Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information

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

B. Program Title:
Traumatic Brain Injury

C. Waiver Number:NE.40199
Original Base Waiver Number: NE.40199.

D. Amendment Number:NE.40199.R04.06

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

10/01/20

Approved Effective Date: 10/01/20
Approved Effective Date of Waiver being Amended: 10/01/18

2. Purpose(s) of Amendment

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

The amendment includes a transition of the administration of this waiver within the Department of Health and Human Services (the single state Medicaid Agency) from The Division of Medicaid and Long-Term Care to the Division of Developmental Disabilities, with oversight from both divisions.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	Main 2
☒ Appendix A Waiver	A-1, A-2, A-5

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

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

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

The amendment includes a transition of the administration of this waiver within the Department of Health and Human Services (the single state Medicaid Agency) from the Division of Medicaid and Long-Term Care to the Division of Developmental Disabilities, with oversight from both divisions.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

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

Traumatic Brain Injury

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NE.40199
Waiver Number:NE.40199.R04.06
Draft ID: NE.010.04.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/18
Approved Effective Date of Waiver being Amended: 10/01/18

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

Participants must have a medical diagnosis of a traumatic brain injury which is defined as a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC), operates the Home and Community-Based Services (HCBS) Waiver for Traumatic Brain Injury (TBI). The Administrator of the HCBS unit reports to the Deputy Director for Delivery Systems within MLTC. The Deputy Director reports to the Director of MLTC.

The objective of the TBI Waiver is to provide participant-centered waiver services to strengthen and support informal and formal services to meet the unique cognitive and behavioral needs of each participant in a specialized assisted living facility. The target population is up to 40 adults with traumatically acquired, non-degenerative structural brain damage who meet nursing facility level of care.

DHHS contracts with an entity to provide: Services coordination (case management), level of care evaluation/reevaluation, service plan development, service authorization, and ongoing monitoring of service delivery for participants of this waiver.

State standards are developed for the waiver service, and resource development staff certify that providers meet waiver standards on an annual basis. Resource development staff and services coordination staff monitor service delivery.

This waiver is a tool to rebalance the long-term care system, and thus Medicaid costs in Nebraska by offering a community alternative to institutional services.

The service delivery method is fee for service.

Amendment effective 10/1/2020
The amendment includes a transition of the administration of this waiver within the Department of Health and Human Services (the single state Medicaid Agency) from the Division of Medicaid and Long-Term Care to the Division of Developmental Disabilities, with oversight from both divisions. The DHHS HCBS team members report to the Division of Developmental Disabilities. The contracts for the Services Coordination agencies will be managed by the Division of Developmental Disabilities.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

The amendment effective 10/1/2020 is a technical amendment.

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: Leschinsky

First Name: Heather

Title: Chief Administrator

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 95026

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509-5026

Phone: (402) 471-2135 **Ext:** ☐ **TTY**

Fax: (402) 742-2337

E-mail: heather.leschinsky@nebraska.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nebraska**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail: DHHS.MedicaidSPA@nebraska.gov

8. Authorizing Signature

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

Signature: Catherine Gekas Steeby

State Medicaid Director or Designee

Submission Date: Jan 19, 2021

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

Last Name: Bagley

First Name: Kevin

Title: Director, Division of Medicaid and Long-Term Care

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 95026

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509-5026

Phone: (402) 471-2135 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: Kevin.Bagley@Nebraska.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

N/A

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this

waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:

Amendment effective 10/1/2020:

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

DHHS-DD performs oversight for Services Coordination contracted entity functions identified in Appendix A.3. in addition to preforming these functions for a some of waiver participants: 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 (DHHS-MLTC), which is the Medicaid agency.

b) The document utilized to outline the roles and responsibilities related to waiver operation:

The Nebraska State Medicaid Plan Section A1-A3, approved March 6, 2014, effective Jan 1, 2014. (NE 13-0030-MM4) outlines designation and authority.

c) The methods that are employed by the designated State Medicaid Director in the oversight of these activities:

The State Medicaid Director is the Director of DHHS-MLTC. Oversight is a collaborative effort among designated staff within DHHS-MLTC and DHHS-DD. Designated Administrators from DHHS-MLTC and DHHS-DD have regularly scheduled meetings to review discovered and/or anticipated issues; direct remediation and/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 DHHS-DD service coordination and DD surveyors as necessary and appropriate; preparing or reviewing statistical and financial data for CMS reports in collaboration with DHHS-DD; attending the quarterly DHHS-DD Quality Improvement (QI) Committee meetings as an active participating member; meeting with DHHS-DD staff to review program and client 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 DHHS-DD; and submitting claims quarterly for federal funds for allowable activities administered or supervised by DHHS-DD.

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.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The services coordination entity performs the following operational and administrative functions on behalf of MLTC:

*Disseminate information concerning the waiver to potential enrollees
*Assist individuals in waiver enrollment
*Conduct level of care evaluation/reevaluation activities
*Develop participant service plan
*Perform prior authorization of waiver service
*Conduct utilization management functions
*Conduct training and technical assistance concerning waiver requirements
*Perform supervisory oversight and training of services coordination staff
*Monitor service provision
*Conduct on-going case management
*Assess and re-assess client needs, strengths, and priorities
*Investigate, resolve, and report incidents and complaints

○ **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:

MLTC is responsible for assessing the performance of contracted entities in conducting waiver operational and administrative functions.

Amendment effective 10/1/2020: 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 on-going review of services coordination billings and follow up as needed.
2) Continuous and on-going review of complaint and incident reports.
3) Continuous death reviews of waiver clients to identify trends, risks, and needed actions.
4) Continuous and on-going monitoring of service expenditures and utilization.
5) Continuous and on-going monitoring of participant enrollment.
6) Continous and on-going reviews of client and provider files and paid claims.
7) Continuous and on-going review of level of care, service plan, health and welfare, choice, financial oversight, and qualified providers.
8) Annual presentation of program data aggregation and analysis to the HCBS Waivers Quality Council for review and recommendation.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐

Function	Medicaid Agency	Contracted Entity
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
HCBS Setting Review Tool

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of findings of non-compliance of LOC evaluations discovered in record reviews that were remediated by the SC agency within 45 days. Numerator =Number of findings of non-compliance of LOC evaluations discovered in record reviews that were remediated by the SC agency within 45 days. Denominator = Number of findings of non-compliance of LOC evaluations discovered in record reviews.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of findings of non-compliance of service plans discovered in record reviews that were remediated by the SC agency within 45 days. Numerator = Number of findings of non-compliance of service plans discovered in record reviews that were remediated by the SC agency within 45 days. Denominator = Number of findings of non-compliance of service plans discovered in record reviews.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

b. Methods for Remediation/Fixing Individual Problems

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

Any contracted services coordination agency is responsible to remediate all identified individual problems identified through its discovery processes in an appropriate and timely manner (45 days). Discovery processes include: inputting data entry; remediating findings in HCBS Off-Site File Reviews, reporting incidents; reporting complaints; and reporting death reviews.

Any contracted services coordination agency is responsible to remediate all identified individual problems identified through its discovery processes in an appropriate and timely manner (45 days). As part of their discovery processes, HCBS Waiver Unit staff conduct reviews of services coordination/resource development files on an annual basis. These reviews ensure all delegated waiver activities are being applied correctly. The review responses are documented in an electronic case management system. Indicators that do not meet standards require remediation/supervisory follow-up. Follow-up action must be taken within 45 days from date of review and be recorded in the "Remediation/Supervisory Action" Section. The HCBS Waiver Unit monitors to ensure remediation activities are completed as assigned.

HCBS Waiver Unit staff are also responsible for overseeing that all individual problems requiring remediation identified during discovery processes are remediated. This is accomplished by individual follow up/remediation, shared resolution, or quality improvement plans.

Individual follow-up/remediation is an informal plan created jointly between the services coordination supervisor and HCBS Waiver Unit staff detailing corrections which must be made. Services coordination supervisors are responsible for reporting remediation activities to the assigned HCBS Waiver Unit staff. Assigned HCBS Waiver Unit staff are responsible for documenting corrections in an electronic case management system.

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 services coordination supervisors and documented by HCBS Waiver Unit staff. The plan details how resolution and results will be monitored and measured. HCBS Waiver Unit staff are responsible for verifying corrections have been made.

The Quality Improvement Plan is a formally-defined process, based on a performance oversight model, to resolve and improve performance when a discovery method has identified an apparent contract violation or immediate risk to 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 the services coordination supervisory staff using the DHHS Quality Improvement Plan template detailing specific, measureable steps, persons responsible, and start and ending dates. The Quality Improvement Plan also details supportive documentation on final follow up. HCBS Waiver Unit staff approves this plan before it is implemented and monitors its progress through completion.

An agency that does not successfully complete the Quality Improvement Plan process or fails to provide delegated functions, may be referred to the HCBS Waiver Unit contract manager for contract review and possible withholding of payment reimbursement.

In addition to individual remediation, practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their specific agency. Services coordination supervisors use the electronic case management system to run reports of file review and other data to evaluate the agency’s performance. Services coordination supervisors may also use the electronic case management system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☒	**Brain Injury**	18	64	☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Participants must have a medical diagnosis of a traumatic brain injury which is defined as a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. This term does not apply to brain injuries induced or caused by birth trauma.

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:

Transition planning is taken into consideration at every annual assessment for the waiver client. As the client nears the maximum age, he/she would be presented annually with options that they may need to choose in the years to come. For example, they could be assisted with applying for housing waiting lists if they needed to make a housing decision in the next year.

Services coordinators assist individuals with locating both Medicaid and non-Medicaid resources which includes all HCBS Waivers in the state.

Individuals who transition from Assisted Living in the TBI waiver to assisted living in the Aged and Disabled waiver are able to stay with the same provider.

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)

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:

MLTC establishes a statewide nursing facility average cost. The established rate for specialized assisted living does not exceed this cost. If an individual needs additional Medicaid services (e.g., nursing or exceptional transportation)which cause service plan costs to exceed this average, the actual cost for that person in an area nursing facility is estimated. Any person whose service plan costs exceed the estimated individual nursing facility cost are found ineligibile for this waiver. Written Notice of Action (NOA)is provided to any applicant whose request for waiver service is denied or to any participant whose service is terminated. The NOA includes information about the Right to Appeal and timeframes and directions for requesting a fair hearing.

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:

An individual found ineligible for this waiver program due to Plan costs in excess of NF costs is provided with information about service options, including other Medicaid services such as nursing facility, home health, or other HCBS waiver programs.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	40

Waiver Year	Unduplicated Number of Participants
Year 2	40
Year 3	40
Year 4	40
Year 5	40

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:

Nebraska has not had a waiting list for the Traumatic Brain Injury Waiver and is not expected to require a waiting list due to available slots. In the event that a waiting list is necessary, regulations found at 480 NAC 5 outline the priority criteria. Priority is assigned in the following order:
(1) Needs in domains which define NF level of care are so severe that the health and welfare of the client are jeopardized, but the needs could safely be met with immediate waiver services;
(2) Family/caregivers are in a crisis/high stress situation;
(3) No informal support network is available to meet identified needs;
(4) Inappropriate out-of-home placement is being planned;
(5) No other program is available to meet the needs identified in the referral;
(6) Support services are required to allow the client to return home (e.g., a Medicaid-eligible recipient is ready to be discharged from a hospital);
(7) A client with an identified waiver service need lacks access to resources to meet needs in domains which define NF level of care AND waiver eligibility is the only method of obtaining Medicaid eligibility; and/or
(8) A client with an identified waiver service need of Assistive Technology and Supports or Home Modification lacks access to resources to meet these specific needs AND waiver eligibility is the only method of addressing the identified needs.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- ( ) **§1634 State**
- (●) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under

the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:
- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  Working Disabled under 1619(b) (Social Security Act Section 1619(b), Disabled Adult Children (Social Security Act Section 1634(c)), Pickle Category recipients (42 C.F.R. 435.135), Disabled Widow(er)s (42 C.F.R. 435.138), Medicaid expansion (42 C.F.R. 435.119)

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

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

Select one:

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

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

Specify percentage: ☐

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

Specify dollar amount: ☐

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount: ☐

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

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods

before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

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

◉ **The following standard included under the state plan**

Select one:

◉ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

(*select one*):

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

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

Specify the percentage:

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

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- (●) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:

- ( ) **The following dollar amount:**

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

- ( ) **The following formula is used to determine the needs allowance:**

  Specify formula:

- ( ) **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to

need waiver services is: 1

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

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Independent Living Center staff perform the level of care evaluations/reevaluations.

- ○ **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:

Independent Living Center staff who perform the initial evaluation of level of care for waiver applicants must possess the following educational and professional qualifications:

A. Education:
(1) Baccalaureate or graduate degree in the human services, education, or health/medical field; or
(2) Registered Nurse, currently licensed in Nebraska; AND
B. Experience: At least two (2) years professional experience in one of the following fields: long-term care; gerontology; rehabilitation; health/disability case management or health/medical.

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

The services coordinator gathers information using functional level of care criteria to determine whether the individual initially meets or continues to meet the nursing facility level of care required for eligibility.

Nebraska uses the same criteria for level of care eligibility in nursing facilities and in this waiver program, with the addition of TBI diagnosis for this waiver. Information gathered with the Functional Criteria form (MILTC-14AD)is entered on the automated Level of Care scoring instrument found on the CONNECT system. (CONNECT is the acronym for Coordinating Options in Nebraska's Network through Effective Communications and Technology. It is the division's automated system for waiver client tracking and other management functions too.)

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

Individuals are evaluated based on the following assessment categories:
*Activities of Daily Living - the ability to self-perform bathing, dressing, eating, locomotion, personal hygiene, toileting, and transferring.
*Risk Factors - issues which cause significant impact to the person's life and functional capacity such as behavior, frailty and safety.
*Medical treatment or observation - a medical condition is present which requires observation and assessment to prevent a decline in health status.
*Cognitive Function - memory, orientation, communication and judgment.

Services coordinators collect the above information on each individual seeking waiver services to determine the functional abilities and care needs of that individual. Individuals who require assistance, supervision, or care in at least one of the following four categories meet the level of care criteria
I. A score of one or more in at least three activities of daily living AND at least one risk factor AND a medical diagnosis of a traumatic brain injury.
II. A score of one or more in at least three activities of daily living AND at least one medical area and intervention AND a medical diagnosis of a traumatic brain injury.
III. A score of one or more in at least three activities of daily living AND at least one area of cognitive limitation AND a medical diagnosis of a traumatic brain injury.
IV. A score of one or more in at least one activity of daily living AND at least one risk factor AND at least one area of cognitive limitation AND a medical diagnosis of a traumatic brain injury.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The process for level of care evaluation/reevaluation is the same and is outlined in the 480 NAC regulations for the Waiver. The services coordinator must meet in person with the individual initially within 14 calendar days of referral date to evaluate nursing facility level of care. The meetings must be held at a date and time convenient to the individual. Level of care reevaluations must be completed every 12 months or sooner if the individual's care needs change.

The assessment evaluates the individual's functional limitations and medical needs as described in Appendix B-6-d and Risk Factors outlined in Appendix D-1-e. Other areas assessed include formal and informal supports, housing, equipment, assistive technology usage and needs, nutritional status, and medication usage.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

Regulations outlined in 480 NAC 5 specify the procedures which ensure timely reevaluations for level of care.
The services coordinator must annually review each participant to assure both continued eligibility and that the well-being of the participant is safeguarded. Reevaluation must take place every 12 months and be documented.

MLTC's electronic case management system, CONNECT, contains reports on the participant's level of care and due dates. These reports allow the services coordinator and their supervisor to manage and plan for re-evaluation.

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

Written documentation of all evaluations and reevaluations are filed at the ILC office and on CONNECT. Nebraska requires this documentation to be maintained for at least six years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
Number and percent of new waiver eligible applicants 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 client system data reports

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

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

Data Aggregation and Analysis:

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

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 client data system reports

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial and annual Level of Care (LOC) determinations reviewed in which LOC criteria were accurately applied. Numerator = number of initial and annual LOC determinations reviewed in which LOC criteria were accurately applied; Denominator = number of initial and annual LOC determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

b. Methods for Remediation/Fixing Individual Problems

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

The services coordinator uses an electronic Level of Care Review tool to record the participant's initial an annual evaluation and reevaluation. A reevaluation is also completed when there is a significant health change.

Activities and processes at the state level have been developed to discover whether the federal level of care waiver assurance is being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that are aggregated and analyzed to measure the overall system performance. The services coordination agencies are responsible to remediate all identified level of care individual problems identified through the HCBS Waiver Unit's discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing Level of Care are the HCBS Waiver Unit File Review and Electronic Reports:

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

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. Services coordination supervisors use an electronic system to run reports of file review and other data to evaluate the agency's performance. Services coordination supervisors may also use the electronic case management system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with services coordination agencies annually. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The services coordinator explains the service options available under this home and community based waiver. The individual is offered the option of accepting nursing facility or waiver services as described in the service plan. If the individual accepts waiver services, they must sign the waiver consent form. The waiver consent form must be updated any time there is a change in the legal ability of the client or legal representative to consent to waiver services. The waiver consent form is not valid until the date the individual's eligibility for Medicaid has been determined. The individual's waiver eligibility period may begin no earlier than the first day of the month in which the individual signed the Waiver consent form and Medicaid eligibility was approved.

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 forms (waiver consent) are contained in the client files at the services coordination agency. Nebraska requires these documents to be maintained for at least six years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following methods are utilized to provide meaningful access to services by individuals with Limited English Proficiency:
*AT&T Language Line is available and used statewide.
*All contracted services coordination agencies are required to provide interpreters when needed to communicate with an individual.

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		
Other Service	**Assisted Living Service**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living Service

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services

Sub-Category 1: 02013 group living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Assisted Living services are provided for participants with a medical diagnosis of a traumatic brain injury in a homelike, non-institutional setting and include personal care and supportive services. This includes 24-hour response capability to meet scheduled or unpredictable client needs and to provide supervision, safety, and security.

The following services are available to the participant: medication administration, transportation, escort services, activities, essential shopping, housekeeping services, laundry services, and personal care services.

Escort service is accompanying or physically assisting a client who resides in an assisted living facility who is unable to access medical care without supervision or assistance.

Activities are social and recreational programming.

Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. 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 the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living service is described in Appendix I-5.
No therapies are included in the assisted living service.
Assisted living includes the provision of personal care services and additional billing for personal care services are not allowed. This is prevented by review and approval of all waiver claims. When a client's residence is noted as Assisted Living any claims for personal care are denied.
Relatives/guardians who provide assisted living services are either employees of a licensed assisted living facility or are the owner of a licensed assisted living facility.

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

The unit of service is billed at a daily rate.

The Assisted Living Services rate includes the provision of five roundtrip medical transportation trips. If the client's service plan reflects the need for more medical transportation, it may be authorized outside of the assisted living service payment, as a state plan Medicaid service. The Assisted Living service does not include medical transportation in excess of 50 miles roundtrip. This also is authorized as a state plan Medicaid service.

The daily rate for each participant is comprehensive and not based on individual services used or not used. The rate is not adjusted and does not depend upon what the individual actually receives. Components may not be billed separately if not all are provided.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assisted Living Service

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Provider must be licensed as an Assisted Living Facility by the Nebraska Department of Health and Human Services Division of Public Health. The licensure regulations are found at 175 NAC 4.

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
*Provide a private living unit with bath consisting of a toilet and sink
*Supply normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap and dental hygiene products
*Provide essential furniture
*Ensure that Provider qualifications for persons administering medications in an assisted living facility as referenced in the Assisted Living Facility licensing regulations (175 NAC 4).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider qualifications are verified by contracted resource developers or DHHS staff.

Frequency of Verification:

Provider qualifications are verified on an annual basis.

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete*

item C-1-c.

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

Contracted Independent Living Center staff conduct case management functions on behalf of waiver participants.

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Waiver regulations found in 480 NAC 5 outline the process to ensure criminal history compliance. Employees of Assisted Living Facility providers must sign a self-disclosure statement approved by DHHS, identifying any record of 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.). Resource development staff review the providers' policy for assuring that appropriate procedures are in place regarding abuse or neglect, safeguarding the well-being of waiver participants. A provider request for local law enforcment information would be generated by the provider, but the documentation that a record was found or was not found would be provided by the law enforcment source. The resource developer has access to this information at initial provider approval and at review.

Assisted living facilities are licensed through the Nebraska Department of Health and Human Services Division of Public Health and governed by Nebraska Administrative Code (NAC) Title 175, chapter 4. These regulations require that assisted living facilities complete criminal background checks on all unlicensed direct care staff.

Background checks are a combination of state (for example, local law enforcement records) and national (for example, Office of Inspector General Office (OIG) website). The OIG and Excluded Parties List System (EPLS) website checks are completed by the provider, as federally required, to ensure the provider has not been excluded from Medicaid participation.
Completion of the criminal history background check policy review is documented in the file and reviewed during the Quality Assurance File Review.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The Department of Health and Human Services maintains the Child and Adult Abuse registries.
All services coordination and resource development staff must be screened against the child and adult abuse registries. DHHS staff conduct the screenings against the registries. Agency providers must have a policy that governs central registry checks for direct service staff. Per 480 NAC 5, each agency waiver provider must have a policy to determine how information found via these registries/website is used for its employees. This policy must assure that no staff person identified through this process poses a danger to the health and safety of any waiver client. The resource development staff determines whether the agency's policy safeguards waiver clients. If the policy does not, staff must not approve the provider or must terminate any existing waiver provider agreement.
(c) The DHHS Medicaid and Long Term-Care Division, HCBS Waiver Services Unit, reviews the process for services coordination agencies. Resource development staff monitor this process for Medicaid providers.

Appendix C: Participant Services

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

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

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

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

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All information regarding home and community based settings is included in the Statewide Transition Plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assisted Living Service	☒

Facility Capacity Limit:

Capacity limited by state license - 52 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Waiver regulations are published on the Nebraska Health and Human Services website, which are readily available to anyone with internet access. Potential providers may apply at any time to become certified as providers of waiver services. The provider enrollment process consists of completing an assessment of standards compliance through an in-person interview conducted by Resource Development staff. Providers then sign a service agreement and are entered on the automated system as an approved Medicaid Waiver provider. The agreements are renewed annually based on continued compliance. This process assures continuous open enrollment of waiver service providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled licensed, certified providers reviewed that initially met provider standards prior to furnishing waiver services. Numerator = number of enrolled licensed, certified providers reviewed that initially met provider standards; Denominator = number of initial enrolled licensed, certified providers reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled licensed, certified providers reviewed that 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):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Activities and processes at the state level have been developed to discover whether the federal Qualified Providers waiver assurance is being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that are aggregated and analyzed to measure the overall system performance. The services coordination/resource development agencies are responsible to remediate all identified provider problems identified through the HCBS Waiver Unit's discovery processes in an appropriate and timely manner (45 days).

The Quality Management Strategies for reviewing qualified providers are:

1. The HCBS Waiver Unit File Review and Electronic Reports.
- Qualified providers quality improvement reviews are completed by the HCBS Waiver Unit on an electronic system for each agency providing resource development.
- The HCBS Waiver Unit staff act as the Resource Developer for providers of the TBI Waiver.
- Reassessment occurs and the required corrections are completed.
- If the provider is found to be qualified, the provider continues to provide services.
- If the provider is found to be ineligible, the provider agreement is terminated.
- Services coordination/resource development supervisors report remediation activities to the HCBS Unit quality staff. The HCBS Waiver Unit quality staff document corrections in an electronic case management. The review documentation must include information that all negative qualified provider issues have been resolved correctly.
- If there is a concern that the 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.
- The HCBS Waiver staff monitors statewide reviews to ensure review and remediation activities are completed as assigned. Review documentation must include information that all negative provider enrollment issues have been resolved correctly.

2. Training for Case Management Agencies:
- All services coordinators/resource developers/supervisors must complete training on the waiver program upon initial hire. To assure all waiver staff are qualified; each trainee will be evaluated for competency by completing a final test. If the required test score of 80% is not achieved, the trainee will need to retake the course and final test.
- The web-based training oversight is provided by the HCBS Waiver Unit staff. They monitor completion of the course and work with the services coordination/resource development supervisor to assure remediation of individual issues. If the trainee does not complete the course successfully, the waiver agency billing for that services coordination/resource development function is not approved.

Practices are in place to assist services coordination/resource development agencies in evaluating whether problems are systemic to their agency. Services 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. Services coordination/resource development supervisors may also use the electronic system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2 of this waiver renewal for additional information.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Services and Supports

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☒ **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:

Independent Living Center staff who have responsibility for service plan development must possess the following educational and professional qualifications:

A. Education:
(1) Baccalaureate or graduate degree in the human services, education, or health/medical field; or
(2) Registered Nurse, currently licensed in Nebraska; AND
B. Experience: At least two (2) years professional experience in one of the following fields: long-term care; gerontology; rehabilitation; health/disability case management or health/medical.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) The services coordinator must, together with the individual, develop a service plan based upon assessment results. This is accomplished by identifying desired individual outcomes related to one or more of the areas of functional criteria and assessment. Upon initial contact with the individual to schedule assessment and care planning, the services coordinator informs the individual that they may include anyone they choose to participate in the planning process. The services coordinator must include in the service plan any outside (that is non-DHHS office or contractor agency) person or agency that the client wishes to receive a copy of the service plan. If this type of step is included, the participant must sign the service plan.

b) The participant has the right and responsibility to participate in decision-making in all aspects of supports and services, including determining who is included in the service plan development process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The Independent Living Center staff provide services coordination (case management) and are responsible for developing the participant-centered service plan. The plan is developed once the initial assessment is completed and reflects the participants's needs, goals, and preferences. During the assessment process, the services coordinator discusses and documents information about current health status, physicians, medications, and medical equipment. This supplements medical information gathered during the level of care evaluation. The initial service plan is developed jointly by the services coordinator and the participant. The services coordinator is responsible for monitoring and overseeing the implementation of the service plan. During the planning process the services coordinator works closely with the provider and the participant to assess and address health care needs. At the initial assessment visit and annual review, discussions include medical appointments (scheduled or needed); any recent illnesses and recovery; condition or therapeutic changes; and summary reporting of ongoing monitoring.

b) The standard tool in use for level of care evaluation/reevaluation is the form MILTC-14AD "Functional Criteria for Aged/Adults". The standard tool in use for assessing additional service needs when developing the service plan is the form MILTC-2AD "Aged and Disabled Waiver Adult Assessment". The in-person assessment includes determining the individual's functional abilities and deficits related to Activities of Daily Living and Instrumental Activities of Daily Living. The individual's needs, strengths, priorities, formal and informal resources/supports; medical and nutritional information; equipment usage and needs; housing status; and risk factors are assessed and documented. A standard mini-mental test may be admininistered as appropriate to further identify memory and orientation limitations. This information guides the development of the service plan. The services coordinator then informs the individual of available services.

c) The services coordinator has primary responsibility to inform the individual from the point of referral through the development of the service plan. Timelines can vary based on individual needs and preferences, although the assessment upon which the service plan is based must occur within 14 calendar days of the date waiver services where requested. The consent form is not signed until the client has participated in the development of the service plan and has reviewed it to ensure all service needs have been addressed. Services coordinators continue to provide information about services through monthly monitoring contact as participant's needs and preferences change. The DHHS website also provides further information on waiver services and other resources.

d) The services coordinator must, together with the individual develop the service plan based upon assessment results. This is accomplished by identifying the individual's needs and desired outcomes related to one or more of the areas in which information is obtained in the assessment. Service plan development builds on the individual's strengths and is intended to strengthen and support informal and formal services already in place, to meet the needs of the participant, and is not intended to replace them. The participant-centered philosophy holds that each client has the right and responsibility to participate to the greatest extent possible in the development and implementation of their service plan.

e) All services the participant receives including waiver and other services (i.e. State Plan services and services furnished through other state and Federal programs) must be documented on the service plan. The role of the services coordinator, together with the participant, is to coordinate waiver and other services, to monitor service provision and to ensure that client needs and desired outcomes are met.

f) The Plan of Services and Supports (service plan) is the document that outlines the objectives that reflect client needs, strengths, priorities and resources. The service plan identifies the service components of Assisted Living to be provided, the amount and frequency of service provision, and the individuals responsible for the delivery of the services required (i.e. the type of provider). Individuals responsible may include the participant, family members, waiver providers, other providers, informal supports, and the services coordinator. The service plan is modified as the participant's needs change, and at least annually. The process for revision or renewal of the service plan is the same process used for initial development. All in-person contacts occur at a time, date, and location convenient to the participant. Visits usually take place at the assisted living where the participant resides. Participants who have daytime activities away from the assisted living may be visited in the evening.

g) Regulations found at Title 480 NAC 5 require the service plan to be modified as the participant's needs change and reviewed annually. The service plan modification or annual review is also a joint services coordinator/participant planning process.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk is identified through the functional criteria, level of care, and assessment processes.
The services coordinator must determine the presence and effect of risk factors. Risk factors are concerns which cause significant impact to the persons life and functional capacity. To be considered a factor, the risk must be immediate and require a significant intervention.
Risk factors to be considered are:

1. Behavior: The ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially appropriate manner.
2. Frailty: The ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk.
3. Safety: The availability of adequate housing, including the need for home modification or adaptive equipment to assure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect.

Strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. The services provided by the assisted living are designed to mitigate risks. Other strategies include developing goals and action steps to address identified risks; referral to services/resources to address risks, as well as the actual use of those services/resources.

Back-up plans are developed on an individual basis to address situations of the unavailability of a provider or informal support; or in the event of a natural disaster or emergency. Back-up plans are written into the service plan. The level of care tool addresses health and safety risk factors. Each participant's service plan is required to have outcomes and action steps which address all needs identified on the level of care tool, including risk factors. The service plan is also required to address the supports and interventions that are related to the identified health and safety risks that are needed to prevent harm to the individual. In addition, all service plans must contain outcomes and action steps which address unavailability of a provider and a plan for what will be done in the event of a natural disaster or emergency. Participants are to be involved in developing the service plan and receive a copy.

The assisted living facility also must have disaster preparedness and management procedures to ensure client care, safety, and well-being are maintained during and following instances of natural disasters, disease outbreaks, or similar situations. Facilities may contract with their local hospital or staffing agencies to supplement staff or contract with local hospitals/nursing facilities for residents to be transported to in the case of emergencies, based on the individual emergency and local resources available. In addition, assisted living facility providers licensed in Nebraska must have building systems that are designed, installed and operated in such a manner as to provide for the safety, comfort, and well-being of the client (175 NAC Chapter 4).

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.

Participants have access to information about the qualified waiver providers that are available to furnish the services included in the service plan. Upon referral to the TBI waiver, the individual is informed by the services coordinator about the waiver - assisted living service. The individual is informed of qualified TBI Waiver Assisted Living providers. Information about qualified TBI waiver providers is available on several public websites.

Participants are supported in choosing from among qualified providers of other Medicaid services such as pharmacy, psychiatrist, and primary care physician.

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 HCBS Waiver Unit conducts records reviews annually that include a review of service plans. A representative sample with a confidence interval of 95% with +/-5% margin of error of service plans for Traumatic Brain Injury waiver participants, through the waiver's Quality Assurance process is reviewed. This review is conducted by DHHS HCBS Waiver Unit staff who are trained on the review tool and have knowledge of waiver regulations, policies, procedures, philosophy, and documentation requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) Services coordinators are responsible for monitoring the implementation of the service plan and updating the service plan as needed when it has been identified the participant's Level of Care and/or assessed needs have changed. Services coordinators are also responsible for monitoring participant's health and welfare. Services coordinators make referrals, as appropriate, to assure client safety (Adult Protective Services, law enforcement and Licensure). Any referrals made to local law enforcement or licensure would be documented in the incident tracking portion of the case management system. For APS reports there are NFOCUS (eligibility system) alerts that are sent to the services coordinator; the first alert is about the intake of an APS referral. The services coordinator will also be notified when an intake has been accepted for investigation. An alert will tell them whether or not the investigation was substantiated or not. A query is created from the eligibility system to track substantiated intakes. Incidents are tracked in the case management system for which reports can be created to track and trend. System changes may be made if trends are identified.

Services coordinators and participants have access to the Nebraska Resource and Referral System which identifies resources in the state related to health and human services. The Services coordinator is responsible for monitoring the participant's satisfaction of services.
b) Services coordinators monitor the service plan by interviewing and observing the participant and their surroundings and interviewing family members, legal representatives and providers regarding the provision of waiver and non-waiver services including health services. The services coordinator then determines, with input from those mentioned previously, whether or not the service continues to meet the participant's needs. When there is a change in the participant's needs the service plan is updated to include a new statement to cover the newly identified need.
The services coordinator also encourages the participant's family to monitor service provision. Services coordinators may monitor service provision by doing unannounced in-person visits.
Services coordinators maintain a working relationship with resource development staff in regard to provider issues or complaints received and service gaps and/or barriers in the service area.
During the service plan monitoring process, if an incident or a complaint is reported to the services coordinator, the services coordinator follows up on what was reported prior to the next monthly contact with the participant. If the issue is more complex or is ongoing an action step will be added to the service plan and will be addressed accordingly.
The services coordinator maintains a working relationship with the Medicaid eligibility worker, monitors Medicaid eligibility using the DHHS systems containing this information. The services coordinator also monitors the share of cost being obligated to Medicaid services, including waiver services in order for the client to maintain Medicaid eligibility.
c) Contact may be more frequent based on participant need. In-person visits must occur at least once every three months, and may occur more often if determined to be necessary by the services coordinator. All in-person contacts will be at a time, date, and location convenient to the participant. Confirmation services being provided by both formal and informal supports and services continue to meet the participant's needs based on interview and observation, review of service usage and cost; review of the participant's desired outcomes; review the participant's satisfaction with the services provided; review of the client's overall health status; review of medical information; and verification that providers comply with the requirements of service provision.

Any issue which requires follow-up is documented by the services coordinator following the monthly monitoring visit or following other contact with the participant and provider. The services coordinator should assist the participant timely and according to the intensity of need. If the problem is more complex or is ongoing, it is added as an outcome or action step on the service plan and addressed accordingly. Follow-up and remediation of complaints and incidents occurs as detailed in the waiver's Quality Improvement System. This includes issue resolution within 30 days with results reported to the HCBS Waiver Unit for review within 15 days after resolution. HCBS Waiver Unit staff review these reports and accept them or provide consultation and direction for additional activity.

The Participant’s Plan of Services and Supports is reviewed at each monitoring visit by the services coordinator with the participant, to ensure participant satisfaction. The plan includes a section regarding provider choice, in which the participant attests that they have freely chosen the providers of their services for the time period of the plan. If the participant indicates dissatisfaction, the services coordinator will assist in finding other available providers for them to choose from. Services coordinators review each participant's satisfaction with the services provided, review each client's overall health status, and verify that the provider(s) is complying with the requirements of service provision. Complaints and incidents identified through service plan monitoring are documented in the Complaint and Incident data system. Incidents must be acted upon immediately by reporting the situation to Adult Protective Services, law enforcement or the Licensure Unit in the DHHS Division of Public Health. Client complaints about the provider are addressed by Services Coordinators as they arise.

Back-up plan effectiveness is monitored through file reviews and through the services coordinators' monthly contacts

with clients.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed for whom assessed needs (including health and safety risk factors) have been addressed in the service plan. Numerator = number of participants reviewed for whom assessed needs have been addressed in the service plan; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation	Sampling Approach *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants reviewed for whom assessed personal goals have been addressed in the service plan. Numerator = number of participants reviewed for whom assessed personal goals have been addressed in the service plan; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants reviewed whose service plans were reviewed and/or revised on or before the annual review date. Numerator = number of participants reviewed whose service plans were reviewed and/or revised on or before the annual review date. Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants reviewed whose service plans requiring revision were revised, as needed, to address changing needs. Numerator = number of participants reviewed whose service plans were revised, as needed, to address changing needs; Denominator = number of participants reviewed whose service plans required revision to address changing needs.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
 # and % of participants reviewed for whom there is monthly monitoring narrative evidence that waiver services were delivered in accordance with the service plan. Numerator: # of participants reviewed for whom there is monthly monitoring narrative evidence that waiver services were delivered in accordance with the service plan. Denominator: # of participants

reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed whose file indicated participants chose among providers. Numerator = number of participants reviewed whose files indicated participants chose among providers; Denominator = number of participants reviewed.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants reviewed whose file indicated participants chose among types of services. Numerator = number of participants reviewed whose files indicated participants chose among types of services; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

b. Methods for Remediation/Fixing Individual Problems

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

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

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. Services coordination supervisors use an electronic system to run reports of file review and other data to evaluate their agency's performance. Services coordination supervisors may also use the electronic system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with services coordination agencies annually. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals who request, apply for, or receive services may appeal any adverse action or inaction. These may include, but are not limited to an individual being denied services, a participant's services being reduced, or a participant being determined ineligible for continued waiver services. Individuals are informed of their right to a fair hearing in writing on a DHHS approved form at the time waiver eligibility is determined and at any time waiver services are reduced, denied, or terminated. This form states services will continue during the period when their appeal is under consideration if the appeal is filed within ten days of the notice given to the individual. The services coordinator must send written notice of denial, reduction, or termination of services to the individual. The notice used is the Notice of Action (Form HHS-6). This notice of adverse action and fair hearing is kept in the participant's file. Notice to individual must contain:

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

The choice of HCBS vs. institutional services is indicated on the consent form. Fair Hearing rights are included and explained with the consent form information. There is also a statement on the Medicaid application form which informs individuals that assistance and resources in a language other than English are available at a toll-free number. Interpreters are instructed to inform individuals of Fair Hearing rights in languages other than English as needed. All notices are system-generated and sent in English or Spanish, based upon the individuals' preferences. Once the individual indicates a language preference, the language is coded in the system and all notices are sent accordingly.

Notice of reduction or termination of services must be mailed at least ten calendar days before the effective date of action. If the termination of waiver services is because of loss of Medicaid eligibility, the effective date of the termination must match the effective date of the termination of Medicaid eligibility, and the timely notice is provided through Medicaid eligibiity.

If the adverse action is to deny acceptance of a waiver referral, the services coordinator must send the notice to the applicant as soon as the decision is made.

This is outlined in 480 NAC 5.

The DHHS Legal Services Administrative Hearing Team tracks all fair hearing requests and findings of order. The HCBS Waiver Unit also maintains a tracking log of appeal hearings and findings of order to identify issues and training needs.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The HCBS Waiver Unit within the Division of Medicaid & Long-Term Care is responsible for the operation of the complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

Each agency providing services coordination and resource development for HCBS Waivers will investigate and track complaints that are likely to result in actions against providers using the following process:

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

Note: Staff may clarify with the participant that the person filing the complaint is indeed representing him/her.

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

3. 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, the agency must document the reason for the extension. This must be documented in the "Description of the Complaint" field on the Local Level Complaint Form.

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

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

HCBS Waiver Unit staff review the content of each complaint and follow up as necessary with agency staff. The statewide results are analyzed and presented to the HCBS Waivers' Quality Council.

The Complaint Process does not take away a participant's right to a fair hearing or right to refer to the HCBS Waiver Unit. Participants are informed of this when they make a complaint to the services coordinator.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including

alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Incident Process records critical events or incidents that bring harm, or risk of harm to participants, including emotional abuse, physical abuse, sexual abuse, environmental event (e.g. fire, weather, flood), financial exploitation, imminent danger, licensing compliance, medication mismanagement, neglect, theft (non-medication), theft of medication, unsafe environment, and other. An incident report may be received from any source and must be reported to appropriate authorities to conduct follow-up action. Appropriate authorities include Adult Protective Services, law enforcement, and DHHS Division of Public Health Licensure Unit for licensed providers.

Agency staff receive and track incidents using the following processes:

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

2. Agency staff must take appropriate action and document that action, including reporting to appropriate authorities and the Waiver resolution activities.

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

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

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

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

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

Individuals and entities required to report: All suspected incidents or critical events are required to be reported to Protective Services or Law Enforcement per Nebraska statute. Waiver staff are mandatory reporters of such events. Timelines for reporting are immediately. As outlined in 480 NAC 5, services coordinators must report to Adult Protective Services/law enforcement/licensure when client safety is at risk. The types of critical incidents include emotional abuse, physical abuse, sexual abuse, environmental event (e.g. fire, weather, flood). Financial exploitation, imminent danger, licensing compliance, medication mismanagement, neglect, theft(non-medication), theft of medication, unsafe environment and other. The use of restraints, seclusion or other restrictive interventions would be reportable as emotional and physical abuse as well as licensing compliance.

Adult Protective Services regulations an be found at 463 NAC 1 and the definition of abuse is located in Nebraska Revised Statues 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 Statue 28-361.01 Neglect means any knowing or intentional act or omission on the part of the caregiver to provide essential services or failure of a vulnerable adult, due to 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, 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.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or

families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Services coordinators provide new participants 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, and services coordinators address protection and safety issues as the need arises.

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

Services coordination agency staff receive training on how to recognize abuse/neglect and also their role as a mandatory reporter to proper authorities. This information is reviewed with participants and their legal representatives annually.

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

The services coordinator's responsibility in the review and response to critical incidents is to recognize and report to appropriate authorities. An investigation of the incident is then conducted by law enforcement, Nebraska Department of Health and Human Services Protection and Safety staff, or the Nebraska Department of Health and Human Services Licensure Unit.

Protective Services staff receive reports of the critical events or incidents specified in item G-1-a and determine response based on the timelines outlined in the Protective Services matrices contained in the protection and safety rules and regulations. The degree of risk applied to the event or incident dictates the manner of protective services response. Adult Protective Services and law enforcement have the primary responsibility of critical event and incident investigation. Data is obtained on an annual basis from the computerized Protective Services system which categorizes reporter types. The HCBS Waiver Unit has a field in the waiver's electronic client information system which identifies reports made to protective services on an individual client basis.

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

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

As outlined in 480 NAC 5, no provider approval will be issued or remain in effect if a registry/website report on the provider (or household member, if applicable) as perpetrator is shown as inconclusive or substantiated. If the Resource Developer learns that a Protective Services investigation is in progress, s/he 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 being 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 to the victim within 10 calendar days on the date of the report being accepted for investigation.

Contact exceptions (i.e. exception for contacting the victim within 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.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Protection and Safety staff are contained within the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services. DHHS is the single-state Medicaid Agency.Protection and Safety staff are responsible for the oversight of the critical incident management system.

On an annual basis, Adult Protection and Safety provide to the HCBS Waiver Unit information about critical incidents that involved waiver participants. Data is obtained and analyzed on participants involved in Protection and Safety reports. The data includes demographical information, types of abuse/neglect reported, and the findings of investigations.

Staff from the Protection and Safety and HCBS Waiver Unit work together to identify strategies to reduce the occurence of critical incidents and to coordinate better on both a system wide and individual client basis. Examples include training of staff from Protection and Safety about this waiver, and cross training to waiver services coordination agencies about Protection and Safety.

The automated Critical Incidents process described above in G-1-b allows data to be collected and analyzed by the action taken.

The Assisted Living Facility Licensure Compliance Log documents all complaints against waiver certified assisted living facilities. Data includes type of complaint and the result of the DHHS Licensure Unit's investigation.

Both MLTC and the HCBS Waivers' Quality Council oversee the results of critical incidents and events on an annual basis,as the data from Protection and Safety is reported to the HCBS Waiver Unit 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 Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing assisted living facilities and overseeing that facilities are in compliance with the Assisted Living Facility licensure regulations. 175 NAC 4-006.04 states that assisted living facility residents must be free of chemical and physical restraints. In addition, mechanical restraints and seclusion are not allowed to be used. Surveyors from the Public Health division may conduct on site compliance inspections on a random basis of up to twenty-five percent of the licensed assisted living facilities. In addition, the Public Health Division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act or 175 NAC 4 (the regulations governing assisted living facilities).

The DHHS Division of Public Health provides compliance survey inspection findings to the HCBS Waiver Unit, which are then forwarded to the services coordination agency.

○ **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 Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing assisted living facilities and overseeing that facilities are in compliance with the Assisted Living Facility licensure regulations. 175 NAC 4-006.04 lists the rights of individuals residing in assisted living facilities. No restrictive interventions, including any restriction of these rights or use of any chemical or physical restraints are allowed per these regulations.

Surveyors from the Public Health division may conduct on site compliance inspections on a random basis of up to twenty-five percent of the licensed assisted living facilities. In addition, the Public Health division conducts focused selection surveys when there is a complaint alleging violation of the Health Care Facility Licensure Act or 175 NAC 4 (the regulations governing assisted living facilities).

The DHHS Division of Public Health provides compliance survey inspection findings to the HCBS Waiver Unit, which is then forwarded to the services coordination agency. Findings are tracked, trended and system changes are made when warranted.

○ **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. The service included in this waiver includes supervision components which assure that waiver clients receive individualized oversight from quality providers to maintain client safety and dignity.

The Nebraska Department of Health and Human Services Division of Public Health is responsible for licensing health care facilities and services. This includes licensed waiver providers of Assisted Living. Regulations in Nebraska Administrative Code Title 175 states 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 Pubic Health Division conducts focused selection surveys when there is a compliant alleging violation of the Health Care Facility Licensure Act.

The DHHS Division of Public Health provides compliance survey inspection findings of Assisted Living Facilities to the HCBS Waiver Unit which are then forwarded to the waiver staff for follow up action.

Services coordination staff are responsible for client monitoring which includes satisfaction interviewing and observation of service delivery. They are positioned to identify potential use of seclusion and would report such a finding to the State as a Compliance Report or an Incident Report. Other quality reviews and billing oversight conducted by State Medicaid staff are also in effect to identify and address inappropriate consideration or use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The service of the Traumatic Brain Injury Waiver is assisted living service. These facilities are licensed by the DHHS Division of Public Health, Licensure Unit. The Licensure Unit has ongoing responsibility for monitoring client medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The second line monitoring method utilized by the Licensure Unit is an on site inspection and record review at the assisted living facility. These methods include monitoring of all medication types, including behavior modifying medications.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Medication management oversight is reviewed as a part of a routine compliance inspection or in response to a complaint regarding medication administration. 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 record reviews and 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 begin followed. The "five rights" are the right medication to the right patient at the right time by the right dosage by the right route. The survey staff also review if PRN medications are administered pursuant to specific physician's orders which detail the symptoms and the frequency for usage. When survey staff note medication administration errors, they follow up by issuing a deficiency report to the assisted living facility. The facility must develop a plan of correction and provide evidence back to the DHHS Division of Public Health that deficiencies have been corrected and what plans are in place to prevent future errors.

All compliance inspection reports and assisted living facility statements of compliance are provided to the HCBS Waiver Unit and services coordinators for review.

Each assisted living facility must provide for a Registered Nurse to review medication administration policies and procedures annually and to provide or oversee the training of medication aides at such facility. Training of medication aides must include, but is not limited to:
1. Facility procedures for storing, handling, and providing medications;
2. Facility procedures for documentation of medications;
3. Facility procedures for documentation and reporting medication errors and adverse reactions;
4. Identification of person(s) responsible for direction and monitoring of medication aides; and
5. Other resident-specific training on providing medications in accordance with the limits and conditions of the Medication Aide Act.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

During any compliance inspection, the method used to ensure that client medications are managed appropriately is the DHHS Division of Public Health Licensure Unit's surveyor observation of 20 medication opportunities. An opportunity is defined as any medication that is or should have been given to the client. If there is one error observed, an additional 20 medication opportunities are observed to determine presence of a system failure. The error rate is calculated by dividing the number of errors by the number of opportunities and multiplying by 100. Errors are considered missing any one of the five rights (right resident, right dose, right drug, right time, and right route), as well as not administering a medication that is physician ordered.

A citation from the Licensure Unit is issued to the assisted living facility for a medication error rate of 5% or greater. When an error is considered significant enough to have a potential or actual adverse effect on the client's health or well-being (i.e. missed insulin dose), a citation is issued regardless of the percentage of medication error rate.

The DHHS Division of Public Health Licensure Unit is responsible for follow up and oversight on medication management. All compliance inspection reports and assisted living facility statements of compliance are communicated to the HCBS Waiver Unit and services coordinators for review. These reports and statements are posted on the DHHS Division of Public Health website and the HCBS Waiver Unit is notified at the conclusion of each inspection or complaint 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.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Each year a random sample of 25% of all licensed assisted living facilities is selected for a compliance inspection, including medication management oversight. Focused inspections are conducted on facilities any time the Licensure Unit deems one necessary. These also include medication management oversight. All compliance inspection reports and assisted living facility statements of compliance are communicated to the HCBS Waiver Unit and services coordinators for review. Such reports are sent via email to the HCBS Waiver Unit, and are then forwarded electronically to services coordination staff. This information is provided to services coordination agencies which are responsible for the waiver certification process for assisted living facilities. Assisted Living Facility statements of compliance are reviewed by staff who complete the waiver certification process and paperwork to determine if outstanding issues are present which may prevent the facility from becoming waiver certified or retaining the waiver certification, and thus being a qualified waiver provider. Common issues may be identified when reviewing a grouping of statements of compliance (as opposed to isolated reviews of the documents). This information is then analyzed against quality assurances and to develop quality training.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The assisted living service includes medication administration as one of the components. Waiver regulations reference that assisted living providers must be licensed and abide by the assisted living facility licensure regulations found at 175 NAC 4 and described below.

As outlined in 175 NAC 4, a client in an assisted living facility may self-administer medications under the following conditions:
1. Be at least 19 years of age;
2. Have cognitive capacity to make informed decisions about taking medication;
3. Be physically able to take or apply a dose of medication;
4. Have capability and capacity to take and apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for non-prescription medication; and
5. Have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The assisted living provider must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

Provision of medications may be provided by the assisted living facility as requested by the participant and in accordance with licensed health care professional statutes and the statutes governing medication provision by unlicensed personnel.

Medication Aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of: 1) a licensed health care professional whose scope of practice allows medication administration; 2) a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration); or 3) a caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for an individual.

A Medication Aide is listed on the Medication Aide registry operated by the Licensure Unit of DHHS, Division of Public Health. Medication Aides are allowed to perform Medication Provision which is a component of Medication Administration that includes giving or applying a dose of medication to an individual and includes helping an individual in giving or applying medication to him/herself. Each Assisted Living Facility must establish and implement policies and procedures that ensure medication aides who provide medications are trained through a Medication Aide Course and have demonstrated minimum competency standards in accordance with the Regulations governing the Provision of Medication Aides and other Unlicensed Persons and the Regulations governing the Medication Aide Registry. Direction and Monitoring means, for the purpose of medication administration by unlicensed persons, the acceptance of responsibility for observing and taking appropriate actions regarding any desired effects, side effects, interactions, and contraindications associated with the medications. Direction and Monitoring may be done by a competent individual for him/herself, a Licensed Health Care Professional, or a caretaker (a person who is directly and personally involved in providing care for a minor child or incompetent adult and/or is the parent, foster parent, family member, friend or legal guardian of such minor child or incompetent adult as referenced in the Nebraska Nurse Practice Act). A licensed health care professional is not mandated to be present during the provision of medication by an unlicensed person.

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

The training requirements for medication aides are outlined in 172 NAC 96-004.02. Medication aides providing services in an assisted-living facility must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a 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.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Assisted living providers are required by licensure regulation to record medication administration errors which are considered missing any one of the five rights (right resident, right dose, right drug, right time, and right route), as well as not administering a medication that is physician ordered. In addition, any adverse reaction to a medication must be recorded by the assisted living facility provider.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Traumatic Brain Injury waiver service is assisted living. DHHS Division of Public Health, Licensure Unit has ongoing responsibility for monitoring licensed assisted living facilities in the administration of medications to all clients, including those who are on this Waiver. The Department of Health and Human Services is the State Medicaid agency and includes both the Division of Public Health and the Division of Medicaid and Long-Term Care. The Licensure Unit is under the Division of Public Health; therefore it is part of the State Medicaid agency. Medication errors made by assisted living facilities are reported to the Department of Health & Human Services.

Second line monitoring method utilized by the Licensure Unit is an on site inspection and record review at the assisted living facility.

A compliance inspection, including medication management oversight, is conducted by the Licensure Unit of DHHS Division of Public Health on all licensed assisted living facilities at least every five years. Each year a random sample of 25% of all licensed assisted living facilities is selected for a compliance inspection,including medication management oversight. Focused inspections are conducted on facilities any time the Licensure Unit deems one necessary. These also include medication management oversight.
Licensure regulations require that an assisted living facility is cited for a medication error rate of 5% or greater. To determine the error rate, 20 medication opportunities are observed by Licensure surveyors. An opportunity is defined as any medication that is or should have been given. As many multiple routes,
residents and administrators as possible are observed. If there are any errors, an additional 20 opportunities are observed for a system failure. The error rate is computed by dividing the number of errors by the number of opportunities and multiplying by 100. Errors are considered missing any one of the 5 rights (wrong resident, wrong dose, wrong drug, wrong time, wrong route) as well as not giving a medication that is ordered. A medication error is cited for anything below 5%. A second medication error is cited when the error is considered significant enough to have a potential (or actual) adverse effect on the resident's health or well being - i.e. missed insulin doses. An assisted living facility must submit a Statement of Compliance with a plan of correction to the Licensure Unit of the Nebraska Department of Health and Human Services, Division of Public Health for all identified citations. The Division of Public Health is responsible for reviewing and approving the Statement of Compliance and plan of correction.

All compliance inspection reports and assisted living facility statements of compliance are provided to the HCBS Waiver Unit and services coordinators for review.These reports and statements are posted on the DHHS Division of Public Health website and the HCBS Waiver Unit is notified at the conclusion of each inspection or complaint review. Monitoring reports provide information on service providers, and may be used and reviewed in the provider application and provider renewal process to determine if the provider meets criteria to be approved as a waiver provider. Trends identified in the review of the monitoring reports are used to set training priorities, as well as give technical assistance to waiver staff and assisted living waiver providers related to improving the quality of the assisted living services. Data is acquired from DHHS Licensure inspection reports and statements of compliance that are completed by the facility. The reports are reviewed and analyzed in order to identify trends related to medication management issues and concerns. Trends identified in the review of the monitoring reports are used to set training priorities, as well as give technical assistance to waiver staff and assisted living waiver providers related to improving the quality of the assisted living services.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to***

prevent instancesof abuse, neglect, exploitation and unexplained death. *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who received information/education about how to report abuse, neglect exploitation and other critical incidents as specified in the approved waiver. Numerator = number of participants reviewed who received information/education; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants' death reviews conducted which did not require additional follow up/remediation. Numerator = number of participants' death reviews conducted which did not require additional

follow up/remediation; Denominator = number of participants' death reviews conducted.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of incident reports where additional actions or waiver resolution activities requested by HCBS staff were completed. Numerator = Number of incident reports where additional actions or waiver resolution activities requested by HCBS staff were completed. Denominator = Number of incident reports where additional actions or waiver resolution activities were requested by HCBS staff.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of HCBS Waiver Incident reports completed with appropriate waiver resolution activity. Numerator = number of HCBS Waiver Incident reports completed with appropriate waiver resolution activity; Denominator = number of HCBS Waiver Incident reports.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of incident reports submitted by Service Coordination Agencies for substantiated Adult Protective Services (APS) intakes. Numerator = Number of incident reports submitted by the Service Coordination agencies for substantiated APS intakes. Denominator = Number of substantiated APS intakes.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants with a substantiated APS intake within the waiver year who didn't have a similar follow up APS intake within the waiver year. Numerator=# of participants with a substantiated APS intake within the waiver year who didn't have a similar follow up APS intake within the waiver year. Denominator=# of participants with a substantiated APS intake within the waiver year.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

b. Methods for Remediation/Fixing Individual Problems

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

A number of activities and processes at both the 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 are aggregated and analyzed to measure the overall system performance.

The services coordination agencies are responsible to remediate all (100%) identified Health and Welfare individual problems identified through its discovery processes in an appropriate and timely manner (45 days).

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

2. The HCBS Waiver Unit File Review and Electronic Reports
- Quality improvement reviews are completed by the HCBS Waiver Unit on an electronic system for each local agency providing services coordination.
- Indicators that did not meet standards require remediation/supervisory follow-up. Indications of abuse, neglect, exploitation, and participant safety risks with no documentation that a referral, investigation and/or action occurred to address the problem are followed up on immediately by the HCBS Waiver unit with the supervisor.
- Services coordination supervisors report remediation activities to the HCBS Unit quality staff. The staff document corrections in an electronic data system. The review documentation must include information that all health and welfare issues have been resolved correctly.
- The HCBS Waiver Unit monitors statewide reviews to ensure review and remediation activities are completed as assigned.
- Besides remediation being accomplished by follow up of individual or systemic issues, the agency could be responsible for a shared resolution or quality improvement plan. Agencies that do not successfully complete their Quality Improvement Plan process or fail to provide some of the delegated functions, may be referred to the HCBS Waiver Unit contract manager for contract review and possible withholding of payment reimbursement.

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. Services coordination supervisors use an electronic system to run reports of file review and other data to evaluate their agency's performance. Services coordination supervisors may also use the electronic system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial review of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with services coordination agencies annually. 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**	☒ **Annually**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state

spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The stated purpose of the HCBS Waivers Quality Improvement System is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a quality management system.

The Home and Community-Based Services (HCBS) Waiver Framework provides guidance as to the state's process for monitoring the safeguards and standards under the waiver. A set of key principles guide the QIS and are contained in the Nebraska's HCBS Quality Improvement System document. Nebraska's QIS uses an evidence-based tiered approach which includes a number of activities and processes at both the local and state levels. This system has been developed to discover whether the federal waiver assurances are being met, to remediate identified problems, and to carry out quality improvement.

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

Nebraska's HCBS Waiver quality oversight involves Program Management and Quality Management staff in the HCBS Waiver Unit of the Medicaid and Long-Term Care Division, Department of Health and Human Services (DHHS). (This is the single state Medicaid agency.) A HCBS Waiver Unit Quality Improvement Subcommittee is composed of staff from both the program and quality areas, as well as representation from services coordination agencies and the Quality Council. This subcommittee meets at least annually to review aggregate data for the TBI Waiver performance measures and any other identified issues. The subcommittee makes recommendations for changes that may lead to systemic improvement in the quality of services, as well as recommendations related to remediation efforts. Relevant reports will be provided to QI Subcommittee members and Quality Council members, as well as other identified stakeholders, and posted on the DHHS website annually. Issues or concerns about the reports will be communicated to the Department and referred back to the QI Subcommittee and/or Quality Council.

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

The Quality Assurance/Improvement staff provides systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under Quality Assurance include reviewing electronic client data, conducting file reviews; and oversight of the various services coordination supervisory efforts. The National Core Indicators – Aging and Disabilities (NCI-AD) is used to assess the outcome of services provided to individuals.

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

Quality reports, which may or may not be related to performance measures, include: death review data, appeals data, supervisory file review data, central office file review data, local level complaint data, central office complaint data, incident data, adult protective service data, electronic participant data system reports, service expenditure data, and service authorization data. Of these reports, the following are compiled by HCBS Waiver Unit staff and analyzed by the HCBS Waiver Unit staff and the Quality Council annually or as needed: death review, appeals, supervisory file review, complaints to agency or HCBS Waiver Unit, incidents, adult protective services, electronic participant data system reports, service expenditures, and service authorizations. These reports are shared with the services coordination agency continuously and on an on-going basis.

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

The State's waiver service delivery design incorporates two functions, services coordination and resource development. These two roles provide checks and balances. Services coordination staff assist the participant to determine their individual choices and needs, eligibility, and service planning. Resource development staff

concentrate on issues of qualified providers, including their compliance with standards. Communications between the two functions is key and both provide continuous monitoring of service delivery.

Following discovery of needed improvement in any area, staff confer, plan, and involve the Quality Council. Lines of communication are fluid to allow information to flow to and from program and quality staff. Information also flows freely to and from the Quality Council and to and from services coordination agencies and other contracted providers. Continuous Quality Improvement, that is statewide systemic program enhancement, occurs through any combination of the following remediation activities:

1. Training and meetings: These are offered or mandated for supervisors, services coordinators, and resource developers, as appropriate.
2. Policy or procedure development or implementation to add, revise, or clarify program expectations determined necessary for program improvement.
3. Informational materials including written guidance for staff or brochures directed toward 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 services coordination/resource development agencies with the HCBS Waiver Unit providing the oversight to ensure completion. Technical assistance is also provided to service delivery staff on a continuous ongoing basis to aid understanding of policies and procedures and to address individual situations.
6. Shared resolution: This is a formally-defined process, based on proactive partnership, to work with 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.
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*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The HCBS Waiver Unit of the Nebraska Department of Health and Human Services' Medicaid and Long Term Care Division is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. The HCBS Unit manager, along with the program staff, is responsible for coordinating the development, implementation and monitoring of any system design changes. The HCBS Unit manager works closely with the HCBS Quality Improvement Subcommittee and the Quality Council to assure the appropriate identified priority system issues are developed, implemented and monitored to assure system change occurs. Annual data is aggregated and compared to the previous baseline evidence to determine if the identified system change is effective.

HCBS Waiver Unit staff review the QIS on an ongoing basis to adjust program outcomes, determine the need to modify data sources and to develop other methods to evaluate progress and services.

As described above in a.i. (System Improvements), the State has a Quality Improvement System in place that includes discovery leading to remediation. In turn, that leads to system improvement. This is an ongoing, circular system with components of discovery, remediation, improvement, design, and operations.
State staff in the HCBS Waiver Unit fulfill the lead role in guiding this improvement along with input from services coordination agencies/offices and the Quality Council.

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

Quality management staff, program management staff, and administrative staff of the HCBS Waiver Services Unit located in the Medicaid and Long-Term Care Division evaluate the effectiveness of the waiver Quality Improvement System on a continuous, ongoing basis. Nebraska QIS strategies stratify information for the Aged and Disabled Waiver (NE.0187) and the Traumatic Brain Injury Waiver (NE.40199). Data for the AD waiver and TBI waiver is aggregated and analyzed separately. The HCBS Unit is located in the Division of Medicaid and Long-Term Care so identified state plan system issues would be relayed to staff responsible for services under the Medicaid State Plan.

The evaluation of the QIS involves assessing the effectiveness of the system in improving the quality of services as well as comparing the system to best practices. If efforts to improve the quality of services are not effective, additional analyses are conducted to identify weaknesses in the current QIS. These analyses aid in identifying potential changes to improve the efficacy of the overall system. In addition, the Quality Council provides an additional review of the effectiveness of the QIS and makes recommendations for improvement.

Just as the assumption is that services can always be improved, the same concept also holds with the QIS system. Efforts are continually being made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements and eliciting additional feedback from agencies and providers regarding quality improvement issues.

System improvements within the scope of current regulations can be implemented within six to nine months. System improvements dependent upon regulatory change are subject to the State timeline for regulation promulgation.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The State does not require providers to secure an independent audit of their financial statements.

The State has a post-payment financial audit in which a representative sample of assisted living claims are reviewed during the HCBS Waiver Unit File Review. The frequency of the audit is annual. A representative sample of claims for a given month are reviewed to ensure they were paid correctly. The audit does not include onsite reviews. The audit verifies: the individual's eligibility to receive services on the date of service, the service was included in the participants approved service plan, the service was actually provided, and the service was provided by a qualified provider. Staff of the HCBS Waiver Unit at central office are responsible for conducting the HCBS Waiver Unit File Review. File reviews are completed annually for a representative sample of TBI Waiver participants.

Prior authorization of services is required for all waiver services. The services coordinator enters the prior authorization on the waiver data system (CONNECT, a client tracking software system) and forwards the authorization to the MMIS payment review unit for claims processing. The DHHS data system, N-FOCUS, contains all Medicaid eligibility information and interfaces with MMIS. All claims are edited against client Medicaid eligibility, prior authorization, and provider approval before payments are issued. The services coordinator contacts the individual at least monthly or per client need, and inquires about services received to ensure needs are being met. The services coordinator compares the Waiver Plan of Services and Supports to the facility's Plan of Care and tasks list to ensure services are being provided to meet the client need.

Assisted living provider claims are entered into and tracked by MMIS. Payment files are then loaded into the State of Nebraska's accounting system, NIS (Nebraska Information System). NIS processes the claims and remits payment to providers on a weekly basis. Provider payments are issued as warrants (paper checks), direct deposit, or payments to a debit card.

MMIS and NIS establish the audit trail necessary for the Nebraska Auditor of Public Accounts office to conduct the single state audit on an annual basis. Auditors conduct audits based on federal audit guides where priorities are identified. Cases are pulled from random samples and auditors request all documentation contained in case files to substantiate the state's process for prior authorization, provider approval, provision of services and claims processing. The random samples selected for the Single Audit are not statistical samples. The Nebraska Auditor of Public Accounts also verifies that the provider is approved and the beneficiaries are Medicaid eligible as part of their audit. Auditors prepare a report of the findings identifying areas where corrective action is needed. DHHS prepares and follows corrective action plans. The provider certification process, along with the billing and payment processes, is reviewed. The Statewide Single Audit is the audit required by the Single Audit Act (Uniform Guidance).

If the audit was conducted by the APA, Program Integrity would review the audit to ensure accuracy and completeness prior to requesting refunds from the provider. If the findings were confirmed and were determined to rise to the level of potential fraud, a referral would be made to the Medicaid Fraud and Patient Abuse Unit. If the findings were confirmed and were not determined to rise to the level of fraud, an education/refund request letter would be sent to the provider and a Program Integrity Adjustment Request form would be completed and sent to the claims processing unit. The provider has 30 days from the date of the letter to appeal, demonstrate that the refund is an error, or repay the refund. If the provider does not repay the refund within 45 days, money will be automatically recouped from future payments.

The Single State Audit and HCBS Waiver Unit file reviews are completed annually. No other reviews are completed.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence interval with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence interval with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of paid claims which were for services rendered for participants enrolled in the waiver and eligible for such services. Numerator=Number of paid claims which were for services rendered for participants enrolled in the waiver and eligible for such services. Denominator=Number of paid claims for the waiver.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Electronic client system data and Connect System Data. Quality Assurance staff compare the Electronic client data reports against the Connect data to assure claims paid were for services delivered.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

Data Source *(Select one):*

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence interval with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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.*

b. Methods for Remediation/Fixing Individual Problems

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

The HCBS Waiver Staff conducts file reviews and reviews claim data reports to ensure continuous improvement. Besides remediation being accomplished by follow up of individual or systemic issues, the agency could be responsible for a shared resolution or quality improvement plan. Payment errors could be referred to Program Integrity for claim recovery processing.

Practices are in place to assist services coordination agencies in evaluating whether problems are systemic to their agency. Services coordination supervisors use an electronic system to run reports of file review and other data to evaluate their agency's performance. Services coordination supervisors may also use the electronic system to perform additional agency specific file reviews. The electronic system enables the agency to perform complete or partial file reviews of identified or suspected problem areas.

Performance measure related data reports developed by the QI Subcommittee will be shared with services coordination agencies annually. This enables agencies to compare their performance with the overall trend of all agencies combined to determine whether or not there might be an agency specific issue.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Medicaid payment for assisted living service is based on rates established by the Division of Medicaid and Long-Term Care.
Each rate consists of three parts: 1) The amount the facility must collect for room and board from the participant; 2)the participant's share of cost (SOC) that must be obligated before DHHS will assume financial responsibility for the service component; and 3)the Medicaid responsibility. The room and board, Medicaid responsibility and participant's share of cost together equal the total monthly rate.
The initial rate developed for the current, single provider of assisted living services at the outset of the TBI waiver was based on the facility's cost reports for the period of January 1, 2001 to June 30, 2002. For state fiscal years 2003 and beyond, the rates were established either through negotiations between the specialized assisted living facility provider and the Director of the Division of Medicaid and Long-Term Care in some years, or through the legislatively mandated percentage for provider rate changes enacted via the Medicaid appropriations.
The State utilizes a variety of methods to solicit public comment. Methods include public forums and provider information meetings, among other avenues of communication. The Federal Benefit Rate has been used as a basis for the room and board amount at a rate of the FBR minus $64. This is to ensure that all participants can maintain their personal needs. The state does use spousal impoverishment rules for a spouse at home, allow for the maintenance needs of the family, and allow for incurred medical expenses.
Because Nebraska has only one assisted living provider which specializes in serving people with Traumatic Brain Injury. That entity is the sole TBI Waiver provider. While the State has continued to be open to contracting with additional providers, other "non-specialized" assisted living facilities in the State which have expressed interest do not have sufficient staff numbers or training to meet the needs of this special, but small population. Due to the rural nature of this State with potential participants widely spaced geographically, licensure requirements, and rates, other providers have not followed through on initial inquiries.
The annual recertification and review process for the facility should allow the State to assure conformance to the provisions of SSA Section 1902(a)(30)(A).
The Legislative appropriations are then applied as an adjustment to the calculated Medicaid Share to determine the Final Medicaid Share. One of the required service coordination activities is determining the estimated total monthly cost of a proposed plan of services and supports and comparing the estimated cost to the Medicaid monthly payment for care in a Nursing Facility. When a participant is eligible in the 217 group, the SSI standard is deducted from their total income. The remainder of their income is paid to the facility as the participant's contribution to the cost of their care, or Share of Cost. Medicaid payments for services are reduced by the amount of the Share of Cost.
The TBI Waiver assisted living rates may change annually, based upon any provider rate adjustment enacted and appropriated by the Nebraska State Legislature for all applicable Medicaid providers. Additionally, the State negotiates with the one existing provider qualified to provide these specialized services to this TBI population. The State negotiated this provider's rates for their other Medicaid services this year, and they did not request any changes to their specialized TBI Waiver assisted living rate, which has been in effect since July 1, 2017.
The annual recertification and review process for the facility allows the State to assure conformance to the provisions of SSA Section 1902(a)(30)(A), by reviewing and recertifying items that are part of the Provider Addendum (MC-190). The Provider Addendum includes items such as, verification that the provider will bill only for services which are authorized and actually provided and assures that the rate negotiated or charged does not exceed the amount charged to private providers. The complete list of General Provider Requirements may be found on the form MC-190. This recertification is completed every year, with every provider.
The State does not post the TBI Waiver's specialized assisted living rate publicly.
The TBI Waiver assisted living rates may change annually, based upon any provider rate adjustment enacted and appropriated by the Nebraska State Legislature for all applicable Medicaid providers. Additionally, the State negotiates with the one existing provider qualified to provide these specialized services to this TBI population.
The percentage rate change would be applied uniformly to all the TBI Waiver assisted living providers.
The legislative appropriations for the Medicaid program define the portion of the overall appropriation intended for a specified rate increase (or decrease).
While the legislature has the authority to define the providers any rate increase (or decrease) apply to, it is not at an individual provider/facility level. Rather, if any specificity is included, it would be at a category level (i.e. physicians, behavioral health services, etc.). However, in general, percentage changes for provider rates included in the budget appropriation has applied across all providers of Medicaid services.
The state will provide a more detailed and revised methodology to CMS. Nebraska will rebase the rate for the assisted living services provided under this waiver, based on the existing provider's cost reports, and submit a waiver amendment at the conclusion of this process. If additional providers become available to provide assisted living services under this waiver, the state would consider at that point whether it is necessary to adjust the rate to assure all providers of the service are paid the same rate under the waiver. The state will be opening a draft version of the waiver amendment in

WMS for CMS review no later than February 1, 2020 and will formally submit the waiver amendment via WMS no later than April 1, 2020. The rate methodology will have an effective date of July 1, 2020.
Public notice was provided on May 25, 2018 providing dates/times/locations of public hearings. This notice also provided information regarding the public comment period and where the public could send written comments.
Amendment effective 7/1/2020:
Public comment process is outlined for this amendment in Main Section 6-I of the application.
The state has completed the process to rebase and revise the rate methodology and rates for the service provided under the TBI waiver. This included a review of rate allowed for room and board, as well as to separately identify the components of the rate which are medical transportation and provider retainer payments.
DHHS received the FY 2019 cost report from Quality Living Inc. This informed the rebasing, as well as the analysis of the adequacy and reasonableness of a rebased rate incorporating the CMS technical guidance received.
The federal benefit rate minus the cost of the personal needs allowance ($64) is an accurate reflection of room and board cost and does not contain any portion of the services under this waiver. Upon analysis of the operating costs of the Assisted Living facility, it was determined the total room & board cost per day was $22.59 and the average room and board paid by client based on the Federal Benefit Rate was:
2018 FBR $750 minus $64 needs allowance Average per day $22.55
2019 FBR $771 minus $64 Average per day $23.24
2020 FBR $783 minus $64 Average per day $23.64
Upon review of the transportation provided by Quality Living Inc., non-emergency medical transportation costs $0.65 cost per day. The cost $11,994 was divided by total inpatient days 18,576 to equal $0.65
The assisted living facility rate does not include retainer payments. However, the state allows assisted living facilities to bill for up to 30 concurrent days the resident is out of the facility. If the resident does not exceed the allotted number of days, the resident's room will be reserved until they return and the expense will be paid by Medicaid.
If the resident does not return to the facility by day 30, all days up to the date of discharge are billed at 90% of the daily rate as a fixed cost allowance for the month of discharge. The day of discharge is billed at the contracted daily rate.
The rate rebasing was developed from the facility's submitted cost report, and based upon the cost of providing the specialized Assisted Living for this very small population. Nebraska's average annual cost under the TBI Waiver has always remained well below the equivalent institutional level of care for this specialized population in the cost neutrality analysis.
The state audits the facility's FYE 6/30/xx cost report annually. The cost report data is used to validate that the rate, combined with any legislatively mandated and appropriated changes, is consistent with the methodology in the approved waiver. Rates are determined by the MLTC Facility Audit team which also determines all Nursing Facility rates. Oversight of the process is handled collaboratively between MLTC Finance and the HCBS Waiver program team.

Each waiver participant is able to inquire with their individual service coordinator for rate information.

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 provider bills Medicaid directly using electronic or paper claim billing and is paid through MMIS. In using electronic billing, the provider may submit the claim through an approved clearinghouse.

The authorization and payment process is-
1. The specialized assisted living provider is approved as a qualified Medicaid provider and loaded into both CONNECT and MMIS. The provider information contains the provider's approved rates, assisted living service, and the effective dates of the provider's Medicaid waiver certification.
2. The services coordinator, after determining that a participant meets all points of Medicaid eligibility, including choice of provider and service, completes an assisted living prior authorization on the waiver participant tracking system, CONNECT. Prior authorization identifies the participant, provider, service, rate, code, and the effective date of waiver payment.
3. The prior authorization is electronically submitted from CONNECT to the Division of Medicaid and Long-Term Care and is entered into MMIS.
4. A copy of the prior authorization is provided to the assisted living provider. The provider enters the waiver resident information from the prior authorization into their billing system.
5. The provider submits an electronic claim for each waiver resident after the month of service has ended.
6. MMIS audits claims against services authorized for the participant, any share of cost, and the provider's established rates.
7. Electronic deposit to the provider's account is made the week following receipt of approved electronic claims.

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:*

The Department of Health and Human Services has an automated eligibility system, N-FOCUS, which is an integrated computer system designed to provide comprehensive information about individuals served. This system assists in Medicaid eligibility determination and shares data across programs.

The MMIS system contains information on all providers who have signed agreements with DHHS to deliver TBI waiver services to eligible participants at set rates and during specific time periods.

The MMIS system which processes claims for the Assisted Living service validates eligibility information against N-FOCUS to assure payments are made only for eligible participants. Payment is made only for the assisted living service, which is described on the participant's service plan. The services coordinator completes ongoing monitoring to ensure that the participant remains living at the assisted living facility, and is receiving assisted living services, and verifies that the services that were paid for were actually provided.

All inappropriate payments are removed from the CMS-64 report, which is the basis for claiming of FFP. If a payment has been determined inappropriate, an Accounts Receivable (AR) record is created in the claims processing system. The FFP is returned when the provider returns the funds. If the provider does not return the funds within 45 days of the creation of the accounts receivable, the provider's next payment will be automatically reduced by the amount of the overpayment. If the provider does not return the funds or has payments large enough that the amount can be auto-recouped, CMS-64 reporting is adjusted. If the overpayment was the result of fraud or abuse, the funds are returned 60 days after the creation date of the AR. Otherwise, the FFP is returned 365 days after the creation of the AR.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***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:

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:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [x] ***Appropriation of State Tax Revenues to the State Medicaid agency***
- [ ] ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The state utilizes the Federal SSI standard, minus a $64 personal needs allowance, as the cost of room and board. The state deducts the SSI standard from the residential rate. This SSI standard is adjusted annually based on cost of living adjustments. Room and board cost is excluded from the FFP.

The SSI standard is protected. From the SSI standard, $64 is retained by the participant for their personal needs. The remainder is due to the facility for the room and board costs. The exact room and board costs change annually with any increase to the SSI standard. In 2018, the room and board amount is $686.

Room and board costs are payment for housing, food, utilities, or items of comfort or convenience, facility maintenance, upkeep or improvement. DHHS informs the client and assisted living provider of the Room and Board and any share of cost the client is responsible to pay.
The billing document used by assisted living facilities captures the share of cost amount to be paid by the client and this is deducted from the payment made to the provider. Share of Cost amounts are not included in Federal Financial Participation requests. The claims payment system has an edit for the share of cost so that it is deducted from payments made to providers, thus ensuring that the client's share of cost is not included in expenditures reported to CMS.

Eligibility for food and energy assistance is determined by another department. Under program rules, a person would not be eligible for such assistance if those items were covered by room and board. Building maintenance would be paid by the facility and should be figured into their overhead cost structure.

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	36670.26	2984.59	39654.85	56134.00	3959.73	60093.73	20438.88
2	37770.00	3133.82	40903.82	57537.35	4058.72	61596.07	20692.25
3	39839.00	4752.88	44591.88	44646.00	1454.07	46100.07	1508.19
4	41033.52	4990.52	46024.04	45762.00	1490.42	47252.42	1228.38
5	42264.09	5240.05	47504.14	46907.00	1527.68	48434.68	930.54

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	40	40
Year 2	40	40
Year 3	40	40
Year 4	40	40
Year 5	40	40

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.*

Estimated average length of stay on the waiver is based on the mean average length of stay on the waiver from 372 reports submitted from 2012 through 2016.

The expected ALOS of 363 days is based on the average of the actual number of days used over the past 5 years. It is expected to maintain that number over the next five years.

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:*

Factor D estimates are based on actual Factors D from 372 reports submitted from 2012 through 2016 for this waiver and an assumption of 3.0% annual rate increases. The growth is a conservative estimate based on the assisted living rates which are loaded into the MMIS and reflect the facility's current rate.

7/1/2020 amendment: The waiver year 3 average cost per unit daily rate was updated based on rate rebasing completed for this waiver application and the annual rate increase of 3% was applied for waive year 4 and 5. The updated basis and methodology estimates were updated based on FY2019 cost reports as described in I-2-a and Nebraska state legislative appropriations for rate increases.

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 D' factor is based on the average of the actual D' from 2012 through 2016. The growth rate of 5% was used based on the average growth of the D factor from 2012 through 2016 which was 5.83%. The State elected to be conservative and use 5%. The data used was the average growth from the previous 5 years and the States projected budget and growth in the program.

7/1/2020 amendment: FY 2019 (waiver year 1) actual expenses were calculated showing Factor D' was $4,331.00, when applying the 5% growth for waiver year 2 the adjusted estimated costs would change to $4,526.55 for Factor D'. Waiver year 3, 4 and 5 have been updated showing 5% growth based on these calculations. The 372 reports will be reviewed to determine if corrections will be needed.

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:*

Factor G estimates are based on actual per-recipient Nursing Facility Costs for a a subset of the Long Term Care recipients who have a Traumatic Brain Injury Diagnosis and an assumed annual increase of 2.5%. The 2.5 percent growth rate reflects the trend factor developed from historical utilization analysis and incorporated into the biennial budget request to the Governor and Legislature for the Nebraska Medical Assistance Program(Medicaid).

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 Factor G estimates are based on actual per-recipient acute care costs for Nursing Facility residents and assumed 2.5% annual increase. This 2.5 percent growth rate reflects the trend factor developed from historical utilization analysis and incorporated into the biennial budget request to the Governor and Legislature for the Nebraska Medical Assistance Program (Medicaid).

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	
Assisted Living Service	

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
Assisted Living Service Total:						**1466810.40**
Assisted Living Service	day	40	363.00	101.02	**1466810.40**	
				GRAND TOTAL:		**1466810.40**
				Total Estimated Unduplicated Participants:		**40**
				Factor D (Divide total by number of participants):		**36670.26**
				Average Length of Stay on the Waiver:		363

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
Assisted Living Service Total:						**1510806.00**
Assisted Living Service	day	40	363.00	104.05	**1510806.00**	
				GRAND TOTAL:		**1510806.00**
				Total Estimated Unduplicated Participants:		**40**
				Factor D (Divide total by number of participants):		**37770.00**
				Average Length of Stay on the Waiver:		363

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
Assisted Living Service Total:						**1593570.00**
Assisted Living Service	day	40	363.00	109.75	**1593570.00**	
				GRAND TOTAL:		**1593570.00**
				Total Estimated Unduplicated Participants:		**40**
				Factor D (Divide total by number of participants):		**39839.00**
				Average Length of Stay on the Waiver:		363

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
Assisted Living Service Total:						**1641340.80**
Assisted Living Service	day	40	363.00	113.04	**1641340.80**	
				GRAND TOTAL:		**1641340.80**
				Total Estimated Unduplicated Participants:		**40**
				Factor D (Divide total by number of participants):		**41033.52**
				Average Length of Stay on the Waiver:		363

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
Assisted Living Service Total:						**1690563.60**
Assisted Living Service	day	40	363.00	116.43	**1690563.60**	
				GRAND TOTAL:		**1690563.60**
				Total Estimated Unduplicated Participants:		**40**
				Factor D (Divide total by number of participants):		**42264.09**
				Average Length of Stay on the Waiver:		363