

# Response to Public Comment on AD and TBI Waiver Changes

To provide clarity and consistency in our responses, responses are noted here by category, reflected in the itemized summary of comments and questions received by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities.

## Participant Services

The Division received 244 comments related to additional limits on services on the Aged and Disabled (AD) and Traumatic Brain Injury (TBI) waivers.

Public comments raised concerns that limits on paid family or live-in caregiver hours could be destabilizing for participants who require continuous or near-continuous support. Commenters indicated that such limits may not align with the needs of individuals with significant support requirements and could create challenges in maintaining stable care arrangements. Some comments also raised questions about potential implications for participant safety, service continuity, and compatibility with applicable labor laws.

Additional comments focused on the proposed cap on waiver services, particularly the rationale for adopting a 150 percent threshold based on a statewide average. Commenters noted that a single statewide benchmark may not fully account for variation in individual needs, especially for participants with complex medical or behavioral support requirements. Questions were also raised regarding the process for identifying and reviewing high-utilization cases, including how reviews would be initiated and how exception or appeal processes would operate, with some commenters expressing concern about the potential for disproportionate impacts on individuals requiring higher levels of support.

### Response:

In response to feedback received during the first round of public comment, the Division removed the originally proposed cap on paid family or live-in caregiver hours. The waiver amendment does not include specific limits on services provided by family members or live-in caregivers.

Instead, the Division included a service limit and utilization review process with exceptions based on a clinical review of the participant's health and safety needs. Participants are limited to no more than 150 percent of the average nursing facility (NF) institutional costs for home and community-based services. This framework supports oversight of high-cost service utilization while maintaining the Department's ability to address participants' health and safety needs and support individuals to live independently in the community.

**Based on public comment, the Division has clarified that exceptions may be approved by the DDD Clinical Team when the participant's need for personal care services, provided by in-home or out-of-home providers, exceeds the 150 percent NF institutional costs and is necessary to support the participant's immediate health and safety needs.**

## Participant Rights

The Division received two comments related to participant rights. These comments expressed concern that the waiver amendment may limit participants' ability to exercise direction over their services. Specifically, commenters noted that Nebraska did not complete Appendix E indicating the use of Self-Direction and indicated that this could be interpreted as limiting participants' ability to hire and dismiss individuals who provide their care.

### **Response:**

The Division appreciates the comments related to participant rights and the use of self-direction. Appendix E was not completed for the Nebraska Aged and Disabled Waiver or Traumatic Brain Injury Waiver because these waivers utilize a modified self-direction approach rather than the formal participant-directed service model described in Appendix E. This is not a change introduced through the proposed waiver amendment. Participants continue to have the right to identify and select appropriate providers and to make informed choices regarding their services and service providers. Participants utilizing Individual-Independent providers are also responsible for the training, scheduling, and direction of their services. Participants may also request assistance with concerns through their Service Coordinator (SC), and they retain the right to appeal decisions or file a formal complaint with the Department.

**The Division will take these comments into consideration for future waiver amendments; however, at this time the Division does not believe additional changes to the proposed waiver language are necessary.**

## Provider Requirements

The Division received seven comments expressing concern regarding the proposed changes to provider requirements in the AD and TBI Waivers. Specifically, commenters raised concerns about the addition of CPR and first aid certification requirements. Commenters noted the potential impact these changes could have on caregivers, including the burden of obtaining and maintaining CPR and first aid certification. Concerns were also expressed about how these requirements might affect the recruitment and retention of staff. Two commenters additionally raised concerns about the removal of fingerprint-based background checks for most services.

### **Response:**

The changes were intended to align the AD and TBI Waivers with standards used across other Medicaid waiver programs. The Division received significant feedback during the first round of public comment regarding the inclusion of fingerprint-based background check requirements. In response to those comments, the requirement for fingerprint-based background checks was removed from the proposed waiver language for most services. However, agency providers are still required to conduct standard background checks for employees and maintain policies governing background screening for direct service staff to ensure no staff person poses a risk to the health and safety of waiver participants. Similar background screening exists for Independent-Individual providers and is conducted by DHHS.

Service Coordinators and resource developers are available to assist individuals and independent providers in identifying local training opportunities, including CPR and first aid certification. In addition, the Department of Health and Human Services will continue to provide free abuse and neglect training as a resource to support providers.

**At this time, the division does not believe additional changes to the proposed waiver language are necessary.**

## Level of Care

The Division received four public comments regarding the Level of Care assessment and methodology. Commenters expressed concerns about the wording and description of the process for Level of Care assessment and reevaluation. Additionally, commenters raised concerns about the timeline for assessments, the transparency of the assessment process, and the overall Level of Care methodology.

### **Response:**

The Level of Care determination used for the waiver is based on the interRAI assessment, which is designed to evaluate the needs, strengths, and preferences of individuals living in community settings. Assessment staff gather accurate and current information through conversations with the participant and, when appropriate, their family members or representatives. Assessors also review additional sources of information, which may include medical records, educational documents, and person-centered plans, to ensure a comprehensive understanding of the participant's needs. The Division is committed to ensuring assessments are conducted accurately and consistently by closely monitoring assessment practices and providing ongoing training and guidance to assessment staff. In addition, built-in quality assurance reviews and monitoring processes are used to support consistent application of the assessment methodology and ensure accurate and objective assessment outcomes.

**At this time, the division does not believe additional changes to the proposed waiver language are necessary.**

## Other Questions and Comments

The Division received 36 additional questions and comments regarding waivers and waiver services that were not directly related to the proposed changes to the AD and TBI Waivers. These comments raised concerns about state funding, electronic visit verification (EVV), the removal of certain services, payment challenges, and the use of respite hours.

### **Response:**

Nebraska's Home and Community-Based Services (HCBS) waivers are funded through a combination of federal and state funds. Providers under the Aged and Disabled (AD) Waiver must comply with requirements from the Centers for Medicare & Medicaid Services related to Electronic Visit Verification (EVV); however, EVV was not part of the waiver revisions open for public comment during this period. Additionally, no services were proposed for removal as part of the AD Waiver renewal or the Traumatic Brain Injury (TBI) Waiver amendment. Respite services are intended to provide temporary care for a participant so the primary caregiver can have relief from ongoing caregiving responsibilities and, consistent with that purpose, respite may not be used to allow the caregiver to attend paid employment or pursue professional development activities.

**The Division will take these comments into consideration when evaluating potential future waiver amendments; however, at this time the Division does not believe additional changes to the proposed waiver language are necessary.**