appendix J – Cost-Neutrality Demonstration	J-1 and 2

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:
Revise Rate Determination Methods, Flow of Billings, and Billing Validation Process in Appendix I.
Update Public Input in Main section.
Update Authorizing Signature information in Main section.
Revise Prospective Individual Budget Amount in Appendix C-4.
Add Main Attachment #2 HCB Settings Waiver Transition Plan.
Add Appendix C-5 Home and Community-Based Settings.

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*):
Comprehensive DD waiver for adults

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.0396
Waiver Number:NE.0396.R02.01
Draft ID: NE.014.02.02

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

E. Proposed Effective Date of Waiver being Amended: 01/01/11

Approved Effective Date of Waiver being Amended: 01/01/11

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**
☐ **A program authorized under §1915(j) of the Act.**
☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Purpose:
The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a menu of services and supports intended to allow individuals with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under this waiver for adults, age 21 years or older, and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer.

Non-specialized services, known as Community Supports are services directed by the individual or family/advocate and delivered usually by independent providers. These self-directed, or participant-directed, services are intended to give the individual more control over the type of services received as well as control of the providers of those services.

Specialized services are traditional habilitation services that provide residential and day habilitative training and are delivered by certified DD agency providers.

Goals:
Prevent institutionalization in an ICF or nursing facility for indivduals whose needs can be met by community based DD providers.

Promote a high quality of service delivery in community based services.

Expand participant direction of services.

Objectives:
Have a sufficient number of waiver slots each year of the waiver in order to have waiver services available to individuals who meet the eligibility criteria.

Continue to work with the Division of Medicaid and Long-Term Care (DMLTC), the Division of Public Health (DPH), DDD Service Coordination, and DDD Disability Services Specialists to develop and enhance a statewide quality improvement plan.

Share and make use of all monitoring data.

Monitor provider quality assurance activities.

DHHS DDD, the single State Medicaid agency operates the Comprehensive Home and Community Based Services (HCBS) waiver for adults with developmental disabilities. DHHS staff enroll independent providers to deliver community supports to eligible individuals. DHHS staff certify DD provider agencies and DDD contracts with certified DD provider angencies to deliver specialized habilitation services. DHHS DDD staff located across the state determines eligibility for this

comprehensive waiver. Services are prior authorized by DDD staff and individualized funding is based on an objective assessment process.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would

have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or

as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The following strategy was utilized for the study and implementation for the rate methodology and revisions to service definitions:
In 2009, provider agencies approached the Nebraska Legislature to request an appropriation to allow for a rate methodology study to be conducted by DDD. A legislative hearing was conducted and ultimately the funds were appropriated. A Request for Proposal (RFP) was released to attract proposals from entities who were experienced in setting rates for DD waiver services and as a result, a contractor was secured. The contractor, in collaboration with DDD and provider agencies developed a provider advisory committee and began working with a subcontractor to gain input from non-provider stakeholders. The advisory committee, the contractor and DDD had multiple in-person meetings and conference calls throughout 2010 to finalize the rate study. In addition, surveys were conducted with providers, waiver participants, family members, advocacy organization representatives, and DD Service Coordinators, and interviews were held with state representatives from 6 states.
A provider cost and wage survey was developed in order to collect data in a uniform format, modeled after a survey developed for use by Wyoming's Division of DD. On Nov. 15, 2010 the survey and instructions were distributed to all certified DD agency providers to give all providers an opportunity through Dec. 10th to respond.
Six states were interviewed and researched to gather comparable information about their HCBS waivers for individuals with DD: IA, SD, WY, TN, FL, and ME, which are similar to NE in either service delivery, population and/or geography. Since DDD was interested in creating a tiered rate system, the contract modeled the methodology off of Wyoming's since their experience was relevant to the development of a methodology for DDD.

The contractor used the most recently available US Bureau of Labor Statistics wage data to review the median wage rates for a range of occupations that were similar to staff occupations at the provider agencies. Median rates for NE as well as IA, KS, SD and WY were examined to provide a point of comparison between the wage rates reported by DDD providers to the NE medians, and to show how NE compares to its peers.

In Dec. 2010, a web-based survey of non-provider stakeholders was conducted to gather their opinions about the services and rates paid to DD providers. Among stakeholder respondents were DD service recipients, family members, advocacy organization representatives, and DD Service Coordinators.

The consulting firm considered the results of the survey in its recommendations around staff wages, benefits, and training, and in June 2011, the firm met with DDD and providers to review a draft of the rates. As a result of the meeting and the additional information gathered in July, adjustments to the rate models were made and the final report was presented to DDD in Oct. 2011. Since then, the final report has been posted on the DHHS public website.

DDD has included in its annual legislative updates since 2011, the study, its impact, and the funding appropriation needed to implement the methodology. All of these documents were posted on the Department's public website. In addition, DDD has a newsletter that is mailed or emailed to providers, advocates and every single person who is

eligible for DD services (those currently receiving services and those who might be waiting). The methodology was explained in the Jan., Feb., and Mar. 2010 issues in addition to updates in the Fall and Winter 2013 editions, once the funding was appropriated by the legislature.

In addition to the public input that was gathered during the development of the methodology itself, a budget request was made in 2012 by the Governor to the Legislature to implement the proposed rate methodology. All legislative hearings are publicly noticed and provider and advocates attended appropriation hearings held in early 2013. The DHHS and provider agencies testified at openly (televised and web-streamed) public hearings. In May 2013 the Nebraska Legislature included appropriation for full implementation of the rate methodology in addition to funding to ensure that every person receives a budget based on their assessed needs. The implementation date was set for July 1, 2014.

From Oct. 2013 through Jan. 2014, DDD held 60 public forums in 23 communities. Meetings announcements were sent directly to every eligible individual, invitations were sent to every provider agency, and notice was given to all DDD staff. Nearly each community had 3 forums: 1 for waiver participants, their families and advocates, 1 for provider staff, and 1 for DDD staff. A consistent power point presentation was utilized at each forum meeting to discuss waiver amendments, renewals and changes in services over the last 5 years and beyond.

As a result of the rate methodology, revisions were anticipated for service definitions to comport with the structure of the methodology. In preparation for implementation, letters were sent in Feb. and Mar. 2014 to every individual in services providing an explanation and a notice of the change in the rate structure, and the revision to their individual budget amount. Every person was given due process rights and individual teams began to meet to make adjustments to service plans as appropriate.

On Mar. 5, 2014 the Nebraska area tribal government and agencies were notified of the submission of the waiver amendments. The letters also provided contact information for questions and comments and opportunities for public comment. No comments were received from the tribal government and agencies.

The waiver amendments were posted to the DDD public website on 12/1/14 for 30 days. No comments were received from the public that were specific to this waiver. Therefore, no changes were made to the waiver.

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

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

7. Contact Person(s)

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

Last Name:

Hovis

First Name:

Pam

Title:

Waiver Manager, Division of Developmental Disabilities

Agency:

Nebraska Department of Health and Human Services

Address:

P.O. Box 98947

Address 2:

301 Centennial Mall South

City:

Lincoln

State: **Nebraska**

Zip:

68509-8947

Phone:

(402) 471-8717 **Ext:** ☐ **TTY**

Fax:

(402) 471-8792

E-mail:

pam.hovis@nebraska.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nebraska**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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: Courtney Miller

State Medicaid Director or Designee

Submission Date: Jun 29, 2015

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

Last Name: Miller

First Name: Courtney

Title: Deputy Director

Agency: Nebraska Department of Health and Human Services

Address: Nebraska State Office Building, 5

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509

Phone: (402) 471-9185 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: courtney.miller@nebraska.gov

Attachments

Attachment #1: Transition Plan

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

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**

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

Specify the transition plan for the waiver:

Services offered in the renewed waiver will include the same services offered in the approved waiver as well as additional services. Residential habilitation services in a person's home, their family home, or a congregate setting; enhanced habilitation services of vocational planning services, prevocational services in a congregate setting, or integrated community employment; provider operated respite services; and team behavioral consultation will continue to be offered under this waiver.

Additional services will be added to this waiver. Services in support of participant direction will include community living and day supports (CLDS) and respite services. Other waiver services will include personal emergency response system; assistive technology and supports (ATS); vehicle modifications; and home modifications. Additional habiliation services will include community inclusion day habilitation services and companion home residential services. Additional enhanced habilitation services will include retirement services; behavioral risk services; and medical risk services.

The changes in the renewal waiver will go into effect January 1, 2011, and each will be transferred to another waiver. There will be no gap in waiver services for each participant and for those participants that choose to continue with the same services and same provider(s), the transition will be behind the scene and seamless for the individual.

Prior to implementation, individuals will be provided information through a variety of methods. The State will develop and provide training to individuals, family/advocates, DDD service coordination staff, and DD agency provider staff on individualized budgeting, self-directing, choosing service options, authorization, and submission of claims. Training will be offered in person and via teleconferencing. Materials on the new services and the new menu of services will be available in hardcopy and electronically.

On an individual basis, just prior to the annual individual program plan (IPP) meeting, the service coordinator will review and discuss individualized budgeting and the new menu of services and assist the individual and/or family/legal representative as necessary to plan a budget, determine services to be purchased, and to choose providers to deliver the chosen services. Individuals may choose to have the same services, same amount of services, and same providers, and in those cases, there will be very little apparent changes.

When health and welfare needs cannot be met within the person's budget, adjustments to services, exceptions to funding or delivery of services, or a referral to another HCBS waiver or non-waiver services and supports will be determined on a case by case basis.

The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

Individuals served in the approved waiver will be eligible to participate in the renewed waiver. A transition plan has been developed for individuals transitioning from waivers 0395 or 0454. Individuals tranisitioning from the 0395 and 0454 waiver will have more choices in services and providers.

Participants in the Residential habilitation services waiver will transition to the renewed waiver on January 1, 2011 because the residential habilitation services waiver will not be renewed and will expire December 31, 2010. CMS and participants will be informed in writing of the non-renewal of the residential habilitation waiver by December 1, 2010. Authorizations will be electronically updated to reflect a change of waiver. At the next regularly scheduled IPP, the document will be revised to reflect any changes in the person's services and supports, including identification of the current waiver.

The Community Supports waiver will be terminated when all participants have transitioned to the renewed waiver. The

transition will occur when their next regularly scheduled IPP meeting occurs. Authorizations and IPPs will be revised to reflect the change in waivers, services, and supports. The State will inform CMS and waiver participants of the termination of the community supports waiver at least thirty days in advance before ending the waiver.

The participant is informed of the opportunity to request a Fair Hearing.

Initially, when a person is determined eligible or ineligible for DD services and with each written notice of decision, the individual and his/her legal representative are informed of and receive a copy of the right to appeal.

The DDSC-53, Rights and Obligations, is provided to the individual and his/her legal representative upon initial referral to services, at the time funding is authorized, and annually at the IPP meeting. The right to have action initiated on their request within 45 days, the right to receive written notice of any decision, the right to appeal a decision, and the right to request a fair hearing within 90 days of the notice of decision is printed on the document.

The DD-SC38, Notice of Decision, is used for eligibility determinations for DD services and funding decisions. "Your Rights" is printed on the document and includes the right to appeal and an explanation of an opportunity for an informal dispute resolution.

The DDD-1, Consent/Request for (waiver) Services, which is used to document consent to receive waiver services and choice between receiving community based waiver services and institutional services also has the right to appeal information printed on the document.

The Service Coordinator provides the right to appeal information to individuals.

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 the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The following service settings are included in this waiver and will be evaluated for compliance with federal HCB settings requirements: Day Habilitation, Vocational Planning Habilitation, Workstation Habilitation, Group Home Residential Habilitation, Respite, Behavioral Risk, Companion Home Residential Habilitation, Medical Risk, and Retirement.

The following service settings will not be assessed: private homes, businesses, and public buildings where In-home Residential Habilitation, Integrated Community Employment, and Community Living and Day Supports are delivered. These services will continue to meet HCB Setting requirements through already existing prohibitions of these services from being provided in provider-owned and controlled settings. The following services are not specific to settings but rather are a type of service delivered to individuals, and therefore will not be assessed.
• Team Behavioral Consultation,
• Assistive Technology and Supports,
• Personal Emergency Response System,

• Home Modifications, and
• Vehicle Modifications.

The following DHHS resources will be utilized by DHHS staff to evaluate and identify service settings that are in compliance with the CMS HCBS rule as well as to identify service settings that are "likely not" community: Provider listings, provider site reviews and compliance surveys, participant experience surveys, self-advocate/family surveys, service coordination monitoring tools, provider self-assessments, and stakeholder meetings.

Applicable to waiver 0396, a review of regulatory compliance in thirty nine areas will be conducted, as identified in the HCBS Transition Plan Matrix – Comprehensive which is posted on the DHHS public website. Needed changes in HCBS waivers, state regulations and internal guidelines that don't comport with all requirements of the rule will be identified and initiated. Provider Self-Assessment tools and Self-Advocate/Family Surveys have been developed to provide information to the state regarding the community nature of day and residential settings and to identify day and residential services settings that are "likely not" community. Needed changes in data sources and performance metrics that relate to and/or demonstrate the current level of compliance with the CMS rule will be identified and initiated. Data sources to be used to measure transition plan activities outlined in the Gantt chart (pages 86 – 91) will be utilized.

The first part of this section describes the strategies that were utilized to gather and consider public input prior to the draft and final transition plans for this waiver. The second part of this section, divided by a line, specifies the state's process to bring this waiver into compliance with federal HCB settings requirements.

The state secured public input into the development of the transition plan for this waiver.

Input on Settings Requirements Prior to Draft Transition Plan(s):

Nebraska's Department of Health and Human Services (DHHS) has initiated a comprehensive review of Nebraska's HCBS waivers and related regulations, policy and procedures to assess and identify changes necessary to comply with the new CMS HCBS rules and ensure people receiving long term services and supports have the same opportunity to access their community that all Nebraska's citizens enjoy. The services currently under review include the Developmental Disabilities Comprehensive Waiver at http://dhhs.ne.gov/developmental_disabilities/Documents/Nebraska-DDACwaiver-2011.pdf, and at http://dhhs.ne.gov/developmental_disabilities/Documents/AmendedDDACWaiverNE0396.pdf, and the Developmental Disabilities Rules and Regulations, found in Title 404 of the Nebraska Administrative Codes at http://dhhs.ne.gov/Pages/reg_t404.aspx.

DDD has shared information regarding the CMS rule and related guidance (including the various webinars) since January 2014 with our stakeholders. With significant impacts anticipated to developmental disability day services, targeted collaboration with developmental disability service providers and other stakeholders was initiated. Service provider representatives even participated with Nebraska staff in our Lincoln office for one of the webinars presented by CMS.

DDD leadership has met monthly with the Nebraska Association of Service Providers (NASP) since July 2014, and NASP was provided multiple opportunities to offer informal and formal input on the transition plan and issues related to the settings challenges. In August 2014, this collaboration resulted in NASP's website publication and outreach efforts to families and provider staff most impacted by the rule to provide education and support prior to the anticipated issuance of the draft transition plan.

The new settings requirements are going to require significant organizational changes of many of our developmental disabilities service providers. Our providers have been active collaborators in this process to ensure that Nebraska continues to provide appropriate services to meet the needs of our vulnerable citizens. With the support of the Nebraska Planning Council on Developmental Disabilities, several providers have already started working with consultants to reorganize their services to promote integrated recreation and community employment, with great initial success. We share a common dedication to supporting individuals with developmental disabilities in our communities with quality services, and appreciate their collaboration through this process.

Multiple forms of public notice were utilized to inform stakeholders that the transition plan was available for public comment.

Nebraska provided a 39 day public notice and comment period (September 5, 2014 through October 14, 2014), providing for the following public input opportunities:

• Emailing to DHHS.HCBSPublicComments@nebraska.gov;
• Faxing to 402-471-9449 attention Christina Mayer;
• Mailing written comments to the Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026;
• Providing in person comments at public meetings; and/or
• Calling Christina Mayer at 1-877-867-6266.

Notice was provided in the following manner:
• Notification to the Nebraska Association of Service Providers on August 25, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on August 29, 2014;
• Delivery via U.S. postal service of a postcard announcement to all recipients of developmental disability services, as well as all individuals on DDD's eligibility registry (i.e. people who are eligible for services, but not currently receiving services) on September 1, 2014;
• Notification of Amendments and proposed State Transition Plan to Nebraska Tribal associations on September 4, 2014;
• Publication on the Nebraska Department of Health and Human Services website, with a specific HCBS Waivers State Transition Page created specifically to support this process (with links to this webpage from both the MLTC and the DDD webpages) on September 5, 2014;
• Email to all DDD staff, DD agency providers, the DD Planning Council, DD Advisory Committee, the ARC of Nebraska, Disability Rights of Nebraska, the Legislative Ombudsman's Office and the Nebraska Legislative Special Committee on Developmental Disabilities on September 5, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on September 7, 2014;
• Publication in the Munroe Meyer Institute Update, an electronic newsletter circulated broadly to stakeholders throughout Nebraska by our University Center for Excellence, on September 12, 2014.

The following language was posted 8/29/2014 in the Omaha World-Herald, a newspaper with statewide circulation:
MEETING NOTICE The Nebraska Department of Health and Human Services (DHHS) will hold public hearings to accept comments on the Department's proposed plans to ensure compliance with new Federal rules which require home and community based services to be provided in "community-like" settings. At these public hearings, DHHS will provide an overview of the requirements of Final Rule CMS 2249-F and CMS 2296-F published in the Federal Register on 1/16/14 which became effective 3/17/14. Hearings will be held from 1 to 3 pm CST on:
• 9/29/14 – Niobrara Room, Kearney Public Library, 2020 1st Ave, Kearney, Nebraska
• 9/30/14 – Lower Level B, Nebraska State Office Building, 301 Centennial Mall South, Lincoln, Nebraska
Interested persons are invited to submit written comments or to attend and comment at the hearing. Written comments must be postmarked or received by 5:00 P.M. 10/02/14 and should be emailed to DHHS.HCBSPublicComments@Nebraska.gov, faxed to 402-471-9449 attention Christina Mayer, or sent to Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026.
The transition plan and background materials can be viewed on the Department's website beginning 09/02/2014 at http://dhhs.ne.gov/Pages/hcs.aspx. The transition plan and background materials can also be requested via mail, email, or by phone at 877-867-6266.
If auxiliary aids or reasonable accommodations are needed to participate in the hearing, please call 877-867-6266. For persons with hearing impairments, please call DHHS at 402-471-9570 (voice and TDD) or the Nebraska Relay System at 711 or 800-833-7352 TDD at least 2 weeks before the hearing date.

A supplemental public notice was posted on September 7, 2014 in the Omaha World-Herald: SUPPLEMENTAL PUBLIC NOTICE Pursuant to 42 C.F.R. §441.301(c)(6)(iii), the Nebraska Department of Health and Human Services (DHHS) is required to give public notice related to the state's plan to comply with new regulation governing the settings in which the delivery of services to Medicaid Home and Community-Based Services waiver recipients may be provided.
Home and Community-Based Waiver Services
Settings Transition Planning
In accordance with and related to new Home and Community-Based Services Settings regulations found at 42 C.F.R. §441.301(c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), the state must submit a plan detailing actions to achieve compliance with the setting requirements. A public notice and comment period of at least 30 days is required for the proposed transition plan. The transition plan is required in conjunction with any waiver amendment or renewal submitted following the implantation of the new regulation which became effective March 17, 2014.
The state's transition plan will be developed with stakeholder input to include public comment through multiple methods. The schedule for transition planning activities and other related information for participating in and submitting comment is posted on the Department's website at dhhs.ne.gov. Initial and ongoing comment may be submitted to the designated e-mail address: DHHS.HCBSPublicComments@nebraska.gov. This public notice and transition plan is available for review on the DHHS website at http://dhhs.ne.gov/Pages/hcs.aspx. A copy of the transition plan is available with the

public notice. Services Coordination staff will make available hard copies of the transition plan to any participant or applicant to the waiver upon request. In addition to the schedule of other comment submission options, an opportunity for public comment will be held at the following locations:
City Date/Time Location and Waiver Specific Presentations
Kearney Sept. 29, 2014; 1:00 – 3:00 p.m. CDT
Niobrara Room, Kearney Public Library, 2020 1st Avenue
All waivers will Be Presented

Lincoln Sept. 30, 2014; 1:00 – 4:30 p.m. CDT
Lower Level B, Nebraska State Office Building, 301 Centennial Mall South
All Waivers Will Be Presented

Omaha Oct. 7, 2014; 9:00 a.m. CDT
Metro Community College, 5330 North 30th St, Building 10 Room 110
Medicaid & Long Term Care Managed Waivers

Sidney Oct. 9, 2014; 9:00a.m. MDT
Western Nebraska Community College, Room 115, 371 College Dr.
Medicaid & Long Term Care Managed Waivers
Individuals who are disabled and need assistance to participate during this meeting should call (877) 867-6266. Individuals wishing to comment in writing on any of the proposed changes should do so on or before October 15, 2014, to the Department of Health and Human Services, attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026.

The matrices were presented at public meetings held in Kearney (September 29, 2014), Lincoln (September 30, 2014), Omaha (October 7, 2014), and Sidney (October 9, 2014). Evidence of Public Notice is posted on the DHHS public website in a fifty-two page document. Evidence of Public Notice is posted on the DHHS public website in a fifty-two page document.

The timeline for collecting, collating, analyzing, and incorporating public comments is identified in the Transition Plan Matrix. DD staff have reviewed, incorporated, and responded to all public comments. All public comments were considered, and responses were prepared and are included with the final plan in a ninety page document. Comments were received from email, fax, and public meetings. Included on the website is a matrix that identifies all 48 comments by date received, applicable waiver directed, commenter identity, source, response (which includes a brief summary of the comment content), whether the plan changed as a result of the comment, and the rationale for why the plan did or did not change.

Most commenters were supportive of the HCBS Rule and the transition process, but others were concerned about the transition process and fear that their current services will not be funded in the future by HCBS waiver funds. As noted in many comment responses, the Identification and Analysis activities noted in the transition plan are important in this respect as Nebraska evaluates current settings for compliance and analyzes options for transitioning all HCBS settings to become compliant with rule. Those activities include stakeholder input, which will allow such concerns raised by commenters to be addressed in the transition process.

Following, is a brief summary of the public comments.
• Expressed concerns about or support of the HCBS rule.
• Posed a question about settings in which HCBS waiver services can be carried out.
• Comments on format of plan.
• Posed questions related to identification and analysis activities in the plan.
• Support of the plan and continued need for stakeholder input during identification and analysis activities.
• Expressed gratitude for a specific waiver service provider.
• Addressed specific waiver services.
• Recommendations related to identification and analysis activities in the plan.
• Posed questions related to cost and accessibility of transportation.
• Expressed concerns about personal preferences, utilization of natural supports, and potential conflicts with CMS health and safety assurances.
• Provided ideas for future services.
• Expressed support for self-advocacy.
• Expressed dissatisfaction with a specific location of public meeting.

• Recommended the utilization of the National Core Indicators tool.
• Inquired on where the public comments were going to be available for review.
• Expressed concerns about timelines outlined in plan.
• Preferred terminology other than “community-like”.
• Posed a question about complaint reporting.

After reviewing and responding to all public comments, Nebraska determined that no substantive changes to the transition plan were necessary. While many great ideas were shared by stakeholders, those ideas can be considered within the context of the current plan. To unnecessarily revise the plan would be more harmful than helpful to HCBS recipients, as substantive revisions would delay transition activities and submittal of HCBS waiver amendments. To address some formatting and terminology questions and concerns, Nebraska has added Supplemental and Clarifying Information to the final transition plan. However, no substantive changes were made to the plan.

This section specifies the state's process to bring this waiver into compliance with federal HCB settings requirements.

The process to bring this waiver into compliance with federal home and community-based settings requirements is described in the state’s statewide transition plan document posted on the DHHS public website at http://dhhs.ne.gov/developmental_disabilities/Documents/TransitionPlan.pdf. The statewide transition plan document is in a matrix format on the website and includes a summary, background information, the CMS HCBS rule, the transition plan requirements, and the final transition plan.

The Comprehensive Transition Plan Matrix, posted on the DHHS website identifies the task, regulatory compliance area, action item, the anticipated start date, the targeted completion date, Nebraska DHHS resources, stakeholders, and expected outcome.

The Matrix specific to this waiver has been converted to plain text and contains exactly the same language contained in the December 1, 2014 submitted Statewide Transition Plan. This waiver-specific transition plan identifies the task, regulatory compliance area, action item, anticipated start date, targeted completion date for timelines to be accomplished, Nebraska DHHS resources, stakeholders, and expected outcome. Each action item, such as remediation strategies, includes the milestones, with beginning and end dates. All settings will be in full compliance with the regulation by March 17, 2019. The state will monitor HCBS settings on an ongoing basis as part of the established survey and certification process. When the state identifies settings that are not “community-like”, the state does not intend to provide evidence that the setting comports with the HCB Settings rule. The Division has a plan with an array of options to bring "not likely" day services settings into compliance that identifies the resources necessary and targeted timeframes for each element of the plan. For any settings that are not capable of coming into compliance, the Division has a plan to transition individuals to alternative services settings.

Nebraska 0396.R02.01 Waiver Transition Plan:

Information contained herein is taken directly from the Nebraska Statewide Transition Plan submitted on December 1, 2014; the following components are specific to the services provided in Nebraska’s 0396.R02.01, Adult Comprehensive Waiver. This plan is organized by task area, then regulatory compliance area. The action item numeration coordinates with the Statewide Transition Plan.

*Supplemental and Clarifying Information: Anywhere 'ongoing' is identified as a target completion date the action item will be met prior to March 17, 2019 and efforts are ongoing to meet or maintain compliance throughout the transition period.

Task: Identification

Regulatory Compliance Area: Community Integration - Day Services

Action Item #37: Identify regulation changes necessary to ensure day services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, CMS Toolkit and Guidance, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community

Liaison
Expected Outcome: Necessary changes to regulatons are identified to comply with new CMS rules regarding day services

Action Item #:38: Identify internal Division guideline revisions nessary to ensure day services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: Necessary changes to internal Division guidelines are identified to comply with new CMS rules regarding day services

Action Item #39: Identify day services settings that that are "likely not" community
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: Provider Listings, Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: There is a list of day service locations that may be considered "not likely" community.

Action Item #40: Create Provider Self-Assessment Tool and revise existing Self-Advocate/Family Surveys to provide information regarding the community nature of day settings.
Anticipated Start Date: 08/15/2014
Targeted Completion Date*: 09/30/2014
Nebraska Health and Human Services Resources: Prior Self-Advocate/Family Surveys, Samples from Other States, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Community Liaison, Technical Assistance Manager, DD Contract Manager
Expected Outcome: A Provider Self-Assessment Tool is created and the DD Community-Based Services Self-Advocate/Family Survey is updated to provide information regarding the community nature of day settings.

Regulatory Compliance Area: Community Integration - Residential

Action Item #41: Identify regulation changes necessary to ensure residential services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, CMS Toolkit and Guidance, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: Necessary changes to regulations are identified to comply with new CMS rules regarding residential services.

Action Item #42: Identify internal Division guideline revisions necessary to ensure residential services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: Necessary changes to internal Division guidelines are identified to comply with new CMS rules regarding residential services.

Action Item #43: Identify residential services settings that that are "likely not" community
Anticipated Start Date: 10/01/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: Provider Listings, Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: There is a list of residential locations that may be considered "not likely" community.

Action Item #44: Create Provider Self-Assessment Tool and revise existing Self-Advocate/Family Surveys to provide information regarding the community nature of residential settings.
Anticipated Start Date: 08/15/2014
Targeted Completion Date*:09/30/2014
Nebraska Health and Human Services Resources: Prior Self-Advocate/Family Surveys, Samples from Other States, CMS Toolkit, ARC of Nebraska, Developmental Disabililities Council, Developmental Disabilities Advisory Committee, Nebraska Association of Service Providers, and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Community Liaison, Technical Assistance Manager, DD Contract Manager
Expected Outcome: A Provider Self-Assessment Tool is created and the DD Community-Based Services Self-Advocate/Family Survey is updated to provide information regarding the community nature of residential settings.

Regulatory Compliance Area: General or Other Requirements

Action Item #45: Review regulations, internal guidelines, and HCBS waivers to identify requirements and language that don't comport with all other requirements of the new CMS HCBS rules that are not already identified herein.
Anticipated Start Date: 07/10/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, DDD Operational Guidelines, Nebraska's DD HCBS Waivers, CMS Toolkit and Guidance, Stakeholder Meetings and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager, Community Liaison
Expected Outcome: Necessary changes to NAC, waiver language, policy and procedures are identified to ensure compliance with lease requirements and roommate choice provisions of the new CMS HCBS rules

Action Item #46: Identify data sources and performance metrics that relate to and/or demonstrate the current level of compliance with new CMS rules
Anticipated Start Date: 07/10/2014
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Quality Review Team Surveys, Quality Improvement Indiciators/Data, CMS Toolkit, Stakeholder Meetings, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: QI Team, Community Liaison, Service Coordination Leadership Team, Quality Review Teams
Expected Outcome: Valid and reliable data produce a performance metric that demonstrates compliance with new CMS rule requirements

Action Item #47: Identify data sources that will be used to measure transition plan activities compliance with new CMS rules
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: ongoing
Nebraska Health and Human Services Resources: HCBS Compliance Plan Matrix (and all related data sources referenced therein), Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator
Expected Outcome: Valid and reliable data produce a performance metric that can be used to assess the success of transition plan actions in meeting the expectations of the new CMS rule requirements

Task: Analysis

Regulatory Compliance Area: Community Integration – Day Services

Action Item #48: Distinguish "likely not" community day services settings that meet requirements of heightened scruntiny from those that do not.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: For community day services, the Division knows which services are fully compliant, which ones are not fully compliant but meet the hightened scrutiny requirements, and is aware of the location and characteristics of settings that are not compliant and do not meet the heightened scrutiny requirements. By fully analyzing the characteristics of the various settings, the Division is better equipped to consider options to obtain full compliance.

Action Item #49: Consider remediation options for "likely not" community day settings that do not meet requirements of heightened scruntiny.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Self-Assessments, Stakeholder Meetings (led by Consultant, to include providers, self advocates/families, service coordinators and advocacy entitites)
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison, QI Team
Expected Outcome: The Division has a plan with an array of options to bring "not likely" day services settings into compliance that identifies the resources necessary and targteted timeframes for each element of the plan. For any settings that are not capable of coming into compliance, the Division has a plan to transition individuals to alternative services settings.

Action Item #50: Draft regulation changes necessary to ensure compliance with new CMS HCBS Rules related to day settings.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404 and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: Regulations comply with the new CMS HCBS rules related to day settings and support DDD activities to ensure compliance

Action Item #51: Draft internal Division guideline revisions necessary to ensure compliance with new CMS HCBS rules related to day settings
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: DDD internal staff guidelines comply with the new CMS HCBS rules related to day settings and support QI Team and Service Coordination Team activities to ensure compliance.

Action Item #52: Review and revise day service definitions to remove reference to facilities-based settings and clarify the Division's mission of serving all individuals in the most integrated setting possible.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*:10/01/2014
Nebraska Health and Human Services Resources: Developmental Disabilities HCBS Waivers, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, DD Waiver Administrator
Expected Outcome: DD HCBS Waivers reflect language that describes the Division's mission to serve all individuals in the most integrated setting possible.

Action Item #53: Review and revise retirement services definition, requirements and restrictions.
Anticipated Start Date: 11/01/2014
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Developmental Disabilities HCBS Waivers, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, DD Waiver Administrator
Expected Outcome: Retirement services are clearly defined to include requirements and restrictions.

Regulatory Compliance Area: Community Integration - Residential

Action Item #54: Distinguish "likely not" community residential settings that meet requirements of heightened scruntiny from those that do not. (For community residential services, the Division has already defined in regulation settings that are "likely not" community residential settings.)
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: By fully analyzing the characteristics of the various settings, the Division is better equipped to consider options to obtain full compliance.

Action Item #55: Consider remediation options for "likely not" community residential settings that do not meet requirements of heightened scruntiny.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Self-Assessments, Stakeholder Meetings (led by Consultant, to include providers, self advocates/families, service coordinators and advocacy entitites)
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison, QI Team
Expected Outcome: The Division has a plan with an array of options to bring "not likely" residential services settings into compliance that identifies the resources necessary and targteted timeframes for each element of the plan. For any settings that are not capable of coming into compliance, the Division has a plan to transition individuals to alternative service settings.

Action Item #56: Review regulation changes necessary to ensure compliance with new CMS HCBS Rules related to residential settings. While the Division has already defined in regulation settings that are "likely not" community residential settings, current regulations allow for an exception to that definition without any confirmation that the settings meet particular criteria ensuring community characteristics.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*: 03/31/2016
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404 and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: Regulations comply with the new CMS HCBS rules related to residential settings and support DDD activities to ensure compliance

Action Item #57: Draft internal Division guideline revisions necessary to ensure compliance with new CMS HCBS rules related to residential settings.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*: 03/31/2016
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: DDD internal staff guidelines comply with the new CMS HCBS rules related to residential settings and support QI Team and Service Coordination Team activities to ensure compliance.

Regulatory Compliance Area: General or Other Requirements

Action Item #58: Analyze other regulations and internal guidelines not specifically addresssed in HCBS Transition Plan to determine whether additional revisions and/or enhancements are needed to ensure compliance with HCBS rule. If revisions are warranted, a plan for implementation is to be created.
Anticipated Start Date: 11/01/2014
Targeted Completion Date*:06/30/2015
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, DDD Guidelines, CMS Toolkit and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: Division regulations and guidance have been fully reviewed and revised to ensure requirements with all new HCBS rules.

Action Item #59: Analyze performance metrics used to assess the current level of compliance with new CMS Rules; revise where necessary to address new requirements.
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Quality Review Team Surveys, Quality Improvement Indiciators/Data
Nebraska Health and Human Services Stakeholders: QI Team, Community Liaison, Service Coordination Leadership Team, Quality Review Teams
Expected Outcome: Performance metrics will demonstrate the level of existing system compliance with new HCBS rules and identify areas where enhanced effort is needed to ensure individuals are being supported in the most integrated way possible.

Action Item #60: Analyze performance metrics and revise where necessary to ensure compliance with all elements of the transition plan (including any new elements that are identified in the Identification and Analysis activities described herein.)
Anticipated Start Date: 10/01/2014
Targeted Completion Date*:05/31/2016
Nebraska Health and Human Services Resources: HCBS Compliance Plan Matrix (and all related data sources referenced therein), Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator
Expected Outcome: Performance metrics will demonstrate the level of compliance with the expectations contained within the transition plan.

Regulatory Compliance Area: Individual Rights

Action Item #61: Coordinate with Stakeholders to design a lease template that can be used by waiver participants living in provider owned or controlled residential settings that meets the requirements of the new CMS HCBS rules
Anticipated Start Date: 01/01/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: Nebraska Association of Specialized Providers Workgroup, CMS Tool box, State and Federal Housing Agencies
Nebraska Health and Human Services Stakeholders: Technical Assistance Team, Contract Manager
Expected Outcome: DHHS has a lease template that can be used to ensure waiver participants are afforded the same tenant rights extended to all Nebraska citizens.

Action Item #62: Promulgate rules that require provider owned or controlled residences to ensure resident's rights are protected by a lease or comparable legally binding agreement.
Anticipated Start Date: 11/01/2014
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404 and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: DDD has rules that ensure waiver participants living in provider owned and controlled settings are afforded the same tenant rights extended to all NE citizens

Action Item #63: Promulgate rules that require provider owned or controlled residences to offer choice of roomates to people sharing bedrooms.
Anticipated Start Date: 11/01/2014
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404 and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: DDD has rules that ensure waiver participants living in provider owned and controlled settings are afforded choice or roommate when sharing a bedroom

Action Item #64: Enhance survey tools and process to more rigorously review human and legal rights processes.
Anticipated Start Date: 10/01/2014
Targeted Completion Date*:05/31/2016
Nebraska Health and Human Services Resources: Service Coordination Monitoring Tools, Provider Site Reviews and Compliance Surveys
Nebraska Health and Human Services Stakeholders: QI Team, Service Coordination Leadership Team
Expected Outcome: DDD regulations ensuring that individual's rights are not improperly restricted are diligently enforced.

Task: Outreach

Regulatory Compliance Area: Plan Creation and Implementation

Action Item #1: Draft a waiver transition plan.
Anticipated Start Date: 07/01/2014
Targeted Completion Date*:09/01/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, HCBS Waivers, DHHS Internal Policies and Procedures, CMS Toolkit and Guidance, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DD Director, MLTC HCBS Administrator, Deputy Director of DD Community Based Services, MLTC Waiver Manager and other Waiver Team Staff, DD Waiver Administrator, DD Operations Administrator, DD QI Administrator, DD Technical Assistance Manager, DD Community Liaison
Expected Outcome: A comprehensive waiver transition plan is drafted that proposes actions necessary to ensure compliance with the new CMS HCBS rules, relevant timelines, resources, stakeholders, and expected outcomes. The transition plan is comprehensive, but is is also severable by applicable waiver - so that, if necessary, the plan may be finalized in stages by waiver.

Action Item #2: Make the waiver transition plan available for public comment.
Anticipated Start Date: 09/03/2014
Targeted Completion Date*:10/15/2014
Nebraska Health and Human Services Resources: DHHS Website, Omaha World Herald Newspaper Announcement, Direct Mailing to DD Service Participants, Direct Outreach to Providers
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: The draft comprehensive waiver transition plan is distributed via multiple mediums to engage and gather public comment for a time period to exceed 30 days.

Action Item #3: Coordinate and hold public meetings.
Anticipated Start Date: 08/01/2014
Targeted Completion Date*:10/15/2014
Nebraska Health and Human Services Resources: Transition Plan, Powerpoint Presentations, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: Stakeholders are able to attend public meetings where the new HCBS requirements are discussed and where they may participate in verbal comment and present questions related to the draft transition plan.

Action Item #4: Review, incorporate, and respond to public comments.
Anticipated Start Date: 09/25/2014
Targeted Completion Date*:11/01/2014
Nebraska Health and Human Services Resources: Transition Plan, Public Comment (in person, via email, telephonic, and fax/mail), DHHS Website, Direct Mailing to Waiver Participants, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff

Expected Outcome: All public comments are considered, responses thereto are prepared and distributed with the finalized plan; if DHHS deems necessary, the transition plan may be modified due to public comment.

Action Item #5: Finalize transition plan for submission to CMS, either comprehensively or separately by specific waiver.
Anticipated Start Date: 10/15/2014
Targeted Completion Date*:11/15/2014
Nebraska Health and Human Services Resources: Transition Plan, Public Comment (in person, via email, telephonic, and fax/mail), DHHS Website, Direct Mailing to Waiver Participants, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: Submit for CMS approval a comprehensive transition plan to include a summary of and response to public comments.

Regulatory Compliance Area: Community Integration – Day Services

Action Item #65: Identify and implement effective strategies for involving stakeholders in the analysis and remediation of "not likely" community day services settings
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Public Meetings, Specialized Provider Workgroup/Meetings, Coordination with the ARC of Nebraska, People First of Nebraska, the Develomental Disabilities Council, and the Developmental Disability Advisory Committee, Nebraska Association of Service Providers, and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, Community Liaison, Technical Assistance Manager
Expected Outcome: Stakeholders including self advocates and their families and friends, providers, and self-advocacy entities will guide and inform the "not like" community day services changes.

Regulatory Compliance Area: Community Integration – Residential

Action Item #66: Identify and implement effective strategies for involving stakeholders in the assessment and remediation of "not likely" community residential settings
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Public Meetings, Specialized Provider Workgroup/Meetings, Coordination with the ARC of Nebraska, People First of Nebraska, the Develomental Disabilities Council, and the Developmental Disability Advisory Committee, Nebraska Association of Service Providers, and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, Community Liaison, Technical Assistance Manager
Expected Outcome: Stakeholders including self advocates and their families and friends, providers, and self-advocacy entities will guide and inform the "not like" community residential changes.

Regulatory Compliance Area: Community Integration – General or Other Requirements

Action Item #67: Share information with individual and their families/guardians, service providers, and advocacy entities on the requirements of the new CMS HCBS rules and the changes they can expect to see as a result of implementation.
Anticipated Start Date: 07/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Transition Plan, DHHS Website, Direct Mailing to Individuals In Services, Articles in the Sower Newsletter, Public/Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services, Waiver Administrator, Operations Administrator, QI Administrator, Technical Assistance Manager, Community Liaison
Expected Outcome: All stakeholders understand the requirements of the new CMS HCBS rules, what they can expect, and how their services will be impacted.

Task: Remediation

Regulatory Compliance Area: Community Integration – Day Services

Action Item #68: Provide education, technical assistance and enforcement of regulatory changes to day services requirements that align with new CMS HCBS rules related to day services settings. This includes enforcement of

progressive discipline to include financial penalties and failure to renew certification for specialized providers.
Anticipated Start Date: 01/01/2017
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, Provider Site Reviews and Compliance Surveys, Provider Training and Technical Assistance, Service Coordination Monitoring Tools, Service Coordination Individual/Family Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, QI Team, Technical Assistance Team, Service Coordination Team, Community Liaison
Expected Outcome: The Division will exercise its authority to ensure compliance with new CMS HCBS rules related to community like day services settings

Action Item #69: Seek and secure resources to support innovation necessary to bring "not likely" community day services settings into compliance with new CMS HCBS rules. This includes evaluation of rate methodology to account for increased provider staffing requirements to support individuals in a more integrated setting.
Anticipated Start Date: 01/01/2016
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: 2017-18 Biennial Budget Request to Nebraska Legislature, Developmental Disability Council Grants, and other State/Federal Grants or Funds
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services, Technical Assistance Manager, DD Fiscal Analyst
Expected Outcome: "Not likely" community day services settings that don't meet the requirements under heighten scrutiny have accessed resources and implemented changes necessary to be compliant with the new CMS HCBS rules

Action Item #70: Reach out to integrated providers of retirement services to increase options available to retirees in developmental disability services. While this may affect both day and residential services, efforts are targeted towards day services as that is where the Division recognizes the greatest risks.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Aged and Disabled Programs, Leagues of Human Dignity, State and Local Chambers of Commerce, State and Local Organizations Targeted at Retirees, Stakeholders, Advocacy Entities
Nebraska Health and Human Services Stakeholders: Technical Assistance Team, Community Liaison, QI Manager, Contract Manager
Expected Outcome: An array of service provider are available to support individuals with developmental disabilities throughout Nebraska to avoid unnecessary institutionalization or other services that may exclude individuals from integrated community enjoyment.

Regulatory Compliance Area: Community Integration – Residential

Action Item #71: Provide education, technical assistance and enforcement of regulatory changes to day services requirements that align with new CMS HCBS rules related to residential services settings. This includes enforcement of progressive discipline to include financial penalties and failure to renew certification for specialized providers.
Anticipated Start Date: 01/01/2017
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, Provider Site Reviews and Compliance Surveys, Provider Training and Technical Assistance, Service Coordination Monitoring Tools, Service Coordination Individual/Family Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, QI Team, Technical Assistance Team, Service Coordination Team, Community Liaison
Expected Outcome: The Division will exercise its authority to ensure compliance with new CMS HCBS rules related to community like residential services settings

Action Item #72: Seek and secure resources to support innovation necessary to bring "not likely" community residential services settings into compliance with new CMS HCBS rules. This includes evaluation of rate methodology to account for increased provider staffing requirements to support individuals in a more integrated setting.
Anticipated Start Date: 01/01/2016
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: 2017-18 Biennial Budget Request to Nebraska Legislature, Developmental Disability Council Grants, and other State/Federal Grants or Funds
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services,

Technical Assistance Manager, DD Fiscal Analyst
Expected Outcome: "Not likely" community residential services settings that don't meet the requirements under heighten scrutiny have accessed resources and implemented changes necessary to be compliant with the new CMS HCBS rules

Regulatory Compliance Area: General or Other Requirements

Action Item #73: Routiely re-evaluate monitoring tools and processes for all services settings to ensure continued compliance with requirements mandated by the new CMS HCBS rules. This includes site characteristic issues, individial rights, and all other aspects relevant thereto.
Anticipated Start Date: 07/01/2017
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: HCB services support access to the greater community, offers opportunities for employment, optimizes independence, facilitates choice and ensures individual rights are protected.

Action Item #74: Routinely review and revise Service Coordination hiring tools, orientation, training curriculum, monitoring tools and other supports to ensure a continued focus on person centered practices, recognition of and advocacy for individual rights, and ensuring that all individuals are supported in the most integrated settings possible.
Anticipated Start Date: 03/01/2015
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Service Coordination Hiring Tools and Orientation Curriculum, Service Coordination Training Curriculum, Service Coordination Monitoring Tools, Service Coordination Recognition Programs, Service Coordination Performance Evaluation Tools, Service Coordination Individual/Family Meeting Tools (including Personal Focus Worksheets and other planning tools), Annual State-Wide Service Coordination Training and Tri-Annual Develomental Disability Conferences
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, Service Coordination Leadership Team, Technical Assistance Team
Expected Outcome: Service coordinators have the skills and tools to facilitate planning that reflects individual needs and preferences and conduct plan monitoring to ensure individual rights, optimize independence, facilitate choice and maximize opportunities to access community and receive services in the most integrated setting

Action Item #75: Provide an annual upate regarding this Transition Plan in the Division of Developmental Disabilities Update provided to the Nebraska Legislature and available to Stakeholders.
Anticipated Start Date: 03/15/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Annual Division of Developmental Disabilities Update
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services
Expected Outcome: The Division is accountable to the Nebraska Legislature and all stakeholders for ensuring compliance with the HCBS rules ensuring that all individuals have access to and are being served in the most integrated setting.

Regulatory Compliance Area: Individual Rights

Action Item #76: Provide additional training to individual and their families, service providers and Divison staff in the area of right restrictions/ensuring individual rights are protected.
Anticipated Start Date: 09/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Technical Assistance and Service Coordination Training Curriculum, Nebraska Association of Service Provider Meetings, the Sower Newsletter, and Individual/Family Meeting
Nebraska Health and Human Services Stakeholders: Technical Assistance Team, Contract Manager, Community Liaison, Service Coordination Team
Expected Outcome: All stakeholders understand the conditions under which and the requirements that must be met before an indivdual's rights are restricted; all stakeholders appreciate, recognize and diligenty protect the rights of all individuals receiving services.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Division of Developmental Disabilities
   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a) DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; execution of Medicaid provider agreements; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and quality improvement activities.

b) The Nebraska State Medicaid Plan Section 1, Citation 1.1(a) outlines designation and authority and was approved by CMS November 29, 2007, with an effective date of July 1, 2007.
c) The State Medicaid Director is the Director of the Division of Medicaid and Long Term Care (DMLTC) within the Department of Health and Human Services. Designated staff within DMLTC reviews reports of provider non-compliance and coordinates corrective action measures with DDD as necessary and appropriate; prepares or reviews statistical and financial data for CMS reports in collaboration with DDD and financial services staff; attends the DDD Quality Improvement (QI) Committee meetings as an active participating member; meets with DDD staff to review program and client issues as necessary and appropriate; tracks the use of Medicaid funding on the use of waiver funding relative to the budgeted amounts; monitors expenditures and budget projections; reviews the development, renewal, or amendments of HCBS waivers and has final approval authority; reviews the cost neutrality formulas developed in collaboration with DDD and financial services staff; and submits claims for federal funds for allowable activities administered or supervised by DDD.

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.:*
   - ◉ **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:

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:

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
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 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: 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:
Of the total number of DDD QI committee meetings, the total number of meetings in which the Medical Assistnce Unit staff participated.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 Nebraska Department of Health and Human Services is the Single State Medicaid Agency. The DHHS Chief Executive Officer has delegated the functions of the Single State Medicaid Agency to the State Medicaid Director in the Division of Medicaid and Long Term Care Services. The State Medicaid Director has the ultimate authority for all of Nebraska's Medicaid services.

The quality management strategy for Nebraska covers all services funded by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD), including the services offered under the HCBS waivers for adults and children with developmental disabilities (#0394, 0396, and 4154) and services funded by state general funds only.

The Divisions of Developmental Disabilities (DDD), Medicaid and Long Term Care Services, and Public Health (DPH), within DHHS currently have a collaborative role in implementation of the home and community based services (HCBS) waivers for adults and children with developmental disabilities.

Day to day operations of administering and monitoring waiver services, as well as completion of waiver applications and any amendments are the responsibility of DDD. Initial and ongoing certification, contract compliance reviews, technical support, commplaint investigations, and development and oversight of the quality management system are the responsibility of DDD.

Enrollment of specialized DD provider agencies and non-specialized, or independent, providers is performed by assigned staff within the DD and CFS (Children and Family Services) divisions of DHHS. Licensing of centers for persons with DD (CDD)is performed by DPH. The Division of Medicaid and Long Term Care (MLTC) Services is responsible for administrative oversight, as described in Appendix A-2-a above, and the Medicaid Director within the Division of MLTC has the ultimate authority for all of Nebraska's HCBS waivers.

A primary method of coordinating the activities of the Divisions is the DDD Quality Improvement (DDD QI) Committee, which was conceptualized in 2004. The DDD QI committee has worked in partnership with the other stakeholders in our services.

The DDD QI structure involves the State DDD QI Committee, consisting of DDD Central Office QI staff, as well as home and community based services waiver management staff from Medicaid, licensing and compliance staff from DPH, and representatives from Service Coordination (SC), and a disability services specialist (DSS). This committee receives reports and information and provides/shares feedback and support to the service districts. The Medicaid HCBS waiver manager verbally reports activities of the DDD QI committee to her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for their review.

The DDD QI committee's responsibility is to determine systems issues, determine strategies to address the issues and to evaluate the effectiveness of the implementation of those strategies. The measures to be reviewed quarterly are pulled together under the HCBS Quality Framework (QF) and CMS' Request for Evidentiary-Based Information (CMS Request). The DDD Deputy Administrator for Quality Improvement, a position within DDD central office, provides oversight of this committee, the subcommittees, and all quality improvement activities. Nebraska's DDD quality management system is dynamic and continually evolving. A continuous evaluation component is built into the system for evaluation of utility, information received and effectiveness of strategies.

While the Quality Framework has provided the overall conceptualization of the QI efforts, there has also been an effort to develop the system to improve the flow of information regarding QI activities between the local Service Coordination and state levels. The overall QI efforts also are designed to promote problem solving at the local service district level, with systems issues being identified through systematic analysis.

While Medicaid staff in the Medical Assistance Unit, Public Health, and the DDD Central Office has been continually involved in Quality Improvement efforts, the need to provide better communication and support at the local level has resulted in the development of a formal QI committee for Service Coordination and Disability Services Specialists. Communication and problem-solving is facilitated between the local Service Coordination districts and DDD central office through regularly scheduled meetings and conference calls of the Service Coordination Administrators, who oversee the work of Service Coordination. During discussions, the DDD Deputy Administrator of Services gathers input from the local SC Administrators and the State Administrator of Community Based DD services makes the final policy decisions.

The DDD QI committee meets monthly and the minutes of the meetings are provided to all members of the committee. The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QI committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The QI activities of DDD and results of reports are communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, the Nebraska DD Council, and DDD-sponsored Town hall Meetings for individuals, families, and other interested parties.

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 for problem correction. In addition, provide information on the methods used by the State to document these items.

Under the area of administrative authority, individual problems are not discovered.

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: As determined by the State Medicaid Director or the DDD Deputy Administrator of Quality Improvement

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐				☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	21		☑
	☑	Developmental Disability	21		☑
	☑	Intellectual Disability	21		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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

- ◉ **Not applicable. There is no maximum age limit**
- ○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

- ◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

  Specify the percentage:

- ○ **Other**

  Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3485
Year 2	3685
Year 3	3835
Year 4	4000
Year 5	4180

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
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:

Waiver capacity will be allocated statewide. Individuals who meet waiver eligibility criteria listed at Appendix B-1-a and B-1-b of this waiver application, will be given a waiver slot.

In the event that all slots were filled, the state would immediately submit an application to increase available slots to serve all eligible individuals.

All eligible individuals have comparable access to all services offered in this waiver.

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:

  All other mandatory and optional groups under the plan are included.

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 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:**

  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:

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 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)

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: 100

○ **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:

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: 100

- ○ **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:

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 an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

Disability Services Specialists are required to have a Bachelor's Degree in psychology, social work, education, public administration or a related human service field and one year experience working in the field of developmental disabilities. They must be able to communicate effectively verbally and in writing, possess excellent interpersonal skills, function as a team leader, team member, work independently, and organize/manage workload. Experience in working with people with DD and knowledge of quality assurance/improvement is preferred, but is not a requirement.

They must have knowledge of current practices in the field of DD, including service coordination, program planning, disability law, medications, the theory of normalization, and provision of habilitation services.

The following abilities are required: Communicate effectively in a variety of situations; develop working relationships with individuals with DD, their families, review team members, community professionals, program directors, agency representatives, and other groups of individuals with interests in DD; analyze behavioral data and formulate habilitation plans; and plan and organize habilitative training programs.

Skills in interviewing techniques, assessing skills, abilities, preferences, and needs and explaining services to individuals, families, and guardians are required.

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.

DHHS-DDD applies the following criteria to determine the need for ICF services:
1. As documented by an evaluation which was made no more than three years before the initial determination of Waiver eligibility, has an intellectual disability or has a severe, chronic disability other than intellectual disability or mental illness which:
A. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
B. Is manifested before the age of 22 years;
C. Is likely to continue indefinitely; and
D. Results in:
(1) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
(a) Self-care;
(b) Receptive and expressive language development and use;
(c) Learning;
(d) Mobility;
(e) Self-direction;
(f) Capacity for independent living; and
(g) Can benefit from habilitation directed toward-
a. The acquisition, retention, and improvement of self-help, socialization, and adaptive skills for the individual's maximum possible independence; or
b. For dependent individuals where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status.

The Developmental Index is the LOC instrument that is utilized.

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 assessment tool for waiver eligibility is comparable to the assessment tool completed for institutional placement. Both tools note skills, abilities, preferences, and needs, and current community based habilitation or ICF active treatment, as applicable, and supports. Provider staff or others who are familiar with the individual complete the applicable tool.
The Developmental Index differs from the ICF LOC tool by assessing skills, abilities, and areas needing improvement for maximizing independence in the community, such as job-readiness, managing personal finances, and accessing community services.
If a former waiver participant enters the State ICF for short-term intensive behavioral treatment, the LOC is determined using the ICF LOC assessment. The outcome of the determinations yielded from the Developmental Index is similar in validity and reliability to the outcome of determinations yielded from the assessment completed for institutional placement.

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 SAME process for evaluation and revaluation for the need for ICF level of care is as follows:

The Division of Developmental Disabilities employs 10 Disability Services Specialists, located across the state to determine initial and ongoing eligibility and annual review of eligibility for HCBS waiver for adults with intellectual or developmental disabilities.

The following eligibility determination information is submitted to the disability services specialist:
1. Psychological evaluation current within 3 years of initial eligibility determination.
2. Current physical evaluation - annual unless waived by the physician.
3. Individual Program Plan (service plan). The Individual Program Plan (IPP) must identify the needs and preferences of the individual and specify how those needs will be addressed. The IPP identifies the individual's personal and career goals, specialized DD services and supports, non-specialized services and supports (also known as community supports), as well as services and supports to be provided by other non-DDD funded resources (including medical services and supports). The annual IPP documents specialized DD provider(s); non-specialized community supports providers; authorized funding amounts and/or units of services; and habilitation/training goals and strategies. The IPP is developed by an interdisciplinary team consisting of the individual; the assigned DDD Service Coordinator; legal representative; family, if the individual chooses; specialized provider staff; and non-specialized community support providers, other professionals, advocates, and/or friends as requested by the individual or legal representative. The IPP is reviewed initially and annually thereafter, and when a participant's changing circumstances may affect waiver eligibility.
4. Semi-annual IPP and all special meetings or addenda to the IPP. Semi-annually and as needed the team meets to review progress and make any necessary changes in the individual's provider(s), services, environment, etc.
5. Developmental Index current within one year of initial eligibility and annual review of eligibility. The Developmental Index is specific to waiver eligibility and identifies an individual's skills, abilities, and areas needing improvement. The Developmental Index is completed by the individual's Service Coordinator and provider staff and reviewed at the IPP meeting. If there are discrepancies between/among the assessments, these discrepancies must be clarified in the IPP.

The DDD service coordinator submits the above eligibility information to the disability services specialist. The disability services specialist verifies Medicaid eligibility, and reviews the information to determine whether the individual meets ICF level of care criteria and therefore waiver eligibility.

The disability services specialist looks at the individual's assessed abilities and needs; how the assessed needs are being met, including DD services, Medicaid State Plan services, generic non-Medicaid community services and supports, and family supports, and considers whether the individual would require the services of an ICF if HCBS waiver was not available. If the individual is determined eligible for the waiver, the individual or legal representative is given the choice between home and community based waiver services and ICF services and the choice and consent to receive waiver services is documented on a form. The disability services specialist prior authorizes the waiver services if HCBS waiver is chosen.

The disability services specialist reviews for eligibility on an ongoing basis, and completes an annual review of the IPP and Developmental Index, and verifies Medicaid eligibility. At any point, the disability services specialist may ask for additional information and clarification.

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):*

Disability Services Specialists use the following procedures and processes to ensure timely reevaluations of level of care: Tickler files, such as Excel spreadsheets, and electronic alerts, and the processes that are components of service coordination.

The supervisor reviews ten percent of each disability specialist's waiver files for compliance with established timelines.

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 DDD Disabilities Services Specialists, who are responsible for the performance of evaluations and reevaluations of level of care, maintain a separate record for each waiver participant. The records are maintained within the office of the disability services specialist.

Appendix B: Evaluation/Reevaluation of Level of Care

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:
The number of new waiver eligibility determinations completed by the disability services specialist within 2 weeks of receipt of all required information.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Review Worksheet and Quality Assurance File Review for New Determinations

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: semi-annually, or as determined by the DDD QI committee

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.

Performance Measure:
Number and percent of waiver participants who have had an annual LOC re-determination within one year of their initial LOC evaluation and within 1 year of their last annual LOC evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Review Worksheet and Quality Assurance File Review for Annual Redetermination

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: as determined by the state DDD QI committee

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:
Of the total number of LOC determinations, the number of LOC redeterminations that were completed accurately according to the processes and instruments described in the approved waiver and according to the approved description to determine participant level of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Review Worksheet and Quality Assurance File Review for Annual Redetermination

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: semi-annually, or as determined by the state DDD QI committee

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 redetermination of eligibility is completed for all (100%) waiver recipients. The timeline for completion of the annual review is within 60 days of the individual's IPP meeting, but no later than 120 days after the meeting. Each of the Disability Services Specialists has created a tickler system to keep track of when annual reviews are due, based on the individual's waiver year, and DDD Service Coordination policies and procedures include components related to waiver eligibiity and review requirements. Annually, the Disability Services Specialist reviews the annual IPP, the Developmental Index (LOC assessment tool), and Medicaid information, and completes a standardized New and Annual redetermination worksheet.

The monitoring process to measure compliance with the above Sub Assurances consists of the DSS Supervisor reviewing a minimum of 10% of the DSS files for compliance with timelines, required paperwork, and whether the eligibility determinations are appropriate. The DSS Supervisor reviews the files and completes the "Annual Supervisory Waiver QA File Review."

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 for problem correction. In addition, provide information on the methods used by the State to document these items.
The state monitors level of care decisions and takes action to address inappropriate LOC determinations, which may include failure to determine eligibility, failure to determine eligibility within established timelines, inaccurate determinations, and missing or incomplete documentation. The state monitors the performance of the disability services specialists through self measurement and look-behind reviews by their Supervisor. The following performance measurements are self reported by marking Yes or No for each initial eligibility determination:
Eligibility is completed within two weeks of receipt of all required information.
HCB waiver services are authorized within one week of eligibility determination.
All required and/or applicable data sources are accurately completed.
The disability services specialists' Supervisor evaluates the performance of the staff, utilizing the quality assurance data at the local level and at the central office level for identificaiton of technical assistance/training needs for all of the disability services specialist and for identification of systems changes,

Monthly quality assurance reports are reviewed at the local level to ensure continued Medicaid and waiver eligibility and accurate service authorizations for participants. The monthly quality assurance reports are generated by NFOCUS, Nebraska's electronic authorization and payment system, and posted on an intra-agency website for access by DDD staff. Disability services specialists, service coordinators, and SC Supervisors review each report and take appropriate action as needed on individual cases. Examples of such action may be assisting the individual with recertification of Medicaid, submitting a service authorization to change or end services, determining waiver eligibility for new Medicaid recipients, etc.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the local QI committee and/or DDD Deputy Administrator for QI

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

   Nebraska waiver participants are afforded choice between waiver services and institutional care.
   Choice of ICF or waiver services is documented on Form DDD-1 "Consent Form". Information about Nebraska's DD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the individual or legal representative in understanding waiver services, funding of his/her services, and the roles and responsibilities of the participants (the individual, family, guardian, DHHS staff, etc.). This information is provided by the participant's Service Coordinator or the Disability Services Specialist.

   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 determination of waiver eligibility and is kept in the individual's waiver file. Form DDD-1 explains the right and process to appeal.

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.

   Form DDD-1, the consent form, is kept in the individual waiver file maintained by the Disability Services Specialist. The records are maintained within the office of the Disability Services Specialist.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on and ongoing basis;
• Oral language assistance services such as interpreters;
• Translation of written materials, such as applications, brochures, due process, and the Notice of Decision;
• Foreign language placards, posters, etc.;
• Second language hiring qualifications; and
• Availability of translators, including sign language.

Foreign language web sites have been developed or are in the development stages.

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	Day Habilitation		
Statutory Service	Group home residential habilitation		
Statutory Service	Integrated Community Employment		
Statutory Service	Respite		
Other Service	Assistive Technology and Supports (ATS)		
Other Service	Behavioral Risk Services		
Other Service	Community Living and Day Supports (CLDS)		
Other Service	Companion Home residential habilitation		
Other Service	Extended Family Home residential habilitation		
Other Service	Home Modifications		
Other Service	In-home residential habilitation		
Other Service	Medical Risk Services		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Retirement Services		
Other Service	Team Behavioral Consultation Services		
Other Service	Vehicle Modifications		
Other Service	Vocational Planning habilitation service		
Other Service	Workstation habilitation 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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Day Habilitation services are formalized training and staff supports that take place in a non-residential setting separate from the individual's private residence or other residential living arrangement. Day Habilitation services are scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Day Habilitation services may be provided to individuals that do not have a clear plan for employment and are therefore not currently seeking to join the general work force. Training activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living. Individuals receiving day habilitation services are integrated into the community to the greatest extent possible.

Day Habilitation may be delivered in integrated community settings or in provider owned and operated settings for a portion of the typical workday. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Staff support is continuous, that is, staff are present at all times the individual is present. Continuous day services are expected to be available for no less than seven hours per day. The provider may operate a location where individuals come to check-in prior to participating in integrated activities and/or to participate in a variety of daily activities related to greater community living. Provider owned and controlled settings also allow for individuals who are experiencing short-term medical or behavioral crisis to participate in activities that are outside the residence.

Habilitation, or teaching and supporting, may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Services are generally not job-task oriented but instead are directed at improvement of basic skills such as attention span and motor skills, and not explicit employment objectives.

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

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

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

Individuals that choose Day Habilitation services may also choose Community Living and Day Supports (CLDS) but these services may not be billed during the same period of the day. Daily rates are available for Day Habilitation services when the person receives this service for four or more hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate. CLDS can only be billed at an hourly rate on days when no daily rate is billed for Day Habilitation. When both services are provided in one workday, both Day Habilitation services and CLDS are billed in hours.

Transportation may be provided between the individual's place of residence and the habilitation (teaching and supporting) service site or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation (teaching and supporting) services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between other habilitation sites should be billed under those waiver services and not this service.

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

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Certified CBDD provider agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.

404 NAC

175 NAC 3-000

Neb. Rev. § 83-1201 through 83-1226

Other Standard *(specify):*

The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code. All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:

1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
3. Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:

Every one or two years as applicable.

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:

Residential Habilitation

Alternate Service Title (if any):

Group home residential habilitation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

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

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State

laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan, also called the individual program plan (IPP) or individual support plan (ISP).

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

Staff support is continuous, that is, staff must be present and awake during the times that individuals are present and awake. Continuous residential services are expected to be available for no less than eleven hours. Generally, residential services will begin at 6:00 am each day. Daily rates are available for Group home residential services when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. As applicable, when the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

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

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

The method by which the cost of room and board is excluded from payment for group home residential habilitation (teaching and supporting) services is specified in Appendix I-5.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of group home residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.

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

When the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity. When the setting in which the landlord tenant laws do not apply, a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

Payments for group residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

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

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community based DD provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Group home residential habilitation

Provider Category:
Agency
Provider Type:
certified community based DD provider
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
175 NAC 3-000
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
Be age 18 or older;

Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IPP, nursing plan of care, or the individual's medical practitioner.

Not be the parent, spouse, or child (biological, step, or adopted) of the participant.

Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:

Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Integrated Community Employment

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Integrated Community Employment (ICE) service is intermittent formalized training and staff supports - needed by an individual to acquire and maintain a job/position in the general workforce at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the individual service plan. ICE services are person-centered and team supported to address the individual's particular needs for ongoing or intermittent habilitation (teaching and supporting) throughout stabilization services and extended integrated community employment services and supports. Intermittent services imply that staff support is provided when the services and supports are needed. ICE, as an intermittent service, can only be billed in half, quarter hours, or full hour increments. An hour of service equates to one clock hour.

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

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

ICE services are primarily provided away from the home, in a non-residential setting, during typical working hours. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the person lives. Intermittent face to face individualized habilitation (teaching and supporting) is provided to assist the individual in maintaining employment. Habilitation (teaching and supporting) goals and strategies must be identified in the service plan and specify in a measurable manner, the services to be provided to meet the preferences and needs of the individual.

ICE services may include a customized home-based business. Habilitation (teaching and supporting) services may be delivered in a customized home based businesses and are allowed in participant directed companion homes. ICE services do not include employment in group settings such as Workstation services, enclaves, classroom settings, or provider-owned and controlled fixed site Day Habilitation settings. In addition, it does not include services provided in provider-controlled residential environments such as Group Homes or Extended Family Homes.

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

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

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

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
Payments that are passed through to users of supported employment programs; or
Payments for training that is not directly related to an individual's integrated community employment services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

ICE stabilization services require at least 40 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue reimbursement at the ICE rate as long as the minimum total number of hours worked for the last three months (including the current month) is more than 120 hours of work (or an average of 40 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 40 hours of employment per month.

Extended ICE services are time limited. Extended integrated community employment services require at least 80 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue payment for the extended ICE services as long as the minimum total number of hours worked for the last three months (including the current month) is more than 240 hours of work (or an average of 80 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 80 hours of employment per month. The provider may claim extended integrated community employment services for up to 24 months in order for the individual to meet their personal and career goals.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment. No more than two individuals may participate in a home-based business at the same participant-directed companion home.

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	certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Integrated Community Employment

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.

205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code. All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
3. Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Respite is the temporary, intermittent relief to the usual non-paid caregiver(s) from the continuous support and care of the individual to allow the caregiver to pursue personal, social, and recreational activities such as personal appointments, shopping, attending support groups, club meetings, and religious services, and going to movies, restaurants, or on vacations. Components of the respite service are supervision, tasks related to the individual's physical and psychological needs, and social/recreational activities. Services are provided on a short-term basis because of the absence or need for relief of those unpaid persons who normally provide care for the individual. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day).

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

Respite is available only to those individuals who live with their usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual.

The amount of authorized services for respite services is not determined using the objective assessment process. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Payment for respite does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Respite services cannot be used as adult/child care while the parents work or attend school.

Respite cannot be provided by members of the individual's immediate household.

These services may be provided in the individual's living situation and/or in a provider-operated residential community setting.

All waiver services and providers must be prior authorized within the following guidelines:
1. The tasks to be performed to meet the needs of the individual are documented in the IPP.
2. For respite services, a unit is defined as an hour, or if eight or more hours are provided in a calendar day, a day. Respite cannot exceed 30 days per waiver year;
3. Unused respite hours are not carried over into the next waiver year;
4. Waiver services must be prior authorized;
5. The date of waiver services authorization is the date that each provider is approved to begin, or the date services begin; and
6. Respite funding is available from one DHHS program source only.

Federal financial participation is not claimed for the cost of room and board.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Contracted community based DD provider agency
Individual	Independent provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Contracted community based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
NAC 205 1-000 through 5-000
NAC 480 chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

A provider of respite must:
1. Be age 18 or older;
2. Not be a member of the individual's immediate household;
3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone;
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
6. Be authorized to work in the United States.

When respite is provided in a community based residential setting such as a group home or extended family home, the CBDD provider may not claim for the cost of room and board.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Independent provider
Provider Qualifications
License *(specify):*
Licensing is not a requirement to be a qualified individual respite provider.

Certificate *(specify):*
Certification is not a requirement to be a qualified individual respite provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.
NAC 404 9-000

A provider of Respite must:
1. Be age 18 or older;
2. Not be a member of the individual's immediate household;
3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone;
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
6. Be authorized to work in the United States.

If Respite is provided outside of the family home, it is recommended that the family visit the facility or home in which the service is to be provided and agree to the provision of services in that location. The provider must ensure that:
1. The home/facility is architecturally designed to accommodate the needs of the individuals being served;
2. An operable phone and emergency phone numbers are available;
3. The home/facility is accessible to the individual, clean, in good repair, free from hazards, and free of rodents and insects;
4. The home/facility is equipped to provide comfortable temperature and ventilation conditions.
5. The toilet facilities are clean and in working order;
6. The eating areas and equipment are clean and in good repair;
7. The home/facility is free from fire hazards;
8. The furnace and water heater are located safely;
9. Firearms are in a locked unit;
10. Medications and poisons are inaccessible; and
11. Household pets have all necessary vaccinations.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
   a) Assume responsibility;
   b) Follow emergency procedures;
   c) Maintain schedules; and
   d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

When respite is provided in a private residence, the independent provider may not claim for the cost of room and board.

Verification of Provider Qualifications

Entity Responsible for Verification:
Nebraska Department of Health and Human Services staff

Frequency of Verification:
Annually

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 and Supports (ATS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

ATS includes devices, controls, appliances, or other items that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment they live in, thus decreasing their need for assistance from others.

1. Approvable items are limited to those necessary to support individuals in their home and must be appropriate to the needs of the individual as a result of limitations due to disability. An assessment will be completed to assist the individual to find an appropriate ATS solution. All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

2. Items that are not covered include: items covered by Medicaid, recreational and/or exercise items, security items, devices or modifications already purchased or completed, computers (some exceptions may apply), furniture or appliances, air conditioners, clothing or bedding, or disposable medical or hygiene supplies.

3. Permanently attached devices, controls, and appliances may not be installed in residential settings that are owned or leased by providers of waiver services. If the individual resides in a rental unit, the individual or family/guardian must obtain written assurance from the landlord that the property will be made available to an

individual with a disability for a period of at least three years after the funding of approved home modifications, by listing the property for rent on www.housing.ne.gov.

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

Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	vocational rehabilitation agency
Agency	Independent Living Center
Individual	Independent provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:

Agency

Provider Type:

vocational rehabilitation agency

Provider Qualifications

License *(specify):*

Licensure is not required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation.

NAC 404 9-000

All providers of waiver services who have direct contact with the individual receiving services must:

1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:

a) Assume responsibility;
b) Follow emergency procedures;
c) Maintain schedules; and
d) Adapt to new situations.

7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verify the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verify the subcontracted provider.

Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:
Agency

Provider Type:
Independent Living Center

Provider Qualifications

License *(specify):*
Licensure is not required.

Certificate *(specify):*
Certification is not required.

Other Standard *(specify):*
A provider of ATS must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of independent living center. Independent living center verifies the subcontracted provider.

Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:
Individual

Provider Type:
Independent provider

Provider Qualifications

License *(specify):*
All independent providers of ATS must meet applicable vendor licensure requirements and maintain current licensure according to local and state codes and statutes.
Neb. Rev. § 71-4603
Neb. Rev. § 81-2101 through 81-2141
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000 .

A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
   a) Assume responsibility;
   b) Follow emergency procedures;
   c) Maintain schedules; and
   d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.
12. Be authorized to work in the United States.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff
Frequency of Verification:
annually or per occurrence

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:
Behavioral Risk Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Behavioral risk services are provided to individuals with complex behavioral needs that require continuing supports and treatment. Behavioral risk services may be required when behaviors place the individual and/or others at risk of harm and may include actual, attempted, or threatened physical harm to oneself and/or others. This includes implicit threats, which is defined as statements and/or acts that reasonably induce fear of physical harm to others. Additionally, examples of behaviors placing oneself and/or others at risk of harm include self-directed actions intended to cause tissue damage, medication non-compliance, destruction of other people's belongings, elopement, and contact with the legal system for the previously mentioned behaviors, as well as other law-breaking behaviors (e.g., stealing, vandalism).

The need for behavioral risk services will be determined by designated staff at Division of Developmental Disabilities (DDD) central office. A risk screen is completed by the individual's IPP team to assist the team in planning, as a guide in giving adequate consideration to risk factors, or at the request of DDD central office. If the risk screen indicates an individual may present a risk of harm to oneself and/or others, the individual may be referred to DD central office for a formal risk assessment.

A risk assessment identifies, evaluates, and prioritizes interventions to implement or attempt to manage/reduce risk. The risk assessment will include the following: description, likelihood, frequency, duration, intensity, imminence, and incapacitation. Additionally, it includes an examination of the function of violence, for example, perceptual distortions, antisocial attitudes, irrational beliefs, labile affect, or interpersonal stressors. A risk assessment will also evaluate "buffering" conditions that reduce the likelihood of risk, for example, residential and day habilitation (teaching and supporting) services, non-DD therapeutic services, an individual's personal strengths (e.g., motivation), support system (e.g., family and friends), ability to establish pro-social judgment, and history of adverse life events.

If DDD central office staff concludes an individual presents a moderate to high risk of harm to oneself and/or others, the individual will be eligible for behavioral risk services. Should an individual present with a dual diagnosis of DD and MI and their risk is a result of issues stemming from Axis I, primary diagnosis of severe persistent mental illness, then the individual will be referred for behavioral health services. Behavioral risk services are not intended to supplant other behavioral health services such as, but not limited to psychiatry, counseling, or individual or group therapy.

Behavioral risk services are provided 24/7 and are considered to be continuous services. This service is an all-inclusive daily rate service that includes residential habilitation (teaching and supporting) services, day habilitation (teaching and supporting) services, transportation, intensive behavioral supports, ongoing safety supervision, and ongoing clinical supports. Because behavioral risk services are all-inclusive, an individual cannot receive these services in combination with another DD waiver service. When behavioral risk service is delivered where the person lives, where the person works, where the person is recreating and socializing, or where the person participates in day services, the service is billed as Behavioral Risk service, and is not billed as

a separate residential habilitation service or a separate day habilitation services.

The provision of behavioral risk services will be under the direction of a supervising mental health practitioner. Behavioral risk services are furnished as specified in the individual program plan. Staffing ratios are flexible and commensurate to meeting the needs of the individuals.

Intensive behavioral intervention strategies and supports require ongoing assessment, professional judgment, and treatment based on ongoing assessment. The provider must have a licensed independent mental health practitioner on staff to oversee the delivery of behavioral risk services by unlicensed direct support professionals.

Residential habilitation (teaching and supporting) services under this service can be delivered in a variety of home settings. Residential habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. An individual cannot be authorized for another residential habilitation service and behavioral risk services at the same time. Formalized training, intensive behavioral supports, and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Day habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports which focus on the acquisition of work skills and appropriate work behavior. Day habilitation services that are provided as part of this all-inclusive service are provided in non-residential settings in the community. An individual cannot be authorized for another day habilitation service and behavioral risk services at the same time. Behavioral risk day habilitation (teaching and supporting) also includes intensive behavioral supports that focus on the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum integration, inclusion, and personal accomplishment in the working community. Day habilitation (teaching and supporting) services, such as day habilitation service activities, workstations, vocational planning service, or integrated community employment are provided away from the home, in a non-residential setting, during typical working hours. Discreet habilitation (teaching and supporting) in preparation for leaving the residential setting during typical working hours is allowed.

Intervention strategies for the delivery of habilitation (teaching and supporting), intensive behavioral supports, ongoing safety supervision, and ongoing supports are determined by the service plan team in conjunction with the supervising mental health practitioner and must be documented in the service plan. Interventions will be based on the individual's assessed needs and, as applicable, will include the following: staff objectives/ safety plans for preventing and/or stopping behaviors that are harmful to the individual or others; habilitation (teaching and supporting) to address acceptable communication of needs and preferences, coping, social, and problem-solving skills; residential and vocational settings, environmental and architectural factors, and location of service delivery; collaboration with behavioral health efforts to meet mental health needs (e.g., counseling, individual/ group psychotherapy, psychotropic medications); and supervision and monitoring strategies, including the type and amount of supervision, law enforcement contacts, provider monitoring responsibilities, and service coordination responsibilities. Restrictive interventions to ensure the safety of the individual and others must be reviewed at every service plan meeting. When applicable, a plan to reduce/eliminate the restriction must be developed, documented in the service plan, and upon request provided to DDD central office.

When determined appropriate by the service plan team and supervising practitioner, a plan to reduce the intensity of Behavioral Risk Services must be developed and upon request, provided to DDD central office.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Because Behavioral Risk service is an all-inclusive service, the cost of transportation is included in the rate paid to providers of Behavioral Risk service. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral risk services are not participant directed. The amount of authorized services for behavioral risk services may not be determined using the objective assessment process.

Payments for behavioral risk services are not made for room and board, the cost of setting maintenance, upkeep, and improvement.

Payment for behavioral risk services does not include payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Behavioral risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service. Each wavier service must be prior-authorized to avoid duplicative billing with another waiver service. An individual cannot be authorized for another day habilitation service or a separate residential habilitation service and behavioral risk services at the same time. The rate for behavioral risk services is set by DDD.

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	certified community-based DD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Risk Services

Provider Category:
Agency

Provider Type:
certified community-based DD provider agency

Provider Qualifications

License *(specify):*
Mental health practitioners require a license and must hold the license in accordance with applicable state laws.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120

Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
175 NAC 3-000
Neb. Rev. § 83-1201 through 83-1226

Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code. All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
3. Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living and Day Supports (CLDS)

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
CLDS provides the necessary assistance and supports to meet the daily needs and preferences of the individual. These participant directed services and supports are provided to ensure adequate functioning in the individual's home, as well as assisting the individual to participate in a wide range of activities outside the home. CLDS may also provides the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated, community settings. The Community Living and Day Supports

service includes the following components:
1. Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid.
2. Supervision and monitoring for the purpose of ensuring the individual's health and safety.
3. Supports to enable the individual to access the community. This may include someone hired to accompany and support the individual in all types of community settings.
4. Supports to assist the individual to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
5. Supports to assist the individual in identifying and sustaining a personal support network of family, friends, and associates.
6. Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
7. Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment.
8. Supports to enable the individual to maintain or obtain employment. This may include someone hired to accompany and support the individual in an integrated work setting. Integrated settings are those considered as available to all members of the community. The employment supports are delivered informally. That is, the provider is not required to write formal training programs with long term goals, short term objectives, strategies, and data collection methodology. The supports delivered under CLDS could be considered "natural teaching moments."
9. Supports to enable the individual to access services and opportunities available in community settings. This may include accompanying the participant to and facilitating participation in general community activities, community volunteer work, and services provided in community settings such as senior centers and adult day centers. CLDS must not be duplicative or replace other supports available to the individual. The services provided under CLDS are different from those provided under Targeted Case Management in that the CLDS provider supports the individual by providing transportation if necessary and remaining with the individual during receipt of the services and community activities. Nebraska service coordinators do not provide direct services and supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
CLDS cannot be provided by the usual caregiver. The term "usual caregiver" means a person(s) who resides with the child, is not paid to provide services, and is responsible for the care and supervision of the child on a 24-hour basis.

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

Assistance with personal care needs or household activities is available only to those individuals who live with an unpaid caregiver.

CLDS is not intended to duplicate or replace other supports available to the individual, including natural supports and state or federally funded services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Household activities and home maintenance activities are for the purpose of fulfilling duties the individual would be expected to do to contribute to the operation of the household, if it were not for the individual's disability.

Homemaker services cannot be authorized when an individual receives Community Living and Day Supports.

Routine health care supports may be furnished to the extent permitted under Nebraska state law.

Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of home maintenance services under CLDS.

The individual must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the individual's home.

Payment for the work performed by the individual is the responsibility of the employer. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment services.

Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of immediate household members, a senior center, adult day center, or employer.

The individual must supply necessary cleaning products and equipment or money for a Laundromat when a provider cleans or cares for the individual's clothing.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. CLDS cannot be delivered at the same time as the delivery of Group Home residential habilitation services, Companion Home Residential Habilitation services, Extended Family Home Residential Habilitation services, In-Home Residential Habilitation services, Workstation Habilitation services, Day Habilitation services, Vocational Planning Habilitation services, Integrated Community Employment services, or Respite services.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	community-based DD provider
Individual	independent

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living and Day Supports (CLDS)

Provider Category:
Agency
Provider Type:
community-based DD provider
Provider Qualifications
License *(specify):*
Licensing is not a requirement to be a qualified individual CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual CLDS provider.
Other Standard *(specify):*
All providers of CLDS services must be Medicaid providers as described in 471 NAC 2-000.
NAC 404 9-000
A provider of CLDS must:

1. Be age 18 or older;
2. Not be a member of the individual's immediate household;
3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone; and
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.

All providers of waiver services who have direct contact with the individual receiving CSP services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
   a) Assume responsibility;
   b) Follow emergency procedures;
   c) Maintain schedules; and
   d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS
Frequency of Verification:
annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living and Day Supports (CLDS)

Provider Category:
Individual
Provider Type:
independent
Provider Qualifications

License *(specify):*
Licensing is not a requirement to be a qualified individual CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual CLDS provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.
NAC 404 9-000
A provider of CLDS must:
1. Be age 18 or older;

2. Not be a member of the individual's immediate household;
3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone; and
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
6. Be authorized to work in the United States.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
   a) Assume responsibility;
   b) Follow emergency procedures;
   c) Maintain schedules; and
   d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Human Services staff

Frequency of Verification:
annually

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:
Companion Home residential habilitation

HCBS Taxonomy:

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

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

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

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

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

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Companion home residential habilitation (teaching and supporting) services may be provided to no more than two other individuals in a residence that is under the control and direction of the individual(s) and can be delivered intermittently or continuously. A companion home may be an apartment, a house, a condominium, or a townhouse which the individual owns or rents. The provider of residential habilitation (teaching and supporting) services in a companion home must be able to document that the individual freely chose their residential setting and housemates and that the lease or mortgage is under the control of the individual.

For continuous companion home residential habilitation (teaching and supporting) services, the provider staff must be present and awake during the times that individuals are present and awake. The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. As applicable, when the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

When the provider claims for overnight awake or overnight asleep staffing, the staff must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan. Continuous residential services are expected to be available for no less than eleven hours with six hours of overnight. Generally, residential services will begin at 6:00 am each day. Daily rates are available for EFH residential services when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Companion home residential habilitation (teaching and supporting) services may be delivered intermittently. Intermittent services imply that community based DD provider staff support is provided when the services and supports are needed and are delivered face-to-face intermittently available to deliver

habilitation (teaching and supporting) to the person receiving services in the family home or in the community. Intermittent companion home residential habilitation (teaching and supporting) services are based on the individual's preferences and assessed needs, and must be documented in the service plan. Intermittent residential services are delivered in accordance with the needs and preferences of the individual, and must be documented in the service plan. Intermittent residential services are billed in hourly rates and an hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Continuous AND intermittent residential services cannot be billed on the same day when the provider is going to bill the daily rate.

Transportation is only provided to the individual, between the participant's companion home and other service sites and places in the community is provided as a component of companion home residential habilitation (teaching and supporting) services. The cost of this transportation is included in the rate paid to providers of companion home residential habilitation services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed. Transportation for the provider to and from the individual's home is not included as a component of this services and cannot be claimed.

When the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity. When the setting in which the landlord tenant laws do not apply, a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

Payments made by the State for companion home residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement.

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

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences, to the extent possible, as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community-based DD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Home residential habilitation

Provider Category:
Agency
Provider Type:
certified community-based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
Be age 18 or older;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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:
Extended Family Home residential habilitation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Extended family home residential habilitation (teaching and supporting) service is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Residential habilitation (teaching and supporting) services provided in a single family home setting are called extended family home (EFH) residential habilitation (teaching and supporting) services. The home is not owned by the individual and is rented or owned by the employee or sub-contractor of the DD provider agency. EFH residential habilitation (teaching and supporting) services are delivered by an employee of the DD provider agency or under a subcontract with a DD provider agency and are continuous services. Continuous residential services are expected to be available for no less than eleven hours. Generally, residential services will begin at 6:00 am each day. Daily rates are available for EFH residential services when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

EFH residential habilitation (teaching and supporting) services are services provided in a setting where the individual and the EFH provider resides and the EFH provider is on-site and immediately available at all times to the individual receiving services, including during the individual's sleep time. The EFH provider must be present and awake during the times the individual is present and awake.

Six hours of overnight staffing are built into the overnight awake and overnight asleep rate for EFH residential habilitation (teaching and supporting) services. The EFH provider may be sleeping, unless awake overnight supervision or assistance is required as documented in the individual's program plan, and must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan.
The method by which the cost of room and board is excluded from payment for residential habilitation is specified in Appendix I-5.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of EFH residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.

When the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity. When the setting in which the landlord tenant laws do not apply, a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

A maximum of three individuals with DD may live in the residence.

Payments for EFH residential habilitation (teaching and supporting) services are not made for room and board, the cost of facility maintenance, upkeep and improvement.

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

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

The provision of EFH residential habilitation (teaching and supporting) services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation (teaching and supporting) services, or Medicaid State Plan services. Residential habilitation (teaching and supporting) services will not duplicate other services provided through this waiver. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	employee or subcontracted provider of a certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extended Family Home residential habilitation

Provider Category:

Agency

Provider Type:
employee or subcontracted provider of a certified CBDD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

DD provider staff delivering direct services and supports must:
(1) Be age 18 or older;
(2) Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
(3) Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Modifications

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Home Modifications are those physical adaptations, or structual changes to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home.

Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

1. Approvable modifications are limited to those necessary to maintain the individual in their own participant-directed home (not provider operated or controlled) or in the family's home, if living with his/her family.

2. Approvable modifications do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual.

3. DDD will not approve home modifications if the adaptations are available under the Medicaid State Plan or from a third party source.
4. The home must not present a health and safety risk to the individual other than that corrected by the approved home modifications.
5. If the individual resides in a rental unit, the individual or family/guardian must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications, by listing the property for rent on www.housing.ne.gov.
6. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	vocational rehabilitation agency
Individual	independent provider
Agency	Independent living center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Agency
Provider Type:
vocational rehabilitation agency
Provider Qualifications
License *(specify):*
Licensure is not a requirement.
Certificate *(specify):*
Certification is not a requirement
Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code titleNAC 471 2-000.

A provider of home modification services must:
1. Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
2. Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;
3. Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;
4. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;
5. Warrant all work, new materials, and new products for a minimum of one year; and
6. Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff verifies the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verifies the subcontracted provider.
Frequency of Verification:
per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Individual
Provider Type:
independent provider
Provider Qualifications
License *(specify):*

All individual providers of home modifications performing electrical or plumbing work must meet applicable local and state licensure requirements and maintain current licensure.
Neb. Rev. § 71-4603
Neb. Rev. § 81-2101 through 81-2141
Certificate *(specify):*
Certification is not a requirement.
Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

A provider of home modification services must:
1. Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
2. Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;
3. Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;
4. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;
5. Warrant all work, new materials, and new products for a minimum of one year; and
6. Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility.
7. Be authorized to work in the United States.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff
Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Agency
Provider Type:
Independent living center
Provider Qualifications
License *(specify):*
Licensure is not required.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

A provider of home modification services must:
1. Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
2. Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;
3. Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;
4. Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;
5. Warrant all work, new materials, and new products for a minimum of one year; and
6. Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of independent living center agency. Independent Living Center verifies the subcontracted provider.

Frequency of Verification:
per occurrence

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:
In-home residential habilitation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Residential habilitation (teaching and supporting) services provided to a participant living in his/her family home are called in-home residential habilitation (teaching and supporting) services and are intermittent services. The home is owned or leased by the individual or their family member. Intermittent services imply that community based DD provider staff support is provided when the services and supports are needed and are delivered face-to-face intermittently available to deliver habilitation (teaching and supporting) to the person receiving services in the family home or in the community.

In-home residential habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Training and supports are designed to provide the individual with face to face habilitation (teaching and supporting). Training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. This service may also include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present.

Intermittent in home residential services are delivered in accordance with the needs and preferences of the individual, and as outlined in the service plan. There are only hourly rates for this services and an hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Transportation is only provided to the individual, between the participant's family home, where In-Home residential habilitation service takes place, and other service sites and places in the community is provided as a component of in-home residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed. Transportation for the provider to and from the individual's home is not included as a component of this services and cannot be claimed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payments for residential habilitation (teaching and supporting) services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

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

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

The provision of in-home residential habilitation (teaching and supporting) services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation (teaching and supporting) services, or Medicaid State Plan services. In-home residential habilitation (teaching and supporting) services will not duplicate other services provided through this waiver. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-home residential habilitation

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
Licensing is not a requirement.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.
DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
3. Be authorized to work in the United States.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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:
Medical Risk Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Medical risk services are provided to individuals with complex medical needs that require continuing supports and treatment but are not assessed to need continuous nursing facility level of care. Complex medical needs may result from the diagnoses of some types of diabetes or seizures or may result from use of g-tubes, g-buttons, j-tubes, tracheotomies, ventilators, or a combination of the above. Treatment or interventions to meet complex medical needs require ongoing clinical assessment, professional judgment, and treatment based on ongoing assessment and cannot be delegated to unlicensed direct support professionals.

Medical risk services are also available to individuals who have a degenerative/regressive condition diagnosed by the individual's medical practitioner and that make further growth or development unlikely. The degenerative/regressive condition requires continuing care and treatment, and significantly impedes independent completion of activities of daily living, and impedes self-directing others to perform activities of daily living. Degenerative or regressive conditions that affect all areas of daily living activities may include cerebral palsy, muscular dystrophy, multiple sclerosis, post-polio syndrome, dementia, Parkinson's disease, Huntington's disease, Alzheimer's, or other neurological impairments.

The need for medical risk services will be determined by designated staff at Division of Developmental Disabilities (DDD) central office. A referral is completed by the individual's IPP team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD central office. When the team, which may include the individual's physician, believes that the individual's needs require medical risk services, the individual may be referred to DD central office for a formal health assessment.

Medical risk services are provided 24/7 and are considered to be continuous services. This service is an all-inclusive service that includes residential and day habilitation (teaching and supporting), health maintenance activities, routine complex medical treatments, ongoing health and safety supervision, and ongoing clinical supports. The provision of medical risk services will be under the direction of a registered nurse. An individual cannot be authorized for another residential habilitation service and medical risk services at the same time. Physical nutritional management plans must be implemented as applicable Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

The residential habilitation (teaching and supporting) under this service can be delivered in a variety of home settings. The residential habilitation component is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Medical risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation (teaching

and supporting) also includes personal care and protective oversight when applicable as well as supervision.

The day habilitation (teaching and supporting) service component, is provided away from the home, unless prescribed to be medically necessary by the individual's physician and approved by DDD central office, and is provided during typical working hours to increase the person's independence, integration, inclusion, personal accomplishment, and employment objectives, as applicable. Day habilitation services that are provided as part of this all-inclusive service are provided in non-residential settings in the community. An individual cannot be authorized for another day habilitation service and medical risk services at the same time. The habilitation (teaching and supporting) services are formalized training and supports, which focus on enabling the individual to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies in the IPP. The habilitative training and supports may include workplace training, increasing socialization and recreational skills and abilities in the community, and skills to assist in access to and integration in their community. The day habilitation (teaching and supporting) component also includes personal care and protective oversight when applicable as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are not an exclusive component of medical risk services and are provided when identified as a need and documented in the service plan.

Assistance with personal needs may include toileting, transfer and ambulation, skin care, bathing, dressing, grooming, meal preparation, eating, extension of therapies and exercise, and routine care of adaptive equipment primarily involving cleaning as needed.

Treatments or interventions to meet complex medical needs or address degenerative conditions are outlined in a nursing plan and included in the person's service plan. Health and safety factors including the type and amount of supervision, environmental conditions, weather conditions, architectural conditions, special diets, and safe evacuation plans are included in the service plan as applicable to the individual.

Medical risk providers must have a sufficient number of Registered Nurses on staff or under contract to develop nursing plans, provide complex medical treatments, train unlicensed direct support professionals, and oversee delegation of health maintenance activities to the extent permitted under applicable state laws.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Medical risk services are not participant directed. The amount of authorized services for medical risk services may not be determined using the objective assessment process.

Complex medical treatments require ongoing assessment, professional judgment, and treatment based on ongoing assessment and can only be delegated to unlicensed direct support professionals to the extent permitted under Neb. Rev. Statute § 71-1, 132.30.

Payments for medical risk services are not made for room and board, the cost of setting maintenance, upkeep, and improvement.

Payment for medical risk services does not include DDD payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The provision of medical risk services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, or Medicaid State Plan services. Medical risk services will not duplicate other services provided through this waiver. Medical risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Risk Services

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
Registered Nurses that provide a complex medical treatment or intervention or that delegate non-complex treatments to direct support staff must be licensed in accordance with applicable state laws and regulations. 172 NAC 97-000 Neb. Rev. § 38-2201
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
175 NAC 3-000
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

DD provider staff delivering direct services and supports must:
Be age 18 or older;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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:**

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

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

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

Service Definition *(Scope)*:

PERS is an electronic device which enables individuals to secure help in an emergency. The individual may also wear a portable PERS button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a PERS button is activated.

A provider of PERS must:

1. Instruct the individual about how to use the PERS device;
2. Obtain the individual's or authorized representative's signature verifying receipt of the PERS unit;
3. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days per week;
4. Furnish a replacement PERS unit to the individual within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Update list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensure monthly testing of the PERS unit; and
7. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the individual in the use of PERS devices, as well as to provide for system performance checks.

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

PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular unpaid caregiver or provider for extended periods of time, and who would otherwise require extensive routine supervision.

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

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

☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent 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:
Independent provider
Provider Qualifications
License *(specify):*
No license is required to be a PERS provider.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

A provider of PERS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. 404 NAC 9-000
Verification of Provider Qualifications
Entity Responsible for Verification:
Nebraska Dept. of Health and Human Services staff
Frequency of Verification:
annually

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:
Retirement Services

HCBS Taxonomy:

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

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

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

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

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

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

Active supports must be furnished in a way which fosters the independence of each individual. Strategies for the delivery of active supports must be person centered and person directed to the maximum extent possible and must be identified in the service plan, also called the individual program plan (IPP) or individual support plan (ISP).

Retirement services and supports may include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of retirement services and supports do not constitute a "full nutritional regimen" (3 meals per day).

Retirement services may be provided as a continuous or intermittent service. Continuous day service activities are provided for seven or more hours per day and delivered in a non-institutional, community setting that may include people without disabilities. Retirement day settings cannot be set up or operated by a DD provider in communities where an existing community senior center or facilities geared for people who are elderly, such as an adult day care center are available. DD provider-operated retirement day settings must be made available to people without disabilities.

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

When retirement services are delivered in a provider operated residence, there must be staff on-site or within

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

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

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

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

Payments for retirement services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for retirement services does not include payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan, also called the individual program plan (IPP) or individual support plan (ISP).

Retirement day supports cannot duplicate or replace existing natural supports, senior centers, adult day care centers, or other community activity centers in the communities in which the person resides.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	independent non-certified individual provider
Agency	certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Retirement Services

Provider Category:
Individual
Provider Type:
independent non-certified individual provider
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual provider for retirement services.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

An independent provider of retirement must:
1. Be age 18 or older;
2. Not be a member of the individual's immediate household;
3. Have knowledge of basic first aid skills and of emergency responses;
4. Agree never to leave the individual alone;
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
6. Be authorized to work in the United States.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
   a) Assume responsibility;
   b) Follow emergency procedures;
   c) Maintain schedules; and
   d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff
Frequency of Verification:
annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Retirement Services

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
No licensure is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
175 NAC 3-000
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code. All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000 .

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
3. Be authorized to work in the United States.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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:
Team Behavioral Consultation Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Team behavioral consultation service is on-site consultation by highly specialized teams with behavioral and psychological expertise when individuals with DD experience psychological, behavioral, or emotional instability which has been resistant to other standard habilitative interventions and strategies that have been attempted by the individual's IPP team. Sometimes in rural areas of the state, community resources, such as psychologists or psychiatrists are not readily available to consult with or participate in meetings, or have very little experience with treating individuals with DD. Team behavioral consultation service may be requested by the IPP team or directed by DDD central office and the need for the service is reflected in the IPP.

Team behavioral consultation (TBC) service includes reviewing referral information, an entrance conference, on-site observations, interviews, and assessments, training to direct support staff, identification of the need for referral(s) to other services if applicable, an exit conference, report of findings and recommendations, and follow-up.

The service begins with submission of a referral to DDD central office to log and forward to the assigned TBC team. The TBC team contacts the individual's service coordinator (SC) to schedule a consultation visit and the SC submits informational packet to the TBC team for review prior to the scheduled visit.

The on-site consultation begins with an initial meeting of the IPP team – the individual, legal representative and/or parent, service coordinator, staff from habilitation service components delivered to the person (day services, residential services, or both day and residential services), other professionals serving the person in the community, as well as TBC service staff.

The TBC service is provided under the direction of a Licensed Clinical Psychologist, and may include the following members, depending upon the individual's needs: a Certified Master of Social Work, a Registered nurse, a licensed mental health practitioner, or other qualified professionals. This meeting is designed to further explore the negative behavior and plan the schedule for the on-site consultation.

Observations where the individual lives, and/or takes part in day services or other activities are conducted at any time of the day or night, depending upon when and where the specific negative behaviors are exhibited. IPP team members are interviewed, and assessments are completed. The current interventions are noted, and efficacy assessed. Behavioral interventions are developed, piloted, and evaluated, and revised, as necessary. Training is delivered to the IPP team as applicable and requested, such as best practices in intervention strategies, medical and psychological conditions, or environmental impact to service delivery.

Findings and recommendations are written and discussed with the team at the exit conference and a copy is provided to DDD central office. The individual is present for the consultation.

If at any time the TBC team identifies a need for a referral as a result of the review of the individual case file, observations, interviews, and/or completion of assessments, the TBC will notify the individual's DDD service coordinator to recommend/direct that a referral be made for needs such as, but not limited to a medication review, dental work, medical evaluation, or nutritional evaluation. Such referral recommendations are documented in the TBC report.

Follow-up begins after the TBC staff has left the community site. It includes all revisions to the recommendations package, and phone, e-mail, and on-site contact with the individual's IPP team in the community. Weekly contact with the IPP team is conducted by telephone or e-mail to provide support and additional recommendations, as needed. Behavioral data and Treatment Integrity checklists are reviewed on an on-going basis, with on-site follow-up conducted if problem behaviors continue to be resistant in spite of

consistently applied efforts. Continued follow-up is provided after each successive on-site visit. The TBC file is closed when there is agreement to do so by TBC staff and the individual's IPP team.

The recommendations from the TBC service provider for addressing behaviors and intervention strategies must be addressed by the individual's IPP team and changes resulting from the recommendations are documented in the IPP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Team behavioral consultation is only available to individuals receiving services from a certified DD agency provider. TBC will not be available to individuals that receive behavioral risk services or retirement services.

Waiver services will not be furnished to an individual while s/he is an inpatient of a hospital, nursing facility, or ICF. Room and board is not included as a cost that is reimbursed under this waiver.

To avoid overlap or duplication of service, team behavioral consultation services are limited to those services not already covered under the Medicaid State Plan or which can be procured from other formal or informal resources such as IDEA or Rehab act of 1973. Furthermore, TBC services will not duplicate other services provided through this waiver.

A unit of team behavioral consultation is defined as a day. The authorized amount of team behavioral consultation is not determined using the objective assessment process. The funding amount and duration of the service is set by DDD and is not based on the objective assessment process described in I-2-a.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	certified home and community based waiver provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Team Behavioral Consultation Services

Provider Category:
Agency
Provider Type:
certified home and community based waiver provider
Provider Qualifications
License *(specify):*
Team behavioral consultaion staff that are a psychologist, medical staff, or a mental health practitioner are required to be licensed in accordance with applicable state laws and regulations.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
172 NAC 94-000
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
3. Be authorized to work in the United States.
4. Have inpatient hospital or ICF beds available for use as needed;
5. Have experience offering team behavioral consultation;
6. Not provide TBC in cases where the provider of subcontracted provide is also the habilitation provider; and
7. Have on staff or under contract a psychologist, medical staff, mental health practitioner, behavioral specialist, and other professionals as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS
Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Vehicle Modifications

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Vehicle modifications to vehicles may be made for purposes of accommodating the special needs or the participant when the vehicle is privately owned by the individual or his/her family and is used to meet the participant's transportation needs.

The vehicle must be in good operating condition and modifications must be made in accordance with applicable standards of manufacturing, design, and installation. The following are excluded specifically from the participant's primary means of transportation:
1) Adaptations or improvements to the vehicle that are of a general utility, & are not a medical or remedial benefit to the individual;
2) Purchase or lease of a vehicle; and
3) Regularly scheduled upkeep & maintenance of a vehicle except upkeep & maintenance of the modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living center
Agency	Vocational Rehabilitation agency
Individual	Independent

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
Independent Living center
Provider Qualifications
License *(specify):*
Licensure is not a requirement.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.
NAC 404 9-000
A provider of vehicle modification services must:
1. Ensure that the vehicle is in good operating condition;
2. Perform modifications in accordance with applicable standards of manufacturing, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS staff verifies the qualifications of independent living center. Independent living center verifies the subcontracted provider.

Frequency of Verification:

per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vocational Rehabilitation agency

Provider Qualifications

License *(specify):*

Licensure is not a requirement.

Certificate *(specify):*

Certification is not required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

NAC 404 9-000

A provider of vehicle modification services must:

1. Ensure that the vehicle is in good operating condition;
2. Perform modifications in accordance with applicable standards of manufacturing, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS staff verifies the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verifies the subcontracted provider.

Frequency of Verification:

per occurrence

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Independent

Provider Qualifications

License *(specify):*

Licensure is not a requirement.

Certificate *(specify):*

Certification is not required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

404 NAC 9-000
A provider of vehicle modification services must:
1. Ensure that the vehicle is in good operating condition;
2. Perform modifications in accordance with applicable standards of manufacturing, design, and installation.
3. Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:
NDHHS staff
Frequency of Verification:
per occurrence

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:
Vocational Planning habilitation service

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Vocational Planning habilitation (teaching and supporting) service is a prevocational service with focus on enabling the individual to attain work experience through career planning, job searching, and paid and unpaid work experience with the goal or outcome of Vocational Planning being integrated community employment. Services are furnished as specified in the service plan and are delivered intermittently. Intermittent services imply that staff support is provided when the services and supports are needed. Vocational Planning services can only be billed in half, quarter, or full hour increments. An hour of service equates to one clock hour.

Vocational Planning habilitation (teaching and supporting) services are formalized training and staff supports

which take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting not owned or controlled by a DD provider, where individuals without disabilities work or meet together. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the person lives. Direct training or teaching and supports will be designed to provide the individual with face to face instruction necessary to learn work-related responsibilities, work skills, and appropriate work behavior.

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

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

Vocational Planning habilitation (teaching and supporting) services may include career planning that is person-centered and team supported to address the individual's particular needs to prepare for, obtain, maintain or advance employment. Habilitation (teaching and supporting) services with focus on career planning includes development of self-awareness and assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Assessment of skills, abilities, and needs is a person-centered team responsibility that engages all team members to support an individual in identifying a career direction and developing a plan for achieving integrated community employment at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The documented outcome is the stated career goals and career direction and strategies for the acquisition of skills and abilities needed for work experience in preparation for integrated community employment. Establishment of career goals may not take place at the same time as other Vocational Planning activities.

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

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

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

Prior to learning to access transportation independently, transportation may be provided between the individual's place of residence and the vocational planning habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between vocational planning

habilitation and day habilitation, workstation habilitation and integrated community employment should be billed under those waiver services and not this service.

Vocational Planning habilitation (teaching and supporting) services may take place in conjunction with Integrated Community Employment services, Workstation habilitation (teaching and supporting) services, Day Habilitation service, or other day activities but may not be billed at the same time during a given day.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Some components of Vocational Planning habilitation (teaching and supporting) services are time-limited. Establishment of career goals through career planning may not exceed three months. If the outcome of career planning is not reached within three months, a team meeting must be held to change the service plan. Unpaid work experiences must lead to paid employment and are therefore time-limited. Work experiences for which the general population is paid to perform may not last beyond six months. Volunteering to provide services and supports in an integrated community setting for which the general population does not get paid to perform are not considered to be a work experience and are not time-limited. No more than three individuals may participate in the same paid or unpaid work experience at the same time.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vocational Planning habilitation service

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226

Other Standard *(specify)*:
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code. All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
3. Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:
Every one or two years as applicable.

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:
Workstation habilitation services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Workstation habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living, and employment. Workstation habilitation (teaching and supporting) services take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such

as within a business or a community setting where individuals without disabilities work or meet together. Discreet training activities and supports during typical working hours is allowed in preparation for leaving the place where the person lives.

Workstation habilitation (teaching and supporting) services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion, inclusion, and personal accomplishment in the working community. Training activities may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

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

Workstation habilitation (teaching and supporting) services are delivered continuously and provide paid work experiences in preparation for competitive employment. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Staff support is continuous, that is, staff are present at all times the individual is present. Daily rates are available for workstation habilitation (teaching and supporting) services when the person receives this service for four or more consecutive hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate.

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

Transportation may be provided between the individual's place of residence and the workstation habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between workstation habilitation and other habilitation service sites should be billed under those waiver services and not this service.

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

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community-based DD provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Workstation habilitation services

Provider Category:
Agency
Provider Type:
certified community-based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.
A qualified DD provider agency must meet certification standards, as described in state statutes and regulations.
205 NAC 1-000 through 5-000
480 NAC chapters 2, 3, 6 and 7
Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

DD provider staff delivering direct services and supports must:
1. Be age 18 or older;
2. Not be the parent, spouse, or child (biological, step, or adopted) of the participant; and
3. Be authorized to work in the United States.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

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.*

- [x] **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.*

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

Service Coordination to waiver participants is provided by the Nebraska Department of Health and Human Services Division of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Nebraska DHHS Central Registries are maintained by employees of DHHS. The background and criminal history checks are conducted by DHHS staff.

Nebraska regulations require that individuals must be treated with dignity and respect, be free from neglect and abuse (physical, verbal, psychological or sexual), receive appropriate medical treatment and receive services in a safe and sanitary environment.

a) Background and criminal history checks are conducted on each certified DD agency provider staff person that has direct contact with individuals served by the agency. The requirement of obtaining the background and criminal history background checks is rooted in state statute 83-1216. Background and criminal history checks are conducted at the time the person is newly hired and employees who provide direct support services may not work alone with individuals served until the results of the registry checks and the criminal history background checks are reviewed by the provider.

b) The background check for certified DD agency provider staff consists of a check of the Central Registries for any substantiated reports of adult or child abuse or neglect. In addition, within ten calendar days of hire, a set of the certified agency staff person's fingerprints is forwarded to the Nebraska State Patrol to initiate the criminal history check. The Nebraska State Patrol (NSP) works in conjunction with the FBI to access information that culminates in a report of any criminal activity with which the person has ever been charged within the United States and the disposition of that case. The results of each of these types of checks are directed to the certified provider agency for their use in making hiring decisions that adhere to applicable state regulations.

In addition to these checks to ensure the appropriateness of individuals hired to provide services to vulnerable individuals, certified providers are required to comply with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Certified and non-certified DD providers must go further than completing background checks to ensure compliance with requirements of the Adult Protective Services law for protection of vulnerable adults and children. They must also adhere to requirements of reporting even the suspicion of alleged abuse and neglect. When providers report alleged abuse and neglect to DHHS Protection and Safety Specialists (PSS) that are not required by law, the PSS shares this information with DDD within 24 hours of receipt. DDD staff reviews the

information and makes a determination whether to do a complaint investigation or handle it in another manner.

c) Certification review activities conducted by DDD staff ensure that mandatory investigations have been conducted. Certification reviews include on-site review activities, development of a written report of findings, review of any plan of correction, and review of follow-up reports submitted by the agency provider that provide updates on the provider's implementation of the plan of correction. Agency systems of operation are also reviewed to verify that mandatory investigations have been conducted, including a review of activities of quality improvement, due process for restrictive procedures and handling of complaints, review of allegations of abuse or neglect, employee background checks, and staff training. DDD staff complete review checklists and utilize the information gathered to develop a written report of findings.

a) Non-certified independent community supports providers who will provide direct contact services and supports, and any member of the provider's household if services will be provided in the provider's home undergo background and criminal history checks before approval and annually if the provider is renewed.
b) The background check and criminal history checks consists of a check of the Nebraska Department of Health and Human Services Central Registries for any substantiated reports of adult or child abuse or neglect, as well as Nebraska's on-line Sex Offender Registry, on-line Department of Justice (DOJ) records, Department of Motor Vehicle (DMV) records, and a check of local law enforcement criminal records. There must be a signed statement giving information about all felony or misdemeanor pending charges, arrests, and convictions. If additional information is needed to evaluate the criminal history of the provider or household member, DHHS will obtain a release of information from the non-certified provider or household member; and request information available from law enforcement. DHHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

c) After DHHS staff completes the background checks, the staff verifies that background checks have been completed by marking the "Request for Provider Approval" form or the "Provider Background Check Results form", whichever is applicable to their job duties. The form includes verification that APS, CPS, and SO registries, DOJ records, and DMV records are checked and the date the registries were checked.

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 Nebraska Department of Health and Human Services Central Registries are maintained by employees of NDHHS. The background and criminal history checks are conducted by DHHS staff. (b) Service coordinators and all waiver providers who will provide direct contact services and supports, and any member of the non-certified independent community supports (CS) provider's household if services will be provided in the CS provider's home undergo registry screening, background and criminal history checks.
(c) There must be a signed statement giving information about all felony or misdemeanor pending charges, arrests, and convictions. If additional information is needed to evaluate the criminal history of the provider or household member, DHHS will obtain a release of information from the provider or household member; and request information available from law enforcement. DHHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

After DHHS staff completes the background checks, the staff verifies that background checks have been completed by marking the "Request For Provider Approval" form or the "Provider Background Check Results form", whichever is applicable to their job duties. The form includes verification that APS, CPS, and SO registries are checked and the date the registries were checked.
No contract is issued prior to completion of background and criminal history checks. See C-2-a above for additional information.

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).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Licensed Center for Persons with Developmental Disabilities (CDD)	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response for C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Center for Persons with Developmental Disabilities (CDD)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
In-home residential habilitation	☐
Home Modifications	☐
Extended Family Home residential habilitation	☐
Respite	☑
Companion Home residential habilitation	☐
Community Living and Day Supports (CLDS)	☐
Team Behavioral Consultation Services	☐
Assistive Technology and Supports (ATS)	☐
Retirement Services	☑
Vocational Planning habilitation service	☐
Day Habilitation	☐
Group home residential habilitation	☑
Medical Risk Services	☑
Workstation habilitation services	☐

Waiver Service	Provided in Facility
Behavioral Risk Services	☑
Personal Emergency Response System (PERS)	☐
Vehicle Modifications	☐
Integrated Community Employment	☐

Facility Capacity Limit:

Capacity is limited by size of group home. The maximum capacity is fourteen.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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.*

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, other than the waiver participant's parent, spouse, or child (biological, step, or adopted) may be direct providers of non-specialized Community Living and Day Supports and Respite services. Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adoptive) may be indirect providers of Assistive Technology and Supports, Home Modifications, and Vehicle Modifications. The State makes payment to relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

The provision of services by the relative is determined through documented team discussion during the planning process. The provision of services is monitored by the participant's state DDD Service Coordinator. Determination that the above circumstances apply is determined by the participant and his/her team and verified during enrollment of the independent provider, prior to the issuing of a contract.
This is determined on a case by case situation by the individual's IPP team. In rural areas, there may not be providers who are available or who have experience in working with individuals with DD. A relative may be available and would know the needs and preferences of the child.
The State does not make payments:
1. Directly or indirectly, to relatives who are the parent, spouse, or child (biological, step, or adopted) of the individual;
2. To members of the individual's immediate household, including relatives/legal guardians;
3. To a legally responsible relative/guardian,
4. For the routine care and supervision which would be expected to be provided by a family, or
5. For activities or supervision for which a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the individual.

The following controls are employed to ensure payments are made only for services rendered:
1. The need for the service is documented in the individual program plan (IPP);
2. DHHS staff have enrolled the independent provider and prior authorized each waiver service to be delivered;
3. When provided by an independent provider, a calendar is completed, listing the date(s) of services(s), the specific task(s), and the times of service, and signed by the waiver participant or designee, verifying the services have been delivered as claimed;
4. A calendar, when applicable and claim are submitted to DHHS for approval and processing;
5. DHHS staff verify and approve the claim and submit claim to DHHS claims processing staff for processing;

and
6. Edits are in place in the computer system.

○ **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.

○ **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:

Process for enrollment of certified DD agency providers is as follows:

DD service provider agencies are certified under applicable titles of the Nebraska Administrative Code. The certification process for DD agency providers is conducted by DHHS DDD staff.

DDD central office staff is responsible for certification and contracting of new agency providers. DDD Central Office staff routinely field inquiries about becoming a certified agency provider of community-based services for persons with developmental disabilities by providing verbal and written information to assist the interested party. These interactions may lead to development of a new service agency provider to increase the availability and choice of services and providers for persons with developmental disabilities.

DDD has developed a process to support DDD central office staff in providing information to interested parties and collecting a consistent set of information to support provider development activities. Written materials were developed into an informational packet and these packets are mailed to interested parties who have asked for further information. The names and other contact information of callers who have asked for packets are recorded on a list kept by the DDD administrative assistant. A provider orientation for interested parties is held twice a year to describe the certification process and answer questions from the prospective providers.

As potential providers submit the required application and policy and procedural manuals, the provider is assigned to a state DDD Program Specialist and communication is initiated to schedule certification work. The Program Specialist reviews information as it is submitted, and provides feedback and timelines throughout the certification work. When all the necessary qualifications are met the potential provider is informed that their agency has met DD provider agency certification requirements.

The following is the process for enrollment of independent providers:

Following the development of the IPP, the individual, legal representative, and family, as appropriate, will work with the state DDD Service Coordinator and other designated DHHS staff to locate independent providers to deliver the services.

Information for becoming an independent provider can be obtained from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff (resource development staff, his/her Service Coordinator, his/her Social Services Worker, and/or the Disability Services Specialist).

Individuals have the option of finding qualified individuals or agencies that are interested in providing non-specialized waiver services. Individuals often draw from their personal networks of family members not living in the household and who are not legally responsible, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students. Individuals utilize the internet as a resource for potential providers.

Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. DHHS staff also makes available to the individuals an extensive list of current service providers enrolled under other HHSS programs, such as chore, child care, respite, HCBS waiver for Aged and Disabled, HCBS waiver for children with
DD, personal assistance services, etc. Individuals interview the potential provider to determine whether the amount of experience, knowledge, and education or training will meet the consumer's needs. The potential provider is referred to DHHS staff for enrollment. All willing and qualified providers can enroll.

DHHS staff are responsible for enrolling independent individual or agency providers as waiver providers. Upon receipt of a referral, DHHS staff responsible for enrolling an independent provider contacts the potential provider to schedule a meeting at the provider's convenience. Following the enrollment meeting, DHHS staff immediately completes the enrollment process and issue a contract to the provider.

There is no timeline for enrollment of independent providers. It is based on the immediacy of the need for the provider. When a provider is needed immediately, to the best of the State's and provider's ability, the provider is enrolled immediately. Some providers are enrolled as back-up providers and the scheduling of the appointment may be delayed. Timelines for DHHS staff are determined by local DHHS administrators. Generally, enrollment is completed within 1 day to 4 weeks of initial contact.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Of the total number of certification/compliance reviews completed on certified provider agencies, the number of providers cited for failure to adhere to required regulations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

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: semi-annually	

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: semi-annually or as determined by the state DDD QI committee

Performance Measure:
Of the total number of newly certified providers, the number of providers that initially meet required background checks prior to delivery of waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

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: semi-annually	

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):*
	Semi-annually or as determined by the state DDD QI committee

Performance Measure:
Of the total number of certified providers, the number of providers that continue to meet all required certification standards.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

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: semi-annually	

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: semi-annually or as determined by the state DDD QI committee

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:
Out of the total number of monitorings, the number of SC monitorings that indicate the management of services, supports, and providers is occurring as documented in the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Community Supports Service Coordination Monitoring

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: semi-annually or as determined by the DD QI committee

Performance Measure:
Out of the total number of background checks completed on non-licensed/non-certified providers, the number of background checks completed prior to provider approval.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Request for Service Provider Approval form or the Provider Background Results form

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: As determined by the State DDD QI committee

Performance Measure:
Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that met initial waiver provider qualifications.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(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: semi-annually or as determined by the DDD QI committee

Performance Measure:

Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that continue to meet waiver provider qualifications.

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

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: semi-annually or as determined by the DDD QI committee

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:
Out of the total number of waiver participants, the number of individuals that had no issues with their non-certified community supports provider performance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Community Supports Service Coordination Monitoring database

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DDD QI committee

Performance Measure:
Of the total number of certified provider agencies that employ staff, the number of agencies that have training records for their employees that indicate these staff have met provider training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

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: semi-annually	

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: semi-annually or as determined by the DDD QI committee

Performance Measure:
Of the total number of certification/compliance reviews completed on certified provider agencies, the number of provider agencies that have met training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

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: semi-annually	

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: semi-annually or as determined by the state DDD QI committee

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.
Monitoring for compliance with the above subassurances is completed at the local level by the individual, the DDD SC, and the disability services specialist. The state QI committee reviews the monitoring data semi-annually. The committee meets monthly and reviews reports on a variety of QI activities on a rotating, scheduled basis. The state QI committee reviews the data for the certification activities semi-annually. Recommendations are made for action by appropriate parties, including DDD management, members of the committee, other committees and other DHHS staff. The QI activities of DDD and results of reports are communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, the Nebraska DD Council, and DDD-sponsored Town hall

Meetings for individuals, families, and other interested parties.

Each DD provider agency is certified by DDD. DDD certifies providers in accordance with state regulations on an annual or biennial basis; depending on the results of the certification review (significant issues can lead to shorter certifications or termination of contracts to provider services). As a part of the certification process, checks are made to ensure providers are conducting services in accordance with regulations, including ensuring training is occurring as specified in regulations and their policies and procedures, that they have a functional QI or QA systems and that they have a functional complaint mechanism.

Summaries of DDD on-site certification activities conducted by the certification teams are reviewed semi-annually by the DDS QI Committee. The DDD on-site certification summary includes the number of certifications conducted and the frequency of compliance issues cited by type.

When the service is managed by the provider, the provider is responsible for furnishing training to their employees.
DDD contracts with certified DD provider agencies for services under this HCBS waiver. DHHS enters into a provider agreement/contract with non-certified independent providers.

Independent providers, which can be individuals or agencies, provide non-specialized community support (CS) services. The Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) does not require licensure or certification for providers of non-specialized waiver services. All providers of waiver services must be Medicaid providers as described in the Title 471 regulations. Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not constitute employment.

Non-specialized CS waiver providers must meet the standards outlined in the approved waiver and in the state regulations. In addition to the general standards and conditions for all non-specialized CS waiver providers, there are specific standards that persons who provide particular types of CS waiver services must meet whether operating independently or through an agency.

Once DHHS approves the provider (contract and authorizations in place), the family trains the provider based on the service that will be provided and the specific needs of the individual and family. A Consumer Handbook is provided to each waiver participant which includes information on the purpose and use of the handbook; an introduction to community supports; rights, responsibilities, and risks; developing a plan; finding providers; hiring providers; training providers; working with providers; personal safety; and monitoring the plan.

Waiver recipients and/or their families also receive a Provider Handbook so that they know, when training and directing their providers, what standards and qualifications providers are expected to meet. The Provider Handbook includes an introduction, respecting the individuals and families, general standards, standards for specific services, and information on authorization and billing.

Providers may receive information about becoming a provider from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff (resource development staff, his/her Service Coordinator, his/her Social Services Worker, and/or the Disability Services Specialist). The potential provider is referred to DHHS staff for enrollment. All willing and qualified providers can enroll.

Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

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 for problem correction. In addition, provide information on the methods used by the State to document these items.
When an issue with performance of an independent provider is identified, a plan to address the issue is discussed and documented. The individual may address the provider or may ask their SC to assist in addressing the concerns or issues with the provider. The SC will follow through with the individual or on behalf of the individual until the issue is resolved.

The DHHS DDD Service Coordinator (SC) is responsible for facilitation and development of the individual program plan (IPP), and then monitoring the implementation of each IPP in its entirety twice annually in addition to the ongoing monitoring of the IPP which may involve specific areas of the IPP within each monitoring session. The SC monitors and responds to whether the services documented in the IPP are authorized and provided; whether management of services, supports, and providers is occurring as documented, whether provider schedule generally follows the preference of the individual/legal representative, and whether the individual and/or legal representative are satisfied with the support of the independent providers. If utilized, the effectiveness of back up plans for the provision of CS services is also monitored.

Waiver participants may ask for assistance from their SC in communicating to their independent providers expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC may increase monitoring activities, participate in discussions with the participant and provider, provide talking points, facilitate revisions to the IPP, or, upon direction from the individual, terminate the authorizations for that provider.

Annually, DHHS staff conducts quality assurrance reviews of a stratified sample of IPPs and additional evidence of the IPP process to ensure the IPP reflects the individual's directions,preferences,and personal and career goals, and are based on adequate assessments of their abilities. When variances are noted, the SC Supervisor oversees the action taken by the Service Coordinator to correct the IPP. DDD central office staff monitors this process to ensure its completion.

DDD Service Coordination monitors the implementation of the IPP to ensure the timely and efficacious delivery of all services specified in the IPP for the person. Full reviews are conducted within 60 days of the annual and semi-annual IPPs. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family or others. The full reviews consist of checking on 42 items grouped into six groupings – rights, habilitation, financial, service needs, health and safety, and home/work environment. Both groups document and enter information into a database. This information is summarized and reviewed by the DDD QI Committee quarterly. The summarized data for the IPP review is also shared with service coordination staff at the local service district level and the Disability Services Specialists. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. Extreme incidents or patterns that threaten an individual's health and welfare are shared with DDD Central Office at the time of the investigation and may result in increased monitoring by service coordination, a certification or contract compliance review, technical assistance, or some other type of remediation and follow-up activities.
In addition, providers are required to report critical incidents (incidents of running away, hospitalizations, injuries requiring medical attention, and deaths) to DDD Central Office and Service Coordination immediately following the incident with submission of the incident report within 24 hours. DDD and Service Coordination staff review these daily and follow-up on significant issues. A database of these incidents is kept by DDD. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on an individual and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the DDD QI committee.

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: semi-annually and/or as determined by the DDD Deputy Administrator for QI

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.
Although the state has a process in place for reporting and management of critical incidents, the Division is revising this process. The DDD central office staff responsible for reviewing and investigating incidents has revised forms and committee reports for implementation in October 2010. The Director of DDD, the Community Based Administrator, Deputy Administrator for Quality Improvement, and the Waiver Manager are reviewing on-line reporting methods for reporting complaints, critical incidents, and events and will transition to the method when a contractor is chosen and systems are in place, beginning in January 2011. Forms related to SC monitoring, review of the IPP, incident and complaint reporting, and the certification activities report are being revised by the Deputy Administrator for Services, the Service Coordination Administrators, and representatives of SC Supervisors and Service Coordinators. The timeline for completing the revisions of these forms will be related to the automated system that will begin in January 2011. Once a vendor is chosen, the above DDD personnel will work with the vendor to revise or transfer forms to the vendor's specification. The system will be brought on-line over the course of the coming year.
In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. Forms related to SC monitoring, review of the IPP, incident and complaint reporting, and the certification activities report are being revised by the Deputy Administrator for Services, the Deputy Administrator for Quality Improvement, the Service Coordination Administrators, and representatives of SC Supervisors and Service Coordinators. The revision of forms and committee reports and the transference of metadata to SharePoint began in November 2010 and will be accomplished by January 1, 2010.

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.

a) The total combined amount of ATS, home modifications, and vehicle modifications cannot exceed $5000.00 per the individual's waiver year.

b) Based on analysis of data from other DHHS programs, research of other states that offer similar services and supports, and current data, the limits have been sufficient to assure the health and welfare of the waiver participants. The expenditures and utilization are tracked and the IPP is reviewed, at a minimum, semi-annually.

c) The state may adjust the limits during the period the waiver is in effect. The limits will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) When health and welfare needs cannot be met within the limits, adjustments, exceptions, or a referral to another HCBS waiver or non-waiver services and supports will be determined on a case by case basis.

e) The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the IPP.

☑ **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.

a) The budget amount is the individually objectively assessed funding amount per the individual's waiver year and is determined by Nebraska Department of Health and Human Services staff. The total combined amount of ATS, vehicle modifications, and home modifications cannot exceed $5,000.00 per the individual's waiver year and is not included in the individual's funding amount.

b) The determination of funding for individuals is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding. An individual's funding for respite, medical risk service, and behavioral risk service is not determined using an objective assessment process.

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding

solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

The individual's service coordinator is informed of the prospective individual budget amount. The SC shares this amount with the individual and their family or legal representative only. The individual's prospective budget amount is not open for public inspection.

c) The state may adjust the limits during the period the waiver is in effect. The limit will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) The participant's health and welfare needs will be addressed by the team. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis.

e) The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the IPP.

☐ **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.

The HCB Settings transition plan is addressed in Attachment #2 HCB Settings, including how the State assessed the settings to determine whether they comport with the HCBS regulations.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Program Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Qualifications of a DHHS DDD Service Coordinator (case manager) are as follows:

Bachelor's Degree and professional experience in: education, psychology, social work, sociology, or human services, or a related field and experience in services or programs for persons with intellectual or other developmental disabilities is preferred.

Ability to: assess the needs of persons with intellectual and other developmental disabilities; evaluate assessments; determine eligibility; develop and assess individual service plans; mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with indivduals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; conduct formal assessments; monitor services provided; apply agency and program rules, policies, and procedures; and organize, and evaluate, and address program/operational data.

Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; the role of the service coordinator; person-centered program planning; the principles of normalization; provision of habilitation services; positive behavioral supports; and statutes and regulations pertaining to delivery of services for individuals with developmental disabilities.

Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities; regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and Department programs, such as Protection and Safety and public assistance programs.

- [ ] **Social Worker**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The individual's DDD service coordinator provides support to the individual to actively lead in the service plan development. The individual also has the option to direct his/her service coordinator to facilitate the service plan development meeting so that the person may actively participate as a team member.

a) Information about the waiver program; the participant/family roles and responsibilities; due process rights; providers' roles and responsibilities; for applicable participant-directed service options, “how to” hire, fire, and direct providers; and claims review and verification is provided to participants and families. Information is provided verbally and in written form prior to entry into the waiver services. Information is provided to individuals and families by DDD staff at a local level as needed.

(b) Persons eligible for DD services have an IPP developed prior to the initiation of waiver services. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process will be determined by the individual and the legal representative, but must at least include the individual, representatives of specialized DD provider(s), the Service Coordinator, and the legal representative if there is one. The IPP must identify the needs and preferences of the individual and specify how those preferences and needs will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources.

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) Persons eligible for waiver services have an Individual Program Plan developed prior to the initiation of services and annually thereafter. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process is determined by the individual or the legal representative, if applicable, but must at least include the individual, the service coordinator and the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The service coordinator is responsible for scheduling, coordinating, and chairing all IPP meetings and facilitating the

participation of all team members. The service coordinator elicits and records facts and information from other team members, advocates for the person receiving services, encourages team members to explore differences and discover areas of agreement so that consensus can be reached, documents the IPP and the specific responsibilities of each team member with regard to implementation of services, supports, and/or strategies, and adheres to the format for documentation of implementation of revisions to the program plan. Meetings are scheduled at a time and place that accommodates the needs of the individual served, the legal representative of the person receiving services (if applicable), the parent(s)(if the person desires parental involvement in the process), and the chosen advocate of the person receiving services (if applicable). Dates for regularly scheduled IPP meetings are scheduled well in advance to assure attendance by all team members. The person receiving services or any other team member of the interdisciplinary team may request a team meeting at any time. Only the requestor may withdraw his/her request.

(b) The IPP must identify the needs and preferences of the individual and specify how those needs will be addressed. Assessments to support the service plan development are determined by the team and may include, but are not limited to, the Inventory for Client and Agency Planning (ICAP), Developmental Index, assessments completed by the specialized DD provider, if applicable, assessments completed during the participant's school years, if applicable, and the Supports Intensity Scale (SIS).

(c) The participant is informed of the services that are available under the waiver prior to plan development. Information is provided when eligibility for DD services is determined, when funding is approved, and upon request.

(d) Prior to waiver entrance, an interdisciplinary team develops a detailed annual plan, which includes, as appropriate:
. employment goals and strategies
• Medical information;
• Nutritional considerations;
. As applicable, physical nutritional management plans;
• Adaptive devices, including support and protective devices;
. Physical and nutritional supports;
• Medical conditions and known allergies;
• Medications;
• Rights and rights restrictions;
• Legal needs;
• Finances;
• Identification of basic and other needs, which include:
  1. Physical survival
  2. Physical comfort
  3. Emotional well-being/happiness and personal satisfaction
  4. Personal independence and self-care
• Description of strategies to meet the needs;
• Requested service(s);
• Description and schedule of strategies, services, and supports to be provided, taking into consideration individual's personal and career goals and identified needs;
• Identified plan to locate provider(s), if applicable;
• Back-up plan, for each participant-directed service, in the event non-specialized services can't be provided or aren't provided as scheduled.

The IPP indicates how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized DD services/supports, non-specialized supports, natural supports, or services/supports from other programs. If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team will re-consider the appropriateness of the individual receiving services through the waiver. This may require referral to other services or programs and the development of an alternate plan.

(e) The IPP must include identification of the prospective budget amount and the projected monthly cost/utilization of the services and supports to be provided, as well as services and supports to be provided by other non-DD funded resources.

(f) The IPP document identifies the services, schedule of delivery of services, and responsibilities to implement the

plan. The service coordinator is responsible for monitoring the implementation of the plan by observing and documenting observations on the IPP monitoring form. Monitoring is completed at a minmum, within 60 days following the annual and semi-annual meetings and as opportunity arises.

(g) The IPP document must be completed and signed by all team members at the meeting. At a minimum, the IPP is developed annually and reviewed semi-annually, and is updated when circumstances and/or needs change.

The purpose of the annual IPP meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the individual to achieve his/her future plan, or personal goals.

The purpose of semi-annual IPP meeting is to review the implementation of the annual IPP, to document the individual's future plans and personal goals, to explore how the team can assist the individual to achieve those goals, to determine what information is needed to develop appropriate supports to assist the individual to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues which have impact on the individual's life.

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.

Assessment is required at least annually in conjunction with development of the IPP to identify the preferences, skills and needs of the person.
Strategies are developed by the team to address areas of risk that are identified through the assessment process. If, for example, it is identified through assessment that a person has the need to have their blood pressure monitored, the team would determine the method for ensuring such monitoring and informal teaching may be provided to enable the person to develop independence in the skills necessary to self-monitor. In addition to the informal teaching, the team would develop a strategy for inclusion in the IPP as a backup plan. The strategy specifies who will be responsible for monitoring the individual's blood pressure and how often it must be monitored.
The following is included in every IPP:
1. A description and schedule of waiver services and supports to be provided, taking into consideration the individual's personal and career goals, preferences and identified needs;
2. The identified provider(s);
3. A back-up plan for each non-specialized service, in the event non-specialized services can't be provided or aren't provided as scheduled. Back-up plans may include a temporary increase in natural supports, hiring additional on-call providers, etc.;
4. Documentation of how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized and non-specialized services, supports, and strategies; natural supports, or services and supports from other non-Medicaid programs.
Further assessment may be required based on the outcome of initial assessment. If the team identifies an elevated risk to the person's health and welfare due to risk-taking behavior or a medical condition, additional steps must be taken to address behavioral or medical risk.
When risk-taking behavior is identified, a risk screen may be completed by the team to further discuss surrounding issues in depth in an effort to problem solve to meet needs that are identified.
The team may explore several categories of risk-taking behavior and discuss precursors and consequences of the behavior as it pertains to the individual.
Upon completion, the team "scores" the risk screen according to their decision whether interventions planned are adequate or whether additional backup support outside the provider agency should be sought.
Such outside support measures include requesting team behavioral consultation, making a referral to specialized or generic behavioral consultation services, or further risk assessment completed through DDD central office oversight. Such assessments are completed by licensed psychologists and provided to DDD central office manager assigned to oversight. The assigned manager may provide recommendations or direction to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options that will best mitigate risks identified and support the individual. The DDD central office management may determine that behavioral risk services are necessary and relay this determination to the individual's team to begin the process of

selecting a behavioral risk service provider.
When medical risk is identified, the need for medical risk services will be determined by designated staff at DDD central office. A referral is completed by the individual's IPP team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD central office. When the team, which may include the individual's physician, believes that the individual's needs require medical risk services, the individual may be referred to DD central office for a formal health assessment. Medical history, current medical evaluations, and a formal health assessment are considered and recommendations or direction are provided to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options that will best mitigate risks identified and support the individual. DDD central office management may determine that medical risk services are necessary and relay this determination to the individual's team to begin the process of selecting a medical risk service provider.
If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team may need to re-consider the appropriateness of the individual receiving his/her current waiver services. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for individuals with developmental disabilities are voluntary, both for the individual and the provider. Choice of providers and services is based on mutual consent.

Nebraska has regulations and processes in place to ensure individuals are provided information about DD services and providers to facilitate informed decisions. DHHS offices are located throughout the state to provide a statewide system of service coordination.

The service coordinator provides the individual, the legal representative, and family, if applicable, information about local community services and supports, service coordination, services funded by DHHS and the Division of Developmental Disabilities (DDD), currently certified DD provider agencies, and non-certified independent non-specialized providers.

Information about local community services and supports, and how to access available services is provided to participants. Answers4Families is an Internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. Feedback on the site can be given instantly, with corrections the next business day, and every resource is updated every six months.

Service coordination staff may assist the individual, family, and/or legal guardian to arrange interviews with potential providers.

Families often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select non-specialized providers.

When the individual is considering assistive technology and supports, home modifications, and/or vehicle modifications, the SC makes a referral to an approved provider to ensure that the referral is an appropriate referral, based on the service definition of the applicable service and the provider's established protocols.

The ATS, home modification, and vehicle modification service includes:
1. An assessment report, which is:
   A. A summary of needs and current support;
   B. Recommendations;

C. Cost estimate and cost coordination, if needed; and
D. Hiring and oversight of subcontractor;
2. If applicable, documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
3. Copy of signed subcontractor bill and signed consumer acceptance form; and
4. Narrative summary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health and Human Services is the state Medicaid agency for Nebraska. All functions related to service plan approval are completed by DHSS staff.

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) Service coordination is responsible for in-person, on-site monitoring the implementation of the IPP and participant health and welfare.

((b) Monitoring mechanisms include:

1. Documenting observations made during a planned monitoring visit or unscheduled visits;
2. A review of all components of the IPP to ensure:
   A. Delivery of services, supports, and strategies in accordance with the IPP, with additional monitoring of behavioral risk services or medical risk services if applicable;
   B. Participant access to wavier and non-waiver services identified in the service plan;
   C. Free Choice of provider(s);
   D. Services meet participant' needs;
   E. Effectiveness of back-up plans, if applicable and utilized;
   F. Participant health and welfare;
   G. Physical nutritional management;
3. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the IPP is necessary;
4. A semi-annual review of the IPP by the SC and the team in-person. The team must review progress, implementation of the IPP, and the need for any revisions to the IPP; and
5. Addressing concerns with the provision of services.

(c) Service Coordination will verify, through ongoing monitoring efforts, that the assistance provided continues to be effective in preventing recurring problems. DDD Service Coordination monitors the implementation of each IPP. This oversight has long been a part of the regulations, policies, and expectations regarding the role of service coordination in monitoring. In-person and on-site full reviews are conducted at least twice annually on each person in services with ongoing in-person and on-site monitoring conducted between the full monitoring. The current on-site monitoring tool is designed to review the implementation of the total IPP after both the annual and semi-annual team meetings. Between these full monitorings, the Service Coordinator conducts ongoing monitoring on-site and in-person. During each of these monitoring sessions, the Service Coordinator may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

Follow-up and remediation process for issues discovered during monitoring:
Observations made during a review or "in passing" are documented. Should immediate safety concerns be evident, the concern will be expressed verbally to appropriate persons to prevent the individual served or others from being harmed. If it is necessary for the service coordinator to intervene to ensure the health and/or safety of the individual, such incidents will be immediately discussed with the SC supervisor. Suspected abuse or neglect will be reported to Adult Protective Services and Child Protective Services as appropriate. Documentation will be completed.

Service coordination observations during the delivery of participant-directed non-specialized services are discussed with the participant and/or family, as appropriate, and the provider, as appropriate as soon as possible, and followed through to resolution. If resolved at this level, resolution will be documented on the monitoring tool or in service coordination narratives. A team meeting may be called to respond to monitoring issues and to adjust the IPP if necessary.

Observations during the delivery of specialized services will be discussed with appropriate provider agency staff as soon as possible. If resolved at this level, the resolution is documented in the SC narratives. If the issue is not resolved, the Service Coordinator will complete a Service Review Memo and send to the provider agency staff supervisor and Service Coordination supervisor. A response is requested within ten days from receipt of the memo.

When a written response is received, the Service Coordinator will review it to ensure that the action taken will correct the problem. If the response is not adequate or no response is received, the Service Coordinator will contact the person to whom the form was sent to find out the status of the response. 1) If the response was inadequate, the Service Coordinator may add comments made by the staff person to the response. If the response is still inadequate, the Service Coordinator will copy the written documentation of noted concerns and send it to his/her immediate supervisor. 2) If no response was received and the staff person indicates when a response will be sent, the SC will use his/her judgement to determine whether to keep the form until the response is received or whether to copy the documentation and forward it to his/her immediate supervisor. The Service Coordinator's supervisor will address the issue with the supervisor of the provider agency staff responsible for making changes or corrections to alleviate the concerns. The Service Coordination supervisor will notify the SC with the results of the contact and the SC will document in the narratives. The issues must be addressed in writing. A response within ten days will be requested if the issue has not been resolved. When a response is received, the supervisor and SC will review the response to ensure that it meets the expectations in correcting the problem. If no response or an inadequate response is received, the Service Coordination Supervisor will copy the written documentation of noted concerns and send it to their local

Service Coordination Administrator.

The Service Coordination Administrator or designee will contact the Area Director of the provider agency to develop a mutually agreed-upon plan of action. If no resolution is achieved, or if trends show that the problems are recurring (such as "no ongoing habilitation provided," "programs not run as written," "programs not run at all," etc.) the Service Coordination Administrator or designee will inform the DDD Central Office of the problems. DDD Central Office staff will review the concerns to determine what steps to take and will notify the Service Coordination Administrator or designee. DDD central office staff may provide consultation/technical assistance to the DD provider agency, perform a focused certification or contract compliance review specific to the delivery of services to an individual or provider setting, or complete a complaint investigation.

During certification reviews conducted by DDD, the IPP is reviewed using the Individual Service Review Checklist and, if behavior modification is a part of the IPP, the Behavior Support Checklist. Certification reviews are conducte annually, biennually, or as determined by DDD management staff.

In addition, the IPP is reviewed annually to determine if the plan developed by the individual's team meets the individual's needs and also to determine if services are implemented in a manner that meets the individual's needs. Areas of services reviewed for example are health, safety, habilitation, and personal goals. The IPP identifies services, supports, interventions, and strategies to be provided by the specialized DD provider agencies as well as services provided by non-specialized independent providers of DD services. When non-compliance issues are identified with the DD provider agency, the types of action that may be taken range from citing a deficiency to termination of the provider agency. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of correction that addresses the issues cited for those individuals identified in the sample as well as address the issue cited on a system level within the specialized provider.

The information derived from monitoring the implementation of the IPP and review of the IPP is entered into an excel spreadsheet. Designated DHHS staff have access to the spreadsheet and may query the data to identify problems and trends.

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 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: 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:
Of the total number of service coordination monitorings, the number of monitorings that indicate medical issues are being addressed as documented in the IPP.

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

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):*

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: semi-annually or as determined by the DDD QI committee

Performance Measure:
Of the total number of service coordination monitorings, the number of monitorings that indicate safety issues are being addressed as documented in the IPP.

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

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: semi-annually or as determined by the local QA/QI committee or the state DDD QI committee

Performance Measure:
Of the total amount of IPP reviews, the number of reviews that indicate medical services are specified and documented on the IPP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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: As determined by the state DDD QI committee

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.

Performance Measure:
Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	As determined by DDD QI committee

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
Of the total number of service plans, the number of IPPs developed by the team annually and reviewed semi-annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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: As determined by the State DDD QI committee

Performance Measure:
Of the total number of Individual Program Plans developed each year, the number of plans that were revised due to a change in a person's needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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: Semi-annually or as determined by the State DDD QI committee

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:
Of the total number of IPP reviews, the number of reviews that indicate the authorized units match the state's electronic authorization and billing system.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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: Semi-annually or as determined by the state QI committee

Performance Measure:

Of the total number of service plans, the number of plans that reflect services were authorized as specified in the plan.

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

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: Semi-annually or as determined by the local QA/QI committee or state DDD QI committee

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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 new waiver participants each year whose records contain an appropriately completed and signed Consent/Request for Services form which offered a choice between institutional and waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Review Worksheet and Quality Assurance File Review

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: semi-annually or as determined by the state DDD QI committee

Performance Measure:
The number and percent of new waiver participants or their legal guardian if applicable, that participated in making a choice of waiver providers.

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

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: sample of persons on this waiver, throughout the state
	☐ **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: As determined by the State DDD QI committee

Performance Measure:
Of the total number of individual and family pre-service plan meetings conducted annually, the number of meetings that reflect the waiver participant was afforded choice between/among waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Program Plan Quality Review

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):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DDD QI committee

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.

In Nebraska, the service plan for participants of this waiver is known as the Individual Program Plan (IPP). The DHHS DDD Service Coordinator (SC) is responsible for facilitation and development of the IPP.

DDD staff reviews a representative sample of the service plan at the time of the initial eligibility determination and following the annual IPP to ensure it meets the waiver and regulatory standards. The process was developed to also ensure the IPP is completed in accordance with timelines and to aggregate the results to identify issues at various levels of the DHHS-DDD.

The DDD staff considers assessment information, the individual's personal goals, and the IPP to determine if the services defined flow from the assessments and personal goals. This review includes not only the waiver services, but also the non-waiver services and other natural and community supports identified in the IPP.

If issues (i.e. institutionalized more than 30 days, loss of Medicaid eligibility, failure to utilize waiver services or failure to address health and safety requirements) are identified that will affect the waiver status of the individual, the Service Coordinator is notified and given a date to respond. Failure to receive corrections will result in the removal of the person from the waiver and notification of the Service Coordination supervisor. Correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver support. Other issues that do not effect waiver funding are passed along to the SC responsible for the development of the IPP.

To allow for increased state oversight of the service plan review process, the responses are entered into a database. The database allows for individual Disability Services Specialists and Service Coordination Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators. This information is reviewed and acted on, as appropriate, at the local level.

In addition, DDD Service Coordination (SC) monitors the implementation of each IPP in its entirety twice annually in addition to the ongoing monitoring of the IPP which may involve specific areas of the IPP within each monitoring session.
In this way, there is an extensive 100% review of the design and the implementation of every IPP for persons receiving waiver services. Monitoring mechanisms include -
1. A review of all components of the IPP to ensure delivery of services as specified by the IPP;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the IPP is necessary; and
3. A semi-annual review of the IPP by the service coordinator and the IPP team. The team reviews progress, implementation of the IPP, and the need for any revisions to the IPP.

The monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the Service Coordinator conducts ongoing monitoring. During each of these monitoring sessions, the Service Coordinator may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the Service Coordination monitoring process, responses on the IPP monitoring forms are currently entered into a web-based database. This allows individual Service Coordinators to track issues that aren't resolved and provide aggregate information for Service Coordination Supervisors, local Service Coordination Administrators, and the DDD central office. The information is useful to the Supervisors and Administrators for looking at the performance of individual service coordinators and providers, as well for identifying any area wide issues. This information is reviewed and acted on, as appropriate, at the local level.

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 for problem correction. In addition, provide information on the methods used by the State to document these items.
If issues are discovered that will affect the waiver status of the individual, the Service Coordinator is notified and given a date to respond. The date of response is determined by the Disability Services Specialist and varies between 5 working days and 10 working days, based on the nature of the issue. Failure to receive corrections will result in the removal of the person from the waiver and notification of the Service Coordination supervisor. Correction of the areas of concern may allow the person to be maintained on the

waiver or to be put back on the waiver, if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health and safety. Other issues that do not effect waiver funding are passed along to the Supervisor of the SC responsible for the development of the IPP.

The SC monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the Service Coordinator conducts ongoing monitoring. During each of these monitoring sessions, the Service Coordinator may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the Service Coordination monitoring process and the service plan review process, the responses are entered into a web-based database. This allows individual Service Coordinators to track issues that aren't resolved and for Disability Services Specialists and Service Coordination Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators, and provide aggregate information for Service Coordination Supervisors, local Service Coordination Administrators, and the DDD central office. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A timeline to address the issues and/or an IPP team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

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: semi-annually or as determined by the state DDD QI committee.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Opportunities for participant direction will be offered to individuals that choose non-specialized community supports. Non-specialized community services are not provider controlled or provider operated. Participant direction of specialized provider services and supports is encouraged to the maximum extent possible when the individual chooses to receive provider operated services.

The underlying philosophy of offering non-specialized community supports is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place. The Division of DD is embracing a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with an intellectual or other developmental disabilities. The DDD service coordinator is involved in supporting participant direction.

(b) The individual has the right and responsibility to participate to the greatest extent possible in the development and implementation of his or her plan. This person-centered plan (the Individual Program Plan or IPP) is individually tailored to address the unique preferences and needs of the person. Participants in the planning process will be determined by the individual/family or the legal representative, if applicable, but must at least include the individual, the service coordinator, the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The IPP must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided as well as services and supports to be provided by specialized (i.e. provider operated) services and other non-DDD funded resources. Community supports (CS) may be utilized either alone or in conjunction with specialized DD services, and non-DD funded services and supports, as appropriate for, and determined by, the individual.

Individuals and/or their families have the right and responsibility to select potential independent community supports providers as well as specialized provider agencies. The individual and/or their family identifies a potential provider; screens the provider to determine capability for delivery of community supports and/or specialized services, based on the waiver participant's needs and preferences, and the potential provider's experience, knowledge, and training; and describes supports to be delivered.

(c) Once the potential CS provider is identified and screened, the individual or family contacts their service coordinator or designated DHHS staff to request enrollment of the provider. At anytime, the individual or his/her

family can request assistance from the SC. The service coordinator may complete the above steps, as directed by the individual and/or family.

Once the CS provider is enrolled and prior authorized for delivery of services, the individual and/or family directs the provider by setting the schedule and determining how the services will be delivered, and, based on the IPP, the type and amount of community supports.

The individual also has the authority to "fire" the provider, by directing DHHS staff to end the authorization for the delivery of community supports. DHHS has the option to retain the contract to allow other individuals to utilize the enrolled provider.

The state is appointed the employer's agent as a means to ensure all requisite IRS rules are being followed. The participant or legal representative signs the form IRS-2678 to appoint the state as the employer's agent. This form is maintained by the disability services specialist and kept in the participant's waiver file in the disability services specialist's office. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider.
Participants are not liable for tax liabilities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [x] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [x] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Group homes with four or more unrelated persons with DD, licensed as a Center for persons with Developmental Disabilities.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Additional criteria that excludes participant-direction:

1) Person meets eligibility criteria for Behavior Risk services;
2) Person meets eligibility criteria for Medical Risk services; or
3) Person chooses Continuous services that are controlled and operated by the DD provider.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Information about participant direction opportunities is available to individuals who are currently receiving DD services as well as to any individual entering DD services. Information is provided to the individual prior to entrance to the waiver and prior to the annual service plan development meeting to allow sufficient time for the particpant to weigh the pros and cons of participant direction and obtaine additional information as necessary. Information about participant direction opportunities is available in a consumer handbook, pamphlet, the DHHS web site, and other public communications, such as information from Nebraska Department of Education about post high school opportunities and information developed through the Nebraska DD Council.

The community supports Consumer Handbook is utilized as a training tool and post-training reference guide for individuals and his/her support system. The Consumer Handbook includes the purpose of the handbook, an overview of community supports, and tips for determining the appropriateness of participant directed services and supports, developing a plan, and putting the plan into action. The Consumer Handbook also includes tips for finding the right provider, participant liability (e.g. participants are not liable for tax liabilities), preparing for an emergency, and additional resources. Additional information available includes the individual program plan, the Semi-annual review, budget worksheet, provider handbook, service utilization and tracking forms, state regulations, and provider calendars.

(b) Prior to implementation of the initial waiver #454, training was provided to individuals and families, and DHHS staff by DDD central office staff. Information about community supports was added to the Service Coordination new hire training, and presentations about community supports are provided by DDD central office as requested.

(c) The participant's service coordinator will provide ongoing training to individuals and families as they choose participant - directed services and supports.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appointment of a representative is a voluntary appointment and the representative is appointed by the participant or legal representative. The responsibilities and extent of decision making authority exercised by the representative is determined by the participant and his/her team and documented in the IPP.

Service coordination provides monitoring to ensure that the representative functions in the best interest of the participant.

The representative may not also be paid to provide waiver services to the pariticpant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Extended Family Home residential habilitation	☑	☐
Respite	☑	☐
Companion Home residential habilitation	☑	☐
Community Living and Day Supports (CLDS)	☑	☐
Retirement Services	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

All DD service coordinators are qualified to provide self –direction guidance. In addition to the basic service coordinator training, DD SCs receive training on the self directed services that are available, such as the types/definitions of services; limits on the amount, frequency, or duration; authorization codes and rates; budget projecting; budget tracking; and the referral process for enrollment of independent providers. The SCs also receive the Consumer Handbook as a training tool.

In addition to the basic service coordination duties performed by DDD service coordinators, the DDD SC provides supports for those who self direct Community Living and Day Supports, Retirement services, and/or Respite services. The SC will review the Consumer Handbook with the participant and their representative if applicable to assist the individual in understanding their responsibilities in hiring, training, screening claims, and dismissing a provider, as well as assisting the individual to recognize potential abuse and neglect situations.

The SC will provide the amount of funding available to the participant and develop the monthly budget with the participant and representative. When determining the rate for an independent provider, the service coordinator and participant and/or representative develop the budget together. The participant is informed of their annual funding allocation and the range of rates to be considered, based on the potential provider's experience and training, and the participant's needs and tasks that the potential provider will perform.

The SC keeps track of monthly expenditures and provides the amount of expenditures to the participant on a quarterly basis or immediately when expenditures exceed the monthly projected budget.

If the participant has not chosen their provider(s), the SC will provide a list of currently enrolled independent providers for the participant to select from, and interview the potential provider with the waiver participant if the participant requests assistance. The SC follows through with DHHS staff responsible for provider enrollment to ensure that the provider is enrolled and authorized to provide the selected services to the participant.

If requested the SC will assist the waiver participant in communicating to the independent provider his/her expectations of what and how the services will be delivered as well as any performance issues that may arise.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
In-home residential habilitation	☐
Home Modifications	☐
Extended Family Home residential habilitation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Companion Home residential habilitation	☐
Community Living and Day Supports (CLDS)	☐
Team Behavioral Consultation Services	☐
Assistive Technology and Supports (ATS)	☐
Retirement Services	☐
Vocational Planning habilitation service	☐
Day Habilitation	☐
Group home residential habilitation	☐
Medical Risk Services	☐
Workstation habilitation services	☐
Behavioral Risk Services	☐
Personal Emergency Response System (PERS)	☐
Vehicle Modifications	☐
Integrated Community Employment	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Nebraska's DD services are voluntary services, for the participant as well as the provider. Each person's funding amount is based on an objective assessment process, and each participant or his/her legal guardian can choose the types of services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD providers are waiver providers.

Funding is determined using an objective assessment process, and the funding follows the individual.

Nebraska offers provider managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

State regulations allow the state to deny or end funding of specific services when:
1. An individual's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF level of care.
2. The individual or legal representative has failed to cooperate with, or refused the services funded by DDD; or,
3. The Individual Program Plan has not been implemented.

The decision to end funding may be based on Service Coordination monitoring, review of the individual program plan, critical incident reports, assessment of risk to the individual and/or community, and complaint investigations conducted by the DHHS staff.

Nebraska offers provider managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	260	
Year 2	360	
Year 3	500	
Year 4	700	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5	825	

Appendix E: Participant Direction of Services

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

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**

- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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.

Initially, annually, and with each written notice of action the individual and his/her legal representative are informed of and receive a copy of the right to appeal. Under this waiver, the written notice of action is known as the Notice of Decision, form DDSC-38. A written notice of any decision made by DDD staff is sent to the participant and/or legal representative.

Notice to an individual must be made of an adverse action under the following circumstances:
The individual does not meet the eligibility criteria for HCBS waiver;
Institutional services are chosen over HCBS waiver;
Chosen provider does not meet qualifications; and
Denial, reduction, suspension, or temrnation of services.

The service coordinator and the disability services specialists provide written and verbal information to individuals. Included in the information provided are assurances that services will continue or be reinstated should the adverse action be contested by requesting an informal dispute resolution (IDR) meeting or a fair hearing.

Notices of adverse action and the opportunity to request a fair hearing are kept in the individual case file in the DDD service coordinator's office.

As applicable, the participant's rights are translated and provided in their primary language.

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.

   DHHS operates the dispute resolution process.

   (a)When requested by the individual or his/her legal representative, an Informal Dispute Resolution (IDR) meeting may be arranged in accordance with state regulations. Any decision regarding the individual's eligibility or funding for services may be disputed by the individual or legal guardian. The issues usually disputed include ineligibility for DD-funded services, denial of immediate funding, or denial of an increase in funding for services currently being provided.

   IDR meetings are facilitated by DDD central office staff acting on behalf of the DDD Administrator. The participant is informed in writing annually that the informal dispute resolution is not a pre-requisite for a Fair Hearing. The state regulations are available to the individual and legal guardian upon request.

   (b)The request for an IDR meeting, if requested within 90 days of receiving notice of the decision being disputed, stays the adverse action as well as the deadline for filing an appeal, or fair hearing. Informal dispute resolution meetings are scheduled promptly, and are scheduled with assistance by the individual’s DD service coordinator. The

IDR meetings are generally held in the local service coordination office.

The meetings are generally attended by the individual and/or their legal representative, a DDD central office staff person who hears the complaint, gathers any additional information, and explains the eligibility and funding process and the person's further appeal rights, the individual's service coordinator and other service coordination administrative staff, and any provider staff or other advocates the individual or legal representative may ask to attend. All are encouraged to offer their perspectives regarding why the decision should be affirmed or reversed. The circumstances of the original situation are reviewed and additional information is often obtained, which is then reviewed by the DDD Administrator, and the original decision is either affirmed or reversed.

The decision is forwarded to the individual and/or their legal representative within one business day of the DDD Administrator's decision via their DD service coordinator.

c)The individual and/or their legal representatives have the option of continuing on to the formal appeal hearing or dropping their request.

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:

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).

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).

DDD defines incidents as allegations or occurrences of abuse, neglect, and exploitation; events that cause harm to individual; events that serve as indicators of risk to participant health and welfare; and public complaints related to providers or participants.

All suspected abuse and neglect reportable under Nebraska state statutes are required to be reported to DHHS Protective Services or law enforcement. Suspected abuse and neglect may be reported by a toll free abuse and neglect hotline that is available 24/7 and posted on the DHHS website. Reports of suspected abuse and neglect are also accepted by e-mail, FAX, or letter.

In addition, under state policies, all incidents, including allegations of abuse and neglect reportable under Nebraska state statutes are currently required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing within 24 hours of the phone call. A separate toll free number at DDD central office has been set up for reporting of incidents and is available 24/7.

The state is currently reviewing on-line reporting and tracking methods and will transition to the method when a contractor is chosen and systems are in place. In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up.

Currently in Nebraska, abuse means any knowing, intentional, or negligent act or omission on the part of a caregiver, a vulnerable adult, or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services to a vulnerable adult.

Exploitation is means the taking of property of a vulnerable adult by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means.

Nebraska state statue mandates the following entities to report: “any physician, psychologist, physician assistant, nurse, nursing assistant, other medical, developmental disability, or mental health professional, law enforcement personnel, caregiver or employee of a caregiver, operator or employee of a sheltered workshop, owner, operator, or employee of any facility licensed by the Department of Health and Human Services Division of Public Health (DPH), or human services professional or paraprofessional not including a member of the clergy.
At a minimum the following incidents must be reported:
1. An individual served leaving supervision where the safety of the individual or others is potentially threatened;
2. Hospitalization due to mental health/behavioral concerns;
3. Injuries which require medical attention to individuals, the provider, or others with whom individuals served by the provider come in contact;
4. Any injuries to individuals in services related to incidents involving restraint;
5. Deaths of persons served;
6. Allegation of abuse or neglect;
7. Allegation of financial exploitation;
8. Discovery of injury of unknown origin; and
9. Use of physical or mechanical restraint.
A report of the above incidents is made to DDD immediately upon the provider, participant, or family becoming aware of the incident.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is provided to participants and his/her legal representative by his/her Service Coordinator, as well as in writing in the participant Consumer Handbook.

Service Coordination must review and provide a copy of the individual rights and the appeal process at the intake meeting and annually thereafter. As applicable, the participant's rights are translated and provided in their primary language. The Consumer Handbook includes who to notify and how to notify the appropriate authorities. DHHS has a statewide toll-free number that is available 24/7.

Advocacy groups, such as Nebraska Advocacy Services, People First, and The Arc have provided training on rights, exercising rights, voting, and due process.

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.

Currently verbal reports of incidents are made to DDD by providers immediately upon the provider becoming aware of the incident. The verbal reports are followed up with written reports within 24 hours of the verbal report being made. The state is currently reviewing on-line reporting and tracking methods and will transition to the method when a contractor is chosen and systems are in place. In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up.

Reports of incidents are made to DDD by phone by provider agency (Contractor) staff persons immediately upon the Contractor becoming aware of the following types of incidents. DDD staff triage the reports daily and determine the appropriate response which depends upon the type and frequency of the incident. At a minimum the following incidents must be reported:
1. An individual served leaving supervision where the safety of the individual or others is potentially threatened;
2. Hospitalization due to mental health/behavioral concerns;
3. Injuries which require medical attention to individuals, the provider, or others with whom individuals served by the provider come in contact;
4. Any injuries to individuals in services related to incidents involving restraint;
5. Deaths of persons served;
6. Allegation of abuse or neglect;
7. Allegation of financial exploitation;
8. Discovery of injury of unknown origin; and
9. Use of physical or mechanical restraint.

When providers report alleged abuse and neglect of adults that is not required to be reported by law, the Protection and Safety staff share this information with the Division of Developmental Disabilities (DDD) within 24 hours of receipt. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

DHHS Protection and Safety staff sends a copy of the intake investigation of reportable allegations of neglect or abuse to DDD when the incident is reported to occur in a DD provider setting.

Timeframes for conducting, completing, and informing the participant of the results of an investigation completed internally by the DD provider are determined by the DD provider agency and are outlined in the DD provider's policies and procedures. Timeframes for state staff are established within the program, following statutory and regulatory mandates when required. Timeframes vary depending upon the involvement of law enforcement, the nature of the critical event, and the legal status of the alleged victim (e.g. State ward).

Each DD provider agency submits an aggregate report of these incidents to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of critical incidents over time.
An aggregate report of these critical incidents is prepared for the DDD QI committee on a quarterly basis. The state QI committee reviews the reports and makes recommendations to the DDD management if necessary.

Investigations of allegations of neglect and abuse are performed by adult protective services (APS) staff in the Division of Children and Family Services. A Priority 1 report of allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult, including death or other vulnerable adults still at risk have 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 and no longer than 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they conduct an investigation and send a written summary of their investigation to the APS worker.

A Priority 2 report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult have a 45-day time frame 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 working days of the receipt of the report into the local office.

Priority 3 reports allege harm to a vulnerable adult which is serious, but not serious enough to be considered Priority 1 or 2 and have a 45-day time frame in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 10 working days of the receipt of the report into the local office.
In accordance with state statutes, upon request or court order, information contained in the registry of adult abuse/neglect is released to the victim or other interested parties. Information to be released and to whom the information can be released is limited by statute and regulations. The victim or legal representative, the reporter of the alleged abuse/neglect, investigating law enforcement, the prosecuting county attorney, the victim's physician, legally responsible agency, defense counsel, the state's designated protection and safety system (i.e. Nebraska Advocacy Services), and state staff responsible for licensing child care programs may be provided information contained on the registry upon request. Upon request, a physician or the person in charge of an institution, facility, or agency making a legally mandated report will receive a written summary of the findings, and actions taken by the Department in response to the legally mandated report.

The State's regulations identify the relevant parties that may request the results of the investigation and these regulations are on the public website. Victims are informed of the release of information contained in the registry upon request at the time of the investigation by the investigator.

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.

The Division of Developmental Disabilities is responsible for overseeing the reporting of and response to critical incidents and events. The state is concurrently revising the reporting form and reviewing on-line reporting methods for reporting critical incidents and events and will transition to the method when a contractor is chosen and systems are in place.

Reports of incidents are made to DDD, using a standardized format, immediately upon the provider, participant, or family becoming aware of the incident. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner, such as ensuring that allegations of neglect and abuse have been referred to DHHS Protection and Safety or law enforcement, referring licensure issues to DPH, complete a focused certification review, or a contract compliance review.Currently the reports are entered into a database, and an aggregate report of these incidents is prepared by the DDD Central Office staff on a quarterly basis. The state QI committee reviews the reports and makes recommendations if necessary.

DDD also requires that contracting DD provider agencies implement a system of performance accountability that includes reporting of critical incidents and events affecting the wellbeing of individuals served. An aggregate report of these incidents, prepared by each provider agency, is forwarded to DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of critical incidents over time.

A quarterly report is written and presented to the State DD Quality Improvement Committee. However, there may be immediate follow-up of individual events.

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 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).

In Nebraska, "restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement, normal function of a portion of the person's body or control the behavior of an individual. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded as a restraint.

The use of mechanical restraints, physical restraints, seclusion, and aversive stimuli are not allowable habilitation techniques and are prohibited. Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. Chemical restraints - drugs, or psychotropic medications used solely for the purpose of modifying behaviors are allowed. PRN psychotropic medications are prohibited.

Restrictive methods used should not be employed as punishment, for the convenience of staff, a substitute for habilitation, or be reactive in design. Drugs cannot be used as a way to deal with under-staffing or as a way to deal with ineffective, inappropriate, or other nonfunctional programs or environments. Corporal punishment, verbal abuse, physical abuse, psychological abuse, denial of an adequate diet, and a person in services disciplining another person served, and placing persons in a totally enclosed crib or other barred enclosure are prohibited.

Physical restraint or separation from harmful circumstances or from individuals at risk can only be used as an emergency safety intervention when the person must be kept form harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the person). Protocols for the use of physical restraint and separation are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention which is not used as a behavioral consequence and utilized pursuant to a safety plan is allowed to respond to an emergency safety situation. In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person would not be put in a room, with the door closed and no one watching them.

Behavioral support plans must address behaviors that are obstacles to becoming more independent; that interfere with the ability to take part in habilitation; self injurious behaviors; or behaviors that are a

threat to others. The provider's policies and procedures must specify and define approved intervention procedures, and include a description of the mechanism for monitoring the use. The following components must be in place in a behavioral support plan, a safety plan, and in order to develop emergency safety interventions specific to each individual:
1. The functional assessments must define the communicative function of the behavior for the person and what purpose the behavior serves in the person's life;
2. A review of the person's day and residential supports and other relevant data must be incorporated in to the functional assessment process;
3. A safety plan for the person must be developed that emphasizes positive meaningful activities, individualized supports, and options that are incompatible with the behavior targeted for change;
4. The plan must include a description of potential stressors and triggers that may lead to the person experiencing a crisis, and then a comprehensive safety program developed and implemented;
5. The individual's safety plan must include the type of physical restraint and separation, the length of time the emergency intervention will be utilized in each instance, and the monitoring procedures that the staff will perform during each instance; and
5. There must be meaningful and individualized data collection and data analysis that track progress. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.
Prior written consent of the person or the legal representative must be obtained.

The use of chemical restraints must be prescribed by a physician, be given as prescribed, and each behavioral support plan utilizing chemical restraints must be reviewed and approved before implementation by the team, including the person or their legal guardian, and by the DD provider agency's review committee.

The provider must establish a Review Committee to provide prior review and approval of all behavior support plans, safety plans, and emergency interventions that use chemical restraints to modify behavior, physical restraints, or separation. The effectiveness of the intervention in conjunction with the behavior support plan must be monitored and reviewed. The Review Committee must have persons qualified to evaluate behavior support research and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications.

Staff must be informed of potential side effects, in non technical terms, so that staff can monitor for early detection of side effects. Reports must be made to the physician based on this review.

When a drug is prescribed without prior knowledge and approval of the team or review committee, the drug is administered as prescribed. Development of or revisions to a behavioral support plan and the committee's review and approval must be completed within 30 days.

Medications must be documented in the IPP with the name, dosage, reason for, and the specific behaviors to be affected by the medication; whether the use of the drug was reviewed by the agency's review committee; and whether the drug is reviewed on an ongoing basis by a physician. Medication to manage behavior must be used only in dosages that do not interfere with the person's ability to take part in habilitation and daily living activities. The use of medication is documented after each drug administration.

The IPP must include that a less restrictive and less intrusive method had been tried and systematically applied and determined to be ineffective before use of chemical restraints or emergency safety interventions such as physical restraints or separation for the purpose of modifying behavior. The team must evaluate and document that harmful effects of the behavior clearly outweigh any potential harmful effects of the use of restraints or separation.

Providers must provide orientation of the agency as well as to each person's services. Orientation to each person's services must specifically include the procedures to be implemented, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior, and provided prior to implementation of the procedures. Providers must train staff prior to assuming their duties. Topics include the philosophy, organization, services, practices and goals of the agency, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior; person rights; abuse and neglect; individual program planning, including individualized

assessments, base lining, data collection, writing habilitation programs, selecting training materials, and reinforcement types and schedules; medication administration (must be completed prior to administration of drugs); basic first aid; CPR; respite care; recordkeeping; and on-the-job training. Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to persons. This training must include:
1. Implementation and development of the IPP and interdisciplinary process;
2. Positive support techniques; and
3. Approved emergency safety intervention techniques.

DD provider staff that administer drugs must meet the competency standards defined in Title 172, Chapter 95, Regulations Governing the Provision of Medications by Medication Aides and other Unlicensed Persons. The competency standards are listed in Appendix G-3-C-ii.

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:

DHHS DDD is responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed.
The methods for detecting the unauthorized use, over use or inappropriate/ineffective use of emergency physical restraints or separation, and behavior modifying drugs and ensuring that all applicable state requirements is performed by state staff and are as follows:
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;
c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring; and
f. Complaint investigations.
The provider's policies and procedures must be based on state regulations applicable to the use of chemical restraints or emergency safety interventions of physical restraint or separation.
Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Detection of unauthorized use of restraints may occur at the time of provider enrollment. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of restraints and separation in emergency safety situations. The provider must have an internal quality review system and a Review Committee. When DDD program staff find policies and procedures that do not comply with regulatory requirements, such as unallowable intervention techniques, an insufficient QI system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

Detection of unauthorized use may occur through on-site certification review activities, which may be unannounced or scheduled. During a scheduled certification review conducted by DDD, delivery of service is reviewed as well as the agency's systems. At least 1 person included in the targeted sample must be taking behavior-modifying medication. At a minimum, 33% of the sample includes persons taking behavior modifying medications. The sample is never of only 1 person and always includes at least 3. If additional people pulled in the sample also take behavior modifying drugs, the reviewer will review all pertinent documentation for those people as well. An entire checklist is devoted to review of the development, approval and review of the chemical restraint and how it is incorporated into a training program designed to lessen the need for the restrictive procedure.

Detection of unauthorized use of restraints may occur during unannounced site visits, or "walk-throughs". Observations are documented on a checklist. If aggressive behaviors, rights restrictions, or injuries are observed, for example, DDD staff will question provider staff and review individual files,

which may reveal unauthorized interventions, inappropriate interventions, or injuries of an unknown nature.

Reporting of incidents is another method to detect unauthorized use of restraints. Providers must report any injuries to persons in services related to incidents involving restraint. A verbal report must be made immediately upon the provider becoming aware of the incident and the verbal report is followed up with a written report within 24 hours or the verbal report being made. The state is reviewing on-line reporting methods for reporting incidents and will transition to the method when a contractor is chosen and systems are in place. Currently, verbal reports of incidents are entered into a database daily. Faxed reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance.

DDD Service Coordination monitoring may detect unauthorized use of restraints. Monitoring of 100 percent is designed to review the implementation of each person's total IPP after both the annual and semi-annual team meetings. Between these scheduled full monitorings, the Service Coordinator conducts ongoing unannounced monitoring, which allows for focused monitoring if issues have been raised or are noted during the time of a full monitoring.
Complaint investigations and investigations of allegations of abuse or neglect performed by DHHS staff may also reveal unauthorized, over use, or inappropriate/ineffective use of restraints.

Action that is taken by the State if it is determined through an investigation that unauthorized restraints/inappropriate interventions/unknown injuries are discovered may include an unannounced on-site focused certification review with deficiencies cited followed by a provider plan of correction and follow-up visits. Action may also include requiring the provider to seek training mandated by the State, placing the provider on probation, limiting admissions, or recoupment of payments made to the provider.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.
Limited data is gathered during the initial provider enrollment activity. The length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered are data that the DDD central office utilizes to improve the provider enrollment process. When a provider has difficulty developing their policies and procedures related to the use of restraints, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by a DDD Program Specialist and is reviewed semi-annually by the DDD QI Committee. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. "walk-throughs"), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the IPP, including delivery of services.

An aggregate report of the incidents, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The DDD QI committee reviews statewide quarterly reports compiled from the statewide database of incidents and events, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual Service Coordinators to track issues that aren't resolved and provide aggregate information for Service Coordination Supervisors, Service Coordination Administrators and the DDD Central Office. This information is reviewed and acted on, as

appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint.

The DD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee.

The operation of the incident management system is overseen by DDD central office. The state is reviewing on-line reporting methods for reporting incidents and will transition to the method when a contractor is chosen and systems are in place.

Currently, verbal reports of incidents are entered into a database daily. Faxed reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The DDD committee reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.
The frequency of the oversight activities varies by activity.
The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Daily, Monday – Friday, each critical incident is reviewed by local state service coordination staff as well as by DDD central office staff. Quarterly, the DDD QI committee reviews an aggregated report compiled from the statewide database of critical incidents and events.

DDD Service Coordination monitoring reports are provided to the DDD QI committees on a quarterly basis. A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the DDD QI Committee.

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 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.

Restrictive interventions that are permitted include an action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights. The use of mechanical restraints, physical restraints, seclusion, and aversive stimuli are not allowable habilitation techniques. PRN (as needed) psychotropic medications are prohibited. Chemical restraints, that is, drugs, or psychotropic medications used solely for the purpose of modifying behaviors are allowed. Physical restraint or separation from harmful circumstances or from individuals at risk can only be used as an emergency safety intervention when the person must be kept form harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the person). Protocols for the use of physical restraint and separation are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention which is not used as a behavioral consequence and utilized pursuant to a safety plan is allowed to respond to an emergency safety situation. In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person would not be put in a room, with the door closed and no one watching them.

The following documentation is required when restrictive interventions are used:
1. Written agency provider policies and procedures;
2. Written positive support plan to be used in conjunction with the restrictive measure, the criterion for the elimination of the restrictive measure, and method to collect data;
3. Written discussion and prior approval by the IPP team and documentation the IPP team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure;
4. Written informed consent;
5. Incident reports related to the use of restrictive interventions; and
6. Orientation, training, and/or competency standards for staff prior to implementation of restrictive measures.

All DD agency providers must be in compliance with state regulations that govern the delivery of home and community-based services and licensing standards for centers for individuals with developmental disabilities (DD).

The provider must develop a policy specifying whether they allow for the use of restrictive measures. If the provider allows the use of restrictive measures, the written policies and procedures must include the following:
1. The restrictive measure determined necessary for one individual must not affect other individuals who receive services in that setting;
2. The restrictive measure must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as an effective positive behavior support plan;
3. The restrictive measure must be the least restrictive and intrusive possible;
4. All restrictive measures must be temporary;
5. Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed;
6. The restrictive measure must be safe for the individual; and
7. Agency-approved restrictive measures must be specified and defined.

Restrictive measures can only be used as an integral part of a written habilitation strategy that is designed to lead to a less restrictive way of addressing the unacceptable behavior and ultimately to the elimination of the behavior for which the restrictive measure is used.

The provider must ensure that the written habilitative strategies stress positive approaches in addressing behaviors. The provider must have written policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual.

Methods for detecting the unauthorized use of restrictive measures include provider enrollment, on-site

certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints. See Appendix G-2-a-i for a description of the methods.

Prior to implementation of a restrictive measure, the provider must ensure review and written approval by the IPP team and rights review committee and written informed consent.

The provider must participate in the IPP team process to discuss and review the proposed restrictive measure prior to implementation. The Individual Program Plan (IPP) must document the IPP team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure. The discussion and approval of the use of the restrictive measure including the following must be recorded in the individual's IPP:
1. The proposed restrictive measures;
2. Methods previously tried and shown to be ineffective;
3. Risks involved with the restrictive measure and risk involved if no restrictive measure is used;
4. Rationale for the proposed restrictive measure;
5. Other possible alternative methods;
6. Description of the positive support plan proposed to be used in conjunction with the restrictive measure to lead to elimination of the restrictive measure and the criterion for the elimination of the restrictive measure; and
7. Frequency that the individual's IPP team will review the effectiveness of the plan, but not less than every six months. The IPP team review must address:
a. The original reason for restrictive measure, current circumstances, success or failure of the positive support plan, and the rationale based on evidence for continued use of the restrictive measure; and
b. Decrease in the use or elimination of the restrictive measure as soon as circumstances justify, based on established and approved criterion in the IPP.
The provider must obtain written informed consent from each individual or legal representative as applicable, for authorization to use a restrictive measure. The written informed consent must be obtained prior to implementation of the restrictive measure.

In addressing behaviors, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual. The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations:

The provider must assure that the following components of positive behavioral supports are in place:
1. The assessment must define the communicative function of the behavior for the individual;
2. The assessment must focus on what purpose the identified behavior serves in the individual's life;
3. A review of the individual's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
4. A safety plan for the individual must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
5. There must be a combination of a planned meaningful day and individualized supports for the individual;
6. The plan must include a description of potential stressors and triggers that may lead to the individual experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
7. There must be meaningful and individualized data collection and data analysis that track the progress of the individual. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

The safeguards, practices, protocols, and documentation for the use of restrictive measures are the same as for the use of chemical restraints to modify behaviors, and the use of emergency safety interventions of physical restraint or separation. See G-2-a-i for additional information.

If restrictive, prior written consent of the person or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of restrictive measures must be documented and reported. Reports of the following incidents must be forwarded to the local State DD Service Coordination:

1. Allegation of abuse or neglect;
2. Use of emergency restraint;
3. Discovery of an injury of unknown origin.

The provider must ensure that employees (including subcontractors and management) responsible for providing supports and services to individuals with developmental disabilities are educated/trained on the minimum requirements necessary to address the individual's needs prior to working with individuals in services.

Staff responsible for providing direct services must demonstrate the competence to support individuals as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with individuals.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with individuals. Employees must complete the following training requirements:
1. Individual's choice;
2. Individual's rights in accordance with state and federal laws;
3. Confidentiality;
4. Dignity and respectful interactions with individuals; and
5. Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with an individual. The following training areas must be addressed:
1. Emergency procedures;
2. Cardiopulmonary resuscitation;
3. Basic first aid;
4. Infection control;
5. Individuals' medical protocols as applicable; and
6. Individuals' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to individuals. This training must include:
1. Implementation and development of the IPP and interdisciplinary process;
2. Positive support techniques;
3. Approved emergency safety intervention techniques;
4. Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
5. Use of adaptive and augmentative devices used to support individuals, as necessary;
6. Other training required by the provider; and
7. Other training as required by the specific service options.

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:

DHHS DDD is responsible for monitoring and overseeing the use of restrictive measures.
The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restrictive measures and ensuring that all applicable state requirements. The State-wide oversight responsibilities listed below employ the same methods described in Appendix G-2-a-i and G-2-b-i. Only additional information is included in this section regarding:
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;

c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring; and
f. Complaint investigations.
a. The provider's policies and procedures must be based on state regulations applicable to the use of restrictive measures.
b. Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Limited data is gathered during the initial provider enrollment activity. The length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered are data that the DDD central office utilizes to improve the provider enrollment process. When a provider has difficulty developing their policies and procedures related to the use of restrictive measures, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.
A summary of certification activities is completed by a DDD Program Specialist and is reviewed semi-annually by the DDD QI Committee. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. "walk-throughs"), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the IPP, including delivery of services.

a. An aggregate report of the critical incidents and events, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The DDD QI committee reviews statewide quarterly reports compiled from the statewide database of critical incidents and events, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.
b. To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual Service Coordinators to track issues that aren't resolved and provide aggregate information for Service Coordination Supervisors, Service Coordination Administrators and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

c. A report of complaint investigations is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint.

The DD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee.

The operation of the incident management system is overseen by DDD central office. The state is reviewing on-line reporting methods for reporting incidents and will transition to the method when a contractor is chosen and systems are in place.

Currently, verbal reports of incidents are entered into a database daily. Faxed reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The DDD committee reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types

and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.
The frequency of the oversight activities varies by activity.
The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Currently each incident is reviewed by DDD staff. Quarterly, the DDD QI committee reviews an aggregated report compiled from the statewide database of critical incidents and events.

DDD Service Coordination monitoring reports are provided to the DDD QI committees on a quarterly basis. A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the DDD QI Committee.

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 use of seclusion as a restrictive measure is not an allowable habilitation technique. DHHS DDD is responsible for monitoring and overseeing the use of restrictive measures.
The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restrictive measures and ensuring that all applicable state requirements. All DD agency providers must be in compliance with state regulations that govern the delivery of home and community-based services and licensing standards for centers for individuals with developmental disabilities (DD).

The State-wide oversight responsibilities are listed below.
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;
c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring; and
f. Complaint investigations.
a. The provider's policies and procedures must be based on state regulations applicable to the use of restrictive measures.
b. Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Limited data is gathered during the initial provider enrollment activity. The length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered are data that the DDD central office utilizes to improve the provider enrollment process. When a provider has difficulty developing their policies and procedures related to the use of restrictive

measures, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by a DDD staff and is reviewed semi-annually by the DDD QI Committee. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

An aggregate report of the critical incidents and events, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The DDD QI committee reviews statewide quarterly reports compiled from the statewide database of critical incidents and events, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual Service Coordinators to track issues that aren't resolved and provide aggregate information for Service Coordination Supervisors, management staff, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint. The DD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee.

The operation of the incident management system is overseen by DDD central office. Electronic reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The DDD committee reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

The frequency of the oversight activities varies by activity. The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Quarterly, the DDD QI committee reviews an aggregated report compiled from the statewide database of critical incidents and events.
DDD Service Coordination monitoring reports are provided to the DDD QI committees on a quarterly basis.

A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the DDD QI Committee.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96). Compliance reviews of the provider are completed by the Division of Public Health within DHHS.

First line responsibility for monitoring participant medication regimens resides with the medical professionals that prescribe the medications, every time that the professional prescribe the medications. The medical professional that prescribes the medications determines the frequency of the monitoring, based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the medical professionals who prescribe them, the pharmacist who fills the prescriptions, and the provider's review committee.

Each provider must establish a committee to provide prior review psychotropic medications used solely for the purpose of modifying behaviors, and issues related to research involving clients, for the purpose of ensuring that client rights are not violated. The agency shall have a review committee which includes -
1. Persons qualified to evaluate behavioral research studies/proposals and the technical adequacy of proposed positive behavioral support plans; and

2. A physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to modify behavior.

First line monitoring methods are carried out by the DD provider, and consist of documenting and reporting to the physician at every appointment, legal representative when requested, and the delegating licensed health care professional:
1) Unsafe conditions of medications;

2) Adverse reactions to medications;

3) Medication errors; and

4) Staff observations regarding the behavior which the medication has been prescribed to reduce.

The second line monitors are licensed health care professionals whose scope of practice allows delegation of medication administration. The health care professionals, usually Registered Nurses, delegate the administration of medication to medication aides. The licensed health care professionals are employees of the DD provider agency or who have entered into a contract with the DD provider.

Second line monitoring activities and frequency of monitoring is determined by the health care professional and the DD provider. The medical professional that prescribes the medications determines the frequency of the health professional's monitoring which may be monthly, quarterly, semi-annually, or annually and is based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues. The DD provider's monitoring activities may include observation of the administration of medications or treatment; review of records relating to medication provision or treatment; review of incident reports related to medication or treatment errors; retraining, and continued observations.

Staff observations regarding the behavior which the medication has been prescribed to reduce are also reported to the provider's review committee when the positive behavioral supports plan for that individual is scheduled for review. Each DD provider must have policies and procedures that identify the frequency of monitoring.

In addition to meeting statutory and regulatory requirements, the DD provider agencies must have policies and procedures addressing the provision of medications, per applicable state regulations.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement that includes frequency of QA/QI monitoring activities. The QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action. The provider's reports of QA/QI activities are reviewed on-site when DDD completes a certification review, annually or every two years, based on the certification status of the provider.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DHHS Division of Public Health (DPH) is responsible for the oversight of compliance with the Neb. Rev. § 71-6718 - 71-6743, known as the Medication Aide Act. The administration of medication is a regulated activity as a method to ensure that participant medications are managed appropriately. 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. Medication aides and other unlicensed persons may help with the physical act and documentation of provision of medication; and, under specific conditions such persons may also assist with monitoring therapeutic effects. Medication aides must be recertified every two years.

The administration of medication by licensed health care professionals is regulated by their respective practice acts. Under these regulations, administration of medication in the home is regulated only if provided through a licensed home health agency or through certified home and community-based providers. These regulations do not govern self-administration of medication. These regulations do not govern the provision of medication in an emergency situation. Licensed home health agencies do not administer medications to waiver participants that receive provided operated waiver services. This section only applies to medications administered by certified DD agency providers.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the

following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Correction (POC) addressing citations. The Plan of Correction must be approved by DDD, and the provider is advised of changes that may be necessary to the POC.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. On an ongoing basis, when a complaint involving the performance of a Medication Aide is received by the DPH by phone, FAX or on-line, an evaluation of the

Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry. The risk of continued harmful practices is eliminated by removing the medication aide from the registry.

DDD service coordination monitors the implementation of the IPP, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual IPP and semi-annual IPP. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

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).

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96).

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.

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 caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

A caretaker has current first-hand knowledge of the recipient's health status and the medications being provided, and has consistent frequent interaction with the recipient. A staff member of a facility, school, or other entity is not a caretaker.

The ability to self administer medication means that the individual is physically capable of:

a. The act of taking or applying a dose of a medication;

b. Taking or applying the medication according to a specific prescription or recommended protocol;

c. Observing and monitoring him/herself for desired effect, side effects, interactions, and contraindications of the medication, and taking appropriate actions based upon those observations;

d. Receiving no assistance in any way from another person for any activity related to medication administration.

The inability to self administer medications means the individual:

a. Is not at least 19 years of age. Minor children may take their own medication(s) with appropriate caretaker monitoring;

b. Does not have cognitive capacity to make informed decision about taking medications;

c. Is not physically able to take or apply a dose of a medication;

d. Does not have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for nonprescription medication; and

e. Does not 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 DD provider agency must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

For recipients who do not have the capability and capacity to make informed decision about medications and for whom there are not caretakers, acceptance of responsibility for direction and monitoring must be provided by a licensed health care professional.

Documentation may be accomplished by any of the following methods:
(1) When licensed health care professionals are employees, entities may identify on an individual basis or by title and job description/role delineation the licensed health care professional or the classification(s) of licensed health care professionals who are responsible to provide direction and monitoring. Written acceptance of responsibility is not required to be recipient specific and can be through acceptance of title and job description/role delineation.

(2) When licensed health care professionals are not employees, entities must identify the licensed health care professional by name, profession, and license number who is designated to provide direction and monitoring. Written acceptance of responsibility needs to be recipient specific.

(3) A licensed health care professional who provides services directly to a recipient for direction and monitoring, rather than indirectly through facility employment, needs to have a written contract with the recipient or other responsible party on behalf of the recipient which identifies acceptance of said responsibility.

The minimum competency standards are defined in regulations. Medication aides and other unlicensed persons who provide medication must:

(1) Recognize the recipient’s right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of a similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

(2) Recognize and honor the right of those recipients, with capability and capacity to make an informed decision about medications, to refuse medications and at no time to be forced to take medications. In the case of a recipient who does not have the capability and capacity to make informed decision about medications, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the recipient.

(3) Follow currently acceptable standards in hygiene and infection control including hand washing.

(4) Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to recipients.

(5) Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s) should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(6) Accurately document medication name, dose, route, and time administered, or refusal.

(7) Provide the right medication, to the right person, at the right time, in the right dose, and by the right route.

(8) Provide medications according to the specialty needs of recipient's based upon such things as age, swallowing ability, and ability to cooperate.

(9) Recognize general conditions, which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in recipient condition, which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(10) Safely provide medications for all ages of recipients according to the following routes: oral, topical, inhalation and instillation as referenced in section 005.

(11) Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

(12) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. 28-372.

(13) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. 28-711.

(14) Recognize the recipient's property rights and physical boundaries.

The regulations relating to medication aides specify that direction and monitoring of the medication administration completed by medication aides will be completed on an ongoing basis. The DD provider agency must have policies and procedures in place for monitoring medication administration by medication aides.

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies. 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:

Medication errors must be reported to the person responsible for providing directions and monitoring. This person could be a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration), a caretaker, or a licensed health care professional.

Medication errors suspected to be abuse or neglect must be reported to DHHS Protection and Safety Services or law enforcement.

Medication errors are any violation of the "five rights" - providing the right medication, to the right person, at the right time, in the right dose, and by the right route, or inaccurate documentation of medication name, dose, route, and/or time administered.

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.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement. The provider's QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the

certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Correction (POC) addressing citations. The Plan of Correction must be approved by DDD, and the provider is advised of changes that may be necessary to the POC.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. Upon request by DPH, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DDD service coordination monitors the implementation of the IPP, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual IPP and semi-annual IPP. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: 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:
Out of the total number of monitorings, at the time of the monitoring, the number of persons free from abuse and neglect.

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

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: Semi-annually or as determined by the local QA/QI committee or the state DDD QI committee

Performance Measure:
Out of the total number of service coordination monitorings, the number of neglect and abuse allegations that were followed up by the DD provider.

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

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: Semi-annually or as determined by the local QA/QI committee or state DDD QI committee

Performance Measure:
Out of the total number of reported incidents of suspected abuse/neglect, the number reported within the required timeframe.

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

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.

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.

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.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Nebraska state statute 83-1202 states that it is the intent of the Legislature that "The first priority of the state in responding to the needs of persons with developmental disabilities should be to ensure that all such persons have sufficient food, housing, clothing, medical care, protections from abuse or neglect, and protection from harm." State regulations require that individuals must be treated with dignity and respect, be free from neglect and abuse (physical, verbal, psychological or sexual), receive appropriate medical treatment and receive services in a safe and sanitary environment. State statute 83-1216 and state regulations also require that all DD providers who will provide direct contact services undergo background and criminal history checks. Department of Health and Human Services (DHHS) also adhere to state statute by completing background and criminal history checks prior to hiring DDD service coordinators.
Information concerning protections from abuse, neglect, and exploitation is provided to participants and his/her legal representative prior to the initiation of services and annually thereafter. Waiver participants may contact DHHS Protective Services or law enforcement. Waiver participants may also tell their DDD service coordinator, a trusted friend or family member who will report the suspected abuse or neglect on the participant's behalf. DHHS has a statewide toll-free number for reporting allegations which is available 24/7.
Nebraska DD providers have had to complete and provide Service Coordination with incident reports for a number of years. Verbal reports of incidents are forwarded to Service Coordination immediately upon the provider becoming aware of the incident. A verbal report must be followed up with a written report within

fourteen days of the provider becoming aware of the incident. DDD tracks the incidents in a database with quarterly summaries developed from that database. The state is reviewing on-line reporting methods for reporting critical events and incidents and will transition to the method when a contractor is chosen and systems are in place.
In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up.

A daily review and triage of the critical incident and events database is completed and when warranted follow-up on individual incidents is completed to gather more information or request clarification.
As a part of Service Coordination monitoring, the expectation is to track incidents by person and by provider to look at trends in incidents and to provide better information to the individual teams to aid defining needed supports for persons. This information is a part of the SC monitoring database.
Service Coordination enters the incident reports into a database, and an aggregate report of these incidents is prepared for the state DDD QI on a semi-annual basis. The state QI committee reviews the reports and makes recommendations if necessary.
Since 1992, Nebraska has had a Death Review Committee to review all deaths of persons served by DD habilitative providers. The Death Review Committee membership includes representatives from DHHS DDD, the Division of PH, Adult Protective Services, and staff from the Medicaid program.
Nebraska's Death Review Committee reviews information submitted by specialized providers of service relative to the death of persons whose services are funded by the State of Nebraska. This is done in an effort to determine trends or individual situations which may indicate training and/or education needs and to provide information to service providers regarding best practices and prevention. The Death Review Committee has expanded their review of deaths of persons to include persons whose services are provided by community supports providers.

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 for problem correction. In addition, provide information on the methods used by the State to document these items.
The State has set up processes to address individual problems as they are discovered.
DHHS staff conducts reviews of each IPP and additional evidence of the process to ensure the IPP reflects the individual's directions, preferences, and personal and career goals, the IPP is based on adequate assessments of their abilities, and that health and safety issues are addressed. When variances are noted, the Service Coordinator and their Supervisor are notified and take action to correct the IPP. If issues are discovered that will affect the waiver status of the individual, the Service Coordinator is notified and given a date to respond. The date of response is determined by the Disability Services Specialist and varies between 5 working days and 10 working days, based on the nature of the issue. Failure to receive corrections will result in the removal of the person from the waiver and notification of the Service Coordination supervisor. Correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health and safety. Other issues that do not effect waiver funding are passed along to the Supervisor of the SC responsible for the development of the IPP.
DDD Service Coordination monitors the implementation of the IPP to ensure the timely and efficacious delivery of all services specified in the IPP for the person. Full reviews are conducted within 60 days of the annual and semi-annual IPPs. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family or others. The full reviews consist of checking on items grouped into six groupings – rights, habilitation, financial, service needs, health and safety, and home/work environment.
When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A timeline to address the issues and/or an IPP team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.
The desk review of the IPP and the on-site monitoring are documented and entered into a database. This allows individual Service Coordinators to track issues that aren't resolved and for Disability Services

Specialists and Service Coordination Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators, and provide aggregate information for Service Coordination Supervisors, local Service Coordination Administrators, and the DDD central office. This information is reviewed and acted on, as appropriate, at the local level.
This information is summarized and reviewed by the DDD QI Committee quarterly. The summarized data for the IPP review is also shared with service coordination staff at the local service district level and the Disability Services Specialists. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.
By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. Extreme incidents or patterns that threaten an individual's health and welfare are shared with DDD Central Office at the time of the investigation and may result in increased monitoring by service coordination, a certification or contract compliance review, technical assistance, or some other type of remediation and follow-up activities.
In addition, providers are required to report critical incidents (incidents of running away, hospitalizations, injuries requiring medical attention, and deaths) to DDD Central Office and Service Coordination immediately following the incident with submission of the incident report within 24 hours. DDD central office and Service Coordination staff reviews these daily and follow-up on significant issues which may include arranging for an IPP meeting, increased monitoring by service coordination, a certification or contract compliance review, a complaint investigation, or technical assistance.
A database of these incidents is kept by DDD. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on an individual and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the DDD QI committee.

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: Semi-annually or as determined by the DDD QI committee or DDD Deputy Administrator and/or Manager for QI

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.
DDD is in the process of expanding the QI strategies for assuring Health and Welfare by improving the methods for the review and follow-up of critical incidents and events.

DDD is revising the reporting process for critical incidents and non-critical events for completion by all DD waiver providers. An on-line report developed by DDD or purchased from a vendor will provide information to DDD service coordination and central office staff simultaneously and will replace the requirements of phoning in a critical incident when immediately becoming aware of a critical incident, followed up by a written report or the critical incident within 24 hours, as well as the requirement to submit a written report of an event within 14 days of the event. The report furnished by providers will include demographic information, antecedents leading up to the event(s), categorizing the event, identification of any injuries, the individual's responses, staff's responses, the provider's immediate follow-up to the critical incident or event, as well as the provider's follow-up to prevent or reduce future incidents. The Director of DDD, the Community Based Administrator, Deputy Administrators for Quality Improvement and Services, and the Waiver Manager are reviewing on-line reporting methods for reporting complaints, critical incidents, and events and will transition to the method when a contractor is chosen and systems are in place, beginning in January 2011. The timeline for completing the revisions of these forms will be related to the automated system that will begin in January 2011. Once a vendor is chosen, the above DDD personnel will work with the vendor to revise or transfer forms to the vendor's specification. The system will be brought on-line over the course of the coming year.

In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. Forms related to SC monitoring, review of the IPP, incident and complaint reporting, and the certification activities report are being revised by the Deputy Administrator for Services, the Deputy Administrator for Quality Improvement, the Service Coordination Administrators, and representatives of SC Supervisors and Service Coordinators. The revision of forms and committee reports and the transference of metadata to SharePoint began in November 2010 and will be accomplished by January 1, 2010.

DDD has developed identifiers or indicators for follow up on individual, provider, and systems issues. DDD service coordination will provide follow-up on an individual basis which may include additional monitoring, facilitation of adjustments to the individual's services, or referral and coordination of additional resources to assure the individual's health and safety. DDD central office staff will be responsible for follow up on specific provider issues, when trends are identified, and when system issues are identified that impact multiple providers. DDD central office follow-up activities may include referral to DHHS protection and safety staff, contract compliance reviews, focused certification reviews, complaint investigations, and communication to internal and external stakeholders to relay revisions or clarification to interpretive guidelines.
The revisions to the critical incident and event reporting process are being piloted and will be implemented by January 1, 2011.

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

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 Nebraska Department of Health and Human Services is the Single State Medicaid Agency. The State Medicaid Director is in the Division of Medicaid and Long Term Care Services. The State Medicaid Director has the ultimate authority for all of Nebraska’s Medicaid services.

The quality improvement strategy for Nebraska covers all services funded by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD), including the services offered under the HCBS waivers for adults (0394, 0396, and 454) and children with developmental disabilities (4154) as well as services funded by state general funds only. Nebraska's QI strategies include stratifying information for each respective waiver.

The Division of Developmental Disabilities (DDD) is responsible for the day to day operations of administering and monitoring waiver services as listed in Appendix A-7., as well as completion of waiver applications and any amendments. Initial and ongoing certification of specialized DD agency providers, contract compliance reviews, complaint investigations, technical assistance/training, and development and oversight of the quality management system are the responsibility of DDD. Enrollment of non-specialized or independent providers is performed by assigned state staff within divisions of DHHS. Licensing of and compliance reviews for centers for persons with DD (CDD) are activities performed by the Division of Public Health (DPH).

A primary method of coordinating the QI activities associated with DD waivers is the DDD Quality

Improvement (DDD QI) Committee, which was conceptualized in 2004 and based on the Quality Framework. The DDD QI committee has worked in partnership with the other stakeholders in our services in an effort to develop the system to improve the flow of information regarding QI activities between the local and state levels. The overall QI efforts also are designed to promote problem solving at the local service coordination district level, with systems issues being identified through systematic analysis.

The DDD QI structure involves the State DDD QI Committee, consisting of DDD Central Office QI staff, as well as home and community based services waiver management staff from Medicaid, licensing and compliance staff from DPH, a service coordination supervisor and a disability services specialist (DSS). This committee receives reports and information and provides/shares feedback and support to the areas.

The Medicaid HCBS waiver manager verbally reports activities of the DDD QI committee to her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for their review.

While Medicaid staff, DPH, and the DDD Central Office have been continually involved in quality improvement efforts, the need to provide better communication and support at the local level has resulted in the development of a formal QI committee for Service Coordination and disability services specialists. Communication and problem-solving is facilitated between the DDD central office and the SC districts through regularly scheduled meetings with the SC Administrators and DDD central office management who oversee the work of the disability services specialists and staff who perform certification activities, contract compliance activities, complaint investigations, and technical assistance. The meeting schedule is based on the type of supervisory structure and occurs weekly, bi-weekly, monthly, or every six weeks.

The service coordination and disability services specialists committees came into prominence as the need to design oversight systems for service plans became a priority with the CMS waiver review request in 2004. While systems did exist for reviewing service plans, referred to as Individual Program Plans (IPP) and the delivery of services, the information was used on a local level with limited systematic analysis at the local area or state level. The design of the improved service plan review and monitoring systems came about with the goal of providing meaningful information for the individual disability services specialist or service coordinator, their supervisors and administrators and the state level administration. The process was developed to complete 100% review of the service plans with the ability for the state to ensure the reviews are completed and to aggregate the results to identify issues at various levels of the DHHS-DDD.

The DDD QI committee's responsibility is to determine systems issues, determine strategies to address the issues and to evaluate the effectiveness of the implementation of those strategies. The measures to be reviewed quarterly are pulled together under the HCBS Quality Framework (QF) and CMS' Request for Evidentiary-Based Information (CMS Request). The DDD central office administration provides oversight of this committee, the subcommittee, and all quality improvement activities. Nebraska's DDD quality management system is dynamic and continually evolving. A continuous evaluation component is built into the system for evaluation of utility, information received and effectiveness of strategies.

The DDD QI committee meets monthly and the minutes of the meetings are provided to all members of the committee. The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QI committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The following DDD QI Committee Report List provides the name of the report, entity responsible for providing the information, and time frame for reviewing the report:
Waiver Eligibility - Disabilities Services Specialists (DSS) - reviewed semi-annually
IPP Review for waiver compliance – Service Coordination Supervisor (SCS) - quarterly
Service Coordination monitoring of implementation of the IPP - DDD service coordination - quarterly
Complaints – DDD central office staff - semi-annually
Certification reviews - DDD central office staff - quarterly
Quality Review Teams - DDD central office staff - quarterly
Incident Reports - DDD central office staff - quarterly
Death Review Committee - DDD central office staff - semi-annually
Fiscal Audits (as necessary) - DDD central office staff – annually

Personal Experience Survey (PES) – DDD PES interviewer – annually
Team Behavioral Consultation activities – DDD central office staff - annually

The minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future. The activities of the QI committees are reported verbally to the service coordination administrators, DDD central office staff, and at local staff meetings, and are recorded in the minutes of each meeting. Requests for follow-up of committee recommendations are sent out via e-mail to the appropriate state staff within the timelines assigned at the committee meetings.

The QI activities of DDD and results of reports are communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, the Nebraska DD Council, and DDD-sponsored Town hall Meetings for individuals, families, and other interested parties.

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: semi-annually or as determined by the state DDD QI committee

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 DDD central office management team is responsible for coordinating the monitoring and analysis of system design changes. The management team works in conjunction with the QI committee and the subcommittee, as well as program staff to develop methods of evaluation when implementing system design changes. The goal is to clearly define the outcome desired as a function of the system change and to hopefully allow the gathering of data and other information related to the state of affairs prior to the system change. A desire is to have baseline information to be able to compare to information following the system change to allow the assessment of the impact the change had on the desired outcome. At the same time, there generally needs to be monitoring systems set up to ensure the change is implemented appropriately across the service system. Again, the effort is to ensure such monitoring systems are in place prior to the implementation of the change to more effectively identify problems and allow fixes to be developed and utilized on the fly.

In cases where this is not reasonably possible, efforts are made to develop alternate strategies to capture information post hoc that will allow a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies can be provided. In 2008, a new IPP format was implemented that assisted in moving the state further along in person-centered planning (PCP). With the implementation of the new IPP format, a plan was in place to review and evaluate the adequacy of the outcome statements based on PCP principles. Following this evaluation, there was development and implementation of training to further enhance our PCP services. The information from the

evaluation provided a baseline by which to compare outcome statements following the training to evaluate the effectiveness of the person centered planning efforts and also helped to identify those areas needing the greatest emphasis in training of PCP principles. Such a strategy aids in clarifying the outcome expected from the system change strategy as well as ensuring that measurement systems are in place that will allow for an empirical method to demonstrate the effectiveness of the strategy in obtaining the desired outcome.

Another such system change was the decision to transfer responsibility for certification activities and complaint investigations from the Division of Public Health (DPH) to the Division of Developmental Disabilities (DDD) in October 2010. A ninety day transition period was planned with the outcomes clearly defined – shift responsibilities from one division to another division within the Medicaid agency; have a stronger presence in the community; respond quickly to complaints; and realigns the statutory accountability and oversight under the Division of DD. Processes for initial certification had to be revised quickly to incorporate responsibilities performed by DPH; additional staff was hired; training on complaint investigation and compliance review techniques was provided, and indicators for the need for further action were developed within the ninety day transition. The quarterly report on certification activities and the semi-annual report on complaint investigations were revised to provide information to the QI committee for evaluation of additional systems changes related to certification activities and complaint investigations.

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

The Quality Improvement Strategy is evaluated on various levels in a relatively systematic basis. Information reviewed by the various committees is scrutinized to assess the reliability and thus, validity of the information being presented each time a committee meeting is held monthly or quarterly. This has led to changes in the measurement instruments and additional training to improve the utility of the information reviewed.

In addition, questions regarding system functioning are reviewed at regularly scheduled Service Coordination Administration meetings (weekly phone calls and in-person meetings every six weeks) as they arise to determine whether the QIS needs to and is effectively monitoring those aspects. For example, questions may be generated regarding the utilization of waiver services over time. While the information can be found by querying staff in each service area and then aggregating the information, the need to monitor this information on a regularly scheduled basis is demonstrating the need to develop a better means to track such information statewide. The state is currently reviewing on-line reporting and tracking methods and will transition to the method when a contractor is chosen and systems are in place.

In the interim, DDD is in the process of transferring current data bases, forms, policies, procedures, and other metadata to SharePoint, an intranet application of the Microsoft Outlook software. This will allow the metadata to be stored in one database for utilization by service coordination and central office staff. All metadata will be organized to allow for stratification by each perspective waiver. The single statewide DDD database will lead to coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. This will allow the DDD administration to access the information as needed in a more efficacious manner.

There is also a self-correcting nature based on strategies used to affect systems change. As the QIS becomes more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

New technology may also lead to system changes and improvements in quality improvement strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed and may lead to new strategies.

The QIS is also affected by the demands of administrators, advocates and self-advocates and other stakeholders for information regarding system functioning. Schalock and Keith's Quality of Life Questionnaire had been used for ten years. However, it was only administered every second or third year, providing only five sets of information over time. The utility of the instrument was limited relative to other potential instruments. Thus, the state decided to utilize the Participant Experience Survey (PES) to replace the QOL survey. Not only was the instrument replaced, but is now used with individuals on a biennial basis,

staggered to provide new information on a continuous basis to better monitor persons' satisfaction with services. A plan for implementation of the PES was developed - a stratified sample number for each waiver of persons throughout the community are interviewed using the Participant Experience Survey. The sample is of sufficient size to keep the expected error rate to 10% or less for each of the waivers. The surveys are conducted by a DHHS staff person who is not affiliated with community services, but who does have experience with interviewing people with DD. This plan was implemented in 2010 and data collected from the PES will be reviewed semi-annually.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability, or integrity, is a joint responsibility of the Division of Developmental Disabilities (DDD) with assistance from the DHHS Operations.

DDD is responsible to ensure the integrity of the day-to-day authorization and claims processes. DDD staff authorizes services, verify individual claims, correct suspended claims, and track the participant's utilization of waiver services. DDD staff may conduct financial reviews of provider claims when concern is raised through monitoring, certification activities, or complaint investigations.

Financial Services within Operations tracks audit reports, operates the cost allocation plan, prepares and monitors budget projections for the Division of Medicaid and Long-Term Care and the Division of Developmental Disabilities, prepare federal and state reports as required, and prepare the CMS-64 and 372 reports.

(a) DD agency providers are required by contract to do an annual audit of their operations. These are submitted to Financial Services and are reviewed by an analyst for any audit findings or exceptions that might impact on State payments by or for the provider.

Services that are delivered by independent individual providers rather than provider agencies do not require an independent audit. Independent individual providers are required to retain financial and statistical records to support and document all claims.

(b) DDD staff and the NFOCUS electronic authorization and payment system do a pre-audit of all provider claims to assure the accuracy of coding and billing.

Independent community supports providers must document on a calendar or separate piece of paper, the type of service provided, the times each service was provided, and the dates the service(s) were provided to each individual. This calendar is submitted to the individual, along with the billing, or claim for services. The individual, legal guardian or representative verifies the accuracy of the claim by reviewing and signing the calendar. The calendar and provider claim are then submitted to DHHS staff.

DD provider agencies submit multi-individual claims to DHHS staff without supporting documentation. However, supporting documentation, including staff timecards, individual attendance records or activity schedules, program data records, or other documentation as determined by the Division must be available to Division staff upon request. The agency must maintain records and documentation in sufficient detail, such as staff timesheets and location of service provision, to allow state staff to verify units of service provided to individuals as certified on the monthly billing document.

Prior to submitting the claim for payment, local DHHS staff are responsible to review and verify the units of services billed by the providers. DHHS staff may provide assistance to providers regarding billing and the codes for billing. As a part of the efforts to ensure accurate billing, Suspended DD Claims Reports are generated for billings that do not match the authorizations for service. DDD Central Office staff review these claims and make adjustments to ensure

accurate billing.

Individual audits of provider claims may be conducted in response to concerns raised by complaints or certification or licensure reviews. DD central office staff will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider calendar and corresponding claim, agency staff time sheets and corresponding claims, service authorizations, service coordination tracking of the utilization of services, and the Individual Program Plan. When issues are found that may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) The State of Nebraska has a statewide single audit of DHHS conducted on an annual basis. The Auditor of Public Accounts, an independent State agency, conducts this independent single audit

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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 waiver claims reviewed that were submitted using the correct rate as specified in the waiver application.

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

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: as determined by the DDD QI committee

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.

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.
Financial accountability is a joint responsibility of the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) with assistance from Financial Services staff within DHHS Operations.

Checks and balances are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The individual's service coordinator (SC) initiates and submits the electronic authorization to their supervisor and disability services specialist who review and approve it and electronically submit the authorization to DDD central office for entry into NFOCUS, the state's electronic authorization and payment system. When the disability services specialist (DSS) completes the annual waiver redetermination and IPP review, the authorization on NFOCUS is matched with the paper authorization and the information in the IPP. When discrepancies are found, the SC and DSS take action to correct errors in the authorization by submitting a new authorization with a change in the provider, service type, service amount, and/or dates of services.

An independent statewide single audit of DHHS is conducted by the State Auditor of Public Accounts (APA) office on an annual basis following each state fiscal year (July 1 – June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses, and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DDD staff responds to findings related to review of randomly selected individual waiver files.

The APA reviews the waiver files for compliance with the states regulations. Each waiver file must include the waiver consent form, IPP, documentation of annual physical exam, service authorization form, and waiver review worksheets. The APA office also requests a copy of the billing document and NFOCUS provider authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the IPP documentation.

The following controls are employed to ensure payments are made only for services rendered:
1. The need for the service is documented in the IPP;
2. DHHS staff have enrolled, certified, and/or contracted with the waiver provider and prior-authorized each waiver service to be delivered;
3. When services are delivered by an independent provider, a calendar is completed, listing the date of service(s), the specific task(s), and the times of service, and signed by the waiver participant or designee, verifying the services have been delivered as claimed and a calendar and claim are submitted for approval;
5. DHHS staff verify and approve the claim and submit claim to DHHS claims processing staff for processing; and
6. Edits are in place in the computer system.

A pre-audit of all specialized provider agency claims is completed to assure the accuracy of coding and claim. Prior to submitting claims to Financial Services for processing, DDD Service Coordination is responsible to review and verify the units of services billed by the providers.

NFOCUS, Nebraska's electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims. A claim must include: The provider that provided the service, the person 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 NFOCUS, the system validates all submitted information against the service authorization on file. Edits are built into NFOCUS to audit the service authorization time period, the claim time period, the number of remaining authorized units, and math computations. Claims that fail to pass validation or auditing are suspended from processing for review by DDD central office staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. On a daily basis Suspended Claims Reports are generated for provider claims that do not match the authorizations for service. 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 that is then sent to the State's electronic accounting system, the Nebraska Information System (NIS).

DDD also conducts internal QI activities related to the use of DDD funding. Claim and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services tracks the use of Medicaid funding and provides monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of our efforts to enhance our monitoring and oversight of the use of waiver funding.

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 for problem correction. In addition, provide information on the methods used by the State to document these items.
Individuals who have chosen to participate and receive waiver services are notified in writing by DHHS staff of the authorized funding amount at the time of choosing a provider and in the development of the IPP. Checks and balances are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The individual's service coordinator (SC) submits the authorization to their supervisor and the disability services specialist for approval and submission of the authorization to DDD central office for entry into NFOCUS, the state's electronic authorization and payment system. When the disability services specialist (DSS) completes the annual waiver redetermination and IPP review, the authorization on NFOCUS is matched with the paper authorization and the information in the IPP. When discrepancies are found, the SC and DSS take action to correct errors in the authorization by submitting a new authorization with a change in the provider, service type, service amount, and/or dates of services. A pre-audit of all individual specialized provider claims is completed to assure the accuracy of coding and claim. Prior to submitting claims to Financial Services for processing, DDD Service Coordination is responsible to review the provider calendar if applicable and claim document and verify the units of services billed by the providers. NFOCUS, Nebraska's electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS DD waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims.

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**

Responsible Party*(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: as determined by local QA/QI committee or the state DDD QI committee

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Information about payment rates is made available verbally and in writing to waiver participants and providers by state DHHS staff. The waivers and rate study are posted on the DHHS public website.

Using the normal budgeting and appropriation process, the Legislature and Governor determine the appropriation level for the DD Aid budget program. The Nebraska Legislature appropriates funding for services, specifying the percentage of increase each budget year, or specifying how a special appropriation is to be spent. The increase in appropriation or a special designation determines the rate increase. DHHS determines the rates, and communicates these rates to the Governor's budget staff and to the Nebraska Legislature's Appropriation Committee.

Public hearings are held to provide opportunities for public comment on the Legislative Appropriations Bill. Dates of the hearings are posted on the Nebraska Legislative website, major newspapers in the state, and at the Nebraska State Capital or other state and public buildings in which the hearings are held. This waiver is a fee for service waiver.

In 2009, the Legislature approved a special appropriation for an assessment of the rate structure for DD services. The rates are based on a study on the actual costs of services conducted by a national consulting firm in 2010 and 2011. A number of tasks were completed to develop rates for services provided under the HCBS waivers 0394, 0396, and 4154. The consulting firm examined DDD's historical payment methodology, met with providers and surveyed stakeholders to gather public feedback about the current system, collected current cost and wage data from providers, utilized Bureau of Labor Statistics wage data, and researched rate methodologies used by other

states.

In general, the model uses assumptions about types of employees, staffing levels, wage rates, benefits and administrative overhead ratios, vacancy rates for both employees and participants, and productivity factors. Rates include an FTE productivity factor of 1.15 (320 hours out of 2080 hours annually), based on the hours for absences due to vacation, sick time, holidays, training, administrative meetings, and activities.

Rates include non-direct cost allocation factors for taxes and benefits for each FTE, determining that the benefits factor is equal to 27.81% of total direct wage expenses. The current non-direct cost allocation factors are: Administration – 35.04%; Non-program contracted services – 3.27%; and program support – 36.0%. The cost of transportation is a non-direct cost allocation that is included in the rates.

The methodology assumes a 1:9 ratio of supervisor to direct staff oversight. Hourly and daily rates assume a direct service staff and supervisor oversight.
Hourly rates are based on one clock hour of service.

All residential rates assume resident sick leave and holidays of 15 eight-hour days in a year.

All daily residential rates begin with the assumption of 168 hours in a 7-day week with 35 hours spent outside of the residence. The remainder is 133 hours in the residence during a 7-day week.

Hourly and daily rates for day habilitation services assume a direct service staff and supervisor oversight. Hourly rates are based on 1 hour of service and the total number of hours assumed for daily rate is 4 or more. A 110 percent adjustment factor was applied to Integrated Community Employment and a 105 % adjustment factor was applied to Vocational Planning because these are services that DDD promotes.

Rates for Group Home Residential setting or continuous Companion Home Residential setting are fixed based upon the required staffing levels and allow for asleep overnight staff, awake overnight staff, or no overnight staff. Eight hours of overnight staffing are built into the overnight awake and overnight asleep rate for Group Home Residential habilitation, Extended Family Home residential habilitation, and Companion Home residential habilitation. The need for and intensity of direct staff support during 8 overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff, and, as applicable, the type of awake overnight supervision or assistance that is required must be documented in each individual's service plan. When the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

Payments are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

The methodology incorporates fixed hourly and daily rates for Day Habilitation, Workstation habilitation, Respite, Group Home Residential habilitation, Extended Family Home residential habilitation, Companion Home residential habilitation, and Retirement.

The methodology incorporates only fixed hourly rates for In-home residential habilitation, Integrated Community Employment, and Vocational Planning habilitation. The hourly rate includes a direct staff person and supervisor component in the base direct care cost, which takes into consideration benefits factors, non-direct cost allocation, FTE productivity factors, supervision span of control, residential rates or day rates, staffing ratios, and adjustment factors.

Day Habilitation and workstation habilitation are continuous day services. When 4 or more hours of continuous day services are delivered in a typical workday within a usual forty-hour workweek, Monday - Friday, the provider of continuous day services may bill a daily rate. When less than 4 hours of continuous day services are delivered, reimbursement is at an hourly rate.

Group home residential habilitation, companion home residential habilitation, and extended family home residential habilitation are continuous residential services. When 4 or more hours of continuous residential services are delivered in one calendar day, Monday – Sunday, the provider of continuous residential services may bill a daily rate. When less than 4 hours of continuous residential services are delivered in a 24-hour period, Monday - Sunday, reimbursement is at an hourly rate.

When both continuous and intermittent services are delivered during day service hours, which are typically during a 40-hour workweek, reimbursement is at an hourly rate.
The Behavioral Risk and Medical Risk service rates are both a fixed daily rate and were developed by the consulting firm based on input from provider agencies that were providing this service as a pilot service. The Behavioral Risk service rate includes reimbursement for supervising practitioner consultation, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation (teaching and supporting) services, and management and overhead costs. The rate also incorporates "difficulty of support" factors, which are intensive behavioral supports, and ongoing safety supervision and supports.

The Medical Risk service rate includes reimbursement for services provided by a Registered Nurse, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation services, and management and overhead costs. The rate also incorporates "difficulty of care" factors, such as but not limited to development of nursing plans, provision of complex medical treatments, training unlicensed direct support professionals, and oversight of delegation of health maintenance activities to the extent permitted under applicable state laws.

The Behavioral Risk and Medical risk services are reimbursed on a daily rate basis of 13.33 hours, and the staffing ratios are flexible and commensurate to meeting the needs of the individual.

The Team Behavioral Consultation (TBC) service rate is a cost adjustment model and includes staff salaries, benefits, and preparation time to review information and schedule the site visit; travel time which varies from 2 to 9 hours one way; on-site time, which includes a preliminary meeting, observing the individual during all awake hours in all settings; and follow-up time, which includes providing report of consultation, conference calls or meetings as necessary, and post recommendation surveys. The rate of this service is adjusted annually, based on the previous year's cost of delivering team behavioral consultation.

Because retirement direct support staff do not provide habilitation services, the base wage rate is lower than the base wage rate for other direct care support staff who provide habilitation. The fixed rates developed by the consulting firm are based on usual and customary rates for similar Nebraska services. The rate includes direct support staff salaries and benefits, management costs, and staffing levels. The retirement service is reimbursed on a daily rate basis of 7.39 hours. When retirement service is delivered intermittently, the rate is hourly, with a basis of 3.69 hours of delivered service.

The hourly rates for Respite services and Community Living and Day Supports (CLDS) delivered by independent providers are based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for issuing a guideline for the range of rates for Respite services and CLDS.

The authorized annual funding amount for any combination of Assistive Technology and Supports, Vehicle Modifications, and Home Modifications is limited to $5,000. The rates for Assistive Technology and Supports, Home Modification, Personal Emergency Response System, and Vehicle Modifications are based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for setting the rates.

The determination of funding for individuals is determined using the Objective Assessment Process as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding, and for all persons in services since July 1, 2014. Funding for Respite, Medical Risk service, and Behavioral Risk service, Assistive Technology and Supports, Home Modification, Personal Emergency Response System, and Vehicle Modifications is not determined using an objective assessment process (OAP).

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely

based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from providers to the State and are not routed through intermediary entities. Preprinted claim forms are generated by NFOCUS, the State's current electronic web-based claims payment system. The claim forms are completed by the provider and submitted for claims processing in the week or month following the delivery of services.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services 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 state's accounting system, the Nebraska Information System (NIS).

All payments are processed through its N-FOCUS sub-system, a recognized component of MMIS, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

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.

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) Waiver services must be prior authorized before payment is made. Authorizations are based upon a determination that the individual meets waiver eligibility criteria, that the services are identified in the approved service plan (i.e., IPP), and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.
(a-c)The authorization and payment process includes the following steps:
1. Waiver eligibility of the individual is determined.
2. Waiver services are identified in the IPP.
3. Waiver service authorization is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.
4. Authorization is entered into NFOCUS, the state's electronic local web-based authorization and payment system.
5. Claim document indicating current authorizations is generated biweekly or monthly and issued to the waiver provider for completion.
6. Upon receipt by DHHS staff, claims are submitted to NFOCUS for processing. Edits in the system verify client and provider eligibility, dates of service, units of service, and rates.

(c) All providers must sign an annual contract or agreement stipulating that the provider shall maintain records and documentation in sufficient detail to allow state staff 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 services are delivered by an independent provider, a service calendar must be submitted with each billing document and signed by the waiver participant or, if applicable, the family member/guardian. Both the calendar and billing document are forwarded to DHHS staff for processing.

The billing validation process verifies that the individual was eligible for Medicaid waiver payment on the date of service.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Providers receive payments directly from DHHS.

Payments for waiver services are made through an electronic data system called N-FOCUS, which is a component of Nebraska's approved MMIS. N-FOCUS (Nebraska Family Online Client User System) determines eligibility and issues payments/benefits for 36 programs administered by Nebraska Department of Health and Human Services. All of the following functions are incorporated into the N-FOCUS application with the exception of the actual issuance of payment that is via the NIS application and is explained below.

(a) After a client is determined to be eligible for Medicaid on N-FOCUS, a separate eligibility process is completed for eligibility for HCBS waiver services. Once waiver eligibility is established, an authorization is completed by the individual's service coordinator and the Disability Services Specialist and submitted to DDD central office, to be entered into N-FOCUS. The eligible individual, 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 specifies the individual 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, the 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 person 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 a local DHHS staff or DDD central office 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 that is then sent to the state's accounting system, the Nebraska Information System (NIS).

(b) All payments are processed as described in item 1 above by DHHS through its N-FOCUS sub-system, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

(c) As described in item 1 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.

(d) 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.

Additional information:
In Nebraska, some DD provider agencies are public providers established by County Commissioners under interlocal agreements. Both private and public providers furnish Integrated Community Employment, Prevocational Workshop habilitation, Community Inclusion Day habilitation, Vocational Planning habilitation, Workstation habilitation, Group Home residential habilitation, respite, Behavioral Risk, Medical Risk, Companion Home residential habilitation, Extended Family Home residential habilitation, In-home residential habilitation, and Retirement, and the payment to these public providers does not differ from the amount paid to private providers.

○ **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*):

- [x] **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:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is a provider of assistive technology and supports, home modifications, and/or vehicle modifications and receive the same rates as all providers for those services.

In Nebraska, some DD provider agencies are public providers established by County Commissioners under inter-local agreements. Both private and public providers furnish Integrated Community Employment, Day habilitation, Vocational Planning habilitation, Workstation habilitation, Group Home residential habilitation, respite, Behavioral Risk, Medical Risk, Companion Home residential habilitation, Extended Family Home residential habilitation, In-home residential habilitation, and Retirement, and the payment to these public providers does not differ from the amount paid to private providers.

The state ICF subcontracts with providers to deliver team behavioral consultation. The payment to the state ICF for team behavioral consultation does not differ from the payment to the subcontracted 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.** *Select one:*

- (●) **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.**

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*:

- [x] **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 establishes the rates and those rates do not include any costs for room and board. The providers bill according to the established rates.

In Nebraska, the individual's SSI payment is for his/her room and board. The rates reflect the exclusion of room and board. Room and board costs are not included in the rates for the following services:
Group home residential habilitation;
Companion home residential habilitation;
Retirement service;
Extended family home residential habilitation;
Medical risk services; and
Behavioral risk services.

Payments for residential habilitation services are made to certified provider agencies of developmental disabilities services using a rate that contains the following elements of cost:
1. Salaries and benefits of frontline or direct care staff;
2. Salaries and benefits of supervisors of frontline or direct care staff;
3. Transportation services to and from facilities for person to receive habilitation services; and,
4. Administrative expenses of the certified provider related to residential habilitation.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	31572.79	5612.00	37184.79	70636.00	3012.00	73648.00	36463.21
2	54125.08	5892.00	60017.08	73461.00	3162.00	76623.00	16605.92
3	53619.97	6187.00	59806.97	76400.00	3320.00	79720.00	19913.03
4	65390.45	6496.00	71886.45	79456.00	3486.00	82942.00	11055.55
5	64948.50	6821.00	71769.50	82634.00	3661.00	86295.00	14525.50

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:
		ICF/IID
Year 1	3485	

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
			3485
Year 2	3685		3685
Year 3	3835		3835
Year 4	4000		4000
Year 5	4180		4180

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 on the waiver is based on the most recently filed 372 (waiver year 2008).

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 for these estimates is as follows:

The sum of users using Integrated Community Employment, Day Habilitation, Vocational Planning Habilitation and Workstation Habilitative services is equal to the number of wavier slots available. The distribution of users between each service type is based on service usage patterns during State Fiscal Year 2010. The total number of slots increase at a rate of 5% each year and are distributed across all service types in the same proportion as the previous year.

The number of Respite users is based on usage patterns established in State Fiscal Year 2010 and include an increase to account for the addition of users from the CSP Wavier (NE.0454). Numbers hold steady the first two years and then increase by 5% thereafter. Behavioral Risk, Medical Risk and Retirement Services are estimates for services that have not been previously offered. Assistive Technology and Supports, Community Living and Day Supports, Home Modifications, Personal Emergency Response and Vehicle Modification services are based on usage patterns during State Fiscal Year 2010 for the Community Supports Program Wavier #0454. Team behavioral consultation users are assumed to remain constant for the first two years, and grow at 5% every year thereafter.

Estimates for number of units per user assume utilization will remain the same as waiver year 2011.

Cost per unit estimates are based on published rates for waiver year 2011, with a 2.5% increase for each year.

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

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

Factor D' is based on actual acute care expenditures for individuals on the waiver in State Fiscal year 2010. The average cost for acute care for this year was $5,345. Price increases of 5% were included for each year.

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

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

The average cost of institutional care per ICF-MR recipient was based on actual expenditures in State Fiscal year 2010. The average cost for this Fiscal year was $67,919. Price increases of 4% were included for each year.

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

Factor G' is based on actual acute care expenditures for individuals in an ICF-MR in State Fiscal year 2010. The average cost for acute care for this waiver year was $2,868. Price increases of 5% were included for each year.

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	
Day Habilitation	
Group home residential habilitation	
Integrated Community Employment	
Respite	
Assistive Technology and Supports (ATS)	
Behavioral Risk Services	
Community Living and Day Supports (CLDS)	
Companion Home residential habilitation	
Extended Family Home residential habilitation	
Home Modifications	
In-home residential habilitation	
Medical Risk Services	
Personal Emergency Response System (PERS)	
Retirement Services	
Team Behavioral Consultation Services	
Vehicle Modifications	
Vocational Planning habilitation service	
Workstation habilitation 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
Day Habilitation Total:						**0.00**
Day Habilitation Hour	Hour	0	0.00	26.64	**0.00**	
Day Habilitation Day	Day	0	0.00	268.70	**0.00**	
Group home residential habilitation Total:						**66461129.44**
Group Home Residential Habilitation Hour	Hour	1500	1510.00	26.77	**60634050.00**	
Group Home Residential Habilitation Day	Day	161	169.00	214.16	**5827079.44**	
Integrated Community Employment Total:						**1542428.92**
Integrated Community Employment	Hour	172	241.00	37.21	**1542428.92**	
Respite Total:						**525172.50**
Respite	Hour	153	250.00	13.73	**525172.50**	
Assistive Technology and Supports (ATS) Total:						**14355.00**
Assistive Technology and Supports (ATS)	Year	5	1.00	2871.00	**14355.00**	
Behavioral Risk Services Total:						**3165736.25**
Behavioral Risk Services	Day	25	365.00	346.93	**3165736.25**	
Community Living and Day Supports (CLDS) Total:						