

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

1. Major Changes

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

Update Public Input (Main-6 Additional Requirements);
 Correct spelling and grammar mistakes (All Appendices);
 Corrected the effective date of the Nebraska State Medicaid Plan (Appendix A-2-a)
 Updated references to the Quality Council and replaced with QI Committee (A-6)
 Updated language for quarterly file reviews (Appendix A-QI-a-ii and b-i);
 Updated the unduplicated participant count to avoid the need for a waitlist and continue to serve all eligible individuals (Appendix B-3).
 Updated the number of individuals served (Appendix B-3-a)
 Updated “assisted living” term to “supported residential living” (Appendix B-5-b-i and d-i);
 Updated the minimum frequency for the provision of waiver services from 60 to 90 days (Appendix B-6-a);
 Updated the process for level of care (Appendix B-6-f);
 Updated the procedures to ensure Timely Reevaluations (Appendix B-6-i);
 Updated language in Maintenance of forms to include service coordination offices (Appendix B-7-b);
 Updated language for quarterly file reviews (Appendix B-QI-a-i and a-ii)
 Added provider types to Chore and Personal Care services (Appendix C-1-a);
 Updated provider standards and provider types for all services (Appendix C-1/C-3);
 Updated the name of the Assisted Living Service to Supported Residential Living (Appendix C-1/C-3);
 Revised Service Specifications for the following services (Appendix C-1/C-3):

- Personal Care
- Respite Care
- Assistive Technology
- Chore
- Companion
- Extra Care for Children with Disabilities

Updated provider types for the following services (Appendix C-1/C-3):

- Personal Care
- Respite Care
- Assistive Technology
- Chore
- Companion
- Extra Care for Children with Disabilities
- Non-medical Transportation
- Personal Emergency Response System (PERS)
- Adult Day Health

Revised and unbundled Service Specifications for Home and Vehicle Modifications, making them two separate services (Appendix C-1/C-3);
 Update language for all services related to school hours set by the local school district (Appendix C-1/C-3);
 Added Other Type of Limit (Appendix C-4);
 Checked boxes for questions (Appendix C-5);
 Updated language to reflect that current service providers are included in the development of the person-centered plan (PCP) and may attend the PCP meeting (Appendix D-1-c and d-i);
 Added information for questions (h) and (i) on the new waiver template. (Appendix D-1-d-i);
 Checked boxes for HCBS Settings Requirements for Service Plans (Appendix D-1-d-ii);
 Updated language to reflect “the number of participants reviewed” (Appendix D-QI-c);
 Updated language for quarterly file reviews (Appendix D-QI-a-i-a, c, d, e and d-ii);
 Updated “assisted living” term to “supported residential living” (Appendix G-1,2, and 3)
 Updated references to the Quality Council and replaced with QI Committee (Appendix G-1-b, d, and e)
 Updated language for quarterly file reviews (G-QI-a-i-a, c, d, and ii, and b)
 Removed references to the Quality Council and replaced with QI Committee (Appendix H-1-a-i, b-i, and ii)
 Updated services that require the use of EVV (Appendix I-1);
 Updated how payments are made, removing NFOCUS and changing to the state-mandated web-based case management system. (Appendix I-1,2, and 3)
 Updated language for quarterly file reviews (I-QI-a-i-a, b, and ii)
 Updated cost analysis information (Appendix J-2)

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 section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Aged and Adults and Children with Disabilities

C. Type of Request: **renewal**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

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

Draft ID: **NE.018.08.00**

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

Regular Waiver

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

07/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155

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

N/A

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

Waiver(s) authorized under section 1915(b) of the Act.

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

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

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility 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 Aged and Adults and Children with Disabilities (A&D Waiver) was established to provide adults and children with physical disabilities and aged adults with community options for services and supports related to their care needs.

Organizational Structure and Service Delivery Methods:

The Nebraska Department of Health and Human Services (DHHS), Division of Developmental Disabilities (DDD), operates the Home and Community-Based Services A&D Waiver. DDD completes eligibility screening and nursing facility level of care determinations for potential waiver participants.

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

DHHS contracts for the provision of service coordination with 1) Area Agencies on Aging for the aged population; 2) Independent Living Centers for adults with disabilities; and 3) Early Development Network agencies for infants and toddlers. State requirements are developed for every waiver service. Resource development staff review individual and agency provider requirements to confirm the providers meet waiver requirements on an annual basis, and with some enrollment functions completed by the Provider Enrollment Broker. This creates additional options for service delivery in the rural and frontier areas of Nebraska. Resource development staff and service coordination staff monitor service delivery.

Goals and Objectives:

The A&D Waiver is based on a person or family-centered, participant-directed philosophy with an emphasis on the use of informal and natural supports in the community. The goal of this waiver is to rebalance the long-term care system Medicaid costs in the State of Nebraska by offering a community alternative to institutional services for persons who meet the nursing facility level of care. This will allow participants to remain at home and prevent institutionalization.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the

participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 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 section 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide 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 statewide 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 section 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 inpatients 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 section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

The public input process for this waiver amendment is done in accordance with 42 CFR 441.304(f). The following strategies are used to secure public input for the 0187 renewal:

Specific to Tribal Notice, the public comment period allows at least 30 days for comment before the anticipated submission date and per the Nebraska State Plan, includes written 30-day notification to all federally-recognized Tribal Governments which maintain a primary office or majority population within the State in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs, and Urban Indian Organizations. Per the Nebraska State Plan, Tribal Governments have 30 days to respond or comment to a proposed state plan amendment, waiver, or demonstration from the date the required notice is submitted. The Tribal Notice for the 0187 renewal was distributed on December 5, 2025, with responses being requested through January 5, 2026. The Tribal Notices are available through the DHHS Division of Medicaid and Long-Term Care (DHHS-MLTC) and DHHS-DDD. A second notice of changes was distributed on February 2, 2026, with responses requested through March 4, 2026.

To reach all stakeholders, the public notice is both electronic and non-electronic to ensure people without computer access have the opportunity to provide input. A public notice seeking public comment indicates the waiver application in its entirety is posted on the DHHS public website and is also available upon request in hard copy via mail, email, or by phone. The public can go to or call a local DHHS office or the DHHS-DDD Central Office to request a hard copy. Public comments can be provided via the internet, e-mail, fax, U.S. mail, or phone calls. Phone numbers, FAX numbers, e-mail addresses, and staff names are provided on the DHHS public website and in the written notice.

DHHS-DDD conducted presentations via webinar on December 10, 11, 16, & 17, 2025. During the public comment period from December 5, 2025, to January 5, 2026, DHHS solicited input through virtual and telephonic opportunities with tribal representatives; waiver participants; families; guardians; advocates; providers; the DHHS public website; and non-electronic public notice in the Omaha World-Herald, a newspaper with statewide circulation.

The state provided statements of public notice and public input procedures. DHHS's public website contained public notice, the full waiver application, a PowerPoint summary of proposed changes to the waiver, a link to e-mail questions or comments, and contact and address to mail comments.

A summary of the 515 comments and questions from 309 individuals received during the initial public comment is listed below:

- The Division received 372 comments related to the change in service limits for personal care services on the AD Waiver. Based on these comments, the Division made substantive changes necessitating an additional public comment period.
- The Division received 111 concerns related to the change in the cost limit on the AD Waiver. Based on these comments, the Division made substantive changes necessitating an additional public comment period.
- The Division received ten comments expressing concern about the proposed changes to provider requirements for CPR and first aid certification and finger-print background checks in the AD Waiver. Based on these comments, the Division made substantive changes necessitating an additional public comment period.
- The Division received 12 concerns related to safeguards for participants on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received four comments expressing concerns related to legal guardians and Legally Responsible Individuals (LRIs) on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received four comments raising concerns related to participant rights on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received six comments expressing concerns related to differences in service types and service definitions across programs and populations on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.

DHHS-DDD conducted an additional presentation via webinar on February 5, 2026. During the second public comment period from February 2, 2026, to March 4, 2026, DHHS solicited input through virtual and telephonic opportunities with tribal representatives; waiver participants; families; guardians; advocates; providers; the DHHS public website; and non-electronic public notice in the Omaha World-Herald, a newspaper with statewide circulation.

Additional information is provided in Main B- Additional Needed Information (Optional) for this section.

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

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

7. Contact Person(s)

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

Last Name:

Green

First Name:

Tony

Title:

Director, Division of Developmental Disabilities

Agency:

Nebraska Department of Health and Human Services

Address:

P.O. Box 98947

Address 2:

301 Centennial Mall South

City:

Lincoln

State:

Nebraska

Zip:

68509-8947

Phone:

(402) 471-6038

Ext:

TTY

Fax:

(402) 471-8792

E-mail:

Tony.Green@nebraska.gov

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

Last Name:

Large

First Name:

Colin

Title:

Policy Administrator

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

Phone:

(402) 853-1452

Ext:

TTY

Fax:

(402) 471-8792

E-mail:

Colin.Large@nebraska.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

Gonshorowski

First Name:

Drew

Title:

Director, Division of Medicaid and Long-Term Care

Agency:

Department of Health and Human Services

Address:

301 Centennial Mall S

Address 2:

City:

Lincoln

State:

Nebraska

Zip:

68509

Phone:

(402) 471-4535

Ext:

TTY

Fax:

(402) 471-2351

E-mail:

Attachments

Drew.Gonshorowski@nebraska.gov

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional information continuing from Main 6. Requirements:

The state provided statements of public notice and public input procedures. DHHS's public website contained public notice, the full waiver application, a PowerPoint summary of proposed changes to the waiver, a link to e-mail questions or comments, and contact and address to mail comments.

A summary of the 293 comments and questions during the second public comment is listed below:

- The Division received 244 comments related to the change in service limits (C-4) for personal care services on the AD Waiver. Based on these comments, the Division added clarifying language that would allow participants using in-home, out-of-home, or a combination of in-home and out-of-home providers to request exceptions.
- The Division received 2 comments related to participant self-direction. The Division clarified that it has not previously completed Appendix E and is not changing its approach to participant self-direction in this waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received 7 comments related to Provider Requirements on the AD Waiver, specifically the requirement for CPR and first aid training. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received 4 comments related to the level of care assessment and methodology on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.
- The Division received 36 comments related to various concerns, including EVV and other services on the AD Waiver. At this time, the Division does not believe additional changes to the proposed waiver language are necessary.

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Developmental Disabilities is the division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The functions performed by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD):

DDD performs oversight for Service Coordination contracted entity functions identified in Appendix A.3. In addition to performing these functions for some of the waiver participants, DDD also 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; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and quality improvement activities. A provider enrollment broker performs enrollment of qualified providers and executes Medicaid provider agreements under the oversight of the Division of Medicaid and Long-Term Care (MLTC), the Medicaid agency.

The document utilized to outline the roles and responsibilities related to waiver operation is The Nebraska State Medicaid Plan Section A1-A3, approved March 6, 2014, and effective January 1, 2015. Designation and authority are outlined in (NE 13-0030-MM4).

The State Medicaid Director is the Director of MLTC. Oversight is a collaborative effort among designated staff within MLTC and DDD. Designated Administrators from MLTC and DDD have regularly scheduled meetings to review discovered or anticipated issues; direct remediation or proactive activities; and strategically plan for collaborative alignment of Nebraska's Medicaid-funded HCBS services.

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

The frequency of the oversight is related to the oversight activity, or collaborative projects and tasks, and ranges from monthly budget activities to annual reporting activities.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
- As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.**

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

- Disseminate information concerning the waiver to potential enrollees
- Assist individuals in waiver enrollment
- Develop Person-Centered Plans
- Review participant service plans to ensure that waiver requirements are met
- Perform prior authorization of waiver services
- Conduct utilization management functions
- Recruit providers
- Execute the Medicaid Provider Agreement, including negotiating rates for applicable services.
 - o Early Development Network does not complete this function.
 - o Area Agencies on Aging and Independent Living Centers complete provider service referrals in the provider enrollment brokerage system for tasks related to completing background checks.
- Conduct training and technical assistance concerning waiver requirements
- Perform supervisory oversight and training of Service Coordination and Resource Development staff
- Monitor claims that are not subject to Electronic Visit Verification (EVV).
 - o Claims subject to EVV can be monitored post-payment in the DHHS system.
- Monitor service provision
- Conduct ongoing case management
- Assess and re-assess participant needs, strengths, and priorities
- Complete quality assurance reviews
- Investigate, resolve, and report incidents and complaints

The Provider Enrollment Broker executes the Medicaid Provider Agreement, including all tasks related to completing background checks for all providers.

Early Development Network (EDN) agencies do not execute the Medicaid Provider Agreement, as this function is completed by staff who are employees of the Department of Health and Human Services (DHHS). DHHS staff conduct this function for Medicaid waiver providers who serve participants who receive service coordination through EDN.

Assigned EDN agencies monitor and approve claims that are not subject to EVV. In some locations, DHHS staff conduct this activity to ensure appropriate claims payment occurs.

A Quality Improvement Organization (QIO)-like entity is the contracted entity that performs tasks associated with the mortality reviews, critical incident review and root cause analysis, and HCBS Final Settings Rule Compliance, in partnership with DHHS.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local

or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

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

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The following methods are used to assess the performance of the contracted entities:

- 1) Continuous and ongoing review of Service Coordination billings and follow-up as needed.
- 2) Continuous and ongoing review of complaints and incident reports. Annual data aggregation and analysis.
- 3) Continuous death reviews of waiver participants to identify risks, trends, and needed actions.
- 4) Conduct participant/family experience surveys or applicable surveys for satisfaction and outcome needs at the discretion of the department. Current surveying is completed with the National Core Indicators – Aging and Disabilities (NCI-AD) survey. Currently, the State is operating under administrative expenditure restraints and implementation is dependent upon budget availability.
- 5) Continuous and ongoing monitoring of service expenditures and utilization.
- 6) Continuous and ongoing monitoring of participant enrollment in the waiver.
- 7) Continuous and ongoing Service Coordination office supervisory and DDD quality staff review of participant and provider files, remediation, and analysis.
- 8) Continuous and ongoing Service Coordination office supervisory and DDD quality staff review of the level of care, person-centered plan, health and welfare, choice, financial oversight, qualified providers, remediation, and data analysis.
- 9) Annually present program data aggregation and analysis to the DDD QI Committee for review and recommendation.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care waiver eligibility 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:

Number and percent of assigned quality assurance reviews completed quarterly by the contracted agencies. Numerator = number of quarterly quality assurance reviews completed by contracted agencies; Denominator = number of quarterly quality assurance reviews assigned to contracted agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic System Reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of mortality reviews in which DDD determined Mortality Review Committee (MRC) took appropriate action. Numerator: Number of mortality reviews in which DDD determined MRC took appropriate action. Denominator: Total number of mortalities reviewed by the MRC.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Electronic database system

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements. Numerator = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements;

Denominator = Number of setting assessments completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCBS Setting Review Tool

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
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):
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Quarterly file reviews are conducted by service coordination/resource developer supervisors. Additionally, DDD quality staff conduct annual file reviews to verify the work of service coordination/resource developer supervisors. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team’s verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Contracted service coordination/resource development agencies are responsible for remediating all individual problems identified through its discovery processes in an appropriate and timely manner (45 days). Service coordination/resource development discovery processes include: inputting data entry; conducting file reviews; reporting death-related and non-death-related incidents; and reporting provider complaints.

As part of their discovery processes, all service coordination/resource development supervisors are required to conduct electronic file reviews of service coordination/resource development files on an ongoing basis as assigned by DDD staff. These file reviews ensure that all delegated waiver activities are being applied correctly. The review responses are documented in an electronic system. File review questions that do not meet standards require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from the date of file review and be recorded in the remediation section of the electronic file review. DDD monitors statewide file reviews to ensure file reviews and remediation activities are completed as assigned.

DDD staff are also responsible for overseeing the remediation of all individual problems identified during discovery processes to ensure they are appropriately remediated. This is accomplished by individual follow-up/remediation, shared resolution, or quality improvement plans.

Individual follow-up/remediation is an informal plan created jointly between the service coordination/resource development supervisor and DDD staff detailing corrections that must be made. Service coordination/resource development supervisors are responsible for reporting remediation activities for file review findings in the electronic file review. Assigned DDD staff are responsible for oversight of remediation activities.

Shared Resolution is a formally defined process, based on proactive partnership, to work with service delivery staff and agencies to resolve and improve instances which (1) reflect performance below expectations that cannot be remediated through technical assistance; (2) indicate a pattern of policy or procedure non-compliance which does not include a participant safety concern; or (3) are identified through formal discovery and determined not egregious as defined in the Quality Improvement Plan process. The Shared Resolution is a plan jointly created with service coordination/resource

development supervisors and documented by DDD staff. The plan details how resolution and results will be monitored and measured. DDD staff are responsible for verifying corrections have been made.

The Quality Improvement Plan is a formally defined process, based on a performance oversight model, to resolve and improve performance when a discovery method has identified an apparent contract violation or immediate risk to participant health and safety. This remediation is appropriate for these egregious issues as well as when other remediation has been unsuccessful or determined ineffective. The Quality Improvement Plan is a formal plan written by service coordination/resource development agency staff using the DHHS Quality Improvement Plan template detailing specific, measurable steps, persons responsible, and start and end dates. The Quality Improvement Plan also details supportive documentation on final follow-up. DDD staff approve this plan before it is implemented and monitor the progress of the plan through completion.

Service coordination/resource development agencies that do not successfully complete their Quality Improvement Plan process or fail to provide delegated functions, may be referred to the DHHS Contracts Administrators Unit for contract review and possible payment reimbursement.

In addition to individual remediation, practices are in place to assist service coordination/resource development agencies in evaluating whether problems are systemic to their agency. Service coordination/resource development supervisors use the electronic case management system to run reports of file review and other data to evaluate the performance of their agency. Service coordination/resource development supervisors may also use the electronic case management system to perform additional agency-specific file reviews. The electronic case management system enables the service coordination/resource development agency to perform either the entire file review or a partial review of identified or suspected problem areas.

Performance measure-related data reports developed by the DDD QI Committee will be shared with service coordination/resource development agencies at least quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency-specific issue.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	0	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

N/A

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

This waiver does not have a maximum age limitation, but the subgroup of "aged" begins at age 65. The maximum age of 64 years for the physical disabled subgroup is to accommodate how the age groups are categorized in the electronic case management system. When an individual reaches age 65, the individual continues on this waiver under the "aged" subgroup. Adults served on this waiver have a choice of their local service coordination agency and transition planning does not occur based on the maximum age limitations outlined in Appendix B-1.

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

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	12000
Year 2	12000
Year 3	13000
Year 4	13000
Year 5	13000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

The waiver provides for the entrance of all eligible people.

Nebraska does not have a waiting list for the Aged and Disabled waiver and is not expected to require a waiting list due to available slots. In the event a waiting list is necessary, applicants shall be prioritized as outlined in Title 480 NAC.

Priority criteria for individuals include the following:

- (A) Needs in domains which define nursing facility level of care are so severe the health and welfare of the participant are jeopardized, but the needs could be safely met with immediate Waiver Services;
- (B) Family or caregivers are in a crisis or high-stress situation;
- (C) No informal support network is available to meet identified needs;
- (D) Inappropriate out-of-home placement is being planned;
- (E) No other program is available to meet the needs identified in the referral;
- (F) Support services are required to allow the individual to return home; or
- (G) A participant with an identified Waiver service need of Assistive Technology and Supports and Home Modifications whose family lacks access to resources to meet these specific needs and waiver eligibility is the only method of addressing the identified needs.

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*):

Section 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)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR § 435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)

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

Specify:

- PCR (435.110)
- MAGI Child (435.118)
- Deemed Newborns (435.117)
- IV-E (435.145)
- M-CHIP (435.229)
- FFC (1902(a)(10)(A)(i)(IX))
- TMA (1925)
- Breast or Cervical Cancer Treatment Group (1902(a)(10)(A)(ii)(XVIII))
- Reasonable Classification (435.222)
- Medicaid Expansion (42 C.F.R. 435.119)

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

Special home and community-based waiver group under 42 CFR § 435.217) Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

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

Recipients who are medically needy with spend-down: The State will use the actual maximum monthly allowable Special Needs Nursing Facility rate to reduce a person's income to an amount at or below the medically needs income limit (MNIL) for people who are medically needy with a Share of Cost.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

Spousal impoverishment rules under section 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 section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027**

(or other date as required by law).

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

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

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 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 section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

- i. Allowance for the personal needs of the waiver participant**

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

- 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 period beginning January 1, 2014 and extending through September 30, 2027 (or

03/31/2026

other date as required by law).

- e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).**

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules of section 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:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g.,

quarterly), specify the frequency:

The minimum frequency for the provision of the waiver service is 90 days. Service Coordinators will make monthly contact with all participants on their caseload to make sure that services are provided as outlined in the person-centered plan. This monitoring will continue when services are provided less than monthly.

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:

Level of care assessors who perform the initial and reevaluation of Nursing Facility Level of Care (NF LOC) for waiver applicants must possess the following educational and professional qualifications:

1. Bachelor’s Degree in a human behavioral sciences field such as human services, social work, psychology, education, sociology, or a related field; OR
2. Four years equivalent experience in services or programs for long-term care, gerontology, rehabilitation, health/disability case management, children with special health care needs, health/medical, education, psychology, social work, sociology, human services, persons with physical, intellectual, or other developmental disabilities or a related field.

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

The Level of Care (LOC) criteria used to evaluate and reevaluate LOC differs for children and adults. The LOC criteria also differ for children based on the child's age.

Children are evaluated based on the following pathways:

- (1) Children age 0-47 Months: To be eligible, the child must have needs related to a minimum of one defined medical condition or treatment as listed in 471 NAC Chapter 43;
 - (2) Children age 48 months through 17 years: NF LOC eligibility can be met in one of three ways:
 - (a) At least one medical condition or treatment need;
 - (b) Limitations in at least six activities of daily living (ADL); or
 - (c) Limitations in at least four activities of daily living (ADL) and the presence of at least two other considerations.
- The age of the child is his or her age on the last day of the month in which the NF LOC determination is made.

Adults age 18 and older are evaluated on the following pathways:

- (1) A limitation in at least three activities of daily living (ADL) and one or more risk factors;
- (2) A limitation in at least three activities of daily living (ADL) and one or more medical conditions and treatments;
- (3) A limitation in at least three activities of daily living (ADL) and one or more areas of cognitive limitation; or
- (4) A limitation in at least one activity of daily living (ADL) and at least one risk factor and at least one area of cognitive limitation.

- 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 Level of Care (LOC) tool used to evaluate and reevaluate LOC differs for children and adults. The LOC tool also differs for children based on the child's age.

- (1) For Children aged 0-47 months: The level of care assessor gathers information using the HCBS Waiver Child's Level of Care tool.
- (2) For Children aged 4-17 years: The level of care assessor gathers information using the interRAI Child and Youth Pediatric Home Care (PEDS-HC).
- (3) For Adults: The level of care assessor gathers information using the interRAI Home Care (HC).

All NF LOC assessment tools used for initial waiver evaluation and reevaluation are comparable to the Functional Criteria for Aged/Adults MLTC-14AD assessment tool completed for institutional NF placement. These tools note Activities of Daily Living (ADLs), Risk Factors, Medical Conditions and Interventions, and Cognitive Function. The participant, their family or guardian, their LOC assessor, and others who are familiar with the participant complete the applicable tool. State regulations that define what constitutes NF LOC do not change regardless of which tool is being used.

While Adults aged 18 and over use a different tool than children aged 4-17, reliability and validity testing completed by previous DHHS-MLTC and DDD personnel using a sampling methodology indicates that the outcome of the determinations yielded from the NF LOC assessment tools was the same as the functional criteria of determination yielded from the assessment completed for institutional NF 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 process for NF LOC evaluation and reevaluation includes a person-to-person assessment and observation with the participant, guardian, or an individual with knowledge of the individual's functioning when needed. The LOC assessor must contact the participant within 14 days of the date of application to schedule the initial LOC assessment. The level of care assessor meets with the participant to evaluate NF LOC. The assessment must be conducted, if possible, at the participant's residence to allow observations of the home situation. The assessment must be held at a date and time convenient to the participant/guardian. Assessments for ages 4 and up are completed by the Eligibility and Enrollment (E&E) Unit.

Adult participants will be assessed by the level of care assessor using the identified NF LOC assessment tool. The NF LOC assessment tool questions are scored by the level of care assessor during the assessment. The participant being assessed shall participate in the assessment. The NF LOC assessment tool includes areas to document information regarding medical conditions and treatments as reported by the participant/guardian and the individual with knowledge of the participant (when applicable). Questions within the NF LOC assessment tool measure the level of independence and support needed for the participant to complete activities of daily living (ADLs), cognitive function, health conditions and treatments, and risk factors. Other areas assessed include formal and informal supports, housing, environment, nutritional status, and medication usage.

Children aged 4-17, will be assessed by the level of care assessor using the identified NF LOC assessment tool. The NF LOC assessment tool questions are scored by the level of care assessor during the assessment. The child may participate if able. The NF LOC assessment tool includes areas to document information regarding medical conditions and treatments as reported by the parent/guardian. Questions within the NF LOC assessment tool measure the level of independence and support needed for the child to complete age-appropriate activities of daily living (ADLs) and risk factors. Other areas assessed include formal and informal supports, housing, equipment and assistive technology usage and needs, nutritional status, and medication usage. The parent/guardian must provide medical documentation to validate medical conditions and treatments reported during the assessment. The level of care assessor will review the medical documentation to validate medical conditions and treatments. Other treatment(s) that may require management through a nursing facility or hospitalizations are evaluated through a clinical review by DDD personnel.

Children aged 0 to 47 months will be assessed by the Service Coordinator (SC) collecting documentation of medical conditions and treatments. A clinical review of the documented medical conditions and treatments is then completed by a DDD personnel to determine NF LOC. The parent/guardian must provide medical documentation to validate medical conditions and treatments reported during the assessment. Other treatment(s) that may require management through a nursing facility or hospitalizations are evaluated through a clinical review by DDD personnel.

The Division will utilize the Electronic Database System to hold NF LOC documentation.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

Regulations outlined in 480 NAC specify the procedures that ensure timely re-evaluations for NF LOC. DDD staff that complete re-evaluations utilize the web-based case management system and the processes within it that are components of case management to ensure timely re-evaluations of waiver eligibility. DDD staff run electronic reports to determine if re-evaluations are conducted timely and review findings at monthly supervision meetings. Reassessment must be completed person-to-person and preferably take place in the participant's home at least every 12 months. The Division's electronic participant tracking system and electronic case management system contain reports on the participant's NF LOC due dates. These reports allow the level of care assessor team and service coordinators to manage and plan for re-evaluation.

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

Written documentation of all evaluations and reevaluations are contained in the participant files within the electronic case management system. The Division will utilize the electronic case management system to hold the Level of Care documentation for when the participant is assessed with either the InterRAI PEDS-HC Assessment or InterRAI HC Assessment. Nebraska requires this documentation to be maintained for at least six years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the 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:

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic System Reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

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

number of participants reviewed for whom LOC is determined.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 925 1262 1003" type="text"/>
Other Specify: <input data-bbox="408 1149 647 1227" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1149 1262 1227" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1373 1262 1451" type="text"/>
	Other Specify: <input data-bbox="719 1597 954 1675" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

and % of initial/annual LOCs reviewed in which LOC criteria were appropriately applied according to the approved waiver. Numerator = # of initial/annual LOCs reviewed in which LOC criteria were appropriately applied according to the approved waiver; Denominator = # of initial/annual LOC determinations reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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 = <input type="text"/> 95% confidence level with +/- 5% margin of error.
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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.

DDD quality staff annually conducts file reviews to verify the work of the Eligibility and Enrollment Unit. The percentage of file reviews will be included in the State's internal on-site review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the services coordination agency and state levels have been developed to discover whether the federal level of care waiver assurances are being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that is aggregated and analyzed to measure the overall system performance. Services coordination agencies are responsible to remediate all level of care related individual problems identified through discovery processes in an appropriate and timely manner (45 days).

The quality strategies for reviewing LOC are:

1. File Reviews

- Level of care file reviews, as assigned by DDD staff, are completed in an electronic system by service coordination supervisors for each agency providing service coordination.
- Remediation must be completed for those file review questions that don't meet standards and must occur within 45 days from date of review.
- If a level of care has not been assessed and determined correctly, the service coordination supervisor refers the issue to DDD staff to be addressed.
- If a participant no longer meets level of care, the waiver case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
- Follow-up action must be recorded in the remediation section of the electronic file review tool.

2. DDD File Reviews and Electronic Reports

- Level of care quality improvement reviews are completed by DDD staff in an electronic system.
- If a level of care assessment has not been adequately determined, the reviewer refers the issue to DDD staff to be addressed.
- If the participant is found to be eligible, they continue to receive services.
- If the participant is found to be ineligible, the waiver case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
- DDD quality staff document corrections in an electronic system. The review documentation must include information that all negative level of care certifications have been resolved correctly.
- If services have been provided for a participant that does not meet level of care, a referral is made to Program Integrity for claims recovery.
- Level of care reports are also conducted to assure service coordination reviews and remediation activities are completed as assigned.

Performance measure-related data reports developed by the DDD QI Committee are shared with services coordination agencies and DDD staff at least quarterly.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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 a choice among waiver services as well as between waiver services and institutional care and this information is provided by the participant's Service Coordinator. Information about Nebraska's DDD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the participant in understanding DDD waiver services, funding for their services, and their roles and responsibilities. The participant or their guardian are offered the option of accepting Nursing Facility or waiver services as described in the Person-Centered Plan.

When the participant or the guardian chooses to accept waiver services, the Service Coordinator obtains the proper signature on the waiver consent form. The consent form must be signed at the initial determination and remains valid as long as the waiver case is open. When guardianship or legal status changes, the Service Coordinator must obtain a new, signed consent (for example, a child whose parent had previously consented becomes an adult or an adult's legal guardianship is transferred to another person).

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

Appendix B: Participant Access and Eligibility

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 by DDD personnel to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on an ongoing basis:

- Oral language assistance services such as interpreters;
- Written materials are available in several languages, such as applications, brochures, due process, and the Notice of Decision;
- Spanish language placards, posters, etc.;
- If there is a need for written publications or materials(s) to be translated, a request can be made by DDD service coordination or others to DDD Central Office.
- Second language hiring qualifications;
- Availability of translators, including sign language;
- Language Line Solutions is available and used statewide; and
- The DHHS website is available in several languages.

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

All contracted Services Coordination Agencies are required to provide interpreters.

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

Appendix C: Participant Services

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

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health Services		
Statutory Service	Personal Care		
Statutory Service	Respite Care		
Other Service	Assistive Technology		
Other Service	Chore		
Other Service	Companion		
Other Service	Extra Care for Children with Disabilities		
Other Service	Home Again		
Other Service	Home Delivered Meals		
Other Service	Home Modifications		
Other Service	Independence Skills Building		
Other Service	LRI Personal Care		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response System (PERS)		

Service Type	Service		
Other Service	Supported Residential Living		
Other Service	Vehicle Modification		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Adult Day Health Services provide structured social and health activities outside of the participant’s home to support health, safety, and community engagement. This service is available to waiver participants aged 18 or older. Providers must work with the participant’s Person-Centered Planning (PCP) team to develop an Adult Day Health Service Plan specific to the participant’s needs.

Service components include:

- Hands-on assistance or cuing with Activities of Daily Living (ADLs);
- Health assessment and health-related activities, including non-complex nursing interventions by trained providers for stable conditions;
- Meal services, if specified in the participant’s Adult Day Health Service Plan (meals provided do not constitute a full nutritional regimen of three meals per day); and

- Recreational therapy, supportive services, and other structured activities.

Adult Day Health Services are provided on an hourly or daily basis as specified in the participant’s PCP. A daily rate is required for six hours or more but less than 24 consecutive hours.

Relatives or legal guardians may serve as employees of a licensed Adult Day Health agency or as the owner of a licensed agency, but in such cases, direct care must primarily be provided by other employees.

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

This service cannot be provided during school hours set by the local school district. This includes all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days also apply to a child who receives homeschooling.

Transportation is not included in this service and must be authorized under the Transportation service.

Physical, occupational, and speech/language therapies are not included in this service.

Adult Day Health may be provided by a relative or legal guardian who is an employee or owner of a licensed agency, but not by a legally responsible individual. When provided by a relative or guardian, direct care must primarily be provided by other agency employees.

A participant cannot be authorized to receive this service at times that overlap with Extra Care for Children with Disabilities, Companion Service, Personal Care, Respite, Independent Skills Building, Transportation Services, Supported Residential Living, or LRI Personal Care.

The Adult Day Health provider must provide sufficient staff to meet the participant’s needs. Other waiver services may not be authorized to send additional staff to the Adult Day Health setting to meet ADL, health, therapeutic, or other participant needs.

This service does not cover natural supports provided by relatives, legal guardians, or fictive kin living in the participant’s home when the support is part of a normal family or household routine, unless the support is clearly above and beyond what is typically expected for a person without a disability.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Service Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed Adult Day Service Agency

Provider Qualifications**License (specify):**

Licensed according to 175 NAC 5: Adult Day Services

Certificate (specify):**Other Standard (specify):**

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Personal Care is a service for participants aged 18 and older, which includes assistance with Activities of Daily Living (ADLs), health-maintenance activities, and supervision provided in a person’s home and other community settings when hands-on care is required for the participant. When this service provision occurs within a provider-owned, operated, or controlled setting, the setting must comply with the Final Settings Rule at 42 CFR 441.301(c)(4)-(5).

Any or all components of this service may be provided when a participant has an assessed need or limitation requiring individualized support and monitoring in the home or a community setting to ensure their safety and prevent incidents that could lead to institutionalization. Tasks include specific ADL activities and health-maintenance activities. Health-maintenance means noncomplex interventions that can safely be performed according to the exact direction of a medical professional or the participant, which do not require alteration of the standard procedure, and for which the results and patient responses are predictable.

This service offers a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance must take the form of hands-on support. Services may be provided episodically or on a continuing basis.

Incidental supervision is only allowable if the participant has an assessed need and cognitive or physical risk requiring individualized support and monitoring in the home or a community setting to ensure their safety and prevent incidents that could lead to institutionalization. Incidental supervision must include meaningful individualized support and monitoring. For

adults, supervision may only be authorized if the interRAI assessment identifies a cognitive or physical risk and individualized support is being provided.

Children aged 16 and 17 may be authorized for this service during transition to adult services when there is a documented need. For these participants, Personal Care is limited to assistance with ADL routines and tasks needed to get ready for the day or for bed, not to exceed three hours per day. This service does not include general supervision or substitute for other aspects of parental responsibility. Personal Care assistance under this service does not overlap with assistance provided under the Extra Care for Children with Disabilities service of this waiver.

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

Providers must bill Companion when no hands-on ADL care is being provided. This may require providers to clock in and out of services throughout the day if a block of service exceeding one hour does not involve hands-on care. Sleep time for participants and providers is not billable.

Services under the HCBS Aged and Adults and Children with Disabilities Waiver are limited to those not otherwise covered under the State Plan, including EPSDT, but must remain consistent with waiver objectives of diverting institutionalization.

Participants are responsible for understanding allowable service delivery in order to oversee and supervise providers on an ongoing basis. Service Coordinators may request documentation of tasks from providers if the state case management system is not used to capture visit verification. The Service Coordinator monitors the participant's person-centered plan, including use or non-use of waiver services, at least monthly. During Person-Centered Planning Team meetings, the scope of service delivery for all services will be reviewed with the participant. Providers are responsible for reviewing documentation of service parameters to ensure appropriate delivery.

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

A participant cannot be authorized to receive this service at times that overlap with Extra Care for Children with Disabilities, Companion Service, Adult Day Health, Respite, Independent Skills Building, Transportation Services, Supported Residential Living, or LRI Personal Care.

If assistance with ADLs is not needed, this service should not be authorized.

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

Personal Care services that can be covered under the State Plan must be furnished to waiver participants under age 21 as services required under EPSDT.

Personal Care services may be provided by a relative or legal guardian, but not by a legally responsible individual.

This service does not cover natural supports provided by relatives, legal guardians, or fictive kin living in the participant's home when the support is part of a normal family or household routine, unless the support is clearly above and beyond what is typically expected for a person without a disability.

This service cannot be provided during school hours set by the local school district. The limitations includes any and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives homeschooling.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Direct Care Provider
Agency	Agency Direct Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Independent Direct Care Provider

Provider Qualifications

License (specify):

No license required.

Certificate (specify):

No certificate required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Providers must:

- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.
- Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
- Have qualifications, experience, and abilities necessary in carrying out chore services comparable to those who will be authorized; and
- Use universal precautions.
- Must have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation, and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Personal Care****Provider Category:**

Agency

Provider Type:

Agency Direct Care Provider

Provider Qualifications**License (specify):**

None required

Certificate (specify):

None required

Other Standard (specify):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV).

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact and annually thereafter. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Respite care is the temporary care of a participant to relieve the usual unpaid caregiver from continuous support and care responsibilities. To be considered a usual unpaid caregiver, must support a majority of the participant's unpaid care needs and must maintain their primary residence at the same address as the participant.

Respite services may be provided to one, two, or three participants with a single provider staff, based on assessed need.

The total cost of group respite shall not exceed the daily respite rate.

Respite may be provided in the participant's home, community settings used by the general public, or one of the following out-of-home settings:

- Private residence of an Independent Respite Provider or by a Licensed Respite Provider,
- Licensed supported residential living as a Licensed Respite Provider,
- Licensed respite facility as a Licensed Respite Provider,
- Licensed or approved childcare home or center as a Licensed Respite Provider.
- At Community Respite Providers, businesses or organizations whose primary operational focus or revenue is not respite or other disability-specific services, including recreational, arts, social, religious, or similar organizations or businesses.
- Day or Overnight camps through a Recreational Respite Camp Provider.
- In the community, when supported by Licensed Respite Providers or Independent Respite Providers.

Providers who are authorized to provide services across more than one waiver may provide respite on a group basis as long as all participants are authorized for a home and community-based respite waiver service.

Federal Financial Participation may not be claimed for room and board when respite is provided in any location that is not a licensed respite facility.

Respite may be provided in institutional settings when approved by DDD Central Office.

This service may be reimbursed at an hourly or daily rate. To bill a daily rate, the provider must be in the same setting as the participant, providing support services and supervision, for a minimum of 8 hours in a 24-hour period 12:00 am to 11:59 pm.

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

This service cannot be provided during school hours set by the local school district. This includes all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days also apply to a child who receives homeschooling.

A Respite provider or provider staff must not provide respite to individuals (18 years and older) and children (13 and younger) at the same time and location, unless approved by DDD Central Office. If Respite is provided to a child and adult at the same time and location there must be documented approval in the person-centered service plan.

Respite care may not be used to allow the usual caregiver to accept or maintain employment, except when the participant is attending a day camp.

Respite may not cover the enrollment fee associated with Respite Camp participation.

Respite care may not be used to allow the usual caregiver to pursue a course of study designed to fit the caregiver for paid employment or professional advancement.

When the need for respite is identified, the amount authorized is based on the assessment of several factors, such as the availability of informal support, potential for abuse/neglect, and caregiver health status.

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

Items or services available through the Medicaid state plan or through another service of this waiver program are not included in this service.

Respite may be provided by a relative or legal guardian, but not a legally responsible individual.

This service does not cover natural supports provided by relatives, legal guardians, or fictive kin living in the participant's home when the support is part of a normal family or household routine, unless the support is clearly above and beyond what is typically expected for a person without a disability.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Respite Provider
Agency	Community Respite Provider
Agency	Licensed Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Individual

Provider Type:

Independent Respite Provider

Provider Qualifications

License (specify):

Not required.

Certificate (specify):

Not required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

Providers must not leave the participant alone while providing respite and must prepare meals or snacks to comply with the participant's dietary needs when provided. Out-of-home providers must ensure their home is accessible and safe.

Providers must:

- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.
- Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;
- Have qualifications, experience, and abilities necessary in carrying out chore services comparable to those who will be authorized; and
- Use universal precautions.
- Must have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.

- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation, and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Community Respite Provider

Provider Qualifications

License (specify):

No License Required.

Certificate (specify):

No Certificate Required.

Other Standard (specify):

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

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

The primary revenue source or operational focus of community respite agencies must not be the provision of respite services. No more than 8 hours of respite per week may be authorized for any single individual.

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV), as required.

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Licensed Respite Provider

Provider Qualifications

License (specify):

Licensed according to 175 NAC Health Care Facilities Services Licensure or 391 NAC Children's Services Licensing.

Certificate (specify):

Not Required

Other Standard (specify):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV), as required.

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
 - Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
 - Be authorized to work in the United States;
 - Be 19 years of age or older;
 - Not be a person legally responsible for the participant; and
 - Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.
- All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Assistive Technology is equipment or a product system, such as devices, controls, or appliances, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants and is necessary to ensure participants' health, welfare, and safety.

The use of assistive technology enables participants who reside in their own homes to increase their abilities to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in their home, or to perceive, control, or communicate with the environment they live in, enable the participant to function with greater independence in their own private home or in the family's home, and decreasing their need for assistance from paid or natural supports.

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.

Assistive Technology includes the equipment or product system, as well as: services consisting of purchasing or leasing assistive technology devices for participants; services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assessments are required to identify the type of assistive technology necessary to meet the participant's assessed need and to aid the waiver participant in utilizing funds outside of the waiver.

Assistive Technology may be self-directed.

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

Assistive Technology is limited to devices, controls, or appliances to assist the participant in the completion of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in their home, or to perceive, control, or communicate with the environment they live in, and must be of direct medical or physical benefit to the participant.

Providers cannot exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals, such as students, must apply the same discount to the participants who would otherwise qualify for the discount.

Assistive Technology has a budget cap of \$10,000 per five-year period. If a participant's needs cannot be met within the established budget cap, the participant may request additional funds through DDD Central Office, up to a maximum of \$20,000.

Damaged, stolen, or lost items not covered by insurance or warranty may only be replaced once every two years.

Items or services available through the Medicaid state plan or through another service of this waiver program are not included in this service.

Assistive Technology cannot be provided for technology available through the local school district. This includes all public education programs funded under the Individuals with Disabilities Education Act (IDEA).

Assistive Technology may be provided by a relative or legal guardian, but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Equipment, Supplies, and Modification Companies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Specialized Equipment, Supplies, and Modification Companies

Provider Qualifications

License *(specify):*

Not required

Certificate *(specify):*

Not required

Other Standard *(specify):*

All providers must comply with all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications. Modifications must be completed in accordance with local and state codes and professional practice standards, and all modifications must be made or overseen by appropriately licensed or certified professionals.

All items and assistive equipment must meet applicable standards for manufacture, design, and installation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker or the Nebraska Department of Education Assistive Technology Partnership

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08060 chore

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Chore services assist in ensuring the health and safety of the participant in their own home. These services are authorized only after verifying that neither the participant nor anyone else in the household is capable of performing or financially providing for the tasks, and that no relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for their provision. Verification of responsibility includes the Service Coordinator reviewing household composition, leases, and other documentation as needed.

If the provider is associated with the home through ownership, sublease, or as a live-in paid caregiver, the tasks are assumed to be covered under the lease and rent collected and may only be authorized through an exception process.

Authorizations will be specific and limited to the individual service components, which include:

Minor Home Repair – repairs to windows, screens, steps or ramps, furnishings, household equipment, and clearing water from drains.

Pest Control – limited to that which is necessary to meet the health and safety of the participant.

Mowing and Site Clearance – limited to that which is necessary to meet the health and safety of the participant and to meet local codes. Mowing cannot exceed 90 minutes per week during the appropriate season. Site Clearance, including clearing nuisance weeds, overgrowth, or debris that pose a risk of local code violation, may be authorized up to twelve (12) hours per year.

Snow and Ice Removal – limited to that which is necessary to ensure safe personal and vehicle egress from the home to the nearest street and the clearing of sidewalks. Service is authorized only when weather conditions require.

Heavy Cleaning– short-term, non-routine cleaning to address participant health and safety, including heavy cleaning and removal of debris to the garbage pickup point. These activities must not duplicate light housekeeping covered under Companion services.

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

Items or services available through the Medicaid State Plan or another waiver service are not included.

Chore services may be provided by a relative or legal guardian, but not a legally responsible individual.

Chore services cannot be provided by any provider or agency staff member who lives in the same private residence as the participant.

This service is not available when the provider is associated with the lease or ownership of the property.

Chore services have a budget cap of \$3,500 per year.

Authorizations for Mowing & Site Clearance and Snow & Ice Removal are limited to a rate of no more than \$100 per hour.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities are limited to additional services not otherwise covered under the State Plan, including EPSDT, but must remain consistent with waiver objectives of avoiding institutionalization.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Non-Care Provider
Agency	Agency Non-Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:

Individual

Provider Type:

Independent Non-Care Provider

Provider Qualifications

License (specify):

No license required.

Certificate (specify):

No license required.

Other Standard (specify):

All providers of waiver services must be a Medicaid provider, and must comply with all applicable professional licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes, as appropriate.

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

No personal care or hands-on assistance may be provided.

Providers must have the qualifications, experience, and abilities necessary to carry out services comparable to those that will be authorized.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Chore

Provider Category:

Agency

Provider Type:

Agency Non-Care Provider

Provider Qualifications

License (specify):

No license required.

Certificate (specify):

No certification required.

Other Standard (specify):

All providers of waiver services must be a Medicaid provider, and must comply with all applicable professional licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes, as appropriate.

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

No personal care or hands-on assistance may be provided.

Providers must employ staff who have the qualifications, experience, and abilities necessary to carry out services

comparable to those that will be authorized.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08040 companion

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Companion is a service for adults aged 18 and older in which social supports are provided in a person’s home and other

community settings. When this service provision occurs within a provider-owned, operated, or controlled setting, the setting must comply with the Final Settings Rule at 42 CFR 441.301(c)(4)-(5).

Allowable tasks are determined through a Service Needs Assessment for routine support. Companion may include support of Instrumental Activities of Daily Living (IADLs), such as light housekeeping, bill paying, errand service, essential shopping, food preparation, laundry service, and other tasks incidental to the care and supervision of the participant.

Supervision is only allowable if the participant has an assessed need and cognitive or physical risk requiring individualized support and monitoring in the home or a community setting to ensure their safety and prevent incidents that could lead to institutionalization. Supervision must include meaningful individualized support and monitoring. For adults, supervision may only be authorized if the interRAI assessment identifies a cognitive or physical risk and individualized support is being provided.

The provision of Companion services does not entail hands-on care. If assistance with ADLs or health-related tasks is required, this service should not be authorized for those tasks or timeframes, and another service should be considered instead.

Companion services may be provided to one, two, or three participants within a single residence, based on assessed need.

Services under the HCBS Aged and Adults and Children with Disabilities Waiver are limited to those not otherwise covered under the State Plan, including EPSDT, but must remain consistent with waiver objectives of diverting institutionalization.

Participants are responsible for understanding allowable service delivery in order to oversee and supervise providers on an ongoing basis. Service Coordinators may request documentation of tasks from providers if the state case management system is not used to capture visit verification. The Service Coordinator monitors the participant's person-centered plan, including use or non-use of waiver services, at least monthly. During Person-Centered Planning Team meetings, the scope of service delivery for all services will be reviewed with the participant. Providers are responsible for reviewing documentation of service parameters to ensure appropriate delivery.

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

If assistance with ADLs or health-related tasks is needed, this service should not be authorized.

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

A participant cannot be authorized to receive this service at times that overlap with Extra Care for Children with Disabilities, Personal Care, Adult Day Health, Respite, Independent Skills Building, Transportation Services, Supported Residential Living, or LRI Personal Care.

This service cannot duplicate provisions of Personal Care, LRI Personal Care, or Chore when authorized in conjunction.

Providers must bill Companion when no hands-on care is being provided. This may require providers to clock in and out of services throughout the day if a block of time exceeding one hour does not involve hands-on care.

Companion is not intended to provide round-the-clock supervision. Participants must be able to live independently or have informal/natural supports to supplement care, particularly for overnight needs.

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

Companion services that can be covered under the State Plan must be furnished to waiver participants under the age of 21 as services required under EPSDT.

This service cannot be provided during school hours set by the local school district. This limitation includes any and all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives homeschooling.

Companion may be provided by a relative or legal guardian, but not by a legally responsible individual.

This service does not cover natural supports provided by relatives, legal guardians, or fictive kin living in the participant's

home when the support is part of a normal family or household routine, unless the support is clearly above and beyond what is typically expected for a person without a disability.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Direct Care Provider
Agency	Agency Direct Care Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Companion

Provider Category:

Individual

Provider Type:

Independent Direct Care Provider

Provider Qualifications

License (*specify*):

No license is required.

Certificate (*specify*):

No certificate is required.

Other Standard (*specify*):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Providers must:

- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.
- Have the knowledge and abilities required to meet the specialized physical, medical, or personal care needs of the participant;

- Have qualifications, experience, and abilities necessary in carrying out chore services comparable to those who will be authorized; and
- Use universal precautions.
- Must have computer skills and access to the technology needed to navigate the state-mandated electronic visit verification system.
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation, and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Companion

Provider Category:

Agency

Provider Type:

Agency Direct Care Provider

Provider Qualifications

License (specify):

None required

Certificate (specify):

None required

Other Standard (specify):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV).

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact and annually thereafter. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627..

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Extra Care for Children with Disabilities

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04080 medical day care for children

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Extra Care for Children with Disabilities is the portion of childcare provided to children related to their medical and disability-related needs. This service is provided to children from birth through age 17 for 12 hours or less per day, but more than two hours per week on a regular basis, in lieu of caregiver supervision.

Care may be provided in the participant's home by an approved in-home childcare provider or in a setting approved or licensed by the Department. The parent or primary caregiver remains responsible for the basic cost of routine childcare. Payment for Extra Care for Children with Disabilities covers the specialized care needs related to the participant's disability and is authorized in accordance with the person-centered plan.

Group rates are available when multiple participants reside and receive care in the same household. In such cases, one caregiver may provide care for up to three waiver participants at the same time. Each participant will have an individual authorization with a reduced group rate applied for overlapping hours.

Extra Care for Children with Disabilities is available only while the usual caregiver(s) are unavailable. In households with multiple caregivers, all must be unavailable at the same time. This service may be authorized for up to 12 hours per day to enable the usual caregiver to:

- Accept or maintain employment (up to 50 hours per week, including commute time);
- Seek employment (up to 12 hours per week, limited to 2 months); or
- Enroll in and attend in-person, regularly scheduled vocational or educational training to attain a high school diploma, equivalent, associate degree, bachelor's degree, or technical certificate from an accredited institution.

Verification of employment schedule, job-seeking activities, or class schedule is required. This service excludes individuals pursuing a second undergraduate degree, graduate degrees or higher, additional certificates or licenses, or coursework to maintain professional certification/licensure. Study time and online classes are not considered in-person attendance and are excluded.

Participants must require care that goes beyond the level of routine supervision provided to children without disabilities or special health conditions in a childcare setting when childcare is provided. Examples of specialized care include, but are not limited to:

- Preparing and administering a tube feeding for nutrition;
- Suctioning a child's airway every hour to remove secretions;
- Providing physical assistance needed to transfer a child in and out of a wheelchair; or
- Changing an ileostomy or colostomy appliance and completing related skin care.

Personal care assistance provided under this service may not overlap with personal care assistance under the Personal Care or LRI Personal Care services of this waiver. A participant cannot be authorized to receive both services simultaneously.

All costs related to the participant's physical, medical, or personal care needs are included in the waiver service rate. Routine childcare costs, which remain the responsibility of parents/guardians, do not cover medically necessary supports for disability-related care. Routine childcare is not a covered waiver service.

Pursuant to the Nebraska Nurse Practice Act, parents/guardians are responsible for training providers in health-maintenance activities. These may include medical treatments, therapies, or medication administration for stable conditions. Agency providers must ensure their caregivers participate in training.

The Department has the authority to establish service rates for Extra Care for Children with Disabilities. Providers must use Electronic Visit Verification (EVV) when this service is delivered in the participant's home.

Routine childcare cost benchmarks are established by the Child Care Subsidy Division rate chart. Extra Care for Children with Disabilities does not include on-call status. This service is designed to provide the necessary health maintenance activities for children ages 0–17 with stable conditions.

The services under the HCBS Aged and Adults and Children with Disabilities Waiver are limited to supports not otherwise covered under the State Plan, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and must remain consistent with waiver objectives of avoiding institutionalization.

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

Extra Care for Children with Disabilities is only available while the usual caregiver is unavailable for reasons of employment, job-seeking, or education. In households with multiple caregivers, all must be unavailable at the same time unless caregiver work schedules do not overlap.

Employment authorization cannot exceed 50 hours per week (including commute time). Job-seeking is limited to 12 hours per week for up to 2 months. Educational activities must be in-person and lead to a first high school diploma, associate degree, bachelor’s degree, or technical certificate. Study time and online coursework are excluded.

The service may not exceed 12 hours per day or be authorized on more than 5 days per week. When caregiver work schedules do not overlap, up to 8 hours per day may be authorized to allow a caregiver to rest or sleep. Expenditures must be cost-effective in comparison to caregiver employment income.

This service cannot be provided during school hours as set by the local school district, including hours covered by public education programs under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days also apply to home-schooled children.

Costs of childcare unrelated to the participant’s disability are excluded. Transportation is not included.

Items or services available through the Medicaid State Plan or through another waiver service are excluded.

Service may be provided by a relative or legal guardian, but not by a legally responsible individual.

Licensed Practical Nurses (LPNs), Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs), and Certified Nursing Assistants (CNAs) are not guaranteed for service delivery, though some agencies may employ them.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Child Care Center
Individual	Licensed Family Child Care Home I or II
Individual	Non-Licensed Child Care Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Extra Care for Children with Disabilities

Provider Category:

Agency

Provider Type:

Licensed Child Care Center

Provider Qualifications

License (specify):

Licensed according to 391 NAC: Children's Services Licensing

Certificate (specify):

Not Required.

Other Standard (specify):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Agency provider employees and back-up staffing delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child;
- Ensure the home is compatible with medical and safety considerations of the child; and
- Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs.
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Extra Care for Children with Disabilities

Provider Category:

Individual

Provider Type:

Licensed Family Child Care Home I or II

Provider Qualifications**License (specify):**

Licensed according to 391 NAC: Children's Services Licensing

Certificate (specify):

No certification is required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

- Family Child Care Home I can have a maximum capacity of 8 children of mixed ages and 2 additional school age children during non-school hours.
- Family Child Care Home I can provide care for no more than 3 infants (under 18 months) per adult as long as no more than 2 infants per adult are under 12 months of age.
- Family Child Care Home I serving mixed ages of children can provide care for no more than 2 additional school-age children during non-school hours as long as no more than 2 children are under 18 months of age.
- Family Child Care Home II can have a maximum capacity of 12 children with two providers present.
- Family Child Care Home II can provide care for no more than 3 infants (under 18 months) per adult as long as no more than 2 infants per adult are under 12 months of age.
- Family Child Care Home II serving mixed ages of children can provide care for no more than 2 additional school-age children during non-school hours as long as no more than 2 children are under 18 months of age.
- Family Child Care Home II may care for up to 12 school age children, including in the child/staff ratio any children under 8 years old who are the provider's own children. Own children is defined as including biological, adoptive, and foster children, stepchildren, and grandchildren.

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Agency provider employees and back-up staffing delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child;
- Ensure the home is compatible with medical and safety considerations of the child; and
- Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs.
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated

03/31/2026

provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Extra Care for Children with Disabilities

Provider Category:

Individual

Provider Type:

Non-Licensed Child Care Provider

Provider Qualifications

License (specify):

Not required.

Certificate (specify):

Not required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV), as required.

Providers must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Demonstrate expertise required to meet the specialized physical, medical, or personal care needs of the child;
- Ensure the home is compatible with medical and safety considerations of the child; and
- Prepare and serve appropriate meals and/or snacks to comply with the child's dietary needs.
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - Cardiopulmonary resuscitation; and
 - Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with designated

provider enrollment broker.

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Again

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Home Again is available to support and enable Medicaid-eligible nursing facility residents to move to a more independent living situation of their choice. To receive this service, a person aged 18 or older must be a current nursing facility resident whose nursing facility services have been paid by Medicaid for at least three months. Persons who are in a nursing facility for rehabilitation purposes are not eligible for this service.

This service includes non-recurring set-up expenses for a participant transitioning from a nursing facility to a living arrangement in a private residence where the participant is directly responsible for their own living expenses.

Items and services covered include essential furniture and furnishings; security deposits that are required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; necessary home accessibility adaptations; and activities to assess need, arrange for and procure need resources. Home Again services do not include rent or mortgage expenses, food, regular utility charges, household appliances, televisions, or items intended for purely diversional/recreational purposes.

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

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

Home Again is furnished only to the extent that is reasonable and necessary as determined through the service plan development process, clearly identified in the person-centered plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

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

Items or services available through the Medicaid state plan or another service of this waiver program are not included in this service.

Home Again may be provided by a relative or legal guardian but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Non-Care Provider
Agency	Agency Non-Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Again

Provider Category:

Individual

Provider Type:

Independent Non-Care Provider

Provider Qualifications

License (specify):

N/A

Certificate (specify):

N/A

Other Standard (specify):

All providers of waiver services must be a Medicaid provider, and must comply with all applicable professional licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes, as appropriate.

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

No personal care or hands-on assistance may be provided.

Providers must have the qualifications, experience, and abilities necessary to carry out services comparable to those that will be authorized.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Again

Provider Category:

Agency

Provider Type:

Agency Non-Care Provider

Provider Qualifications

License (specify):

Not required.

Certificate (specify):

Not required.

Other Standard (specify):

All providers of waiver services must be a Medicaid provider, and must comply with all applicable professional licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes, as appropriate.

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

No personal care or hands-on assistance may be provided.

Providers must employ staff who have the qualifications, experience, and abilities necessary to carry out services comparable to those that will be authorized.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat.

§ 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Home-Delivered Meals is a service for adults age 18 and older which provides a meal prepared outside the participant’s home and is delivered to their home. Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., up to 2 meals per day, and which do not constitute a full nutritional regimen as permitted).

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

Home-Delivered Meals may be provided by a relative or legal guardian but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency home delivered meal provider
Individual	Independently operated home delivered meal provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency home delivered meal provider

Provider Qualifications

License (*specify*):

Not required.

Certificate (*specify*):

Not required.

Other Standard (*specify*):

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

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Agency provider employees, back-up staffing, and volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of a current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Independently operated home delivered meal provider

Provider Qualifications

License (specify):

Not required.

Certificate (specify):

Not required.

Other Standard (specify):

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

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the

state-mandated web-based case management system.

Providers must:

- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Home Modifications are physical adaptations to the participant's private home or to the family's home when living with their family. Home modifications are necessary to ensure the health, welfare, and safety of the participant, or necessary to enable the participant to function with greater independence in their own private home or in the family's home and decrease their need for assistance from paid or natural supports. Home Modifications are intended to support a participant's assessed Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs, as well as entry and exit from the home.

Home Modifications must be provided within the current foundation of the home and may not add to the total square footage of the home, except when necessary to complete an adaptation, such as installation of ramps or other means of accessible entry and egress.

Home modifications will be provided in accordance with applicable local and state building codes.

Home Modifications may be self-directed.

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

Home Modifications have a budget cap of \$10,000 per five-year period. If a participant's needs cannot be met within the established budget cap, the participant may request additional funds through DDD Central Office up to a maximum of \$20,000.

Modifications are limited to the participant's primary residence and to those rooms essential to meeting the participant's Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), including, but not limited to, the participant's primary bathroom, bedroom, or kitchen, and to provide for the participant's primary entry and egress. Such modifications include the installation of ramps and grab-bars, widening of doorways, bathroom modifications, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.

Modifications or improvements to the home that are general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant are not allowed. The participant's home must not present a health and safety risk to the participant other than what is corrected by the approved home adaptations. Home Modifications shall exclude costs for improvements exclusively required to meet local building codes. The amount authorized for the service is based on the lowest cost necessary to meet the participant's assessed need when the person cannot complete the ADL, IADL, entry, or exit independently.

When the home is rented or leased, the property owner's permission must be secured prior to the approval of the modification.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers discounts to the general public shall apply those same discounts to the participant who would otherwise qualify for the discount outside of the waiver.

Home Modifications may be provided by a relative or legal guardian, but not a legally responsible individual.

Home Modifications will not be approved to adapt living arrangements for a residence owned or leased, operated, or controlled by a provider of waiver services, or for participants residing in a licensed foster care setting.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Equipment, Supplies, and Modification Companies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Specialized Equipment, Supplies, and Modification Companies

Provider Qualifications

License (*specify*):

Not required

Certificate (*specify*):

Not required

Other Standard (*specify*):

All providers must comply with all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications. Modifications must be completed in accordance with local and state codes and professional practice standards, and all modifications must be made or overseen by appropriately licensed or certified professionals.

All items and assistive equipment must meet applicable standards for manufacture, design, and installation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker or the Nebraska Department of Education Assistive Technology Partnership

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independence Skills Building

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Independence Skills Building is a service for adults aged 18 and older in which rehabilitative training occurs focused on activities of daily living (ADLs), instrumental activities of daily living (IADLs), and home management skills necessary to increase a participant's independence.

Independence Skills Building may be provided directly to the participant or to a participant and their unpaid caregiver to promote the participant's independence. Training may occur in the participant's home or in the community but at least 60% of the service must occur in the participant's home.

Independence Skills Building may be provided to one, two, or three participants within a single residence or community setting, based on assessed need.

This service differs from Chore, Personal Care, Companion, and LRI Personal Care because Independence Skills Building involves rehabilitative training of the participant or participant and unpaid caregiver by the provider, not the direct completion of the ADL or IADL task.

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

Independence Skills Building services are authorized when there is a stated goal and plan for rehabilitative training,

documented in the state-mandated case management system. Services are continued only as long as there is measurable progress toward the identified goal(s).

Independence Skills Building is not authorized when the public school system or rehabilitation services are responsible for providing training for independent living; when training is for the participant to acquire general educational background, knowledge, and skills to prepare for vocational training or for actual vocational training; or when the training requires a licensed audiologist, hearing aid dealer, occupational therapist, optometrist, physical therapist, speech pathologist, or other related health care professional.

Children aged 16 to 17 may be authorized for this service during transition to adult services when there is a documented need. For these participants, Independence Skills Building is limited to ADL/IADL and home management skills for which there is no support provided by the public school system or rehabilitation services. For children 16 to 17, this service is not to exceed three hours per day. This service does not include general teaching or skills development, or other aspects of normal parental responsibility.

ISB may be provided by a relative or legal guardian, but not by a legally responsible individual.

This service does not cover natural supports provided by relatives, guardians, or fictive kin living in the home when the support is part of a normal family or household routine, unless the support is clearly above and beyond what is typically expected for a participant without a disability. The Service Coordinator verifies natural supports through review of household composition, participant statements, and other available documentation.

This service may not duplicate or overlap with services covered under the Medicaid State Plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
Transportation is not included in this service.

This service cannot be provided during school hours set by the local school district. This includes all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days also apply to a child who receives homeschooling.
Services under the HCBS Waiver for Aged and Adults and Children with Disabilities are limited to additional supports not otherwise covered under the Medicaid State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Direct Care Provider
Individual	Independent Direct Care Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Independence Skills Building

Provider Category:

Agency

Provider Type:

Agency Direct Care Provider

Provider Qualifications**License (specify):**

None required

Certificate (specify):

None required

Other Standard (specify):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV).

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact and annually thereafter. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Independence Skills Building****Provider Category:**

03/31/2026

Individual

Provider Type:

Independent Direct Care Provider

Provider Qualifications**License (specify):**

Not required.

Certificate (specify):

Not required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Providers must:

- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

LRI Personal Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Legally Responsible Individual (LRI) Personal Care is a service for participants of all ages that provides assistance with Activities of Daily Living (ADLs) and health-maintenance activities, and may also include Instrumental Activities of Daily Living (IADLs) provided in a participant’s home and other community settings.

This service offers a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may include hands-on help (performing the task for the participant.

Health-maintenance means noncomplex interventions that can safely be performed according to exact direction of a medical professional or the participant, which do not require alteration of the standard procedure, and for which the results and patient responses are predictable.

Nebraska defines Extraordinary Care as hands-on assistance with ADLs and IADLs that exceeds the range of activities a parent or spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age. LRI Personal Care requires a participant to meet the definition of Extraordinary Care. Nebraska utilizes the state-mandated assessment tool to determine whether a participant meets this definition.

LRI Personal Care under the waiver differs in scope and nature from the State Plan personal care service. A participant cannot be authorized to receive LRI Personal Care and State Plan personal care services at the same time.

This service differs from the State Plan service in that it may be provided by a Legally Responsible Individual when employed by an agency or as an Independent Personal Care Provider.

This service may not be self-directed.

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

If assistance with ADLs or health-related tasks is not required, this service should not be authorized.

Transportation is not included in this service.

A participant cannot be authorized to receive this service at times that overlap with Extra Care for Children with Disabilities, Personal Care, Companion Services, Adult Day Health, Respite, Independent Skills Building, Supported Residential Living, or Transportation Services.

This service cannot duplicate provisions of Companion, Personal Care, or Chore if authorized in conjunction.

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

LRI Personal Care may only be provided by a legally responsible individual for the participant.

Personal care services that can be covered under the State Plan must be furnished to waiver participants under the age of 21 as services required under EPSDT.

This service cannot be provided during school hours set by the local school district. This limitation includes all public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives homeschooling.

Services under the HCBS Waiver for Aged and Adults and Children with Disabilities Waiver are limited to additional services not otherwise covered under the State Plan, including EPSDT, but must remain consistent with waiver objectives of avoiding institutionalization.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Direct Care Provider
Individual	Independent Direct Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: LRI Personal Care

Provider Category:

Agency

Provider Type:

Agency Direct Care Provider

Provider Qualifications

License *(specify):*

None required

Certificate *(specify):*

None required

Other Standard (*specify*):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV).

All providers are responsible for ensuring that all agency employees and volunteers complete required criminal history screenings prior to direct participant contact and annually thereafter. This includes Nebraska Data Exchange Network (NDEN) screening. Providers must verify these screenings have been successfully completed and that results meet all applicable regulatory and policy requirements prior to services being rendered.

Agency provider employees and back-up staffing or volunteers delivering direct services and supports must:

- Meet and adhere to all applicable employment or volunteer standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - Cardiopulmonary resuscitation; and
 - Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: LRI Personal Care

Provider Category:

Individual

Provider Type:

Independent Direct Care Provider

Provider Qualifications

License (*specify*):

No license required.

Certificate (*specify*):

No certificate required.

Other Standard (*specify*):

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system and Electronic Visit Verification (EVV).

Providers must:

- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Be legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

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

Non-Medical Transportation services may be provided by a relative or legal guardian but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Transportation Provider
Individual	Individual Transportation Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Agency Transportation Provider

Provider Qualifications

License (specify):

Certificate (specify):

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

Other Standard (specify):

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

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

Providers must:

- Provider must have a valid driver's license Neb. Rev. Stat §60-484 with no more than three points assessed against their Nebraska driver's license within the past two years or meet a comparable standard in the state in which they are licensed to drive.
- Ensure drivers have not had their driver/chauffeur's license revoked within the past three years.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Providers must be registered as a Certified Commercial Carrier/Common Carrier or a Public Service Exempt Transportation provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual Transportation Provider

Provider Qualifications

License (specify):

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

Certificate (specify):

No certification is required.

Other Standard (specify):

Independent providers, who are also legal guardians, must be approved by DDD Central Office to provide this service.

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

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

Providers must:

- Use their own personally registered vehicle to transport the participant.
- The provider must maintain the minimum vehicle insurance coverage as required by state law.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

PERS is an electronic device that enables a participant age 19 years or older to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a help button is activated. The response center has trained professionals to respond timely when the button is activated. The service includes installation, upkeep, and maintenance of the PERS device.

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

To receive PERS, the participant must have the cognitive and physical ability to use the PERS equipment.

Participants need for the device must be jointly determined by the service coordinator and the participant.

The PERS must:

- Ensure response is provided 24 hours per day, 7 days per week.
- Be replaced within 24 hours of malfunction of unit by the provider.
- Tested monthly by the provider to ensure proper function.
- Have accurate responder contacts, updated at least semi-annually, by the provider.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Equipment, Supplies, and Modification Agencies

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:

Specialized Equipment, Supplies, and Modification Agencies

Provider Qualifications**License (specify):**

Not Required

Certificate (specify):

Not Required

Other Standard (specify):

All providers must comply with all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications. Modifications must be completed in accordance with local and state codes and professional practice standards, and all modifications must be made or overseen by appropriately licensed or certified professionals.

All items and assistive equipment must meet applicable standards for manufacture, design, and installation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker or the Nebraska Department of Education Assistive Technology Partnership

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Residential Living

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Supported Residential Living is an array of support services of personal care and support that promote participant self-direction and participation in decisions, which incorporate respect, independence, individuality, privacy, and dignity in a home-like non-institutional setting that meets the HCBS setting requirements. These services include assistance with or provision of personal care activities, activities of daily living, instrumental activities of daily living, and health maintenance. This includes 24-hour response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security.

Depending on the needs of the participant, Supported Residential Living service may include socialization and recreational activities and programming; escort services to accompany or physically assisting a participant who is unable to travel or wait alone to medical appointments; essential shopping, health maintenance activities, housekeeping activities, laundry services, medication assistance, personal care services, and transportation services. When provided to a participant, the above services are included in the comprehensive rate paid to the supported residential living provider and are not billed separately.

Provider qualifications for persons administering medications in an assisted living facility are referenced in the assisted living facility licensing regulations (175 NAC 4).

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

Supported residential living includes the provision of personal care services and additional billing for personal care services is not allowed. When a participant’s residence is documented as an assisted living facility, any claims submitted for personal care are denied.

Relatives/guardians who provide supported residential living services are either employees of a licensed assisted facility or are the owner of a licensed assisted living facility.

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

The supported residential living provider must directly provide a minimum of five round-trip medical appointments. Medical transportation for round-trip trips in excess of 50 miles and round-trip trips in excess of five per month may be approved for additional reimbursement as a state plan Medicaid service. The supported residential living provider must also make reasonable accommodations for round-trip transportation for activities and resources identified in the participant’s person-centered plan.

Medical transportation in excess of 50 miles round-trip is available as a state plan Medicaid service.

The supported residential living provider must furnish three meals per day, seven days per week. The meals are furnished as part of the residents’ room and board costs paid to the facility.

Items or services available through the Medicaid state plan or through another service of this waiver program are not included in this service.

Supported residential living may be provided by a relative or legal guardian but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Personal Emergency Response Services (PERS) is the only waiver service that may be authorized in conjunction with supported residential living.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Residential Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Licensed according to 175 NAC 4: Assisted Living Facilities

Certificate *(specify):*

Not required.

Other Standard *(specify):*

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

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

All providers of waiver services must possess computer skills and have access to the necessary technology to navigate the state-mandated web-based case management system.

Providers must:

- Provide a private living unit with bathroom consisting of a toilet and sink for each participant receiving Waiver-supported residential living service. Semi-private rooms will be considered on a case-by-case basis and require prior approval of the Department.
- Provide essential furniture, at a minimum, a bed, dresser, nightstand or table, and chair, if a participant does not have those items.
- Supply normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products.
- Furniture and equipment used by participants must be adequate.
- Toilets must be in working order and easily accessible from all program areas.
- A telephone must be available for participant use.

Agency provider employees and back-up staffing delivering direct services and supports must:

- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
 - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
 - o Cardiopulmonary resuscitation; and
 - o Basic first aid;
- Be authorized to work in the United States;
- Be 19 years of age or older;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

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

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

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

Service is not included in the approved waiver.

Service Definition (Scope):

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant’s primary means of transportation to accommodate the special needs of the participant. Vehicle Modifications are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant.

The following are specifically excluded: Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; Purchase or lease of a vehicle; Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications; Adaptations to automobiles or vans owned or leased, operated or controlled by providers of waiver services; and Adaptations to vehicles that are not the participant’s primary means of transportation.

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

Vehicle Modifications have a budget cap of \$10,000 per five-year period. If a participant’s needs cannot be met within the established budget cap, the participant may request additional funds through DDD Central Office, up to a maximum of \$20,000.

Items or services available through the Medicaid state plan or through another service of this waiver program are not included in this service. This service is not available to facility providers or for participants residing in a licensed foster care setting.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers discounts to the general public shall apply those same discounts to the participants who would otherwise qualify for the discount outside of the waiver.

Vehicle Modifications may be provided by a relative or legal guardian, but not a legally responsible individual.

The services under the HCBS Waiver for Aged and Adults and Children with Disabilities waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Equipment, Supplies, and Modification Companies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modification

Provider Category:

Agency

Provider Type:

Specialized Equipment, Supplies, and Modification Companies

Provider Qualifications

License (specify):

License not required.

Certificate (specify):

Certification is not required.

Other Standard (specify):

All providers must comply with all applicable federal, state, and local laws and regulations, including maintaining appropriate licenses and certifications. Modifications must be completed in accordance with local and state codes and professional practice standards, and all modifications must be made or overseen by appropriately licensed or certified professionals.

All items and assistive equipment must meet applicable standards for manufacture, design, and installation.

All guardians enrolling as providers after 7/1/2025, to deliver direct services and supports, must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff in combination with the designated provider enrollment broker or the Nebraska Department of Education Assistive Technology Partnership

Frequency of Verification:

The program compliance is completed annually by contracted resource developers, DHHS, and the provider screening and enrollment vendor, to ensure revalidation is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

C-1: 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 section 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Area Agencies on Aging, Independent Living Centers, DHHS staff, Early Development Network, and Assistive Technology Partnership staff conduct case management functions on behalf of waiver participants.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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):

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations, and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal history and/or background investigations are required for:

- (a) All Services Coordinators and Resource Development staff
- (b) Individual providers
- (c) Persons employed by contracting provider agencies. Waiver resource development staff are responsible for submitting provider referral information for criminal history checks for individual providers and verifying that agencies have completed criminal history checks for their employees. The Medicaid Agency completes criminal history checks for Services Coordination and Resource Development staff.

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

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

The Resource Developer will work with Program Integrity and Provider Relations when service provider approval needs to be denied or terminated. Service provider approval will be denied or terminated immediately when there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the participant.

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

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

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

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

A Legally Responsible Individual (LRI) is defined as the natural or adoptive parents of a minor child or spouse of the waiver participant. A legally responsible individual is limited in service provision to the LRI Personal Care Service for services identified in the state-mandated assessment tool as extraordinary care. When the LRI Personal Care Service is provided by an independent provider, it must be deemed to be in the best interest of the participant with prior approval by DDD Central Office. Payments for services rendered will be made according to services outlined in the participant's individual service plan and will be monitored as outlined in Appendix D-2.

Provider agencies may hire LRIs to provide waiver services when the individual is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure claims are submitted only for services rendered and for the services, activities, and supports specified in the service plan.

The State makes payment to LRIs when it is determined the individual meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any LRI is only made when the service provided is not a function the LRI would normally provide for the participant, without charge, due to the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider. The provision of services by the legally responsible individual is determined through documented team discussion during the planning process, on a case-by-case situation by the participant's service plan team.

To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the relative provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

The provision of services is monitored by the participant's service coordinator. The service coordinator monitors, at a minimum quarterly, that services are furnished and paid as specified in the service plan. To ensure the provision of services is in the best interest of the participant, and exceeds the range of activities a parent or spouse would ordinarily perform, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the LRI, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Designated DDD personnel and contracted service coordination agencies ensure payments are made only for services rendered by prior authorization of all services based on the participant's needs and by reviewing submitted billing documentation.

The State does not make payments to members of the participant's immediate household for home modifications or respite; or for activities or supervision when a payment is made by a source other than Medicaid.

To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the LRI provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the participant.

The following controls are employed in the state-mandated web-based case management system to ensure payments are made only for services rendered:

- The need for the service is documented in the service plan;
- The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
- DHHS personnel have prior authorized each waiver service to be delivered;
- At the time services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to electronic recording of time in and time out and habilitation data;
- A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
- An Explanation of Payment is issued electronically; and
- Edits are in place in the electronic systems.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

A relative legal guardian is defined as a court appointed legal guardian of a participant who is also the spouse, adult child, parent, or other relative of the participant. Relatives are defined as any person related to the participant by blood or marriage to the third degree of consanguinity, including a foster parent, foster child, stepparent, stepchild, and adopted children and their adoptive parents, per Neb. Rev. Stat § 49-1443.01. In the case of an Indian child, relative is defined in Neb. Rev. Stat. § 43-1503. Payment may only be made to relatives who are not legally responsible for the participant.

Relative legal guardians and non-legally responsible participant relatives may provide services. Any potential provider meeting general and specific service standards has the right to be a provider. Relative legal guardians and non-legally responsible participant relatives may provide services as specified in the service definitions, scope, and limitations in accordance with provider standards outlined in Appendix C-1/C-3. Relative legal guardians and non-legally responsible relatives may provide all waiver services except for the following: Personal Emergency Response System (PERS) and Home and Vehicle Modification.

Provider agencies may hire participant relative legal guardians and non-legally responsible relatives to provide waiver services when the relative legal guardian or relative is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure claims are submitted only for services rendered and for the services, activities, and supports specified in the service plan.

The State makes payment to relative legal guardians and non-legally responsible participant relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any relative legal guardian and non-legally responsible participant relative provider is only made when the service provided is not a function the relative legal guardian or non-legally responsible participant relative would normally provide for the participant, without charge, due to the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider. The provision of services by the relative legal guardian or non-legally responsible participant relative is determined through documented team discussion during the planning process, on a case-by-case situation by the participant's service plan team. The provision of services is monitored by the participant's state DDD service coordination personnel.

To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the relative provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Service coordination personnel monitor, at a minimum on a quarterly basis, that services are furnished and paid as specified in the service plan.

Designated DDD Personnel ensure payments are made only for services rendered by prior authorization of all services based on the participant's needs and by reviewing submitted billing documentation.

The State does not make payments to members of the participant's immediate household for home modifications, respite, and homemaker services; to a legally responsible relative or guardian; or for activities or supervision when 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 legal guardian or a non-legally responsible relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) which are available to the participant.

The following controls are employed in the state-mandated web-based case management system to ensure payments are made only for services rendered:

- The need for the service is documented in the service plan;
- The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
- DHHS personnel have prior authorized each waiver service to be delivered;
- At the time services are delivered, documentation is completed by the provider to support the delivery of the

service, such as, but not limited to electronic recording of time in and time out and habilitation data;

- A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
- An Explanation of Payment is issued electronically; and
- Edits are in place in the electronic systems.

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:

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

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) **The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;** (b) **How the 1915(c) HCBS will assist the individual in returning to the community; and** (c) **Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

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:

and % of newly enrolled licensed, certified providers reviewed that met waiver and licensure/certification standards prior to furnishing waiver services. Numerator = # of newly enrolled licensed, certified providers reviewed that met waiver and licensure/certification standards prior to furnishing waiver services; Denominator = # of newly enrolled licensed, certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Records reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 30px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

Performance Measure:

and % of enrolled licensed, certified providers reviewed that continued to meet waiver and licensure/certification standards at annual review. Numerator = # of enrolled licensed, certified providers reviewed that continued to meet waiver and licensure/certification standards at annual review; Denominator = # of enrolled licensed, certified providers reviewed that have had an annual review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Records reviews, combined on and off site.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

<p>Sub-State Entity</p>	<p>Quarterly</p>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with +/- 5% margin of error.</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis(check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

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

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Records reviews

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 = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of enrolled non-licensed, non-certified providers reviewed that continued to meet waiver standards at annual review. Numerator = number of enrolled non-licensed, non-certified providers reviewed that continued to meet waiver standards at annual review; Denominator = number of enrolled non-licensed, non-certified providers reviewed that have had an annual review.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Records reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of newly enrolled non-licensed, non-certified providers reviewed that met waiver standards prior to furnishing waiver services. Numerator = number of enrolled newly non-licensed, non-certified providers reviewed that met waiver standards prior to furnishing waiver services; Denominator = number of newly enrolled non-licensed, non-certified providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Records reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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:

and % of all newly hired Service Coordination (SC) and Resource Development (RD) staff that meet criteria for successful training in accordance with state requirements and the approved waiver. Numerator= number of newly hired SC and RD staff that meet criteria for successful training in accordance with state requirements and the approved waiver. Denominator=number of newly hired SC and RD staff.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Quarterly file reviews are conducted by resource developer supervisors. Additionally, DDD quality staff annually conduct file reviews to verify the work of the resource developer supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal off-site and on-site review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the service coordination/resource development agency and state levels have been developed to discover whether the federal qualified provider waiver assurances are being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that is aggregated and analyzed to measure the overall system performance. Resource development agencies are responsible to remediate all (100%) identified provider problems identified through discovery processes in an appropriate and timely manner (45 days).

The quality strategies for reviewing qualified providers are:

1. File Reviews:

- File reviews are completed by resource development supervisors for each agency providing service coordination.
- For those file reviews that do not meet standards, supervisory remediation follow-up must occur with the resource developer within 45 calendar days from date of review.
- If after further review the provider does not continue to meet qualifications, the provider agreement is terminated.
- The resource development agency notifies DDD for referral to Program Integrity for possible claim recovery.

2. DDD File Reviews and Electronic Reports:

- Quality improvement file reviews for qualified providers are completed by DHHS staff in an electronic system for each agency providing resource development.
- Reassessment occurs, as applicable, and the required corrections are completed.
- If the provider is found to be qualified, they continue to provide services.
- If the provider is found to be ineligible, the provider agreement is terminated.
- Resource development supervisors report remediation activities to DDD staff. DDD staff document corrections in an electronic system. The review documentation must include information that all negative qualified provider issues have been resolved correctly.
- If services have been provided, a referral is made to Program Integrity for claims recovery.
- If there is a concern that the resource development agency didn't meet performance compliance, they are responsible for a Shared Resolution or Quality Improvement Plan that will demonstrate how the agency will remediate and then determine system improvement.
- DDD staff monitor statewide reviews to ensure review and remediation activities are completed as assigned. Review documentation must include information that all negative provider enrollment issues have been resolved correctly.

3. Training for Service Coordination/Resource Development Agencies:

- All services coordinator/resource developers and their supervisors must complete training on the Aged and Disabled Waiver Program upon initial hire. To assure all waiver staff is qualified; each trainee will be required to meet the criteria for each training module applicable to their job.
- Oversight for this training is provided by DDD. DDD staff monitor completion of the course and work with the service coordination/resource development supervisor to assure remediation of individual issues. If the trainee does not complete the course successfully, DDD staff will work with the DHHS Contracts Administrators Unit to determine and monitor the completion of appropriate remediation activities

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

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Participants shall be limited to no more than 150% of the average NF institutional costs for home and community-based services only. Exceptions may be approved by DDD Clinical Team beyond this limit if the participant's need for personal care services exceeds the 150% service limit and is necessary to support the participant's immediate health and safety needs.

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 in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

All HCBS settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS at 42 CFR §441.301(c)(4)(i).

All HCBS settings are selected by the individual from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board at 42 CFR §441.301(c)(4)(ii).

All HCBS settings optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact at 42 CFR §441.301(c)(4)(iv).

All HCBS settings facilitate individual choice regarding services and supports, and who provides them at 42 CFR §441.301(c)(4)(v).

All HCBS provider-owned or controlled residential settings all individuals sharing units to have a choice of roommate in that setting at 42 CFR §441.301(c)(4)(vi)(B)(2), and have the freedom and support to control their own schedules and activities, and have access to food at any time at 42 CFR §441.301(c)(4)(vi)(C).

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

1. All settings types utilized by this waiver currently exist within the HCBS system and have previously been validated and continue to be monitored for compliance with the Final Settings Rule. AD Providers will have an assessment completed when they enroll as a new provider and during their annual review. AD Providers may complete the heightened scrutiny worksheet as requested by DDD. This process is overseen and monitored by the DDD Quality Team.

2. At the time of submission of this waiver application, all settings, including Adult Day settings, Childcare settings, Respite settings, assisted living facilities, and private homes, will be monitored through monthly reviews of person-centered plans with participants and at annual review meetings facilitated by Service Coordinators (SC). The DDD quality team monitors settings for safety, environmental factors, personal well-being, and issues related to community integration through a combination of a random, stratified sampling strategy as well as targeted assessment when necessary. Settings may be selected for targeted assessment for any number of reasons, including previous settings assessment results, consumer or public concern regarding compliance with the final rule, or other issues.

3. Nebraska's monitoring efforts will occur at the individual, provider, and state levels. All settings, including private homes, are continually monitored through monthly reviews of person-centered plans with participants and at annual review and semi-annual meetings facilitated by SCs, which include Home & Community-based Services (HCBS) settings criteria in the monitoring process.

Monitoring efforts at the individual level include a review of person-centered service plans. Relevant forms include indicators of compliance with the HCBS final rule. DDD will ensure that service delivery system staff continue to receive training on person-centered planning philosophy and practice, including the empowerment of the individual to fully understand the range of options available to them and their rights in making individual choices. Training will emphasize an individual's right to select where they live and to receive services from the full array of available options, including services and supports in their own or family homes. The trainings will include curricula on supporting informed choice and identifying areas that providers must address. Guidance will be provided to SCs on how to educate individuals about person-centered philosophy and practice, which supports federal HCBS setting requirements. It will also include rights, protections, person-centered thinking, and community membership.

Monitoring efforts at the provider level for all provider-owned, operated, or controlled settings include ensuring current providers maintain compliance. Licensing, certification, and/or service delivery system staff will be critical to ensuring compliance of providers. Strategies to ensure ongoing compliance will include:

1. Ongoing licensing inspections and certification reviews by appropriate staff; and
2. Ongoing HCBS setting compliance monitoring to ensure that settings continue to comply with the HCBS regulations.

At the State level, DDD will ensure staff members are appropriately trained on the HCBS regulations and expectations. DDD works with Department of Public Health (DPH) licensure and certification staff to reduce duplication of effort in each Division's survey process.

DDD staff will conduct ongoing monitoring for all provider-owned, operated, or controlled settings through the use of file reviews and also through the annual provider review process, to assure continuous monitoring and improvement. All provider-owned, operated, or controlled settings are monitored for all parts of the HCBS Final Rule. This will include determining sample sizes to ensure providers are complying with HCBS regulations on an ongoing basis.

DDD staff will also actively monitor the provision of services and supports identified in the participant service plan at a frequency and intensity which ensures needs are met and that any necessary revisions to the service plan are completed. This includes monitoring individual private homes, non-licensed settings, and anywhere services are received.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

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, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (*see Appendix D-1-d-ii of this waiver application*).

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Plan (PCP)

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*Select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The qualifications of a Service Coordinator are:

1. Bachelor’s Degree in a human behavioral sciences field such as human services, social work, psychology, education, sociology, or a related field; OR four years equivalent experience in services or programs for long-term care, gerontology, rehabilitation, health/disability case management, children with special health care needs, health/medical, education, psychology, social work, sociology, human services, persons with physical, intellectual, or other developmental disabilities or a related field.
2. Knowledge of: current practices in the field of community-based services for aged persons or persons with physical, intellectual, or other developmental disabilities; person-centered planning; Americans with Disability Act (ADA) standards; self-direction; community integration; the principles of social role valorization; provision of habilitation services; positive behavioral supports; and, statutes and regulations pertaining to delivery of services for participants; and
3. Knowledge of: program resources/services available in Nebraska for aged persons or persons with physical, intellectual, and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities (DDD); regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; Vocational Rehabilitation services; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and economic assistance programs; and
4. Ability to: mobilize resources to meet participant needs; communicate effectively to exchange information; develop working relationships with participants, their families, interdisciplinary team members, agency representatives, independent providers, and advocates or advocacy groups; analyze data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) program rules, policies, and procedures; and organize, evaluate and address program/operational data.

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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- Direct oversight of the process or periodic evaluation by a state agency;**
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The participant's Service Coordinator (SC) provides support to the participant to actively lead in the development of their service plan. The participant also has the option to direct their SC to facilitate the service plan development meeting so the participant may actively participate as a team member.

The SC supports the participant in the development of their service plan by:

1. Assisting the participant in selecting services and supports that will meet the participant's needs and personal goals;
2. Participating in team meetings as a knowledgeable professional, bringing person-centered values to the process by:
 - a. Contributing information about services, providers, and other resources;
 - b. Advising the participant annually of their right to file a complaint or appeal;
 - c. Offering feedback to the providers and other team members before the PCP meeting; and
 - d. Facilitating PCP meetings (documented on the PCP).
3. Assuring the plan:
 - a. Is based on assessments and other information that identify and address the participant's personal goals, needs, preferences, services, and supports;
 - b. Identifies the type, amount, frequency, duration, and the provider of services; and
 - c. Includes signatures from all people participating in the PCP meeting.
4. Monitoring the service delivery and, when needed, taking action to ensure the PCP is implemented as agreed upon; and
5. Determining whether to schedule a team meeting or to obtain verbal approval and amending the PCP when any team member requests a meeting.
 - a) The supports and written information that are made available to the participant to direct and be actively engaged in the service plan development process: Prior to the service plan meeting(s), the SC works with the participant to coordinate invitations for their service plan meetings, dates, times, and locations. The process of coordinating invitations includes the participant's input for who to invite, times and locations of convenience to the participant, and the inclusion of remote meetings when feasible to enhance full and active engagement for all.

Service planning teams are comprised of people who know and care about the participant. The participant and their family, the SC, service provider(s), and other persons chosen by the participant (e.g., advocates, natural supports, and friends) participate in the service plan process or parts of the process.

The process provides necessary information and support to ensure the participant and family direct their service plan meeting to the maximum extent possible and are empowered to make informed choices and decisions. The planning process reflects the cultural considerations and communication needs of the participant and the family. The participant is encouraged and assisted to participate in every aspect of their service planning meeting as fully as they are able and choose to do so.

The participant and their family direct the development and any updates to the person-centered service plan, and others sign to indicate their participation and agreement in supporting the participant in developing a person-centered service plan according to their hopes and dreams in living the life they choose for themselves.

- b) The participant's authority to determine who is included in the process: Persons involved in the planning process will be determined by the participant, but must at least include the participant, service provider(s), and the SC. When a participant objects to provider participation, the service plan team must attempt to accommodate the objection while allowing participation by the provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Who develops the plan, who participates in the process, and the timing of the plan:

Participants eligible for waiver services have a person-centered plan (PCP) developed prior to the authorization of the waiver services and annually thereafter. The PCP reflects the participant's waiver and non-waiver services, needs, goals, and preferences. The person-centered planning meeting is where the SC explains the available service array, including provider options and conflict of interest. The purpose of the meeting is to:

- 1) Discuss information gathered about what is important to and for the participant;
- 2) Identify other services or programs and informal supports the participant has available outside of waiver services; and
- 3) Identify what supports the participant's needs to be safe and healthy while leading the life of their choosing.

The PCP is individually tailored to address the unique preferences and needs of the participant.

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

Members in the planning process are determined by the participant but must at least include the participant, relevant service providers, and the SC. Informal supports and the prospective waiver provider(s) may be included, dependent upon the participant's choice of who to include in the process. The SC is responsible for scheduling, coordinating, and documenting all service plan meetings and facilitating the participation of all included in the planning process.

The SC elicits and records facts and information, advocates for the participant, and documents the specific responsibilities of those involved in the planning process with regard to the implementation of services, supports, and strategies. The SC adheres to the processes for PCP development and the authorization of services. Meetings are scheduled at a time and place that accommodates the needs of the participant. Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all involved in the planning process. The participant or those identified in the planning process may request a meeting at any time.

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

The service plan must identify the needs, goals, and preferences of the participant and specify how those needs, goals, and preferences will be addressed. In order to accomplish this, the participant's strengths, capacities, and areas needing growth to support the service plan development are determined by the participant and the individuals they invited to develop the PCP.

When a child aged 0 to 47 months receives Services Coordination from the Early Development Network (EDN), the Nebraska Early Interventions Program Individual Family Support Planning process (EI-1) and HCBS Waiver Child's Level of Care tool are utilized for family service planning. Health and welfare is addressed through a variety of assessments that may be provided by the family, services coordinator, the education system, or medical professionals.

When a child aged 0 to 47 months receives Service Coordination from the Division of Developmental Disabilities, the HCBS Waiver Child's Level of Care tool is utilized for person-centered planning. Health and welfare is addressed through a variety of assessments that may be provided by the family, service coordinator, the Education System, and/or Medical Professionals.

Youth ages 4 to 17 years are assessed with the interRAI Pediatric Home Care Assessment. Health and welfare is addressed through a variety of assessments that may be provided by the family, service coordinator, the Education System, and/or Medical Professionals.

Adults age 18 and older are assessed with the interRAI Home Care Assessment. Health and welfare is addressed through a variety of assessments that may be provided by the family, service coordinator, and/or Medical Professionals.

The interRAI is used to measure the participant's level of independence and support needed for the participant to

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

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

The SC is responsible for informing the participant of available services under this waiver. Information about available services is shared with the participant from the point of referral through the development of the PCP. The participant is informed of the available waiver services during the initial plan development and annually during the PCP meeting. The SC continues to provide information about services through monthly monitoring contacts, and as the participant's needs and preferences change. The DHHS website provides further information on waiver services and other resources.

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

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

(e) How waiver and other services are coordinated:

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

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

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

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

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

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

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

(h) How the participant engages in and/or directs the planning process:

The participant is encouraged and assisted to participate in every aspect of their service planning meeting as fully as they are able and choose to do so, including the date, time, and location of the PCP meeting, directing the development and any updates to the PCP, sharing their goals and needs, and identifying outside supports (e.g., advocates, natural supports, and friends) to participate in the development of the PCP or parts of the process.

(i) How the state documents consent of the person-centered service plan from the waiver participant or their legal representative:

All members of the PCP team, including the participant, will sign the PCP signature page to indicate their participation and agreement with the information and identified supports outlined in the PCP. When a participant is unable to sign the PCP signature page, the SC will indicate the reason the participant is unable to sign. The PCP signature page will be attached to the PCP.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

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

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

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

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

The assessment tools inform the SC of potential health and safety risk factors. Each participant's PCP is required to have outcomes and action steps that address all needs for ADLs and IADLs, including risk factors. The PCP also is required to address the supports and interventions related to the identified health and safety risks needed to prevent harm to the participant. The PCP must contain backup plans to address the unavailability of a provider or informal support and what will be done in the event of a natural disaster or emergency. Backup plans are created on an individual basis and are tailored to the participant's needs. All participants are to be involved in writing the person-centered plan and the identified action steps.

Resolutions of incidents and will be reported to the Division of Developmental Disabilities.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for participants eligible for the Aged and Adults and Children with Disabilities (A&D Waiver) are voluntary, both for the participant and the provider. Choice of providers and services is based on the choice of the participant. The provider must enroll and meet Medicaid requirements.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Department of Health and Human Services (DHHS) is the State Medicaid Agency for Nebraska, and the Division of Developmental Disabilities (DDD) is a division within the Medicaid agency. PCPs are subject to approval by DDD and oversight is exercised on a routine and periodic basis.

DDD reviews a sample of service plans retrospectively through its quality assurance process. Quarterly on-site file reviews are conducted by Services Coordination supervisors. Additionally, DDD quality staff annually conducts off-site file reviews to verify the work of the services coordination/resource developer supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal off-site and on-site review processes.

The Medicaid agency reviews 100% of all PCPs for participants who have died during their waiver eligibility. Service coordination agencies are responsible for remediating all PCP-related problems identified through the discovery process in an appropriate and timely manner (45 days). PCP reviews, as assigned by DDD, are completed in an electronic system by service coordination supervisors for each agency providing service coordination. These file reviews ensure that PCPs are completed accurately, are consistent with assessed needs, and that services are delivered in accordance with the participant's PCP. If a PCP needs to be revised, the service coordination supervisor provides the SC with information concerning corrections needed. Required corrections are documented by the SC on the PCP form.

Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation, or action occurred to address the problem must be followed up on immediately with the SC. If the participant's PCP cannot assure the participant's safety, the case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services. Follow-up action is recorded in the remediation section of the electronic file review tool.

Service coordination supervisors use an electronic case management system to run reports of file reviews and other data to evaluate the performance of their agency. Services coordination supervisors may also use the electronic case management system to perform additional agency-specific file reviews. The electronic case management system enables the services coordination agency to perform either the entire file review or a partial review of identified or suspected problem areas.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a.) The entity responsible for monitoring the implementation of the service plan and participant health and welfare:

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

b.) The following describes the monitoring process:

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

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

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

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

c.) The following describe the frequency of monitoring:

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

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

SC review each participant's satisfaction with the services provided, review each participant's overall health status, and

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

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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:

**Number and percent of participants reviewed for whom all assessed needs (including health and safety risk factors) have been addressed in the person-centered plan.
 Numerator = number of participants reviewed for whom all assessed needs (including health and safety risk factors) have been addressed in the person-centered plan;
 Denominator = number of participants reviewed.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of participants reviewed for whom all assessed personal goals have been addressed in the person-centered plan. Numerator = number of participants reviewed for whom all assessed personal goals have been addressed in the person-centered plan; Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.

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: 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:

Number and percent of participants reviewed whose person-centered plans were reviewed and revised on or before the annual review date. Numerator = number of participants reviewed whose person-centered plans were reviewed and revised on or before the annual review date. Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

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: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants reviewed whose person-centered plans were revised, as needed, to address changing needs. Numerator = number of participants reviewed whose person-centered plans were revised, as needed, to address changing needs; Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

and % of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-

centered plan. N = # of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-centered plan. D = # of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

e. *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:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

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: <input style="width: 100px; height: 20px;" type="text"/>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
---	--	--

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with +/- 5% margin of error. </div>
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually	Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	Continuously and Ongoing	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

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: <input style="width: 100%; height: 20px;" type="text"/>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Quarterly file reviews are conducted by service coordination supervisors. Additionally, DDD quality staff annually conduct file reviews to verify the work of the service coordination supervisors. The percentage of file reviews will be included in the State's review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the service coordination agency and state levels have been developed to

discover whether the federal service plan waiver assurances are being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that is aggregated and analyzed to measure the overall system performance. Service coordination agencies are responsible to remediate all service plan-related individual problems identified through discovery processes in an appropriate and timely manner (45 days).

The quality strategies for reviewing service plans are:

1. File Reviews:

- Service plan reviews, as assigned by DDD, are completed in an electronic system by service coordination supervisors for each agency providing service coordination. These file reviews ensure that service plans are completed accurately, consistent with assessed needs and services are delivered in accordance with the participant's service plan.
- Remediation must be completed for those file review questions that do not meet standards and must occur within 45 calendar days from the date of the file review. If a service plan needs to be revised, the service coordination supervisor provides the service coordinator with information concerning corrections needed. Required corrections are documented by the service coordinator on the service plan form.
- Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation and/or action occurred to address the problem must be followed up on immediately with the service coordinator.
- If the participant's service plan cannot assure the participant's safety, the case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
- Follow-up action is recorded in the remediation section of the electronic file review tool.

2. DDD File Reviews and Electronic Reports:

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

Practices are in place to assist service coordination agencies in evaluating whether problems are systemic to their agency. Service coordination supervisors use an electronic case management system to run reports of file review and other data to evaluate the performance of their agency. Service coordination supervisors may also use the electronic case management system to perform additional agency-specific file reviews. The electronic case management system enables the service coordination agency to perform either the entire file review, or a partial review of identified or suspected problem areas.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 488 794 568" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 801 1337 882" type="text"/>

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.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In this waiver, “participant” means the individual receiving waiver services and any person authorized to act on behalf of the participant.

Participants are advised of their appeal rights at the time of initial level of care determination by DDD personnel and annually, thereafter, by their Service Coordinator (SC) at the time of the person-centered plan (PCP) meeting, facilitated by their SC. At the annual PCP meeting, the participant is given a Notice of Rights and Responsibilities. Hearing rights are also provided with the Notice of Action.

Participants will receive and have the opportunity to dispute a Notice of Action in any of the following circumstances:

1. The applicant is determined ineligible for Medicaid HCBS waiver services;
2. The applicant is not given the choice of Medicaid HCBS waiver services as an alternative to institutional care;
3. The participant’s choice of providers is denied; or
4. Services to the participant are denied, suspended, reduced, or terminated.

Participants may also appeal any action, inaction, or failure to act with reasonable promptness because:

1. Their application is denied;
2. Their application is not acted upon with reasonable promptness;
3. Their assistance or services are suspended;
4. Their assistance or services are reduced;
5. Their assistance or services are terminated; or
7. They think the Department's action was erroneous.

When issued, the Notice of Action includes information about the Request for a Fair Hearing, and advises participants of their right to a hearing, the method by which to obtain a hearing, and that they may represent themselves or use an attorney, friend, or other spokesperson when they begin receiving services and annually thereafter. This information is also posted on the public website at www.dhhs.ne.gov/developmental_disabilities.

Designated Department of Health and Human Services Division of Developmental Disabilities (DHHS-DDD) staff complete and retain the Notice of Action in Nebraska’s electronic local web-based system for claims processing. The Notice of Action is mailed to the participant at least ten days prior to the action being taken, in accordance with 42 CFR 431.211. The Notice of Action includes advisement that services will continue (or be reinstated) until the final outcome of the fair hearing if the participant requests a hearing within ten days of the mailing of the Notice of Action.

Request for Fair Hearing must be submitted in written hardcopy or electronic form, and submission may be done via mail, email, fax, phone, or in person at any local DHHS office. All Notices of Action and Requests for Fair Hearing are maintained in electronic form, in accordance with the Records Retention Schedule applicable to DHHS-DDD. Fair hearing rights are provided in English and Spanish according to the language spoken at home on file and may be translated into other languages upon request.

In order to exercise the right to a hearing, the participant must file a petition with DHHS-DD. The petition may be made on a form provided by DHHS-DD for such purpose, or in another writing that contains at least the following information:

1. The name and contact information of the petitioner (the participant’s or guardian’s name, address, and phone number, and signature);
2. The specific decision contested;
3. The date of the decision contested; and
4. Any other information that the participant wants to be included at the hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **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.

Do not complete this item.

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

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

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

- **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).

The types of grievances/complaints that participants may register (Participants are advised in the Notice of Rights and Obligations that filing a grievance or complaint is not a prerequisite for filing for a Fair Hearing):

Participants receiving supports through the waiver may register the following types of grievances/complaints:

1. Safety, endangerment, or welfare issues;
2. Suspicion of Medicaid fraud;
3. Violations by providers of DDD Medicaid regulations, DDD regulations or policy by DDD policies;
4. Issues related to a participant's SC; or
5. Difficulty with DDD Medicaid services or providers; or
6. Issues with services being provided in settings that respect participant choices, promote community integration, and uphold their right to privacy and dignity, as outlined in the HCBS Final Settings Rule.

Service Coordination complaint/grievance process:

1. Service Coordination Agency staff receives a complaint about the provision of services from a participant or participant's representative. The report may be given either verbally or in writing. Service Coordination Agency Staff must begin completing the electronic Local Level Complaint Form once the report is received.

Note: Services Coordination Agency staff may clarify with the participant that the person filing the complaint is indeed representing him/her.

2. Service Coordination Agency staff must begin the investigation and respond to the complainant either verbally or in writing within 7 working days.

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

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

5. Upon resolution of the complaint, Service Coordination Agency staff will finalize the Local Level Complaint Form. Service Coordination Agency staff will email the complaint to the Division of Developmental Disabilities (DDD) staff to inform the DDD staff that a complaint has been completed. This must be completed within 15 working days of the complaint being resolved.

DDD staff review the content of each complaint and follow up as necessary with Services Coordination Agency staff. A complaint alleging a violation by the State in general may also be filed.

The statewide results are analyzed and presented to the DDD QI Committee as needed or requested.

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in

the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Local Level Incident and Death Review Process records critical events/incidents and deaths. Reports of incidents may be received from any source, including sources other than the participant or participant representative.

Critical events or incidents are those events that bring harm or risk of harm to participants including abuse, neglect, exploitation, or licensing violations. These events must be reported to appropriate authorities to conduct follow-up action. Appropriate authorities include Adult or Child Protective Services, Law Enforcement, and Regulation and Licensure (for licensed providers/facilities).

Situations of environmental events (e.g. fire, weather, flooding) that cause risk to participants and imminent (life-threatening) danger will also be tracked through this process. These situations will be reported to DDD staff and also to other authorities as appropriate.

Explained and unexplained deaths are reviewed to safeguard the health and well-being of all HCBS waiver participants by identifying trends that may indicate training and education needs. Unexplained deaths are those deaths for which the reason or cause of the death is unclear or unknown.

Providers must report the following types of critical incidents to DDD:

- Allegation, suspicion, or actual events of verbal, physical, sexual, psychological, emotional abuse, neglect, or exploitation of a child or vulnerable adult.
- Allegation or suspicion of financial exploitation.
- Misuse or unauthorized use of restrictive interventions or seclusion.
- A medication error resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death.
- Unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

Providers must also report the following incidents to the state when the incident occurs during the delivery of services or as a result of the failure to deliver services:

- Actual or Potential Airway Obstruction
- Communicable Disease
- Death of a Participant
- Emergency Situations
- Fall with Significant Injury
- Fatal 5
- Incidents Involving Emergency Personnel Requiring Emergent Response
- Infestations
- Injuries of Unknown Origin Raising Suspicion
- Injury Requiring Medical or Nursing Interventions beyond First Aid
- Medication Errors
- Misconduct not Involving Law Enforcement
- Missing Person(s)
- PRN Psychotropic Medication Usage
- Property Damage
- Suicide Attempts
- Swallowing Inedible Items
- Unplanned Hospital/Emergency Room/Urgent Care Visit
- Use of Emergency Safety Interventions
- Vehicle Accident

Electronic incident forms will be completed for all reports of incidents or deaths received by or known to local agency/office staff. Types of incidents recorded on the electronic incident forms are abuse, neglect/unsafe environment, financial exploitation/theft, licensing violations, environmental events (e.g. fire, weather, flooding), imminent (life-threatening) danger, and deaths. Multiple types of incidents may be recorded on the same incident form if they happened at the same time.

When an incident (i.e., abuse, neglect/unsafe environment, financial exploitation/theft, licensing violations, imminent danger) becomes known to local agency/office staff, local agency/office staff must take appropriate action by reporting the incident to appropriate authorities. Appropriate authorities would include Adult or Child Protective Services and Law

Enforcement as appropriate for all types of incidents, and Regulation and Licensure for incidents involving licensed providers/facilities. Depending on the situation, it may be appropriate to contact more than one type of authority. The action taken and the date the action was taken will be documented on the electronic incident form.

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

For incidents representing imminent (serious or life-threatening) danger or environmental events (e.g. fire, weather flooding), the Service Coordination Agency supervisor or designee must notify DDD staff by the next working day that a situation of imminent danger or environmental event has occurred. This notification may occur by either telephone or email. By the end of the following working day, DDD staff will review the incident with the supervisor to determine if appropriate action is being taken (appropriate authorities have been notified) and if appropriate waiver resolution activities are occurring.

For incidents representing deaths, local agency/office staff should notify the designated DDD staff by the next working day by telephone or email.

Service Coordination Agency staff will perform waiver resolution activities in order to mitigate the incident that has occurred and ensure the health and safety of the participant. These activities will be documented on the electronic incident form, along with the date of completion of the activity. Multiple activities may need to be performed depending on the nature of the incident.

Timelines for Service Coordination Agency Staff for Incidents that are not death-related:

Within 30 working days of the day the incident is reported to Service Coordination Agency staff, the incident must be resolved (waiver resolution activities completed), unless unforeseen circumstances arise. The completed electronic incident form must be submitted to DDD staff (using the electronic data management system) within 15 working days of completion of the waiver resolution activities. If unforeseen circumstances arise that prevent the incident resolution from occurring within 30 working days, the Service Coordination Agency will notify DDD staff of the reason for the delay. When the incident resolution has been completed, the local agency/office will submit the incident form to DDD.

Timelines for Service Coordination Agency Staff for Incidents that are death-related:

After notifying DDD staff of the death by telephone or email, the Service Coordination Agency staff will complete the electronic incident form and email the completed electronic incident Form to DDD staff (using the link in the electronic system). The Service Coordination Agency staff will then upload the following service coordination records to the participant's electronic case file within 10 working days of notification:

- Notification of Client Death Form
- Assessment current at the time of death
- Person-Centered Plan current at the time of death
- Hospice Plan of Care, if active at the time of death
- Home Health Plan of Care, if active at the time of death
- Autopsy and Police Reports when completed, if available.

Timelines for DDD staff for Incidents that are not death-related:

DDD staff and the QIO-like entity will review the completed electronic incident form Within 30 working days of the day the incident is reported to Service Coordination Agency staff, the incident must be resolved (waiver resolution activities completed) unless unforeseen circumstances arise. The completed GER must be submitted to DDD staff (using the electronic data management system) within 15 working days of completion of the waiver resolution activities. If unforeseen circumstances arise that prevent the incident resolution from occurring within 30 working days, the Service Coordination Agency will notify DDD staff of the reason for the delay. When the incident resolution has been completed, the local agency/office will submit the incident form to DDD.

Timelines for DDD staff for Incidents that are death-related:

A preliminary review of the records regarding the participant's death and circumstances around the death will be conducted by the appropriate DDD staff. Additional information or action by Service Coordination Agency Staff may be requested at any time during the review of the death. If additional information/action was required, upon receiving the appropriate information, the DDD staff will complete the review. DDD staff will inform Service Coordination Agency Staff by email that the electronic incident form, along with the death review, have been completed, approved, and

finalized.

DDD staff will analyze the statewide results for all incident forms and present findings to the DDD QI Committee. Referrals to the appropriate authorities do not replace the need for a Service Coordination assessment of participant needs and revision of the person-centered plan when necessary. The statewide results are analyzed and findings are presented to the DDD QI Committee.

Guidelines for mandatory reporting for abuse, neglect, and exploitation for the adult/aged population can be found on the DHHS website at <http://dhhs.ne.gov/Pages/Adult-Protective-Services.aspx>.

Guidelines for mandatory reporting for abuse, neglect, and exploitation of children can be found at <http://dhhs.ne.gov/Pages/Child-Abuse.aspx>

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

The definition of child abuse or neglect is located in Nebraska Revised Statutes 28-710. Child abuse or neglect means knowingly, intentionally, or negligently causing or permitting a minor child to be: placed in a situation that endangers his or her life or physical or mental health; cruelly confined or cruelly punished; deprived of necessary food, clothing, shelter, or care; left unattended in a motor vehicle if such minor child is six years of age or younger; sexually abused; or sexually exploited by allowing, encouraging, or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films, or depictions.

DDD annual reporting on the initiation of critical incident investigation, critical incident investigation and resolution, and completed corrective action plans related to critical incidents must meet a 90% minimum performance level for occurring within state-specified timeframes per the HCBS Final Settings Rule.

- 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.

Service Coordinators provide new participants and legal representatives with written information on their right to be free from abuse, neglect, and exploitation. This includes information on how to notify appropriate authorities of abuse, neglect, or exploitation by calling the toll-free Nebraska Abuse/Neglect Hotline. This information is given to the participant upon waiver eligibility and discussed during monitoring visits. Participant health and welfare is monitored during visits with participants, and Service Coordinators address protection and safety issues as the need arises when working with their participants.

All Service Coordinators are mandatory reporters, so any instance of abuse, neglect, or exploitation related by the participant to the Service Coordinator during monitoring would be reported to appropriate authorities including Adult or Child Protective Services, Law Enforcement, and Regulation and Licensure (for licensed providers/facilities).

Service Coordinators do in-home visits, giving the participant the opportunity to file a report in person. If at times other than when the Service Coordinator is doing visits, participants may report to any mandatory reporter, including but not limited to medical professionals, law enforcement, caregivers, employees of any facility licensed by the Department, or human services professionals.

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

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

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Service Coordinators' responsibility in the review and response to critical incidents is to recognize and report to appropriate authorities. Investigations of the incident is conducted and the primary responsibility of the appropriate authorities which may include Adult or Child Protective Services, Law Enforcement, and Regulation and Licensure (for licensed providers/facilities).

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

The DDD QI Committee assists in identifying methods to analyze this data and identify trends.

As outlined in regulations Title 480 NAC, Service Coordinators must report to the appropriate authorities which may include Adult or Child Protective Services, Law Enforcement, and Regulation and Licensure (for licensed providers/facilities) when participant safety is at risk.

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

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

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

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

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

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

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

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

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

Child Protective Services (CPS) timelines for investigations are similar to APS timelines with a couple of exceptions. For

Priority 1 allegations, the practice is that CPS staff immediately begin the investigation unless law enforcement is there. Documentation must be done within 24 hours. The other major difference is that CPS investigations must be completed within 30 days. Additional information about the Child Protection and Family Safety Act may be found in Nebraska Revised Statute Sections 28-701 to 28-727.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Adult or Child Protective Services staff are contained within the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services. DHHS is a single-state Medicaid Agency. Protection and Safety staff are responsible for the oversight of the critical incident management system.

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

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

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

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

Both the DHHS (the Medicaid agency) and DDD QI Committee oversee the results of critical incidents and events on an annual basis, as the data from Protection and Safety is reported to the waiver unit at least once per year. Data from this process is part of Nebraska's quality management process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The State does not permit the use of restraints by any provider of any waiver service. Services such as personal care, chore, respite, escort during transportation, and extra care for children with disabilities include supervision components that assure that waiver participants receive individualized oversight from qualified providers to maintain participant safety and dignity.

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

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

Service Coordination Agency staff are responsible for participant monitoring, which includes interviewing the participant regarding the satisfaction of their care, observation of service delivery, and documenting the monitoring. They are positioned to identify potential use of prohibited restraints and would report such a finding to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also intended to identify and address inappropriate consideration or use of any type of restraint.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State does not permit the use of restrictive interventions by any provider of any waiver service. Services such as personal care, chore, respite, escort during transportation, and extra care for children with disabilities include supervision components that assure that waiver participants receive individualized oversight from qualified providers to maintain participant safety and dignity.

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

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

Service Coordination Agency staff are responsible for participant monitoring which includes interviewing the participant regarding the satisfaction of their care and observation of service delivery. They are positioned to identify potential use of restrictive interventions and would report such a finding to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also in effect to identify and address inappropriate consideration or use of restrictive interventions.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State does not permit the use of seclusion by any provider of any waiver service. Services such as personal care, chore, respite, escort during transportation, and extra care for children with disabilities include supervision components that assure that waiver participants receive individualized oversight from qualified providers to maintain participant safety and dignity.

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

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

Service Coordination Agency Staff are responsible for participant monitoring which includes interviewing the participant regarding the satisfaction of their care and observation of service delivery. They are positioned to identify potential use of seclusion and would report such a finding to the State as a complaint report or an incident report. Other quality reviews and billing oversight conducted by DDD staff are also in effect to identify and address inappropriate consideration or use of seclusion.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

- **Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

One service of the Aged and Disabled waiver is the Supported Residential Living service. These facilities are licensed by the DHHS Division of Public Health, Licensure Unit. The Licensure Unit has ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

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

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

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

Each assisted living facility must provide for a Registered Nurse to review medication administration policies and procedures annually and to provide or oversee the training of medication aides at such facility. Training of medication aides must include, but is not limited to:

1. Facility procedures for storing, handling, and providing medications;
2. Facility procedures for documentation of medications;
3. Facility procedures for documentation and reporting medication errors and adverse reactions;
4. Identification of person(s) responsible for direction and monitoring of medication aides; and
5. Other participant-specific training on providing medications in accordance with the limits and conditions of the Medication Aide Act.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Supported Residential Living service includes medication administration as one of the components. Waiver regulations reference that Supported Residential Living providers must be licensed and abide by the assisted living facility licensure regulations found at Title 175 NAC 4 and described below.

As outlined in Title 175 NAC 4, a participant in an assisted living facility may self-administer medications under the following conditions:

1. Be at least 19 years of age;
2. Have cognitive capacity to make informed decisions about taking medication;
3. Be physically able to take or apply a dose of medication;
4. Have capability and capacity to take and apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for non-prescription medication; and
5. Have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The Supported Residential Living provider must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

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

Medication Aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of:

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

A Medication Aide is listed on the Medication Aide registry operated by the Licensure Unit of DHHS, Division of Public Health. Medication Aides are allowed to perform Medication Provision which is a component of Medication Administration that includes giving or applying a dose of medication to an individual and includes helping an individual in giving or applying medication to themselves. Each Assisted Living Facility must establish and implement policies and procedures that ensure that medication aides who provide medications are trained through a Medication Aide Course and have demonstrated minimum competency standards in accordance with the Regulations governing the Provision of Medication Aides and Other Unlicensed Persons and the Regulations governing the Medication Aide Registry. Direction and Monitoring means, for the purpose of medication administration by unlicensed persons, the acceptance of responsibility for observing and taking appropriate actions regarding any desired effects, side effects, interactions, and contraindications associated with the medications. Direction and Monitoring may be done by a competent individual for themselves, a Licensed Health Care Professional, or a caretaker (a person who is directly and personally involved in providing care for a minor child or incompetent adult and/or is the parent, foster parent, family member, friend or legal guardian of such minor child or incompetent adult as referenced in the Nebraska Nurse Practice Act). A licensed health care professional is not mandated to be present during the provision of medication by an unlicensed person.

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

The training requirements for medication aides are outlined in Title 172 NAC 96-004.02. Medication aides providing services in an assisted-living facility must successfully complete a 40-hour course. The course must be on the competency standards identified in Title 172 NAC 96-005.01A. These competencies include:

1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);

- 6. Having the ability to understand and follow instructions;
- 7. Practicing safety in application of medication procedures;
- 8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
- 9. Having knowledge of abuse and neglect reporting requirements; and
- 10. Complying with every recipient’s right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

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

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies and allows for the Medication Aide Act described above. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act.

- **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:

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

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

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is

performed and its frequency.

One of the Aged and Disabled Waiver's services is Supported Residential Living and the DHHS Division of Public Health, Licensure Unit has ongoing responsibility for monitoring licensed assisted living facilities in the administration of medications to all participants, including those who are on this Waiver. The Department of Health and Human Services is the State Medicaid agency and includes both the Division of Public Health and the Division of Developmental Disabilities. The Licensure Unit is under the Division of Public Health; therefore it is part of the State Medicaid agency. Medication errors made by assisted living facilities are reported to the Department of Health & Human Services.

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the 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.

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

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 substantiated abuse/neglect/exploitation/unexplained death incidents where required/recommended follow-up (safety plans, corrective action plans, provider sanctions, etc.) was completed. N=# of substantiated abuse/neglect/exploitation/unexplained death incidents where required/recommended follow-up was completed. D=# of substantiated abuse/neglect/exploitation/unexplained death incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1451 1264 1536" type="text"/>
Other Specify: <input data-bbox="408 1675 647 1760" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1675 1264 1760" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1899 1264 1984" type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of participants' death related incidents reviewed which did not require additional follow up/remediation. Numerator = number of participants' death related incidents which did not require additional follow up/remediation; Denominator = number of participants' death related incidents.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

and % of participants and/or legal guardians who received information about how to identify and report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver. N = # of participants and/or legal guardians who received information about how to identify and report abuse, neglect, exploitation and other critical incidents. D = # of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% confidence level with +/- 5% margin of error."/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <input style="width: 100%;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Number and percent of incident reports submitted by Service Coordination Agencies for substantiated Adult and Child Protective Services (APS/CPS) intakes. Numerator = Number of incident reports submitted by the Service Coordination agencies for substantiated APS/CPS intakes. Denominator = Number of substantiated APS/CPS intakes.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of non-death related Critical Incident reports completed with appropriate waiver resolution activity. Numerator = number of non-death related Critical Incident reports completed with appropriate waiver resolution activity; Denominator = number of non-death related Critical Incident reports.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

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

	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number and percent of critical incident trends where systemic intervention was implemented. Numerator = number of critical incident trends where systemic intervention was implemented. Denominator = Number of critical incident trends identified.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic system reports

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (<i>check each that applies</i>):
-----------------------------------	--	---

collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level with +/- 5% margin of error.
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">95% confidence level with +/- 5% margin of error.</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

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
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

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

Quarterly file reviews are conducted by service coordination supervisors. Additionally, DDD quality staff annually conduct file reviews to verify the work of the service coordination supervisors. The percentage of file reviews will be included in the State's review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the service coordination agency and state levels have been developed to discover whether the federal Participant Safeguards waiver assurance is being met, to remediate identified problems, and to

carry out quality improvement. These processes and activities generate information that is aggregated and analyzed to measure the overall system performance.

When individual problems related to health and welfare are identified through discovery processes, service coordination agencies are responsible for remediating those problems in an appropriate and timely manner (45 days).

The quality strategies for reviewing health and welfare are:

1. Incident and death review process:

- The service coordinator uses an electronic incident form in the electronic case management system to record critical incidents, including death-related incidents and non-death-related incidents.
- Once the incident report has been completed, it is electronically submitted to DDD staff.
- The incident is reviewed by assigned DDD staff to determine if the waiver resolution activities are complete. If further remediation is necessary, DDD staff review the incident with the service coordinator and/or service coordination supervisor to determine appropriate actions. Remediation is documented by DDD staff on the electronic incident report form.
- After remediation is completed, DDD staff complete the state oversight review section of the electronic incident form and finalize the form.
- Unexplained deaths will be referred by the DDD staff person reviewing the death-related incident to the Mortality Review Committee for additional review.

2. File Reviews:

- As part of their discovery processes, all service coordination supervisors are required to complete electronic file reviews of service coordination files on an ongoing basis as assigned by DDD staff. These file reviews ensure that any identified individual issues of abuse, neglect, and exploitation are addressed.
- These review activities are documented in an electronic file review. File review questions that do not meet standards require remediation/supervisory follow-up.
- Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation and/or action occurred to address the problem must be followed up on immediately with the service coordinator.
- If a reassessment is needed and it is determined waiver services and supports are sufficient to ensure the participant's health and welfare, the participant may continue on the waiver. If waiver services and supports are insufficient to ensure the participant's health and welfare, the case is closed, a notice of action is sent to the participant, and the participant is referred to other possible services.
- Follow-up action is recorded in the remediation section of the electronic file review tool.

3. DDD File Reviews and Electronic Reports:

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

Practices are in place to assist service coordination agencies in evaluating whether problems are systemic to their agency. Service coordination supervisors use an electronic case management system to run reports of file reviews and other data to evaluate the performance of their agency. Service coordination supervisors may also use the electronic case management system to perform additional agency-specific file reviews. The electronic case management system enables the agency to perform either the entire file review or a partial review of identified or suspected problem areas.

Performance measure-related data reports developed by the DDD QI Committee will be shared with service coordination agencies at least quarterly. This enables agencies to compare their performance with the overall trend of all agencies

combined to determine whether or not there might be an agency-specific issue.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The stated purpose of the DDD Waivers Quality Improvement System (QIS) is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a quality management system.

The DDD HCBS Waiver Framework guides the state's process of monitoring the safeguards and standards under the waiver. A set of key principles guide the QIS and are contained in Nebraska's HCBS Quality Improvement System document. Nebraska's QIS uses an evidence-based tiered approach which includes several activities and processes at both the service coordination/resource development agency and state levels. This system has been developed to discover whether the federal waiver assurances are being met, to remediate identified problems, and to carry out quality improvement.

Nebraska's HCBS Waiver quality oversight involves DDD program and quality staff. Additionally, DDD Data Management and Operational Reporting team ensures sampling approaches are sufficient to produce the correct sample based on the team's verification of the appropriate sample universe.

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

DDD quality staff provide a systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under quality include reviewing electronic participant data, conducting file reviews; implementing NCI-AD surveys; and oversight of the various service coordination/resource development agency quality efforts.

Both DDD program and quality staff are involved in discovery related to death and non-death related incidents; complaints; and data collection and analysis.

A DDD QI Committee is composed of staff from both the program and quality areas, as well as representation from service coordination/resource development agencies. This committee meets at least quarterly (or four times per year) to review aggregate data for waiver performance measures and any other identified issues. The committee makes recommendations for changes that may lead to systemic improvement in the quality of services, as well as recommendations related to remediation efforts. Relevant reports will be provided to DDD QI Committee members, as well as other identified stakeholders, and posted on the DHHS website at least quarterly. Issues or concerns about the reports will be communicated to DDD and referred back to the DDD QI Committee.

Using electronic systems, additional quality reports are generated as needed or requested by the DDD QI Committee, service coordination/resource development agencies, or stakeholders.

The State's waiver service delivery design incorporates two functions, service coordination and resource development. These two roles each focus on a key area. Service coordination staff work with participant's needs, eligibility, and service planning. Resource development staff concentrate on issues of qualified providers, including their compliance with standards. Communication between the two functions is key and both provide continuous monitoring of service delivery.

Following the discovery of needed improvement in any area, DDD staff confer, plan, and involve service coordination/resource development agencies, the DDD QI Committee, as needed. Continuous Quality Improvement, that is statewide systemic program enhancement, occurs through any combination of the following remediation activities:

1. Training and meetings:
 - These are offered or mandated for supervisors, service coordinators, and resource developers, as appropriate.
2. Policy or procedure development or implementation to add, revise, or clarify program expectations determined necessary for program improvement.
3. Informational materials including written guidance for staff or brochures directed toward participants or the public.
4. Best practices:
 - This includes the identification, dissemination, and implementation of best practice concepts on a statewide

basis.

5. Remediation of individual problems.

- This is the responsibility of the service coordination/resource development agencies with DDD staff providing the oversight to ensure completion. Technical assistance is also provided to service coordination/resource development staff on a continuous ongoing basis to aid understanding of policies and procedures and to address individual situations.

6. Shared resolution:

- This is a formally defined process, based on proactive partnership, to work with service coordination/resource development agencies/staff to resolve and improve instances which:
 - (1) Reflect performance below expectations that cannot be remediated through technical assistance;
 - (2) Indicate a pattern of policy or procedure non-compliance that does not include a participant safety concern;
 or
 - (3) Identified through formal discovery and determined not egregious as defined in the Quality Improvement Plan process.

7. Quality Improvement Plan:

- This is a formally defined process, based on a performance oversight model, to resolve and improve performance when a discovery method has identified an apparent contract violation or immediate risk to participant health and safety. This remediation is appropriate for these egregious issues as well as when other remediation has been unsuccessful or determined ineffective.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text"/>

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.

DDD is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. DDD staff, are responsible for coordinating the development, implementation and monitoring of any system design changes. DDD staff work closely with the DDD QI Committee to assure the appropriate identified priority system issues are developed, implemented and monitored to assure system change occurs. Quarterly and/or annual data is aggregated and compared to the previous baseline evidence to determine if the identified system change is effective.

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

As described in H-1.a.i. (System Improvements), the State has in place a Quality Improvement System that includes discovery leading to remediation. In turn, that leads to system improvement. This is an ongoing, circular system with components of discovery, remediation, improvement, design, and operations.

DDD quality staff fulfill the lead role in guiding this improvement along with input from service coordination/resource development agencies, and the DDD QI Committee.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

DDD quality, program, and data staff evaluate the effectiveness of the waiver Quality Improvement System on a continuous, ongoing basis. Nebraska QIS strategies stratify information for the Aged and Disabled Waiver (NE.0187) and the Traumatic Brain Injury Waiver (NE.40199). Data for the AD waiver and TBI waiver is aggregated and analyzed separately. Identified Medicaid State Plan system issues are relayed to staff responsible for services under the Medicaid State Plan.

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

Just as the assumption is that services can always be improved, the same concept also holds with the QIS system. Efforts are continually being made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements, and eliciting additional feedback from agencies and providers regarding quality improvement issues.

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

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

Just as the assumption is that services can always be improved, the same concept also holds with the QIS system. Efforts are continually being made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements, and eliciting additional feedback from agencies and providers regarding quality improvement issues.

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

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

--

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

The DHHS Financial Services unit operates the cost allocation plan, prepares and monitors budget projections for MLTC and DDD, prepares federal and state reports as required, and prepares the CMS-64 reports.

a) The state-mandated web-based case management and MMIS systems establish the audit trail necessary for the Nebraska Auditor of Public Accounts (APA) to conduct the single state audit on an annual basis. The APA conducts audits based on federal audit guides, where priorities are identified. Cases are pulled from random samples, which may or may not be statistically valid representative samples with a 95% confidence level and +/- 5% margin of error. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> is used annually to validate the sample size.

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

b) DDD staff tests a sample of provider billings in its file review process as part of the ongoing Quality Management system. One or more providers of the participant's case are selected for the audit. Paid claims are reviewed against the prior authorization, documentation of service provision, and provider certification process, to ensure appropriate payment was made to the provider. Reviews may differ by service type. Tested claims are selected to create a statistically valid representative sample with a 95% confidence level and +/-5% margin of error. These reviews occur quarterly.

Quarterly on-site file reviews are conducted by local-level supervisors. Additionally, DDD quality staff annually conducts off-site file reviews to verify the work of the local-level supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal off-site and on-site review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at <http://www.raosoft.com/samplesize.html> is used annually to validate the sample size.

c) The Nebraska Auditor of Public Accounts (APA) and DHHS are responsible for conducting these financial audits. The APA is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. The APA conducts the audits on an annual basis.

The state implemented an Electronic Visit Verification System in January 2021. The following services are subject to EVV:

- LRI Personal Care*
- Personal Care*
- Respite Care (In-Home)*
- Companion*

Providers are required to use the EVV system. EVV data collected is used to monitor the State's financial integrity and accountability as an element of the post-payment review processes."

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 Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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

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

Performance Measure:

Number and percent of paid claims reviewed which were paid only for services rendered in accordance with the reimbursement methodology specified in the approved waiver.

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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 = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95% confidence level with +/- 5% margin of error.</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	<p>Other Specify:</p> <input type="text"/>	

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):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p>Other Specify:</p> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p>Other Specify:</p> <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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):
<i>State Medicaid</i>	<i>Weekly</i>	<i>100% Review</i>

<i>Agency</i>		
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px;"><i>95% confidence level with +/- 5% margin of error.</i></div>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record reviews

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	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error. </div>

<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <input type="text"/>

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

Quarterly file reviews are conducted by services coordination/resource development supervisors. Additionally, DDD quality staff annually conducts file reviews to verify the work of the service coordination/resource development supervisors. The percentage of the file reviews will be included in the State's review processes. Those processes will be reviewed annually by the DDD Data Management and Operational Reporting team to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error based on the DDD Data Management and Operational Reporting team's verification of the appropriate sample universe. The Raosoft calculator at

<http://www.raosoft.com/samplesize.html> will be used annually to validate the sample size.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A number of activities and processes at both the service coordination/resource development agency and state levels have been developed to discover whether the federal level of care waiver assurances are being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that is aggregated and analyzed to measure the overall system performance. Service coordination/resource development agencies are responsible for remediating all claims-related individual problems identified through discovery processes in an appropriate and timely manner (45 days).

The quality strategies for reviewing claims are:

1. File Reviews:

- As part of their discovery processes, all service coordination/resource development supervisors are required to complete on-site electronic file reviews of service coordination/resource development files on an ongoing basis as assigned by DDD staff. These file reviews ensure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. File review responses are documented in an electronic system.*
- The service coordination/resource development agencies are responsible for remediating all claim problems identified through its discovery processes in an appropriate and timely manner (45 days). File review questions that do not meet standards will require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from the date of the review and be recorded in the remediation section of the electronic file review.*
- As applicable, payment errors are referred to Program Integrity for claim recovery processing.*

2. DDD File Reviews and Electronic Reports:

- DDD staff monitor statewide file reviews to ensure review and remediation activities are completed as assigned. Review documentation must include information that all claims are coded and billed correctly and have been resolved correctly.*
- DDD also conducts off-site file reviews and reviews claim data reports to ensure continuous improvement of service coordination/resource development agencies.*
- Besides remediation being accomplished by follow-up of individual or systemic issues, the service coordination/resource development agency could be responsible for a shared resolution or quality improvement plan.*
- As applicable, payment errors are referred to Program Integrity for claim recovery processing.*

Practices are in place to assist service coordination/resource development agencies in evaluating whether problems are systemic to their agency. Service coordination/resource development supervisors use an electronic case management system to run reports of file review and other data to evaluate the performance of their agency. Service coordination/resource development supervisors may also use the electronic case management system to perform additional agency-specific file reviews. The electronic system enables the service coordination/resource development agency to perform either the entire file review or a partial review of identified or suspected problem areas.

Performance measure-related data reports developed by the DDD QI Committee will be shared with service coordination/resource development agencies at least quarterly. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency-specific issue.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p>Other Specify:</p> <div data-bbox="317 331 794 416" style="border: 1px solid black; height: 38px; width: 299px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div data-bbox="863 618 1340 703" style="border: 1px solid black; height: 38px; width: 299px;"></div>

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

This waiver employs a fixed rate method of rate determination for the following services: Supported Residential Living Services, Adult Day Health Services, and Non-Medical Transportation. These fee-for-service rates are established by the state Medicaid agency. The Division of Medicaid and Long-Term Care (MLTC) publishes the following fee schedules on an annual basis.

DDD Fee Schedule: <https://dhhs.ne.gov/Pages/AD-Provider.aspx>

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

Initial rates for the Supported Residential Living Services were determined through a public stakeholder process. Numerous meetings were held with provider association groups to determine the current formula, which recognizes urban and rural variances. Resource development staff share with DDD staff information they have directly received from providers on the adequacy of rates and rate-setting methods.

For the Supported Residential Living Service, variable rates are utilized to account for differences in costs for rural/urban and single/multiple occupancy. Standard Rates are for licensed and waiver-certified facilities that did not receive a grant through the Nursing Facility Conversion Cash Fund. Health Care Trust Fund rates are for licensed and waiver-certified assisted living facilities that received a Grant from the Nursing Facility Conversion Cash Fund. The Nursing Facility Conversion Cash Fund. Rates are adjusted when additional funding is appropriated by the Legislature.

Health Care Trust Fund rates are set at 95% of the Standard Rates. Both the Standard Rates and the Health Care Trust Fund rates are further broken down into rural and urban rates. Rates differentiate between the single occupancy of an assisted living unit and the multiple occupancy of one unit. Each rate consists of three parts:

- 1) The amount the facility must collect for room and board from the participant;*
- 2) The Medicaid responsibility; and*
- 3) The participant's "share of cost" (SOC) must be obligated before HHSS will assume financial responsibility for the service component.*

The room and board, Medicaid responsibility, and participant's share of cost together equal the total monthly rate.

DDD Central Office is the responsible entity for rate determination oversight. DDD Central office provides oversight of rate determinations. These reviews were conducted for the purpose of studying and, when necessary, rebasing provider rates. DDD intends to perform comparable reviews on an ongoing, periodic basis for the purpose of determining the adequacy of rates. DDD intends to study rates and, when necessary, rebase rates at least Every five years, but may be rebased more frequently depending on the availability of resources.

Rates for other waiver services are currently set on an individual provider basis through a negotiation process between the provider and the local resource developer. Rates are reviewed annually at the time the provider's annual agreement is scheduled to end. Providers also may request renegotiation if a participant's care needs have increased. The provider may not charge the State more than privately paid individuals are charged. The state Medicaid agency has the authority to establish rates for these services, which include: Chore, Companion, Extra Care for Children with Disabilities, Respite services, Home Again, Independence Skills Building Services, LRI Personal Care, Personal Care, and Personal Emergency Response System. Rate negotiating takes into account the level of participant service need, the skill level of the provider, and geographic location. Rates are established based on usual and customary rates that are not more than the provider would charge a private paying individual. Following negotiation, all new rate determinations are reviewed

and approved by DDD Central Office to ensure that rates fall within a meaningful range and do not exceed what is usual and customary.

Rates for LRI Personal Care are set on an individual provider basis through a negotiation process between the provider and the local resource developer. Rates are reviewed annually at the time the provider's annual agreement is scheduled to end. Providers also may request renegotiation if a participant's care needs have increased. The provider may not charge the State more than privately paid individuals are charged.

Home-delivered meal rates are a combination of fixed and negotiated rates, depending on provider type, and are negotiated by DDD Central Office based on provider costs. Home Modification and Vehicle Modification, Assistive Technology, and Personal Emergency Response System are provided at a market rate and approved on a per-case basis. These payments are managed through a bidding process and reviewed by DDD Central Office.

DDD Central Office is the responsible entity for rate determination oversight. DDD Central office provides oversight of rate determinations, which are reviewed every 5 years.

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

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

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The state currently has four different flows of billings for services provided on the Aged and Disabled waiver:

1. Service claims processed through the state-mandated web-based case management system that are not subject to EVV: The following services are processed by this flow of billings:

- Adult Day Health Services*
- Extra Care for Children with Disabilities*
- Home Delivered Meals*
- Independence Skills Building*
- Non-Medical Transportation*
- Personal Emergency Response System (PERS)*
- Chore*

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

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

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During payment processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's accounting system, EnterpriseOne, which then generates claim payments to the provider.

The program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the EnterpriseOne. The state-mandated web-based case management system stores the timestamp and user ID for all new or updated information related to this process.

Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to EnterpriseOne. Claims are processed on a daily basis.

2. Service claims processed through the state-mandated web-based case management system that are subject to EVV: The following services are processed by this flow of billings:

- LRI Personal care*
- Personal Care*
- Respite Care (In-Home)*
- Companion*

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

3. Service claims processed through MMIS:

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

4. Service claims processed directly through EnterpriseOne (formerly NIS):

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

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

5. Claims processed through MMIS: Claims for the following services are processed through MMIS:
- Supported Residential Living

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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

Claims are paid when:

- 1) The individual was eligible for Medicaid waiver payment on the date of service;
- 2) The service was included in the participant's approved service plan; and
- 3) The services were provided.

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

A post-payment review is completed as part of the Nebraska HCBS Waivers Quality Improvement System (QIS) off-site and on-site review processes. The DDD staff complete off-site reviews, and supervisory staff at local level agencies contracted to provide services coordination complete on-site reviews. The review form is the same for both the off-site and on-site reviews.

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

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

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

Assistive Technology and Home and Vehicle Modification claims are processed through the EnterpriseOne by DHHS Finance staff. Claims are coded by DHHS based on billings submitted by Assistive Technology Partnership contracted staff for eligible participants.

Claims are paid when:

- 1) The individual was eligible for Medicaid waiver payment on the date of service;
- 2) The service was included in the participant's approved service plan; and
- 3) The services were provided.

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

c) All providers sign an agreement every five years stipulating that they maintain records and documentation in sufficient detail to allow the State to verify units of service provided to individuals as certified on the state billing document. Each billing document must be signed by the provider or submitted through the Electronic Visit Verification (EVV), certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

When waiver services are delivered by an independent provider and are not subject to EVV, a service timesheet is

submitted with each billing document and signed by the waiver participant or, if applicable, the family member/guardian. Both the timesheet and billing document are forwarded to local waiver staff who are responsible for reviewing and verifying the units of services billed by the provider. When these services are subject to EVV, the provider documents required billing data in the EVV system and sends this to Tellus, the state EVV data aggregator for processing.

Participants are provided the choice of providers and have employer authority with hire and fire rights. The person-centered plan (PCP) has a provider choice section signed by the participant during the development of the plan, indicating the participant has freely chosen providers for the time period of the PCP. Service Coordinators are to make monthly contact with participants to evaluate the effectiveness of the PCP and the quality of the services provided, and ascertain if both the formal and informal supports being provided continue to meet the participant's needs, and the participant's satisfaction with the services.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

All providers are paid directly by the state Medicaid agency.

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

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

Payments for waiver services are made through the state-mandated web-based case management system, which is not an approved MMIS. The following functions are incorporated into the application, with the exception of the actual issuance of payment which is via the NIS application and is explained below.

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

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

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

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During payment processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher which is then sent to the state's accounting system, the Nebraska Information System (NIS).

- All payments are processed as described above by the Nebraska Department of Health and Human Services System through the state-mandated web-based case management system and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.*

- The payment processes ensure a proper audit trail is maintained because the waiver service payment is linked on a per-participant basis to the provider. Each service is prior authorized and the prior authorization number, which links the provider to the participant and the service, is present on the claim. If the prior authorization number is not*

on the claim, the claim will be denied. As described above, the program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the Nebraska Information System (NIS). The state-mandated web-based case management system stores the timestamp and user ID for all new or updated information related to this process.

- Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

--

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

--

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements

under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

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

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

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15656.19	8370.34	24026.53	45689.56	4855.40	50544.96	26518.43
2	16663.50	8537.75	25201.25	46603.36	4952.51	51555.87	26354.62
3	16104.83	8708.51	24813.34	47535.42	5051.56	52586.98	27773.64

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)
4	16763.42	8882.68	25646.10	48486.13	5152.59	53638.72	27992.62
5	17443.61	9060.33	26503.94	49455.85	5255.65	54711.50	28207.56

Appendix J: Cost Neutrality Demonstration

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

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	12000		12000
Year 2	12000		12000
Year 3	13000		13000
Year 4	13000		13000
Year 5	13000		13000

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.

The average length of stay is calculated as an average between waiver days for NFOCUS waiver services (calculated by the count of days of service for all claims by person) and averaged with the average number of days of assisted living. These were based on the waiver year 2023 actuals from the most recent 372 report. The ALOS is expected to remain constant because the new participants added are expected to have similar care needs to those already on the waiver. It is not expected that the new participants would need to receive services longer than the current population.

Appendix J: Cost Neutrality Demonstration

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

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The estimated number of users per service, average units per user, and average cost per unit are based on waiver year 2023 actuals from the most recently completed 372 report for these services and inflated each year of the renewal by a population growth factor and a price growth factor. The 2023 actuals are trended to waiver year 1 using the same methodology. The population growth factor was applied to the expected number of users for each service and is the same for each service. The price growth factor was applied to the average cost per unit for each service and it was the same for each service. The estimates assume average units per user consistent with those in the most recently completed 372 report. They are not increased or decreased by a factor.

The population growth factor is based on the growth rate of 'individuals with a disability, under age 65 years, percent, 2015-2019' statistic for the state of Nebraska published by the United States Census Bureau (retrieved July 14, 2021, from <https://www.census.gov/quickfacts/NE>). The cost growth factor is based on historical appropriations made by the Nebraska Legislature for rate increases for these services.

Personal Care estimates based on uniform allocation from chore service and a review of the most recent 372 WY2 report. Companion estimates based on uniform allocation from chore service and a review of the most recent 372 WY2 report. Assistive Technology estimates based on actual 2019 data consistent with other services and a review of the most recent 372 WY2 report. Home and Vehicle Modifications estimates based on actual 2019 data consistent with other services and a review of the most recent 372 WY2 report.

LRI Personal Care estimates are based upon Personal Care service rates from the most recent 372 WY2 report.

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

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

The estimates are based on waiver year 2023 actuals for acute services for the waiver population and inflated each year of the renewal by a growth factor of two percent.

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

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

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

Based on waiver year 2023 (August 1, 2022 - July 31, 2023) actuals of nursing facility expenditures and inflated each year of the renewal by a growth factor of two percent.

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

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

The estimates are based on waiver year 2020 (August 1, 2022 - July 31, 2023) actuals for state plan services for the nursing facility population and inflated each year of the renewal by a growth factor of two percent.

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

Appendix J: Cost Neutrality Demonstration

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

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health Services	
Personal Care	
Respite Care	
Assistive Technology	
Chore	
Companion	
Extra Care for Children with Disabilities	
Home Again	
Home Delivered Meals	
Home Modifications	
Independence Skills Building	
LRI Personal Care	
Non-Medical Transportation	
Personal Emergency Response System (PERS)	
Supported Residential Living	
Vehicle Modification	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Services Total:						1228345.02
Adult Day Health Services Day	Day	112	117.00	89.88	1177787.52	
Adult Day Health Services Hourly	Hour	30	75.00	22.47	50557.50	
Personal Care Total:						48654706.08
Personal Care Hourly	Hour		1644.00	18.28	48654706.08	
<p>GRAND TOTAL: 187874309.25 Total Estimated Unduplicated Participants: 12000 Factor D (Divide total by number of participants): 15656.19 Average Length of Stay on the Waiver: 184</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1619				
Respite Care Total:						2247900.16
Respite Care Day	Day	391	12.00	93.83	440250.36	
Respite Care 1:1	Hour	727	122.00	15.90	1410234.60	
Respite Care 1:2	Hour	309	112.00	7.95	275133.60	
Respite Care 1:3	Hour	206	112.00	5.30	122281.60	
Assistive Technology Total:						1294734.35
Assistive Technology	Occurrence	265	1.00	4885.79	1294734.35	
Chore Total:						2339679.48
Chore Day	Day	119	12.00	146.23	208816.44	
Chore Hourly	Hour	1619	72.00	18.28	2130863.04	
Companion Total:						39883308.48
Companion 1:1	Hour	1104	1644.00	18.28	33177761.28	
Companion 1:2	Hour	309	1644.00	9.14	4643083.44	
Companion 1:3	Hour	206	1644.00	6.09	2062463.76	
Extra Care for Children with Disabilities Total:						5052322.90
Child / Youth Care Hourly	Hour	727	368.00	14.66	3922077.76	
Child / Youth Care Day	Day	278	53.00	76.71	1130245.14	
Home Again Total:						3310.92
Home Again	Occurrence	2	1.00	1655.46	3310.92	
Home Delivered Meals Total:						13.46
Home Delivered Meals	Day	2	1.00	6.73	13.46	
Home Modifications Total:						2856394.84
Home Modifications	Project	598	1.00	4776.58	2856394.84	

GRAND TOTAL: 187874309.25

Total Estimated Unduplicated Participants: 12000

Factor D (Divide total by number of participants): 15656.19

Average Length of Stay on the Waiver: 184

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independence Skills Building Total:						129870.00
Independence Skills Building 1:1	Hour	5	1000.00	18.28	91400.00	
Independence Skills Building 1:2	Hour	2	1000.00	9.14	18280.00	
Independence Skills Building 1:3	Hour	3	1000.00	6.73	20190.00	
LRI Personal Care Total:						8857870.00
Agency	Hour	309	1000.00	25.59	7907310.00	
Individual	Hour	52	1000.00	18.28	950560.00	
Non-Medical Transportation Total:						576244.22
Non-Medical Transportation By Mile	Mile	104	780.00	0.73	59217.60	
Non-Medical Transportation By Hour	Hour	43	62.00	17.11	45615.26	
Non-Medical Transportation By One Way Trip	One Way Trip	262	98.00	18.36	471411.36	
Personal Emergency Response System (PERS) Total:						648668.96
Personal Emergency Response System (PERS)	Unit	1982	8.00	40.91	648668.96	
Supported Residential Living Total:						73262166.04
Assisted Living Rural / Single	Month	2079	7.00	2445.26	35585868.78	
Assisted Living Urban / Single	Month	2054	7.00	2445.26	35157948.28	
Assisted Living Rural / Multiple	Month	101	7.00	1807.86	1278157.02	
Assisted Living Urban / Multiple	Month	98	7.00	1807.86	1240191.96	
Vehicle Modification Total:						838774.34
Vehicle Modification	Project	134	1.00	6259.51	838774.34	
<p>GRAND TOTAL: 187874309.25</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants): 15656.19</p> <p>Average Length of Stay on the Waiver: 184</p>						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Services Total:						1297569.96
Adult Day Health Services Day	Day	116	117.00	91.68	1244280.96	
Adult Day Health Services Hourly	Hour	31	75.00	22.92	53289.00	
Personal Care Total:						51736289.28
Personal Care Hourly	Hour	1668	1664.00	18.64	51736289.28	
Respite Care Total:						2362305.52
Respite Care Day	Day	403	12.00	95.71	462853.56	
Respite Care 1:1	Hour	749	122.00	16.22	1482151.16	
Respite Care 1:2	Hour	318	112.00	8.11	288845.76	
Respite Care 1:3	Hour	212	112.00	5.41	128455.04	
Assistive Technology Total:						1360498.23
Assistive Technology	Occurrence	273	1.00	4983.51	1360498.23	
Chore Total:						2458734.84
Chore Day	Day	123	12.00	149.15	220145.40	
Chore Hourly	Hour	1668	72.00	18.64	2238589.44	
Companion Total:						41879190.24
Companion 1:1	Hour	1137	1644.00	18.64	34842409.92	
Companion 1:2	Hour	318	1644.00	9.32	4872421.44	
Companion 1:3	Hour	212	1644.00	6.21	2164358.88	
Extra Care for Children with Disabilities Total:						5306811.90
<p>GRAND TOTAL: 199961998.29 Total Estimated Unduplicated Participants: 12000 Factor D (Divide total by number of participants): 16663.50 Average Length of Stay on the Waiver: 184</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child / Youth Care Hourly	Hour	749	368.00	14.95	4120698.40	
Child / Youth Care Day	Day	286	53.00	78.25	1186113.50	
Home Again Total:						3377.14
Home Again	Occurrence	2	1.00	1688.57	3377.14	
Home Delivered Meals Total:						2018131.20
Home Delivered Meals	Day	1440	204.00	6.87	2018131.20	
Home Modifications Total:						3001219.76
Home Modifications	Project	616	1.00	4872.11	3001219.76	
Independence Skills Building Total:						130470.00
Independence Skills Building 1:1	Hour	5	1000.00	18.64	93200.00	
Independence Skills Building 1:2	Hour	2	1000.00	9.32	18640.00	
Independence Skills Building 1:3	Hour	3	1000.00	6.21	18630.00	
LRI Personal Care Total:						9287720.00
Agency	Hourly	318	1000.00	26.10	8299800.00	
Individual	Hourly	53	1000.00	18.64	987920.00	
Non-Medical Transportation Total:						605040.76
Non-Medical Transportation By Mile	Mile	107	780.00	0.75	62595.00	
Non-Medical Transportation By Hour	Hour	45	62.00	17.45	48685.50	
Non-Medical Transportation By One Way Trip	One Way Trip	269	98.00	18.73	493760.26	
Personal Emergency Response System (PERS) Total:						681367.44
Personal Emergency Response System (PERS)	Unit	2041	8.00	41.73	681367.44	
Supported Residential Living Total:						76952183.42
Assisted Living Rural / Single					37379975.92	
<p>GRAND TOTAL: 199961998.29</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants): 16663.50</p> <p>Average Length of Stay on the Waiver: 184</p>						

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Month	2141	7.00	2494.16		
Assisted Living Urban / Single	Month	2115	7.00	2494.16	36926038.80	
Assisted Living Rural / Multiple	Month	104	7.00	1844.02	1342446.56	
Assisted Living Urban / Multiple	Month	101	7.00	1844.02	1303722.14	
Vehicle Modification Total:						881088.60
Vehicle Modification	Project	138	1.00	6384.70	881088.60	
<p>GRAND TOTAL: 199961998.29</p> <p>Total Estimated Unduplicated Participants: 12000</p> <p>Factor D (Divide total by number of participants): 16663.50</p> <p>Average Length of Stay on the Waiver: 184</p>						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Services Total:						1358051.73
Adult Day Health Services Day	Day	119	117.00	93.51	1301939.73	
Adult Day Health Services Hourly	Hour	32	75.00	23.38	56112.00	
Personal Care Total:						53719935.84
Personal Care Hourly	Hour	1718	1644.00	19.02	53719935.84	
Respite Care Total:						2353365.68
Respite Care Day	Day	415	12.00	97.62	486147.60	
Respite Care 1:1	Hour	771	112.00	16.54	1428262.08	
Respite Care 1:2	Hour				303806.72	
<p>GRAND TOTAL: 209362787.51</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 16104.83</p> <p>Average Length of Stay on the Waiver: 184</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		328	112.00	8.27		
Respite Care 1:3	Hour	219	112.00	5.51	135149.28	
Assistive Technology Total:						1428373.58
Assistive Technology	Occurrence	281	1.00	5083.18	1428373.58	
Chore Total:						2584544.04
Chore Day	Day	127	12.00	152.13	231846.12	
Chore Hourly	Hour	1718	72.00	19.02	2352697.92	
Companion Total:						44026583.04
Companion 1:1	Hour	1171	1644.00	19.02	36615858.48	
Companion 1:2	Hour	328	1644.00	9.51	5128096.32	
Companion 1:3	Hour	219	1644.00	6.34	2282628.24	
Extra Care for Children with Disabilities Total:						5574681.35
Child / Youth Care Hourly	Hour	771	368.00	15.25	4326852.00	
Child / Youth Care Day	Day	295	53.00	79.81	1247829.35	
Home Again Total:						3444.68
Home Again	Occurrence	2	1.00	1722.34	3444.68	
Home Delivered Meals Total:						2117724.00
Home Delivered Meals	Day	1483	204.00	7.00	2117724.00	
Home Modifications Total:						3155664.25
Home Modifications	Project	635	1.00	4969.55	3155664.25	
Independence Skills Building Total:						133140.00
Independence Skills Building 1:1	Hour	5	1000.00	19.02	95100.00	
Independence Skills Building 1:2	Hour	2	1000.00	9.51	19020.00	
Independence Skills Building 1:3	Hour	3	1000.00	6.34	19020.00	
<p>GRAND TOTAL: 209362787.51</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 16104.83</p> <p>Average Length of Stay on the Waiver: 184</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LRI Personal Care Total:						9780740.00
Agency	Hour	328	1000.00	26.63	8734640.00	
Individual	Hour	55	1000.00	19.02	1046100.00	
Non-Medical Transportation Total:						636334.00
Non-Medical Transportation By Mile	Mile	110	780.00	0.76	65208.00	
Non-Medical Transportation By Hour	Hour	46	62.00	17.80	50765.60	
Non-Medical Transportation By One Way Trip	One Way Trip	278	98.00	19.10	520360.40	
Personal Emergency Response System (PERS) Total:						715857.12
Personal Emergency Response System (PERS)	Unit	2102	8.00	42.57	715857.12	
Supported Residential Living Total:						80849588.82
Assisted Living Rural / Single	Month	2205	7.00	2544.04	39267257.40	
Assisted Living Urban / Single	Month	2179	7.00	2544.04	38804242.12	
Assisted Living Rural / Multiple	Month	107	7.00	1880.90	1408794.10	
Assisted Living Urban / Multiple	Month	104	7.00	1880.90	1369295.20	
Vehicle Modification Total:						924759.38
Vehicle Modification	Project	142	1.00	6512.39	924759.38	
<p>GRAND TOTAL: 209362787.51</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 16104.83</p> <p>Average Length of Stay on the Waiver: 184</p>						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Services Total:						1407534.66
Adult Day Health Services Day	Day	121	117.00	95.38	1350294.66	
Adult Day Health Services Hourly	Hour	32	75.00	23.85	57240.00	
Personal Care Total:						55877587.20
Personal Care Hourly	Hour	1752	1644.00	19.40	55877587.20	
Respite Care Total:						2583666.88
Respite Care Day	Day	424	12.00	99.57	506612.16	
Respite Care 1:1	Hour	787	122.00	16.88	1620716.32	
Respite Care 1:2	Hour	334	112.00	8.44	315723.52	
Respite Care 1:3	Hour	223	112.00	5.63	140614.88	
Assistive Technology Total:						1482864.24
Assistive Technology	Occurrence	286	1.00	5184.84	1482864.24	
Chore Total:						2687412.24
Chore Day	Day	129	12.00	155.18	240218.64	
Chore Hourly	Hour	1752	72.00	19.40	2447193.60	
Companion Total:						45811062.84
Companion 1:1	Hour	1195	1644.00	19.40	38112852.00	
Companion 1:2	Hour	334	1644.00	9.70	5326231.20	
Companion 1:3	Hour	223	1644.00	6.47	2371979.64	
Extra Care for Children with Disabilities Total:						5802262.53
Child / Youth Care Hourly	Hour	787	368.00	15.55	4503528.80	
Child / Youth Care Day	Day	301	53.00	81.41	1298733.73	
Home Again Total:						3513.58
Home Again	Occurrence	2	1.00	1756.79	3513.58	

GRAND TOTAL: 217924428.31

Total Estimated Unduplicated Participants: 13000

Factor D (Divide total by number of participants): 16763.42

Average Length of Stay on the Waiver: 184

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						2202318.72
Home Delivered Meals	Day	1512	204.00	7.14	2202318.72	
Home Modifications Total:						3284673.12
Home Modifications	Project	648	1.00	5068.94	3284673.12	
Independence Skills Building Total:						155210.00
Independence Skills Building 1:1	Hour	6	1000.00	19.40	116400.00	
Independence Skills Building 1:2	Hour	2	1000.00	9.70	19400.00	
Independence Skills Building 1:3	Hour	3	1000.00	6.47	19410.00	
LRI Personal Care Total:						10157840.00
Agency	Hour	334	1000.00	27.16	9071440.00	
Individual	Hour	56	1000.00	19.40	1086400.00	
Non-Medical Transportation Total:						659677.90
Non-Medical Transportation By Mile	Mile	113	780.00	0.78	68749.20	
Non-Medical Transportation By Hour	Hour	47	62.00	18.15	52889.10	
Non-Medical Transportation By One Way Trip	One Way Trip	283	98.00	19.40	538039.60	
Personal Emergency Response System (PERS) Total:						744739.84
Personal Emergency Response System (PERS)	Unit	2144	8.00	43.42	744739.84	
Supported Residential Living Total:						84100881.76
Assisted Living Rural / Single	Month	2249	7.00	2594.93	40851982.99	
Assisted Living Urban / Single	Month	2222	7.00	2594.93	40361541.22	
Assisted Living Rural / Multiple	Month	109	7.00	1918.51	1463823.13	
Assisted Living Urban / Multiple	Month	106	7.00	1918.51	1423534.42	
<p>GRAND TOTAL: 217924428.31</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 16763.42</p> <p>Average Length of Stay on the Waiver: 184</p>						

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modification Total:						963182.80
Vehicle Modification	Project	145	1.00	6642.64	963182.80	
GRAND TOTAL: 217924428.31 Total Estimated Unduplicated Participants: 13000 Factor D (Divide total by number of participants): 16763.42 Average Length of Stay on the Waiver: 184						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Services Total:						1471675.32
Adult Day Health Services Day	Day	124	117.00	97.29	1411483.32	
Adult Day Health Services Hourly	Hour	33	75.00	24.32	60192.00	
Personal Care Total:						58139616.12
Personal Care Hourly	Hour	1787	1644.00	19.79	58139616.12	
Respite Care Total:						2687248.78
Respite Care Day	Day	432	12.00	101.56	526487.04	
Respite Care 1:1	Hour	803	122.00	17.21	1685994.86	
Respite Care 1:2	Hour	341	112.00	8.61	328833.12	
Respite Care 1:3	Hour	227	112.00	5.74	145933.76	
Assistive Technology Total:						1544253.68
Assistive Technology	Occurrence	292	1.00	5288.54	1544253.68	
Chore Total:						2796976.08
GRAND TOTAL: 226766903.58 Total Estimated Unduplicated Participants: 13000 Factor D (Divide total by number of participants): 17443.61 Average Length of Stay on the Waiver: 184						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Day	Day	132	12.00	158.28	250715.52	
Chore Hourly	Hour	1787	72.00	19.79	2546260.56	
Companion Total:						47667286.80
Companion 1:1	Hour	1219	1644.00	19.79	39659872.44	
Companion 1:2	Hour	341	1644.00	9.89	5544373.56	
Companion 1:3	Hour	227	1644.00	6.60	2463040.80	
Extra Care for Children with Disabilities Total:						6040792.32
Child / Youth Care Hourly	Hour	803	368.00	15.87	4689648.48	
Child / Youth Care Day	Day	307	53.00	83.04	1351143.84	
Home Again Total:						3583.84
Home Again	Occurrence	2	1.00	1791.92	3583.84	
Home Delivered Meals Total:						2294687.88
Home Delivered Meals	Day	1543	204.00	7.29	2294687.88	
Home Modifications Total:						3417581.52
Home Modifications	Project	661	1.00	5170.32	3417581.52	
Independence Skills Building Total:						158320.00
Independence Skills Building 1:1	Hour	6	1000.00	19.79	118740.00	
Independence Skills Building 1:2	Hour	2	1000.00	9.89	19780.00	
Independence Skills Building 1:3	Hour	3	1000.00	6.60	19800.00	
LRI Personal Care Total:						10573730.00
Agency	Hour	341	1000.00	27.70	9445700.00	
Individual	Hour	57	1000.00	19.79	1128030.00	
Non-Medical Transportation Total:						688736.66
Non-Medical Transportation By					70863.00	
<p>GRAND TOTAL: 226766903.58</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 17443.61</p> <p>Average Length of Stay on the Waiver: 184</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mile	Mile	115	780.00	0.79		
Non-Medical Transportation By Hour	Hour	48	62.00	18.52	55115.52	
Non-Medical Transportation By One Way Trip	One Way Trip	289	98.00	19.87	562758.14	
Personal Emergency Response System (PERS) Total:						774722.88
Personal Emergency Response System (PERS)	Unit	2187	8.00	44.28	774722.88	
Supported Residential Living Total:						87504919.18
Assisted Living Rural / Single	Month	2294	7.00	2646.82	42502635.56	
Assisted Living Urban / Single	Month	2267	7.00	2646.82	42002386.58	
Assisted Living Rural / Multiple	Month	111	7.00	1956.88	1520495.76	
Assisted Living Urban / Multiple	Month	108	7.00	1956.88	1479401.28	
Vehicle Modification Total:						1002772.52
Vehicle Modification	Project	148	1.00	6775.49	1002772.52	
<p>GRAND TOTAL: 226766903.58</p> <p>Total Estimated Unduplicated Participants: 13000</p> <p>Factor D (Divide total by number of participants): 17443.61</p> <p>Average Length of Stay on the Waiver: 184</p>						