Advisory Committee on Developmental Disabilities

Meeting Minutes
March 11, 2026

I. Call to order:

Mike Browne called to order the regular meeting of the Advisory Committee on Developmental Disabilities (DD) at 10:00 am on Wednesday, March 11, 2026. This meeting was a hybrid meeting with in-person attendance at Conference Room P, 5220 South 16th St, Lincoln, NE and virtually via Zoom.

II. Roll call:

The following persons were present:

Advisory Members Present: Dorothy Ackland, Mike Browne, Dianne DeLair, Phil Gray, Jennifer Hansen, Shane Hunter, Kristen Larsen, Cris Petersen, Lorie Regier, Paige Rivard, Mark Shriver, Joe Valenti, Angela Willey, Jennifer Miller
Advisory Members Absent: Suzanne Wahlgren
DHHS Staff: Tony Green, Jenn Clark, Kristen Smith, Tyla Watson

III. Approval of Agenda:

- Motion made by Chris Petersen 2nd by Dianne DeLair to approve agenda as presented. Roll call vote taken. Motion carried.
  - All in Favor: Dorothy Ackland, Mike Browne, Dianne DeLair, Jennifer Hansen, Shane Hunter, Kristen Larsen, Jennifer Miller, Cris Petersen, Lorie Regier, Paige Rivard, Mark Shriver, Joe Valenti, Angela Willey
  - All Opposed: None

IV. Approval of January Meeting Minutes:

- Motion made by Joe Valenti 2nd by Cris Petersen to approve the January minutes as presented. Roll call vote taken. Motion carried.
  - All in Favor: Dorothy Ackland, Mike Browne, Dianne DeLair, Jennifer Hansen, Shane Hunter, Kristen Larsen, Jennifer Miller, Cris Petersen, Lorie Regier, Paige Rivard, Mark Shriver, Joe Valenti, Angela Willey
  - All Opposed: None
  - Abstain from voting: None

V. Division of Developmental Disabilities (DD) Updates:

- **interRAI Update – Presented by Kristen Smith, DHHS**
  - Handout: interRAI Update – January 31, 2026
    - 643 initial & 2,342 renewal interRAI' s
  - Handout: interRAI Appeal Data – January 31, 2026
    - 237 Total appeals
      - 130 Active Appeals
      - 107 Closed Appeals
        - 61 Affirmed Appeals
        - 46 Dismissed/Withdrawn

- Question: Out of the 237 appeals - Can we get a reason for appeal? Response: The Division receives the appeal information from our appeal office. The reason for the appeal is the interRAI. Division is not currently tracking details breaking down from there.
- Question: Prior to the interRAI was the number of appeals the same? Response: No, directly prior to the implementation of the interRAI, the number of ICAP appeals was lower. However, when the ICAP was initially implemented the number of appeals was higher.
- Question: Why does the interRAI look at the last three days. Our kids don't always display all of their behaviors in the last three days. Response: The interRAI utilizes a three-day look-back window for specific items as it increases the accuracy of the recall of the interviewee(s). The behavior specific questions responses also include "present, but not in last 3 days" to capture what behaviors are currently occurring. Additionally, there are other items, such as history of violence, that have longer look-back windows to capture intensity or frequency.
- Question: How do we recruit waiver service specialists (WSS)? Response: Through regular DHHS hiring practices. WSS are required to have a Bachelor degree related to Health Services field or equivalent work experience.

➢ **Waiver Update**

- League of Human Dignity A&D Waiver transition of Service Coordination to the State of Nebraska
  - The Division is currently interviewing for the Service Coordination (SC), SC Supervisor, and Administrator positions. We hope that many people will be able to keep the services coordinator they previously had and it will be a smooth transition.
  - Change to go into effect April 1, 2026.
  - Committee Discussion/Feedback:
    - With all of the activities going in the division currently could we have waited? Response: We continue to review all our contracts and spending, as part of that review it was determined there would be tax dollar savings to transition Service Coordination to the State of Nebraska. There is no easy time to make a change. This is a budgetary change.

- A&D waiver amendment, Second 30-day public comment period closed March 9, 2026
  - Committee Discussion:
    - Concerns regarding budget neutrality. To calculate budget neutrality, the State uses the average of all nursing home individuals. Would like the division to consider comparing people with similar needs (apples to apples) not the full average. Response: There are different ways to meet budget neutrality. There are things that could be explored with CMS. The high-cost people are currently included in the average. There are always pros and cons to changing the way we calculate this.

- Question: Can you explain what the exception process will look like and how families would request? Answer: exception processes would be for those above the 150%. The request will be simple. The Service Coordinator will fill out a simple form. The clinical team will review with their nurses. We have quite a few people that have people come into their homes and wrap services around them.
- Concern is for those that really need more.
- Those that live at home with a caregiver can't go over the 150% they are working for free. This is the concern at a national level.

(NOTE: Break for public comment – see section VI)

- **Policy Manual Changes Update**
  - Handout: HCBS Provider Policy Manual Updates Presentation
  - Handout: 5.2 Funding Tiers – Update for Policy Manual
    - Question: Some of the comments we heard are about the algorithm. Does DHHS know the algorithm? Response: No, the Case Mix Index (CMI) algorithm is proprietary information owned by interRAI not the Department. The Departments algorithm (grouping of scores) for using the CMI to calculate budget tiers, is published on the public website.

VI. Public Comments received at 11:00 AM (Following waiver update)

- Public Comments attached – Attachment A
  - Public Comments received from:
    - Stacy Pfeifer, ARC of Nebraska
    - Carol Salber, Guardian
    - Tori Sorensen, Parent
    - Curt Safranek, Parent
    - Brook Fine, Parent
    - Mark Rolfsmeyer, Parent/Guardian
    - Cathy Martinez, Autism Family Network, Parent
    - Dominic Gillen, Family
    - Lehn Straub, Father/Power of Attorney
    - Molly Mailander, Family
    - Dilan Sorensen, Self Advocate
    - Shelly Jorges, Mother/Guardian
    - Savannah Baclich, Family
    - Anna Keyzer, Parent
    - Susan Brown, Mother
  - Written public comments received from:
    - Ed James, Independent Provider
    - Mr. & Mr. Stone, Family
    - Trevor Hinze, Family
    - Leila Johnson, Mother
    - Ronald Rehtus & Angela Rehtus, Parents/Legal Guardians/Conservators
    - Matt & Ame Creglow, Parents

- Committee Discussion following public comment:
  - Concerns with the quality of staffing, doing assessments. Some of these assessors are not doing a good job all the time. Example given: Assessor was supposed to be there at 11:00 and doesn't get there until 1:00 PM.
  - Question: Is it possible that a secondary person could do the interRAI and see what the result comes out to or do we have to stick with the first assessor? Answer: The family can bring corrections to the divisions. We will correct prior to the appeal if there is evidence that the answers are incorrect.
  - Comments: How do we educate people? How can we help address the situation? What are the points in the system that do need to be changed? I don't necessarily think it's the algorithm. In every situation you will have people with adverse outcomes. There are times that people are not happy. Where are the right points to make good quality outcomes. I could be wrong, but I don't think it's the interRAI. It's better than ICAP.
  - Question: Can the division re-band the interRAI results? Answer: Yes, the division can re-band them. States build those to define policy, set budgets. We took the case mix index (Which we have no control over – this is interRAI' s case mix index) and band the results to the budget tiers. This is also how the ICAP scores were done via banding of scores.
  - Feel the appeal process should be done independently outside of DHHS.
  - Concerning the funding. Developmental Disabilities continue to go up. Feels as though A&D is seeing a reduction.
  - It's not normal parental care. These people are working 24/7. I don't know how we do this. I know that number can increase.
  - Division Comment: Many states are grappling with this, paid caregivers, and what it looks like. Some states would look at Nebraska and say we are very generous. Every state does it differently.

VII. Quality Management/Liberty Update:

- Handout: Quality Team Strategic Plan 2026 – Paul Edwards, DHHS and Betty Smith, Liberty
- Four initiatives focus on the quality improvement strategy
  - National Core Indicators – working to increase participant satisfaction with services. Expand participant choice and control in daily life.
    - National Core indicator Dashboard – team managers interactive dashboard to increase accessibility of survey results. https://dhhs.ne.gov/Pages/Public-Data-Dashboards.aspx
    - Will be sending out notice to those selected to participate in the Aging and Disabled adult consumer survey this month.
    - Latest State of the Workforce 2024 Survey report has been released.
  - Critical incident management process – Reduce emergency and safety incident & Strengthen provider readiness
    - Question: How are we confirming general event reports (GER's) are correct. Just because one is marked as a medium doesn't mean it shouldn't be a high? Answer: Quality unit reviews 100% high-level GER's and does spot

check 10% Medium-level GER's. Do work with providers on report, review T-logs, and we are continuing to look at processes

- Human and Legal Rights – Reduce unnecessary human and legal rights restrictions.
- Mortality Review – screening for potential quality concerns.
  - Mortality review conducted on 100% mortality for HCBS Waivers and Beatrice State Developmental Center (BSDC)
  - Includes Mortality Review Committee - to address individual and systemic issues and analyze trends to generate recommendations to DDD for improving the quality of services
    - *Follow-up:* Committee request to have a member of the Advisory Committee (Shane Hunter) on the Mortality Review Committee if possible.

VIII. New Business:

- Olmstead Plan Goal – Lorie was asked by the Olmstead committee to bring this goal to the attention of the Advisory Committee
  - Strengthening Pathways to Access: Nebraska's Olmstead Plan found on the Olmstead Plan webpage: https://dhhs.ne.gov/Pages/Olmstead.aspx
    - **Goal 2: Enhance Data Collection and Utilization to Address Unmet Needs**: By June 2031, Nebraska will implement a comprehensive data collection system to identify the average wait time for all home and community-based services from the point of application and from the point of authorization until services begin and the percentage of authorized hours provided. Reporting will include the identification of appropriate data by 2026, and publishing an annual report on service utilization trends starting in 2027 indexed to existing participant experience assessments to assess overall system services quality.
    - The dates set in the goal are tied to the dates that are being required as part of the Centers for Medicare and Medicaid Services (CMS) Access Final Rule.

IX. Adjournment: Committee meeting ended at 2:00 PM

Next Meeting:
May 13, 2026
In-Person Meeting

Susan Samuelson, Parent, Nebraska Rare, Hunters Hope Heroes for Duchenne
Mother, Son with Complex needs. Works with Paige. Just made aware of the proposed changes December 5, 2025. I have organized a press conference to bring awareness of these changes. Feel this is inexcusable. Reducing the hours to 40 hours a week from 120, for some families this is how they survive. The families, whether they can speak or not, have a right to choose who provides services to their family. Changing these hours by such an extreme amount of time. They have got to be able to support their lives in a home-based setting. I am really, really concerned how this is taking away the rights on the individuals. There are not a lot of facilities that will take these people.

I speak on behalf of the Duchen community. If there was a place for them to go, the amount of time and care. There is no way the facilities can support that. We are setting us up for disaster. You are pushing people to the edge with these proposals. The state has now said you can have up to 30 hour of the care with a facility coming in. Some families do not feel comfortable having people come into their homes that are not family. This is setting us up for disaster. Cutting services in the waiver is not the correct place to cut services.

Heidi Sommer, Parent
Son recently stopped walking. He has a rare disease, he is regressing. He has been on hospice for 2 years. They are choosing quality of life. His dad is his person and he is her person. Scared to die, because I care for my son 24 hours a day. I feel guilty that I have a job, that I want to spend time with my husband and daughter. Should be able to support our children and still live our lives. Son got on the waiver in 2018. So he has not cost the state a lot of money. People seem to think that families are living large. Have lived below are means.

I did the homework. There are currently no nursing homes that will take her son. The proposed changes will not work. I don't want my son to go there. This is to make the point that they would not take him. Going to the nursing home is not what our family wants.

I think you do some incredible work. Ending the waitlist is great, but not the at the expense of others. You have kids on a waitlist that have school. Our one love in the state is Munroe Meyer. He goes to programs there.

Before our caregiver got there, because they're not capable. A lot of Balance, I end up just doing things myself. So, why not pay per individual? Agency get $30 an hour, the average pay for parents is $15.00.

May 15th, I need to know what the plan is. I need to know which nursing homes will support my child. I don't think they exist. Cost those on the higher budgets than my son. It's just flat-out dangerous, from a safety perspective. It makes me very sad, I can't think about it. There are 168 hours a week. Why not just give them a flat rate. Feels like forced institutionalized.

Your whole department is overworked. This is no blame on the parents. We need to work together with out parents and agencies and try to tell you what my day looks like. I can't go to the bathroom because they would fall if I left their side. So I have think, do I eat or drink? Probably just not today. That is terrible.

Thank you for your time. On the outside he looks completely fine. He is a sweet pleasure.

Lisa Hobza, Parent
So I'm just gonna speak off the cuff. I have a 22-year-old daughter, with complex medical needs…So, my daughter was never supposed to survive her birth. She was diagnosed in utero. I was encouraged to terminate my pregnancy. Just because of life choices, that's not a choice for me. She's 22 years old.

They type of person, a person like my daughter didn't exist 20 years ago. My daughter would have never lived. She's trained, she's has a G-button, has a shot. She had lots of extra months. I think these changes to the program are not looking at the person. My Daughter is kind of unique. She qualified for Medicaid since birth. Since she left the hospital, received private duty though managed care, and so she turned 19 years old. She qualified for social security. I was told by Human Services that I needed to apply for to supplement her nursing care needs. In the first 19 years of life, that didn't allow us to use any extra services, it only provided for more prescriptions for nursing care.

The family is taking care of the shortage. Having people come into the home can cause stress. Not taking care of the individual who has been in constant stress.

My husband and I will continue to work. Still have 3 additional children. Not people have said really nasty comments, like, I should have never had one. You know that's very different. That all my focus should have been on Noel and her cares, but managed them all until she turned 18. This change was made on the AD waiver.

Now I'm fighting to read the waivers and manage her care. Due to her complex medical needs, she does quality for personal care. Due to the medical risks, the assessments that she needs, because she has seizures, she can not clear her own. People have to be trained, she needs to be sucked and she gets plugged, so they need to change it, she's non-verbal. She can't ask for help.

By capping the hours at 40 hours, which is unacceptable. There is no one else to do it. So I do it to show the need for her care. I have asked for more hours too.

I had my fair hearing with the state, because they have reduced hours to an all-time low. 40 hours, which wouldn't even allow me to work outside the home. Because there's travel time, there's break time. All those kinds of things are forcing me to either reduce my work hours at home and take a lower-wage job because I get paid less to provide care. That's not good for her, that's not good for me. As I continue to lose hours through

the MCO. I want to want, to provide care for my daughter, I don't want to feel like I have to. Altough she is stable, they want to take my nursing hours away.

I'm not a unique situation. She may qualify for some additional hours because she has been stable. They want to take my nursing hours away and stop it with a person from a company. They will provide her personal care, but not her medical care.

By having people that are unqualified to care for her, maybe these outside caregivers that are making $13 an hour to empty the trash, supervise a shower, make meals. I have to set her up. I have to still do everything. My daughter is a true joy, it's just to much for these people, they're not going to come back.

There needs to be some care coordination between the MCOs. What they qualify for, long-term care. During my fair hearing, they were like the state will pay for her to go a nursing home. But like Heidi said, no one will take them. The level of care is weighing down the base. Someone living an active life in a nursing home, she can't. She needs constant care. She can't wait, even if she wanted to. She could stare at the ceiling. There is still the risk that she'll have a seizure and she can't roll. She's been aspirating.

I was fortunate enough to have the Medicaid director come to my house and meet my daughter. See all of her things, and I appreciate it. There isn't a one-size-fits all. I think it's very individualized. Kind of like the DD Waiver, there's different levels of care.

I appreciate the changes to the waiver. I don't think there is a one size fits all. I will tell you that all needs are different. I was willing to give up some of my hours. They want us to cut laundry to 30 minutes. So, when you are talking about doing laundry it was 2 hours. I don't watch the washer and dryer to do laundry. That's unfair to me, to charge 2 hours for laundry, that's not how it is. It's very much how long it takes me to walk downstairs you know. So I accept the reduction in hours. Same thing with cleaning the bathroom. I don't need to get paid. If my daughter had her own bathroom and it was gonna take additional time to clean her bathroom, it would be better for me to accept payment for cleaning that bathroom. But she shares with her sibling. I would have the clean the bathroom anyway.

Checks and Balances. There's people that have used the system. You've been taught to fight for the max, because when you turn around, they're gonna take it away. We are creating a problem that doesn't need to exist. We're trying to….create a life…to exist. I fear that there is a huge gap.

Laura Vajgt, Parent
I have a daughter, she's 21 years old. Me and my husband care for her because we're unable to get nurses into our house that are comfortable working on ventilators. She is bed dependent. She's missing a piece of her brain. And she requires all care. I originally, tried for an entire year, fought to get on the DD waiver. And when they suffer for the intra-RAI, they put her at a lower tier than I assumed she would be. Now I kind of figured out

that that was a scam as well. Doing so, Jenn told me that the AD waiver would be the best place for my daughter and her parents.

Well, Jenn, thank you. Thank you for that. So, a couple thoughts here. Um, I know that you guys have cut a lot of people since July. We've been doing cuts. With this proposal, you haven't given these cuts a good amount of time to see if anything was coming out of those financially that would benefit. I know you like to keep using the, oh, we got 300% increase. It's obvious, okay? We're not all stupid, that's obvious. Did you guys realize this when you opened that door for LRI?

It's you're doing and you're taking it off the backs of us. Okay, I find that really interesting. There is no place to send my daughter, which clearly you know, and Jenn knows, because I messaged her, and I said, "What do we do here?" Because there's a lot of parents like me…If you drop the pay, we cannot provide a safe environment. They will have to go to an institution. And I'm not talking, like, a nursing home for a grandma or grandpa. I'm talking 24-hour ventilators. Okay, and I don't… I think you guys are confused. Do you understand what that means? Did you think about that with your proposal? Did you call around? Because the ambassador said they never have had someone like her. There's nowhere for her to go.

Sorry, this is really frustrating for me.

A lot of parents are going to end up taking their kids to a hospital. And they're going to end up… I don't know how much does insurance charge, you guys are going to end up forking the bill for all this. Do you know how much an ICU would cost for a ventilator to stay till a bed open up? There isn't anything out there. You do not have a plan. Go back to the drawing board, figure it out.

Mr. Green, I think you are an absolute conflict of interest in those intra-RAI results. Shame on you. Jenn, putting us on this side, when you knew, you knew this was coming is insulting to me and all these other families.

I honestly… I don't know how you guys are leaving your house. It's very frustrating for me as a mother. There is no support outside. Mr. Green, why don't you come and suction my child through the night? Jenn, why don't you change her poopy pants? Why don't you care for her?

I don't think you guys have a clue what you're doing. Go back to the drawing board. Figure it out again. Use some education when you're thinking about stuff like this. You're creating a community problem in these hospitals.

With not having adequate places to put these individuals. Sorry for the frustration, but that's all I gotta say.

Jennifer Melvin, Parent
I will try to be as brief as I can. Thank you for having open comments today, I know this is frustrating for all of us. I am a parent of a 27-year-old disabled, completely disabled child as well.

I do appreciate you guys taking the time to listen to us parents. I reiterate everything that every other mom has said here with the hours. And the math, is not mathing. I just wanted to make you aware I had a meeting with my daughter's service coordinator this week. We live in the Hastings area. And in past Zooms, Jen had said to… utilize respite and a few other things, day programs. My daughter has had a slew of medical emergencies over the years, and has had brain surgery. She has to take injections every day for blood clots. I have sent in this letter to Mr. Green and other people, so you guys have this in the public comments, my daughter's history.

She has 15 to 30 seizures a day, and to reiterate another Mom's comments. Sorry, I'm trying not to cry right here. We got about 2 hours of sleep last night, and it wasn't all at once, because my daughter does not sleep. Because of 15 to 30 seizures on average a day.

We will go maybe one or two days a month without a seizure. When we have in-home care. All they will do is stand and watch. They cannot put her on their side, they cannot clear her airway, make sure she doesn't aspirate. We were told very early on that Tabitha would need in-home care. And our caseworkers told us to buck up. There was a gap in the system. We did what we could. We were told to…train ourselves to take care of her, because there was nowhere for her to go. Nursing homes will not take anybody under the age of 55. In our area. There is no respite in the Hastings, Kearney, Grand Island area of 100-some people, there is not one respite provider signed up.

We currently… they are currently paying someone to come into my home twice a week, so that way I can either take a nap, get laundry done, whatever. But I'm here in case there's a seizure, because they can't take care of her. They pay them $48 an hour. I started out at $9, and I only got bumped up because the cost-of-living increase with the minimum wage. So, at $15 an hour … if you guys pay somebody $30… 30 hours a week…at the 48, that's $14.40 a week. For 112, it's $16.80. And that pays for my daughter to have two rooms. She's got an exercise playroom, her own bathroom, her own bedroom, handicap accessible house everything that we need.

I'm trying to keep this very short, and I apologize. But my frustration right now, I guess…These changes started in October. And it kept getting pushed back off of the calendar, and you guys knew about this stuff. being proposed, months ago, and waited until Christmas time to tell us for the open comments.

The only good thing that's come out of this is I've met other moms like us. But my daughter has a rare genetic disorder that was not diagnosed until 2008. And there are less than, like, a thousand in the entire world that have this very rare genetic disorder. You guys are putting the lives of the very most vulnerable in jeopardy. And I fear that if

this goes through, there will be death and injury. And, quite frankly, sadness is already here.

This is a very, very real concern for us families. We are now looking at having to move, because we can't afford the house that we modified for our daughter. That she loves. She has blood clot in her leg, can't walk, has wheelchairs, needs oxygen that Medicaid and our insurance won't cover.

So please, please visit some of these families when they ask you to and take a hard look at us parents that are sacrificing everything. Everything to fill the gap that we were told by HHS that we had to fill, because you guys don't have the resources for our children.

Thank you.

Wendy Anderson, Common Coalition & Parent

Hi, my name is Wendy Anderson. Professionally, I represent the Common Coalition, where we're here to protect the rights for individuals with disabilities. I appreciate all of your time. Not a day goes by that I don't receive a phone call of a family member in tears, worried about the care for their loved ones, worried about having to lose their job to care for them, or what are they going to do about their house with life problems when they can't afford it anymore?

Professionally, I ask you to consider your daily lives. And then if you don't have an individual with a disability living in your house, to consider all of the stress that's on top of that.

Personally, I have 3 children. My youngest is here with me, learning about the process of this. My older children had disabilities. My son, Dexter, is 16 years old. He was 6 months old, he was diagnosed with a rare genetic disorder tuberous sclerosis.
So he has non-cancerous tumors throughout his body, seizures, epilepsy, autism, intellectual disabilities, we can come up with a list here. Suddenly, in September, he had to have emergency brain surgery.

We live in Iowa. My parents are from Lexington, Nebraska. They're elderly, they're coming down with dementia. I live 4 hours away from my parents. All of my son's care is in Omaha, therapist, his doctor's visits, we have an open enrollment in the Madame School. So we spend at least an hour and a half. Every day, driving him to and from school, and his therapies, and all of that.

We would like to move to Nebraska. I have elderly parents that someday, I might have to look into a care home for them. We can't move to Nebraska. We have a business. We would like to move to Nebraska. We can't move any of… Because we aren't able to get the care and the support that we need in the next person. And I know there's other families like mine that would like to move to Nebraska.

Because of the changes in the blocks and the systems and things that are happening, we aren't able to. And it's really sad, because. I don't know how I'm going to be able to help care for my parents, unless I leave my family here, and we don't have any support here.

In Iowa, it's just us, so we'd like to move closer to my family. My sisters. We just aren't able to because of my son. So, thank you again, um, for all that you're doing, and everyone's perspectives that you're taking into consideration.

Alana Schriver, Parent
Hey, everyone. I'm gonna speak as a parent who's service coordinator has only reached out once in the last 6 months. I'm not on the A&D waiver, it's a different waiver. Based on what all these parents are saying, and how impossible it is to find alternative care, that should be a responsibility of service coordination, and that if service coordination does not have a real viable alternative solution to capping these parent-caregiver hours, we shouldn't do this.

I think everyone has shared how difficult it is to find an actual nursing home placement, even if you want that option. From what I'm hearing, Ambassador is the only place accepting individuals like this right now, and that's $1,000 a day. I don't think the state should be able to cap someone's hours from a health and safety perspective, unless there is actually a real viable alternative with an open bed, willing to take that specific individual and their needs on Medicaid in real time. Otherwise, I don't think it is safe to cap that person's hours.

Secondly, it is incredibly difficult to find a provider to come to your house, because the wages are so low for this challenging work. Our rate methodology for the A&D waiver had a study done a couple of years ago that recommended increasing the rates and then tying those to inflation.

I understand that there is a budget deficit in Nebraska, and rates are stagnant, but…that is not a revenue issue, that is 100% a policy problem. And this administration is choosing policies that value tax cuts for corporations. And the wealthiest Nebraskans on the back of the aging and disabled. I know the other parents here have expressed frustrations that maybe people on the DD waiver are getting more money, or should be getting cut.

This is not a competition between other types of disabilities …aging or disabled persons or other waiver programs. This is a competition between wealthy corporations getting their taxes capped at 3.99%, which costs the state $720 million in revenue per year. They're putting that on the backs of the aging and disabled. It's not a state revenue issue. It's a policy problem. And this shows the values of our administration, and I was surprised. I shouldn't have been surprised, but I was appalled at Governor Pellin's comments in the Nebraska Examiner article. I spoke with that reporter right after Governor Pillen did.

And he told me even some additional things Governor Pillen had said. So, this is Governor Pillen's DD Advisory Committee. He refuses to meet with any of us face-to-face, so if you

can pass the message on to him. He wants to go back to this utopia in his mind of neighbors helping neighbors or not paying grandmas to do a grandma's job.

Back in the day, these individuals, to Lisa's point, didn't survive a lot of times to adulthood. We've had medical advances, so we have more people with disabilities living longer. It's a pro-life stance, to walk the walk and support them through that life.
Also…I don't know any grandma whose grandma role involves changing the diaper of a 45-year-old man. My son's only 13, and his grandparents are in their 80s. They're going to need caregivers soon. Not that we live anywhere near each other, they're on a farm in the middle of nowhere, there are no services. In the area where my parents live, so I can't live next to them. To say we should be relying on local charities, or neighbors, or churches is, I hope, willfully obtuse. I would hope. He's not that ignorant, but if he is, he needs to actually meet with these parents face-to-face, and visit their homes, and see for himself. The results of his decisions.

If you want more reliable care, you need to increase the rates and pay for quality workforce, so that a workforce is available, and you need to have real alternatives that service coordinators can actually give families when their hours are cut.

Thanks.

interRAI Results – January 2026 Report

Approved interRAI Initials		
Total Initials InterRAIs	643	
Waiver Recommendations		
CDD	337	52%
DDAD	74	12%
Manual Review Needed	13	2%
FSW	213	33%
N/A (SC Only)	6	1%
Totals	643	100%
Need for Continuous Residential		
Threshold Met	314	49%
Threshold Not Met	98	15%
Manual Review Needed	9	1%
N/A (for FSW or DDAD Waiver)	222	35%
Totals	643	100%
Funding Recommendations		
FSW	69	11%
Basic	173	27%
Intermediate	170	26%
High	188	29%
Advanced	43	7%
Totals	643	100%

Approved interRAI Renewals		
Total Renewal InteRAIs	2342	
Waiver Recommendations		
No Change	1958	84%
Increased to CDD	158	7%
Decreased to Lower Waiver	200	9%
Manual Review	4	0%
No Previous Waiver	16	1%
Increased to DDAD	6	0%
Totals	2342	100%
Need for Continuous Residential		
Threshold Met	1608	69%
Threshold Not Met	611	26%
Manual Review Needed	8	0%
N/A (for FSW or DDAD Waiver)	115	5%
Totals	2342	100%

Funding Recommendations		
Decreased 3 Tiers	2	0%
Decreased 2 Tiers	52	2%
Decreased 1 Tier	350	15%
No Change	1213	52%
Increased 1 Tier	539	23%
Increased 2 Tiers	70	3%
Increased 3 Tiers	3	0%
FSW to Funding Tier	65	3%
No Previous Funding Level	38	2%
Funding Tier to FSW	10	0%
Totals	2342	100%

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Developmental Disabilities
DD Advisory Committee
interRAI Appeals
July 1, 2025 – January 31, 2026

Total InterRAI Appeals:	**237**
Active Appeals:	130
Closed Appeals:	107

Closed Appeals Outcomes	
Affirmed	61
Dismissed/Withdrawn	46
Reversed	0

HCBS Provider Policy Manual Updates

Presentation to the Developmental Disabilities Advisory Committee

March 11, 2026

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Helping People Live Better Lives.

Chapters without Changes

- Chapter 1—Introduction
- Chapter 2—Eligibility and Entry into Services
- Chapter 4—Service Coordination
- Chapter 6—Self Direction
- Chapter 8—Partnership with Vocational Rehabilitation
- Chapter 9—Central Office Approval

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Overview of Proposed Changes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Helping People Live Better Lives.

Chapter 3—Participant Rights and Rights Restrictions

3.2 Person-Centered Plan Team Review of Restrictions

- Updated language to remove the reference to the semi-annual PCP team rights restriction review.

3.4 Agency Provider Human and Legal Rights Review Committee

- Updated language to remove the reference to the semi-annual PCP team rights restriction review.
- *Agency Provider Human and Legal Rights Review Committees must still meet semi-annually to review new or changed rights restrictions but does not need to review all rights restrictions when previously approved.*

3.8 Emergency Safety Interventions

- Updated language to the annual review of all utilizations of Emergency Safety Interventions (ESI) by the PCP.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Chapter 5—Person-Centered Planning and Implementation

5.2 Funding Tiers

- Updated language to describe the relationship between interRAI assessment and Case Mix Index (CMI).
- Updated to include CMI ranges by Funding Tier.

Nebraska Funding Tier	Child/Youth ChYRI Groups	Adult Group Number	CMI Range
Basic	E	1-4	0.45-0.75
Intermediate	G, F	5-20	0.76-1.23
High	D, H, A	21-29	1.24-1.50
Advanced	B, C	30-33	1.51-2.01
Risk	Clinical Exception	Clinical Exception	Clinical Exception

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Chapter 5—Person-Centered Planning and Implementation

5.5 Person-Centered Plan Team

- Updated language to remove reference to the semi-annual PCP team meetings.

5.7 Annual Person-Centered Plan Meeting

- Updated language to remove reference to semi-annual meetings.
- Added clarifying language specific to revising the Person-Centered Plan as necessary, at least annually, or whenever necessary due to a change in the participant's needs. Service Coordination will maintain monthly contact and quarterly in-person reviews.

5.8 Semi-Annual Person-Centered Plan Meeting

- Removed this section.

5.10 Habilitation Programs

- Updated language to remove reference to semi-annual meetings.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Chapter 7—Provider Requirements

7.2 Agency Provider Requirements

- Updated language:

  When the employee or contractor will provide approved services in their home, all members of the employee or contractor's household age 13 or older must pass the Central Registry of Child Protection Cases and Adult Protective Services check. When the employee or contractor will provide approved services in their home, all members of the employee or contractor's household age 18 or older must pass the same background and registry checks as the employee or contractor.

- Updated language:

  When an SLP has children under the age of 13, another adult, not on the SLP contract, must live full-time in the home and be noted in the Home Study Survey to provide care and supervision to the child in the event of an emergency.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Policy Manual – 2026 Timeline

Draft changes to the manual

DONE

Quarter 1 HCBS Provider Meeting Notice

DONE

February 24

DD Advisory Committee Notice

TODAY

March 11

Planned Publication date

April 1

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Helping People Live Better Lives.

5.2- Funding Tiers

Some services incorporate a tiered rate structure to compensate providers based on the acuity of the participant. The following services have tiered rates: Day Supports, Community Integration, Child Day Habilitation, Continuous Home, Host Home, Shared Living, and Youth Continuous Home. Reimbursement for these services is tiered based on the participant's Case Mix Index (CMI) score, as developed through the interRAI assessment framework.

CMI scores are derived from case-mix groupings generated through interRAI assessments. Case-mix systems classify individuals into groups with similar support needs and expected resource utilization, promoting consistent and equitable allocation of funding. A CMI of 1.0 represents the average cost to serve a participant; values below 1.0 indicate lower-than-average cost, while values above 1.0 indicate higher-than-average cost.

For funding alignment, Nebraska applies CMI ranges to the Basic, Intermediate, High, and Advanced tiers across waivers. The children and youth budget system utilizes Child and Youth Resource Index (ChYRI) groupings, while the adult budget system utilizes Case-Mix Groups for Developmental Disabilities (CMGDD) groupings. Participants of all ages use the same CMI ranges for alignment to funding tiers.

The four funding tiers representing CMI scoring bands from the lowest CMI to highest CMI scores are: Basic Tier, Intermediate Tier, High Tier, and Advanced Tier. The level of support differs between tiers; service options at each tier are available to support participants. The Clinical Support Team may provide a funding tier exception of Risk for individuals with high supervision and support needs based on behavioral or medical complexities.

Nebraska Funding Tier	Child/Youth ChYRI Groups	Adult Group Number	CMI Range
Basic	E	1-4	0.45-0.75
Intermediate	G, F	5-20	0.76-1.23
High	D, H, A	21-29	1.24-1.50
Advanced	B, C	30-33	1.51-2.01
Risk	Clinical Exception	Clinical Exception	Clinical Exception

Advanced Tier individuals typically require 1:1 supervision for safety as required by the PCP. Individuals at the Risk always require 1:1 but may require additional intermittent supervision for safety as required by their PCP.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Developmental Disabilities

Quality Team Strategic Plan 2026

January 2026

Contents

DHHS Mission and Values

DHHS Mission

- Helping people live better lives.

DHHS Values

- **Constant Commitment to Excellence**

  Takes timely action in regard to tasks or information; works to eliminate mistakes; looks for, and embraces, opportunities for organizational improvements; actively seeks to provide prompt, efficient, and courteous service; shows initiative.

- **High Personal Standard of Integrity**

  Avoids any impropriety, bias, or conflict of interest; follows through on commitments; is truthful; shows good judgment in decisions made.

- **Positive and Constructive Attitude and Actions**

  Maintains constructive communication with others; supports co-workers, customers, and clients; expresses appreciation for the efforts and work of others; is constructive and helpful.

- **Openness to New Learning**

  Open to new ideas and trying new ways of doing things; open to the idea that a given view or opinion is often made better by the input of others; open to the challenge of unfamiliar tasks and problems.

- **Dedication to the Success of Others**

  Aids in the growth and success of colleagues; treats all people with respect and dignity; views the success of the whole as a personal success; gives the assumption of good intent to others.

Participant Rights

- DHHS, Division of Developmental Disabilities (DDD) holds participants in the highest regard and ensures the protection of all participants receiving services and supports from DDD and its subcontractors.
- All participants have the same legal, human, and civil rights and freedoms guaranteed to all citizens.

2026 Quality Initiatives

Executive Summary

The 2026 Quality Initiatives reflect DHHS's commitment to improving participant safety, autonomy, and overall service quality through **strategic initiatives** and **measurable outcomes**. This ensures that the DDD Quality Team sets a clear vision for quality improvement and tracks progress through rigorous, data-driven measures.

Four initiatives represent the foundation of this quality improvement strategy: Critical Incident Management Process, Mortality Review, Human and Legal Rights, and National Core Indicators.

Initiative	Expected Outcomes
Critical Incident Management Process	• Strengthen provider readiness and adherence to key action steps. • Reduce emergency and safety incidents. • Improve participant health and well-being.
Mortality Review	• Enhance provider preparation and compliance. • Close quality gaps among decedents. • Increase timely detection of deaths and screening for potential quality concerns.
Human and Legal Rights	• Reduce unnecessary human and legal rights restrictions. • Decrease psychotropic polypharmacy. • Promote dignity and autonomy for participants.
National Core Indicators	• Increase participant satisfaction with services. • Ensure service plan goals reflect each person's vision of a good life. • Expand participant choice and control in daily life.

This Strategic Plan looks at information from 2025 for each of the four initiatives and how that information drives the DDD Quality Team's plans for 2026.

Critical Incident Management Process (CIMP)

The DDD Quality Unit conducts critical incident reviews for all Home and Community Based Services (HCBS) waivers across the state. This includes:

- Developmental disabilities (DD) waivers: Family Support Waiver (FSW), Developmental Disabilities Adult Day (DDAD) Waiver, and Comprehensive Developmental Disabilities (CDD) Waiver.
- Waivers with Nursing Facility (NF) Level of Care: Aged and Disabled (AD) Waiver and Traumatic Brain Injury (TBI) Waiver.

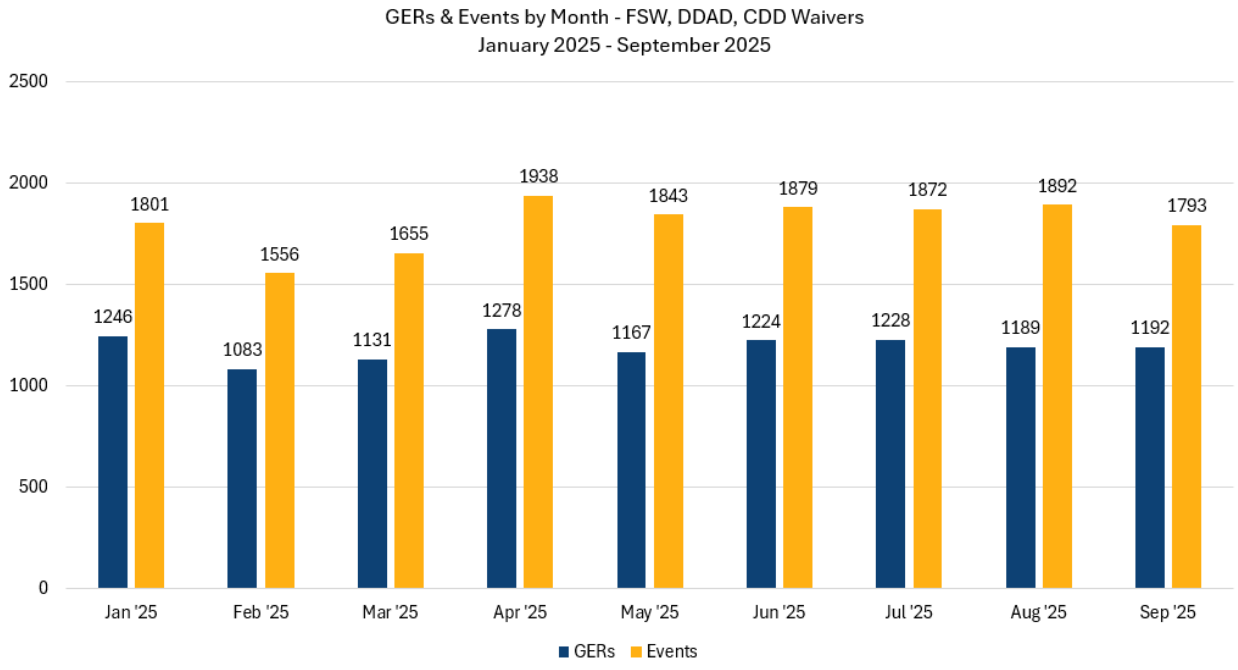
Reviews are conducted by:

- Monitoring the quality of the General Event Reports (GER);
- Reviewing General Event Report Resolutions (GERR); and
- Doing in-depth Root Cause Analyses (RCA) for incidents meeting escalation criteria.

The Quality Unit reviews 100% of High-Level GERs and 10% of Medium-Level GERs for all waivers. One GER may contain multiple critical incidents/reportable events.

Through reviews, Incident Review Specialists determine if an incident meet the criteria to have a Root Cause Analysis (RCA). When an incident does, an RCA is initiated. A collaborative process occurs with the participant's person-centered planning team to identify the root cause and develop a thorough plan to remediate and help prevent or lessen recurrence.

2025 Incidents and Events per Waiver



2026 Plan

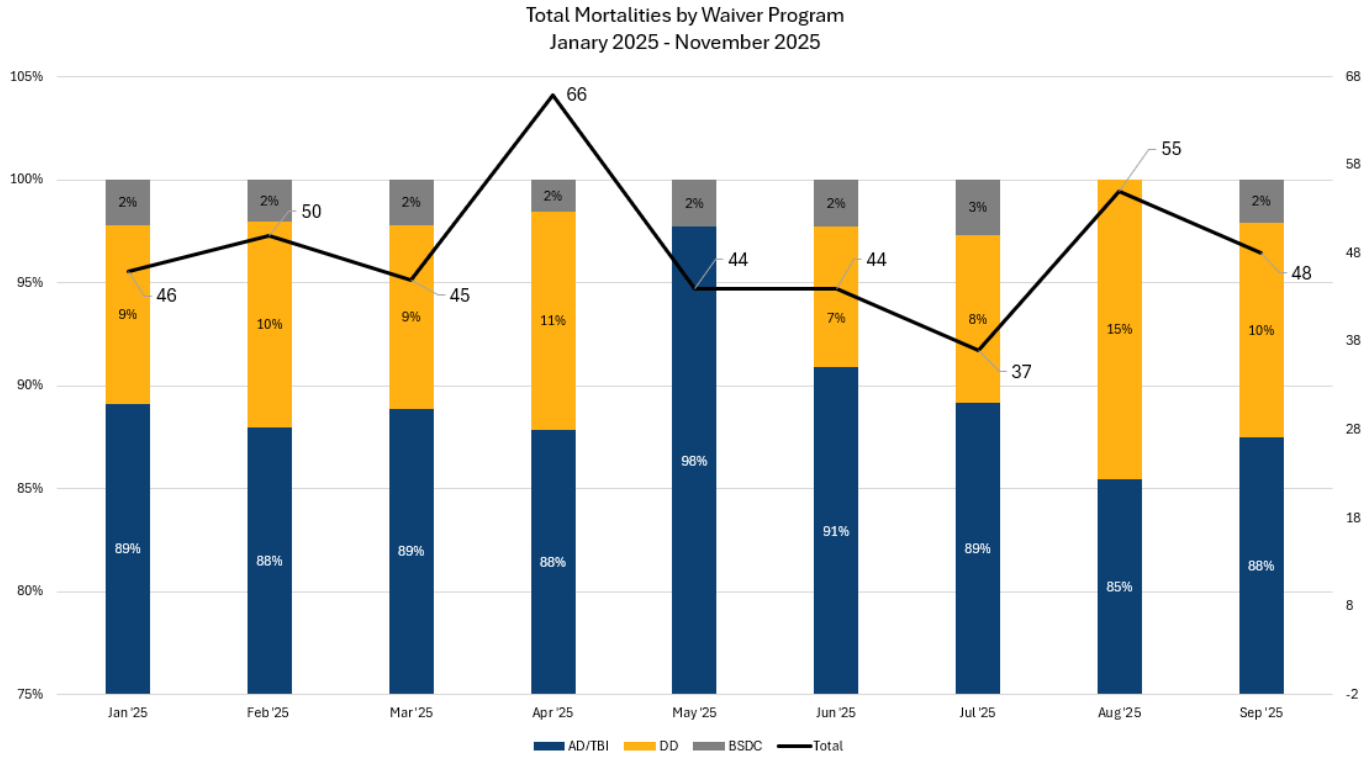
Safeguard participants' health and safety while promoting improved outcomes by the following:

- **Continue** to develop and enhance the Critical Incident Management Process (CIMP) to review General Event Reports (GER) and complete Root Cause Analysis (RCA) to assist the provider in preventing incident recurrence while seeking to maintain the safety of involved participants.
- **Implement** initiatives and establish tracking mechanisms to reduce the frequency of RCAs identifying quality-of-care or service plan concerns across all waivers.
- **Focus on** Comprehensive Mortality Reduction Initiative. *More information about this focus is included in the Conclusion section of this document.*

Mortality Review Process

A mortality review is conducted on 100% of mortalities for Nebraska's HCBS Waivers and at the Beatrice State Developmental Center (BSDC).

The Mortality Review Process includes triage, determining other participants at risk, initial mortality review, and comprehensive mortality review. It can take up to four months for a mortality review to be completed; therefore, information provided in charts for 2025 is through September.



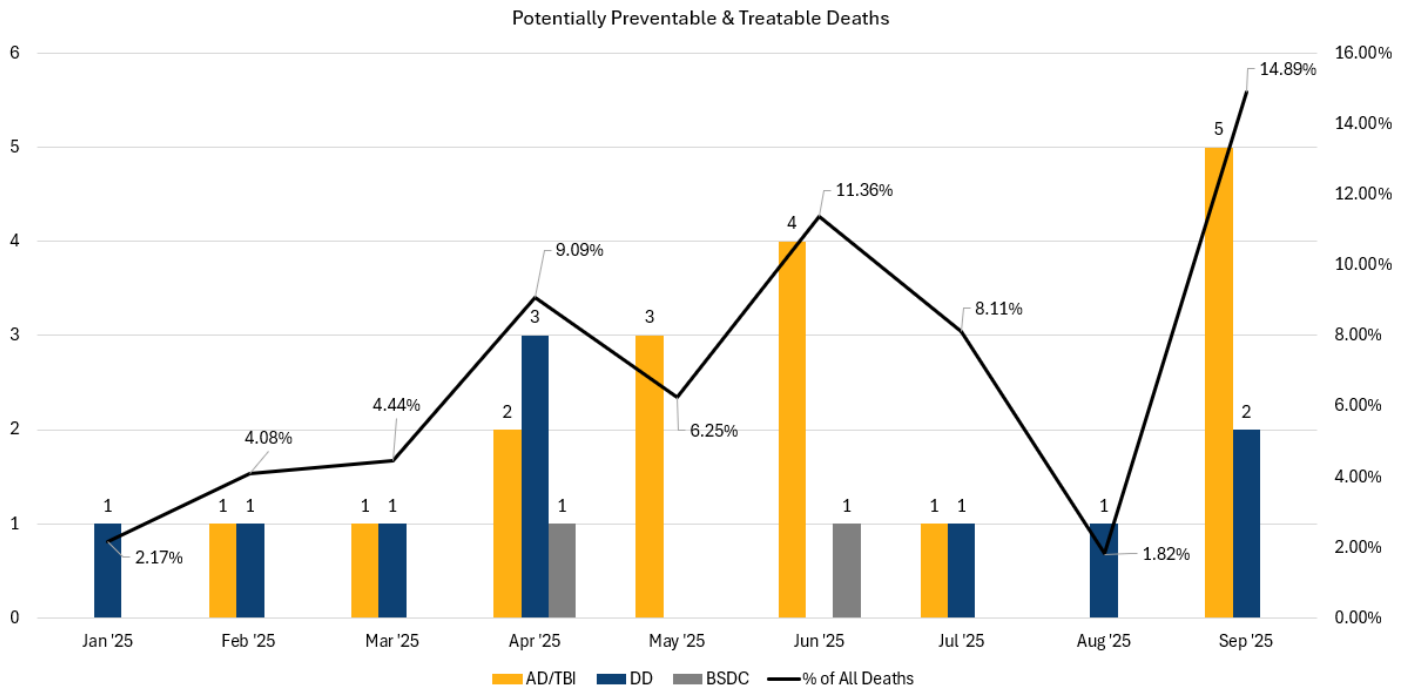
All mortality cases are reviewed to:

- Identify factors that may have influenced the participant's health leading to their death;
- Any information indicating the death was potentially preventable; and
- Determine any concerns related to quality of care, level of service, delays in emergent care, or abuse, neglect, or exploitation (ANE).

Mortality Review Committee (MRC)

The MRC includes DDD Quality Team members and external partners. It meets quarterly. They identify trends in mortality data, make individual or systemic recommendations, and support the implementation of recommendations leading to quality improvement initiatives at systemic and provider levels. MRC recommendations seek to improve the quality of care and prevent avoidable deaths.

In 2025, from January through September, there were 29 deaths identified as potentially treatable or preventable. This is across all HCBS waivers and at BSDC.



2026 Plan

- **Continue** the mortality review process and quarterly meetings of the Mortality Review Committee to address individual and systemic issues and analyze trends to generate recommendations to DDD for improving the quality of services.
- **Implement** initiatives and monitoring systems to track and reduce mortalities associated with quality-of-care issues, delays in emergency response, service level deficiencies, or abuse, neglect, and exploitation across all waivers.
- **Focus on** decreasing mortalities linked to the 'Fatal Five Plus' conditions. The "Fatal Five Plus" refers to six serious, often preventable health conditions that pose the greatest risk of death for individuals with Intellectual and Developmental Disabilities (IDD): **Aspiration, Bowel Obstruction, Dehydration, Seizures, Sepsis, and Gastroesophageal Reflux (GERD).** By prioritizing these high-risk areas, a quality plan can achieve the greatest impact on safety outcomes, minimize human tragedy, and reduce significant financial and operational costs.

Human and Legal Rights Review

Monthly reviews are conducted on a sample of agency provider Human and Legal Rights Committee (HLRC) case note entries, monitoring for compliance with DDD policies around restrictions. Through these reviews, data is collected and identified compliance issues are addressed with agency providers and participant teams as needed.

Human and Legal Rights Advisory Committee (HLRAC)

The HLRAC includes DDD Quality Team members and external partners. It meets quarterly and provides recommendations about how to best support participants to reduce the need for rights restrictions over time. The HLRAC makes individual and systemic recommendations that support less restrictive interventions and improved outcomes for DD Waiver participants.

2025 Key Takeaways

Since March 2024, restrictions and HLRC documentation for 770 participants has been reviewed for compliance.

Celebrations

- 97% of reviewed participant restrictions are being used as DDD policy allows.
- 91% of participant files reviewed did not contain unapproved/unidentified rights restrictions.

Opportunities

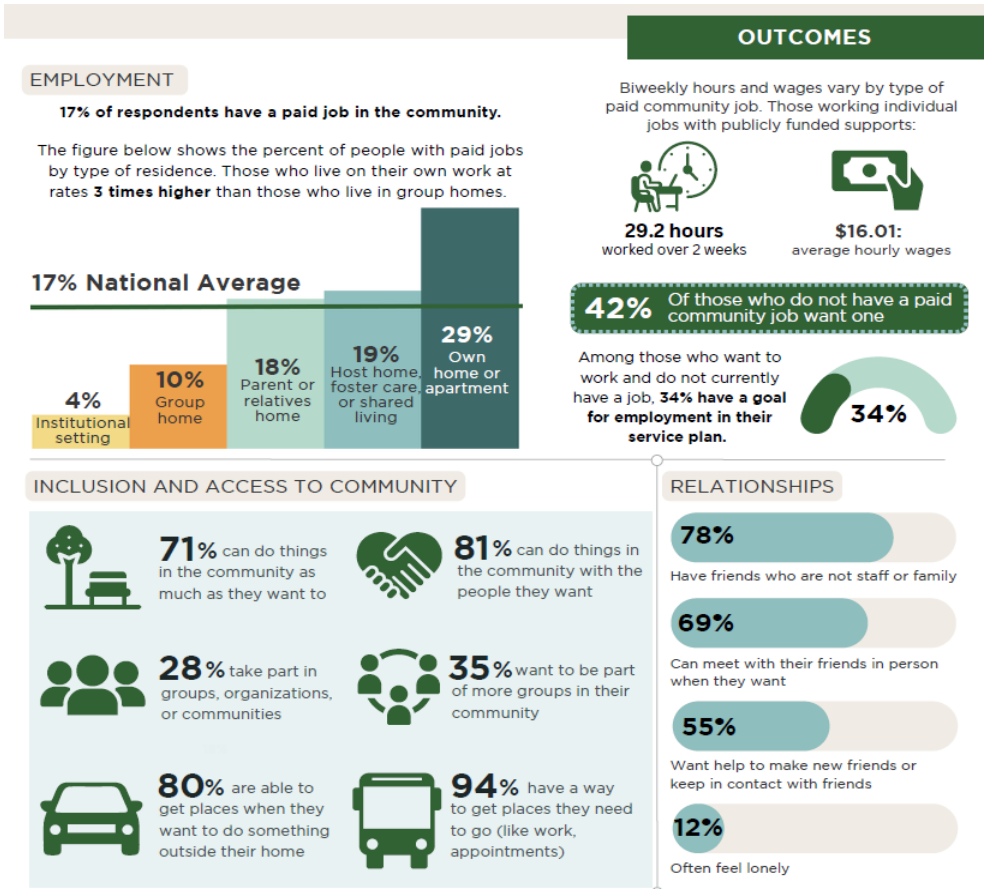
- 23% of HLRC case notes reviewed were not uploaded within the 10 day timeframe set in DDD policy.
- 30% of HLRC case notes and submitted documentation contained some information that was not consistent with the participant's person-centered plan or other records reviewed.

2026 Plan

- **Continue** to operate the HLRAC quarterly to address individual and systemic recommendations to DDD. This group provides consultation regarding human and legal rights and restrictions imposed through approved person-centered plans and ensure people are exercising their full rights.
- **Continue** to refine the processes for key data capture points and provide education regarding rights restrictions and the HLRC processes to internal and external stakeholders.

National Core Indicators (NCI)

The DDD Quality Team leads the administration of NCI surveys for participants using Developmental Disabilities (DD) and Aged and Disabled (AD) waiver services. These surveys provide critical data on participant satisfaction and lived experiences, while identifying opportunities for system improvement. This information is essential for guiding policy decisions and ensuring that services align with the needs and preferences of participants.



NCI Dashboard

The DDD Data Team manages an interactive dashboard to increase accessibility of survey results and promote better use of survey information. By delivering real-time results, visualizing trends, and supporting data-driven decision-making, the dashboard enables stakeholders to monitor performance and identify areas for improvement with greater efficiency. DDD remains committed to advancing person-centered planning, empowering participants to plan their lives, find their voice, and work toward achieving their goals.

2026 Plan

The DDD Quality Team will strengthen data-driven decision-making by:

- **Continue** and expand the use of NCI survey insights and enhance the interactive dashboard for greater accessibility and impact.
- **Implement** strategies to effectively disseminate findings and integrate results into the broader strategic planning process.

2026 Quality Initiatives – Strategy Focuses

In 2026, the DDD Quality Team will implement measurable targets to track progress and ensure accountability. These goals prioritize reducing preventable deaths, improving care standards, and strengthening provider compliance across all waivers. Enhanced visibility of key performance metrics and trends will empower leadership to make informed decisions that address preventable mortality and RCA related quality concerns statewide.

Focus	Expected Outcomes
Comprehensive Mortality Reduction Initiative	• Reduce to <5% the proportion of participant mortalities associated with quality-of-care issues, delays in emergency care, level of service concerns, or ANE. • Reduce to <5% the proportion of participant mortalities linked to Fatal Five Plus conditions. • Reduce to <5% the proportion of participant deaths classified as preventable and unexpected.
Root Cause Analysis (RCA) Compliance and Follow-Up	• Reduce to <5% the proportion of RCAs identifying quality of care or service plan concerns. • Reduce to <4% the proportion of compliant providers receiving an RCA action plan who experience a similar incident within 12 months.

Conclusion

The 2026 Quality Strategic Plan reflects the commitment from DHHS to advancing person-centered practices, safeguarding participant health and rights, and strengthening provider accountability across all HCBS waivers. By aligning **strategic initiatives** with **measurable outcomes**, DDD ensures quality improvement efforts are both visionary and data driven.

Through the initiatives and focuses outlined in this plan, the DDD Quality Team aims to reduce preventable incidents and deaths, promote dignity and autonomy, and elevate the overall quality of services delivered to Nebraskans.

This plan is a living framework that will evolve through continuous monitoring, stakeholder collaboration, and evidence-based practices. Together, these strategies position DDD to achieve its primary goal: ensuring every individual has the opportunity to live a safe, meaningful, and self-directed life.